

Eurohealth

RESEARCH • DEBATE • POLICY • NEWS

Volume 12 Number 3, 2006

French health system reform: Implementation and future challenges



Interview with Xavier
Bertrand, French
Minister of Health

Pharmaceutical and
human resource
policies in France

Hospital reform:
a new era of
public/private
competition?

LSE Health, London School of Economics and Political Science, Houghton Street, London WC2A 2AE, United Kingdom
fax: +44 (0)20 7955 6090
email: eurohealth@lse.ac.uk
www.lse.ac.uk/LSEHealth

Editorial Team

EDITOR:

David McDaid: +44 (0)20 7955 6381
email: d.mcdaid@lse.ac.uk

FOUNDING EDITOR:

Elias Mossialos: +44 (0)20 7955 7564
email: e.a.mossialos@lse.ac.uk

DEPUTY EDITOR:

Sherry Merkur: +44 (0)20 7955 6194
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EDITORIAL BOARD:

Reinhard Busse, Josep Figueras, Walter Holland, Julian Le Grand, Martin McKee, Elias Mossialos

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Paul Belcher: +44 (0)7970 098 940
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DESIGN EDITOR:

Sarah Moncrieff: +44 (0)20 7834 3444
email: westminster.european@btinternet.com

SUBSCRIPTIONS MANAGER

Champa Heidbrink: +44 (0)20 7955 6840
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Published by LSE Health 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.

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

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

Printing: Optichrome Ltd

ISSN 1356-1030

LSE Health

C O M M E N T

Plus ça change.....?

Plus ça change, plus c'est la même chose – the more things change, the more they stay the same! All too often this can be said of health care reform. It is apt therefore, that much of this issue of Eurohealth is devoted to the French health system. Zeynep Or, Chantal Cases and colleagues at the Institute for Research and Information on Health Economics (IRDES) in Paris have brought together contributions describing and reflecting on the consequences of major reforms enacted in 2004. We are especially delighted to feature an interview with Xavier Bertrand, French Minister of Health.

Previously ranked by WHO as the best performer, the French health system is not without problems. It has traditionally operated with little regard to efficiency or cost containment. It has the highest rate of pharmaceutical use in the EU, while, until recently at least, there has been little attempt to incorporate cost effectiveness into policy making. The health workforce is ageing; geographical inequalities in access to services exist. Moreover, promotion and prevention have not been high priorities.

The 2004 reforms make use of economic incentives to influence the behaviour of health professionals and the public. These include a system of gate keeping for primary care, activity-based payments and managerial freedom in hospitals, incentives to use generic drugs, support for general practice training and investment in public health campaigns.

Will the reforms lead to sustainable change? Will the French experience be of relevance elsewhere in Europe? In truth, it is too early to say, but the initial signs are encouraging. According to M. Bertrand, for the first time in ten years the Statutory Health Insurance has stayed within expenditure limits. The potential to realise greater savings while still investing in high quality innovative therapies remains strong. It is to be hoped in a few years, when speaking of the reforms we might be able to say *plus ça change, plus c'est la différence!*

David McDaid *Editor*
Sherry Merkur *Deputy Editor*

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Michael W Adler is Professor Emeritus of Genitourinary Medicine, Centre for Sexual Health & HIV Research, Royal Free & University College Medical School, University College London, UK.

Yvon Berland is Professor of Medicine and President of the French National Observatory of Health Professions.

Xavier Bertrand is the Minister of Health, France.

Yann Bourgueil is a Research Director, Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France.

Chantal Cases is Director, Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France.

Isabelle Durand-Zaleski is Head of Department at the Department of Public Health, APHP hôpital Henri Mondor, Paris, France.

Anne-Maree Farrell is Lecturer, School of Law, University of Manchester, Manchester, UK.

Carine Franc is a Researcher at the Institut National de la Santé et de Recherche Médicale and the Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France.

Jack Friedman is a Post Doctoral Fellow, Department of Comparative Human Development, University of Chicago, Illinois, USA.

Nathalie Grandfils is a Research Fellow, Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France.

Melanie Lisac is Project Manager, International Network Health Policy & Reform Coordinator, Bertelsmann Stiftung, Gütersloh, Germany.

Anna Melke is a former journalist and currently a PhD candidate, School of Public Administration, University of Göteborg, Sweden.

Robert Mendelsohn is Edwin Weyerhaeuser Davis Professor, Professor of Economics, and Professor in the School of Management, Yale School of Forestry and Environmental Studies, New Haven, Connecticut, USA.

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Philipa Mladovsky is a Research Assistant at LSE Health, London School of Economics and Political Science, UK.

Zeynep Or is Senior Economist, Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France.

Dominique Polton is Director of Strategic Research and Development, Caisse Nationale d'Assurance Maladie, Paris, France.

Gérard de Pourville is Research Director, Centre National de la Recherche Scientifique and also at Institut National de la Santé et de Recherche Médicale, Paris, France.

Caroline Rudisill is a Research Assistant at LSE Health, London School of Economics and Political Science, UK.

Catherine Sermet is a Research Director, Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France.

Sophia Schlette is Project Director, International Network Health Policy & Reform Coordinator, Bertelsmann Stiftung, Gütersloh, Germany.

Eurohealth in perspective

Objectives

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

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

Backed by experts

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

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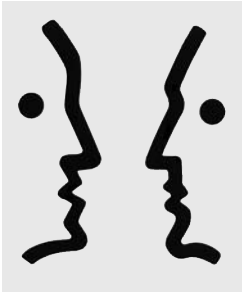
We very much value your continued feedback and suggestions on future topics and potential contributions. These can be sent in the first instance to the Editor, David McDaid at d.mcdaid@lse.ac.uk

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Debate:

Can adaptation reduce the health effects from climate change?



Summary: This article argues that much of the available literature on the impact of climate change on health has grossly overestimated the likely effects by persistently ignoring the potential of adaptation to reduce actual negative health outcomes. Specific examples are provided for malaria and heat stress. Spending resources on adapting to climate change, helping individuals avoid diseases and providing medical protection (such as vaccines) can all be effective measures in reducing the risk of climate change related illness.

Key words: Climate change, Public health, Adaptation, Malaria, Heat stress,

Robert Mendelsohn

There are many predicted damages associated with climate change but one of the

most salient and difficult to weigh is the potential loss of health.¹ Scientists predict that there are many mechanisms that might lead to future mortality and morbidity.² Infectious diseases may increase as warming increases the territory of dangerous vectors such as mosquitoes or tsetse flies. Heat waves could kill unsuspecting citizens. Concentrations of ozone could increase. There could be malnutrition, fish and shellfish poisoning, stress from migration, and more frequent or severe floods, droughts and storms.

Although the numbers of potential deaths and illnesses from climate change are uncertain, estimates in the literature are frequently large. For example, a 2.5°C warming is predicted to cause 137,000 potential deaths per year.³ A doubling of carbon dioxide (CO₂) may cause 360–520 million cases of malaria.⁴ Health damages reported for the US alone range from \$9 to \$69 billion,¹ out of total climate change damages of between \$61 and \$139 billion. The literature gives the

impression that human health is one of the primary reasons to curb greenhouse gas emissions.

This article argues that the climate health literature has grossly overestimated the likely health effects from climate change by persistently ignoring the potential of adaptation to reduce actual negative health outcomes. Victims are likely to take measures to avoid future risks, for example by reducing exercise in the heat of the day or by avoiding mosquito bites with netting. Public health organisations can take important measures to reduce the spread of infectious diseases by spraying mosquitoes or inoculating people against potential diseases. The result of all of these adaptations is that the actual number of people that will die or become ill from climate change may be quite small. Greenhouse gases are not likely to cause the large ‘potential’ increases in future morbidity and mortality predicted by the literature.

Two important mechanisms where the links between climate and health have been quantified are reviewed: malaria and heat stress. In both cases the potential threat and plausible adaptation response are discussed in detail and the article concludes with a discussion of the policy ramifications of these arguments.

Vector-borne diseases

There are many infectious diseases that may be climate sensitive because they depend on an ecological vector (mosquitoes, flies, snails) to spread.² If climate conditions change, the geographic domain of that vector may change as well. The disease may be able to spread to new territories where the local population represent ‘potential’ new cases.

Two of the most prominent infectious diseases that have a clear link with climate are malaria and dengue fever.² Both diseases depend on mosquitoes which have very specific climatic ranges. For example, malaria is caused by the pathogen *Plasmodium falciparum* and *Plasmodium vivax*. These pathogens are transmitted by the Anopheles mosquito, which requires minimum temperatures of 20°C for breeding. Furthermore, the breeding season must be long enough to allow the pathogen to come to maturity. As temperatures warm, currently cool wet places become potential new infection zones. For a specific climate scenario, researchers count the number of people who live in these new zones in order to estimate the number of potential new cases. Using this approach, it was estimated that climate change could cause between 360 to 520 million new potential malaria cases by 2100 depending on the

Robert Mendelsohn is Edwin Weyerhaeuser Davis Professor, Professor of Economics, and Professor in the School of Management, Yale School of Forestry and Environmental Studies, New Haven, Connecticut, USA.

Email: robert.mendelsohn@yale.edu

Do you disagree? Eurohealth would like to invite your responses to this article. If you are interested in presenting an alternative perspective please send a brief outline of your proposed argument to Sherry Merkur at s.m.merkur@lse.ac.uk

future climate scenario.⁴

This estimation assumes that there is no adaptation. Individuals make no attempt to avoid the illness and governments and non-profit organisations do nothing to slow the vector or disease. In practice, however, individuals, non-profit organisations and governments are likely to respond to new health threats. Individuals can avoid being bitten by reducing outdoor activity at times of the day when mosquitoes bite or by wearing protective clothing. Individuals can also install mosquito nets to keep these insects from indoor locations. Governments can spray areas with high infection rates to reduce mosquito populations and they, together with non-profit organisations, may invest in vaccines that protect populations from a disease. Health care organisations can treat diseases when they occur to lessen their impact. All of these responses can reduce the effect of vector borne diseases, most specifically malaria.

For example, yellow fever is caused by a virus that is transmitted by mosquitoes, the *Aedes aegypti*. Climate change could increase the number of potential cases of yellow fever as the geographic range of the *Aedes aegypti* increases.⁵ However, there is a vaccine that limits yellow fever. Furthermore, infected countries have initiated mosquito controls in places where yellow fever once was rampant. As a result, yellow fever is largely under control, even in developing countries.

Controlling malaria is more than just a possibility. Current climate conditions allow malaria to exist in many countries including parts of Europe and the United States. The Lewis and Clark expedition at the beginning of the nineteenth century reported malaria along the Ohio River. However, health controls such as those listed above have largely wiped malaria out of these wealthy countries. In fact, there are virtually no malaria cases in any country with a per capita income greater than \$3,100.⁶ As development increases incomes over the next century, few countries will remain below this critical minimum income.

Heat stress

Daily mortality has been linked with heat waves in temperate climates.^{7,8} Heat waves are short periods of unusually high temperatures. The literature has noted that daily mortality rates climb during these events, for example, in 1995 a heat wave in Chicago killed 514 people⁹ while

another in London increased mortality by 15% that same year.¹⁰ Heat waves have most impact on older people and seem to affect cities more than rural areas.^{8,10}

Although developing countries may be particularly vulnerable to heat waves, the bulk of the current evidence comes from studies in developed countries. Some authors speculate that global warming will cause additional mortalities from heat waves.^{2,11} They argue that future warming will increase the magnitude and severity of heat waves. In the absence of any adaptation, this prediction might be reasonable; however, there are a number of adaptations that individuals can make. First, over several years, they can become physically acclimatised,¹¹ that is, their bodies will adjust to higher temperatures making them less vulnerable. Second, vulnerable individuals can adjust their activity schedules to avoid the hottest times of the day. Many cultures in warm climates, for example, take siestas during early afternoon. Third, building structures can be changed to reduce heat build-up and increase air conditioning. Because people do take these precautions as the risk increases, the threshold temperature where one begins to see heat related mortality increases in warmer locations.² Therefore, the actual number of heat related deaths from global warming is likely to be quite small.

Conclusion

Literature predicting the number of potential poor health cases arising from climate change conspicuously avoids incorporating adaptation. The resulting 'potential' numbers of cases of illness and death grossly overestimate the numbers that are likely to occur. If adaptation was factored into future predictions, the actual number of new cases of illness and premature mortality is likely to be much smaller than the literature now predicts.

The emphasis of the literature on potential cases rather than likely cases has distorted climate change policy. Because of these large numbers, human health effects are often cited as one of the primary reasons to control greenhouse gases.¹³ However, if the actual number of health cases is small and abatement quite costly, abating greenhouse gases may be a very poor strategy for protecting human health. Abating more traditional pollutants such as small particulates, sulphur dioxide, ammonia and nitrogen oxides

would likely generate greater health benefits per ton than controlling greenhouse gases.

In contrast, spending resources on adapting to climate change may be a very effective way to protect human health. Limiting harmful vectors, helping individuals avoid diseases, and providing medical protection (such as vaccines) can be effective measures to reduce the risk of climate change related illness. Once these diseases are under control, the impact from climate change will likely be minimal. Furthermore, the abatement programme has the added benefit of preventing millions of cases of illness today rather than only at the end of the century.

Another important but broader abatement strategy is simply development. As per capita incomes rise, individuals and societies can afford to take measures to reduce health risks on their own. The near absence of malaria in countries with incomes over \$3,100 is a stark case for the influence of anti-poverty programmes. Clearly, as incomes rise, other potential concerns, such as having adequate resources to purchase food, will also disappear.

Scientists concerned about the link between health and climate should focus more attention on how society can manage the environment and health services in order to reduce health effects. Rather than exaggerating the threat of climate change, the most important task is to bring infectious diseases and other concerns under control so that they are no longer a threat today or in the future. Health analysts need to take adaptation seriously and begin to develop practical plans to limit the health impacts of climate change.

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Sexually transmitted infections in Europe

Michael W Adler

Summary: Sexually Transmitted Infections (STIs) present a major public health problem with far reaching health, social and economic consequences. This review is limited to three important STIs seen in the European Union (EU) – chlamydial and gonococcal infections and syphilis. It looks at epidemiological trends, reports consequences and costs, and sets out principles for the effective control of STIs. The extent to which both services and notification systems have been developed varies throughout the EU; however, the EU can identify and endorse common principles that it would wish to see applied, as well developing a programme of collaborative work.

Keywords: Sexually transmitted infections, Public health, Gonorrhoea, Chlamydia, Syphilis, Europe

Introduction

Sexually Transmitted Infections (STIs) present a major public health problem and are common causes of illness and death in the world with far reaching health, social and economic consequences.^{1–2} Failure to diagnose and treat the more traditional infections, such as gonorrhoea, chlamydia and syphilis, can often have a deleterious effect on pregnancy and the new born, e.g., miscarriage, prematurity, congenital and neonatal infections and blindness. Other complications and sequelae, particularly in women, such as pelvic inflammatory disease, ectopic pregnancy, infertility and cervical cancer are large health and social problems. The majority of infections with the human immunodeficiency virus (HIV) are acquired through the sexual route. Also, it is important to realise that the presence of an STI, particularly genital ulcer disease, but also genital discharges, can enhance both the acquisition and transmission of HIV.

The facts and size of the problem

This short review will be limited to three important STIs seen in the European

Union (EU) – chlamydial and gonococcal infections and syphilis. Other infections such as genital warts and herpes are not covered here, but the trends are similar to the three diseases to be discussed. Also, not all countries are reviewed since clear trends can be seen from those selected, or adequate data is not available.

Surveillance and services

The availability of services and surveillance/notification systems vary between European countries and will thus affect our understanding of the epidemiology.³ There is no comprehensive information and surveillance system or uniform service provision within the EU. However, the United Kingdom has had a free and confidential network of clinics since 1918. These clinics are run by specialists, who provide regular statistical returns of cases seen and diagnoses to the Health Protection Agency. These data do not cover cases diagnosed outside clinics, for example, within primary care. Despite this, the UK surveillance system is considered to be one of the best in Europe. In contrast, many other European countries do not have specialists in STIs or dedicated clinics. For example, patients may be seen privately, by dermato-venerologists or in primary care. Notification is often voluntary and incomplete.

These differences in service provision and capture of the data make it difficult and

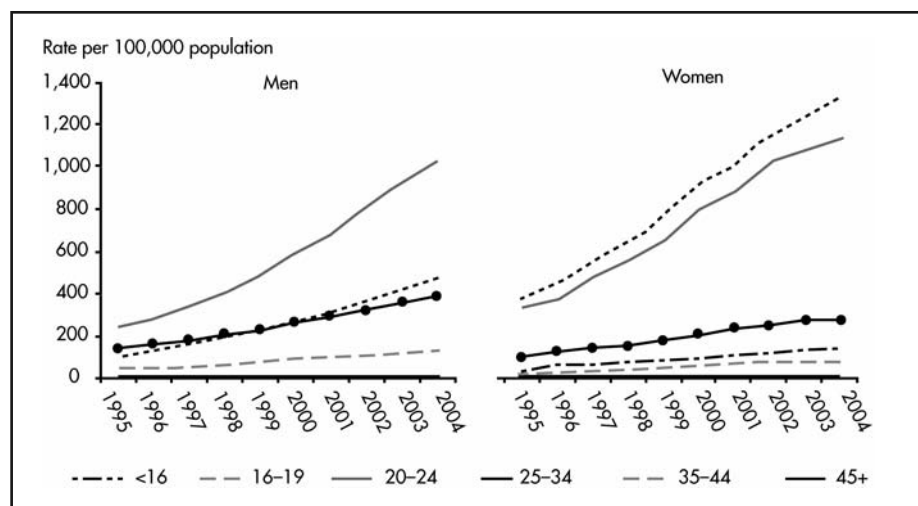
Michael W Adler is Professor Emeritus of Genitourinary Medicine, Centre for Sexual Health & HIV Research, Royal Free & University College Medical School, University College London, UK. Email: MADler@gum.ucl.ac.uk

Table 1: Number of cases of gonorrhoea – selected European countries

Country/Year	1995	2000	2001	2002	2003	2004	% increase last decade
Belgium	130	145	241	289	304	321	(146%)
Denmark	287	335	304	230	186	414	(44%)
Ireland	91	290	349	214	186	–	(104%)
Sweden	246	590	529	505	596	569	(131%)
United Kingdom	10,598	20,520	–	24,958	24,157	24,157	(128%)
Azerbaijan	2,039	952	–	–	–	2,580	–
Belarus	16,963	9,887	–	–	5,757	–	–
Estonia	2882	867	–	–	532	–	–

Table 2: Number of cases of chlamydia – selected European countries

Country/Year	2000	2001	2002	2003	2004
Belgium	689	790	1,064	1,468	1,653
Finland	11,731	12,142	13,681	–	–
United Kingdom	63,037	–	82,206	89,431	–
Azerbaijan	1,344	–	262	–	95
Belarus	7,991	12,187	13,248	17,548	–
Estonia	3,805	4,187	4,107	2,094	–

Figure 1: Rates of genital chlamydial infections by sex and age group

Data sources: KC60 and STISS/ISD(D)5 returns from Genito-Urinary Medicine (GUM) clinics, United Kingdom.

unwise to compare numbers and rates of STIs between countries within the EU. At best the data gives some indication of trends within countries.⁴

Gonorrhoea

In the early to mid 1970s most European countries saw a peak in cases of gonorrhoea. It is thought that the advent of HIV infection in 1980 led to safer sex and accelerated the reduction in gonorrhoea. However, this has not been sustained in all countries.

Since the mid 1990s, most countries have seen an increase in gonorrhoea rates and numbers of cases (Table 1). For example, Belgium, Denmark, Ireland, Sweden and the UK have shown substantial increases over the last decade of 146%, 44%, 104%, 131% and 128% respectively. The data from Eastern Europe are often incomplete and difficult to interpret in relation to trends. Rates of gonorrhoea vary with age, sexual orientation and social deprivation. In the UK the highest rate of gonorrhoea in men are seen in those aged 20–24 years and in women 16–19 years of age.

Chlamydial infection

In most countries, genital chlamydial infection is the commonest diagnosed STI with very marked increases (Table 2). This increase reflects changing sexual behaviour and increased partner change. However, of importance is that fact that some countries are implementing national screening programmes and using non-invasive, more acceptable urinary based assays, which will give rise to an increased prevalence but not necessarily incidence, even though most experts feel that both are occurring. As with gonococcal infections, the young are disproportionately affected (Figure 1). In other countries, particularly Denmark and Norway good laboratory notification systems are in place, which also show considerable increases over the last decade.

Syphilis

Syphilis was a major problem during the first half of the 20th century, but declined dramatically with the wide-scale use and availability of penicillin in the late 1940s and 1950s. In many EU countries it virtually disappeared in the late 1980s and mid 1990s, but now most countries are showing an increase, particularly in men who have sex with men (Table 3, Figure 2).

Consequences and cost

Complications are costly to both the country and the individual. For example,

between 10–40% of patients with chlamydial trachomatis infections develop pelvic inflammatory disease (PID) and some go on to experience ectopic pregnancy and infertility.^{5–6} Swedish data suggests that women who had a history of PID were six times more likely to have an ectopic pregnancy and fourteen times more likely to have tubal factor infertility than women without evidence of PID.⁷ The number of cases of PID are probably increasing in the EU, but the actual data are not easily available. This occurs because the clinical diagnosis is often inaccurate and usually only hospitalised cases are notified.⁸

Infertility can often be associated with chlamydial and gonococcal infections. Fertility rates in the 25 countries of the EU have been steadily declining since the 1960s – from 2.59 (1960) to 1.88 (1980) to 1.46 (2002) (Table 4). This may be partly due to the increase in the two infections mentioned but no good data exists within countries showing this direct correlation. It should be recognised that other causes of infertility also exist.

The financial costs of PID are considerable. For example, the costs of subfertility services in the UK could be £75 million per year but the economic impact has never been actually been studied.⁹ In the United States, direct and indirect costs associated with PID and its sequelae were estimated at over \$4.2 billion in 1990 and were anticipated to exceed \$10 billion by 2000.¹⁰

Why are STIs increasing?

Further policy and strategic decisions should be based on an understanding of why STIs are increasing in the way described. Like many socio-medical conditions, for example, suicide, alcoholism, cancer and heart disease the explanation for the increases are multi-factorial some of which are:

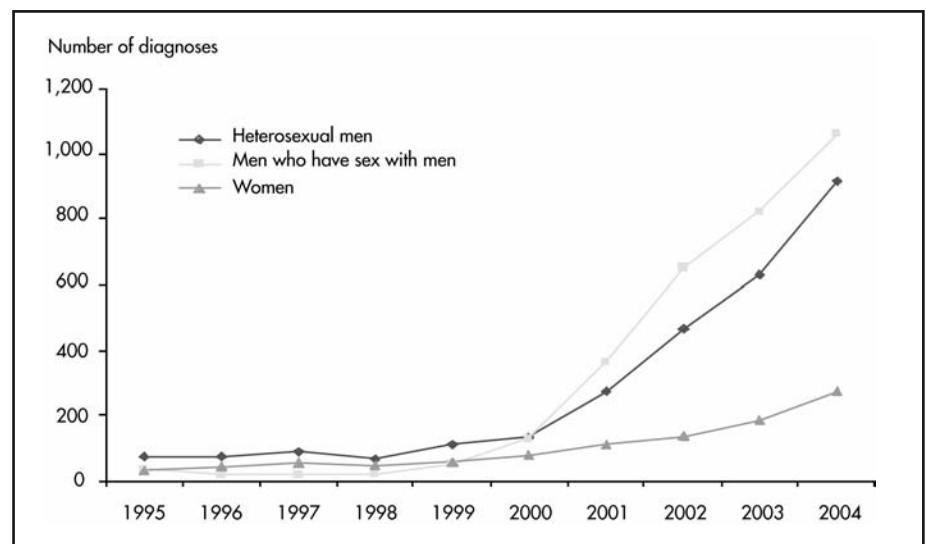
Attitudes towards sex and sexual behaviour – declining age of first intercourse; increasing number of lifetime partners; increasing number of individuals having concurrent partnerships; increasing proportion of men who have ever had a homosexual partner; and increasing unsafe sex.

Social/economic – populations are now more mobile nationally and internationally; tourism has increased with visitors to areas of the world with particularly active prostitution and high levels of

Table 3: Number of cases of chlamydia – selected European countries

Country/Year	2000	2001	2002	2003	2004
Belgium	25	271	204	300	302
Denmark	54	51	35	79	114
Finland	204	159	128	138	–
Ireland	46	279	303	235	–
Sweden	99	78	128	178	194
United Kingdom	1,784	–	–	–	2,254
Azerbaijan	512	–	–	–	282
Belarus	10,527	–	–	4,810	–

Figure 2: Diagnosis of syphilis (primary and secondary) by exposure category



Data sources: KC60 and STISS/ISD(D)5 returns from GUM clinics, United Kingdom.

Table 4: Fertility rates in Europe

	1960	1970	1980	1990	2000	2002
EU-25	2.59	2.34	1.88	1.64	1.48	1.46
EU-15	2.59	2.38	1.82	1.57	1.50	1.50

STIs and HIV; certain groups (professional travellers, armed forces and immigrants) are at risk – they are separated from their families and social restraints; poverty, urbanisation, war and social migration often result in increased levels of prosti-

tution; and stigma within a society can isolate individuals so that they do not seek out appropriate health promotion, information and services.

Structural – a failure to provide adequate services and partner notification will result

in an increase in STIs; paradoxically the introduction of good services will appear to lead to an apparent increase in STIs as more people are diagnosed.

Strategic and policy implications for the control of STIs

A set of principles can be established for effective control of STIs:

Reduce infectiousness of STIs – i.e. using condoms

Reduce duration of infection – Encourage diagnosis and treatment of symptomatic infection, such as encouraging health seeking behaviour and asymptomatic infection screening, partner notification and targeted treatment.

Reduce risky behaviour – reduce the rate of partner change; delay onset of sexual intercourse; improve selection of partners.

These principles are usually classified as primary and secondary prevention. Primary prevention aims to keep individuals uninfected. These include: behavioural interventions that are aimed at enhancing knowledge, skills, and attitudes to help people protect themselves against infection, for example, health promotion to decrease partner change and increase condom use; structural interventions that are aimed at broader societal and economic issues that drive the spread of STIs; and biomedical interventions including condoms, vaccines, vaginal microbicides, or male circumcision to prevent the acquisition of infection. Secondary prevention aims to reduce the risk of individuals infected with an STI transmitting onwards. Secondary prevention works to enhance health seeking behaviour; improve access to diagnosis and treatment; ensure appropriate case management early detection and treatment of symptomatic and asymptomatic infection; and encourage partner notification (contact tracing).

Supporting primary and secondary prevention

The implementation of effective control programmes requires underpinning with support components. These include: (i) training for health care workers and educators; (ii) laboratory services in place to support clinical services. At least one reference laboratory should be developed in every country to allow for quality control and analysis of referred specimens; and (iii) information systems or surveillance should be implemented together, such as epidemiological data for magnitude

and trend assessments to provide data for programme planning and monitoring. Various surveillance methods can be used, such as clinical notification, laboratory notification, sentinel sites surveillance (either of syndromes or of aetiological diagnosis), prevalence studies in specific population groups and aetiological surveys in patients.

What is the role for the European Union?

Each country will develop its own approach to control of STIs. The extent to which both services and notification systems have been developed varies throughout the EU; however, the EU can identify and endorse common principles that it would wish to see applied as well as having a programme of collaborative work. Thus, it is essential that the following are in place:

- Effective sex and health education / promotion starting in schools with uniform syllabus
- Condom availability
- Services for the diagnosis and treatment of STIs and partner notification run by those with specialist knowledge
- Screening programmes: consideration to be given to national or opportunistic screening programmes, for example, chlamydia
- Training of those providing services
- Surveillance/notification in place to monitor/control programmes and trends
- Effective research programmes: laboratory, behavioural, clinical and epidemiological

Therefore, the EU has a role in many aspects of addressing the increasing challenge of STIs, such as making best practice in all of above available to all countries; encouraging training for health care workers through the use of experts in the field of STIs in the countries; developing basic, applied and behavioural research within countries and encouraging the exchange of workers throughout the EU to share expertise and knowledge; as well as encouraging and facilitating a uniform dataset and basic surveillance system for STIs throughout the EU.

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This article was prepared based on a policy brief prepared for the European Commission, DG Employment and Social Affairs, under the project Health Status and Living Conditions (VC/2004/465).

Obesity-control policies in Europe

Philipa Mladovsky and Caroline Rudisill

Summary: Worsening diets and rising levels of physical inactivity have contributed to Europe's obesity prevalence reaching epidemic proportions. This has resulted in a range of policy actions at the international, EU and national levels. Yet coordination across EU countries remains underdeveloped. Improved evidence on effectiveness and cost effectiveness of obesity prevention programmes, harmonisation of data and a stronger focus on obesity in children all merit greater attention.

Keywords: Obesity policy, Europe, Evidence

Obesity prevalence in the World Health Organization European Region has now reached epidemic proportions having tripled over the last two decades.¹ Between 10–27% of men and 10–38% of women in the European Union are obese, compared to the United States where obesity has reached 28% of men and 34% of women. In fact, Cyprus, the Czech Republic, Finland, Germany, Greece and Malta have a higher proportion of overweight individuals in their populations than the United States.² Diabetes, cardiovascular diseases and certain forms of cancer are some of the conditions associated with overweight and obese individuals.

Europe's growing prevalence rates of overweight children is of particular concern. England and Poland display the sharpest rates of increase over the last twenty years.² Childhood obesity creates particular health concerns not only because 50–75% of overweight or obese children will remain obese in adulthood,³ but also because they show early signs of 'diseases of old age', such as type 2 diabetes.²

These alarming trends highlight the need for immediate policy interventions and strategies to curb the rise in obesity and prevent associated chronic diseases.

Philipa Mladovsky and Caroline Rudisill are Research Assistants at LSE Health, London School of Economics and Political Science, UK.

Email: p.mladovsky@lse.ac.uk

Without further action, an estimated 150 million adults (20% of the population) and 15 million children and adolescents (10% of the population) in the WHO European Region will be obese by 2010.¹

“need for immediate policy interventions and strategies to curb the rise in obesity”

Public health experts lay the blame for this phenomenon partly on a 'snacking' culture and the more general consumption of foods and drinks with high calorific content. They point to the replacement of the traditional 'family meal' with a fast food culture where individuals consume foods of less nutritional value that are also high in fat, salt and calorific content. Children can be nutritionally disadvantaged at an early age. The regulation of school meals may be weak; caterers usually have few incentives to provide healthy options. Meanwhile, many schools raise additional revenue through site based vending machines selling sweets and sugary drinks to pupils.

Changes in diets are but one factor, another is the reduction in physical activity seen in most of Europe. Increased automation in the workplace and at home has reduced the need for physical labour. Moreover, individuals may walk or cycle to work and school much less than in the past, while there may be financial incentives to sell 'brownfield' school sports fields for urban development projects. While the importance of diet and physical activity cannot be stressed enough, it should also be acknowledged that genetic predisposition and ethnicity as well as socioeconomic factors such as income and education level will have a substantial impact on the risk of obesity for any one individual.

Economic impact

In addition to profound adverse long-term health consequences, there is also a substantial economic burden. Specifically, this includes health and social care system costs due to increased use of primary and secondary health care services as well as long-term care. These are however far outweighed by the costs of long-term absence and premature retirement from the labour market due to increased morbidity and mortality. The LipGene project (<http://www.lipgene.tcd.ie>) reviewed recent obesity trends in the EU-15, finding

This article is based on a section of the 2006 report 'Health Status and Living Conditions in an Enlarged Europe' prepared for the European Commission, DG Employment and Social Affairs, under the European Observatory on the Social Situation.

that in 2002 at least half had obesity levels greater than 20% among men and women, with total annual costs of €32.8 billion.⁴ Interventions to combat obesity cost a fraction of this. For example, an EU-wide subsidy to reduce the market price of meat and dairy products that have a better fatty acid profile would cost approximately one third of the total costs of obesity.⁴ This analysis is of course somewhat simplistic and it is crucial to determine whether such interventions actually work before any major investment.

European and international obesity policy

The scale of the obesity epidemic has resulted in a range of actions at the international, European and national levels. WHO has adopted a broad-ranging approach to obesity through its Global Strategy on Diet, Physical Activity and Health.⁵ This fosters the formulation and promotion of national policies, strategies and actions to improve diet and encourage physical activity. WHO also issues recommendations on many related issues including consumer information, marketing to children, agricultural policies, food production, taxation, subsidies and direct pricing, transport, physical education and nutrition in schools, and incentives to encourage preventive health services. To implement these recommendations, WHO further recommends the establishment of national coordinating mechanisms as well as multi-sectoral and multi-disciplinary expert advisory boards with close local involvement. It also advocates continuous monitoring of major risk factors and further research, especially through community-based demonstration projects and policy evaluation.

European level actions

The importance of coordinated action at an EU-level was recognised in the publication by the European Commission (EC) of a consultative Green Paper on obesity in 2005.⁶ The paper noted the potential for industry self-regulation of the marketing of foods high in fat and sugar as well as the importance of clear communication of the links between diet and risk of disease. The consultation invited the opinions of all stakeholders on such issues as how best to incorporate healthy diets and physical activity into the workplace; ways to better integrate public health campaigns against obesity with health care service actions; and methods to reduce differences in obesity inducing lifestyles across socio-

economic groups.

Responses to the consultation included those of governments, public health institutions, industry, academia and the general public and were published in September 2006. Many responses called for an increasingly multi-sectoral approach, with greater coordination amongst EU countries in setting guidelines and making use of evidence-based findings. They also highlighted the need to focus on child and youth obesity as well as clearer, evidence-based nutrition information for the public. The EC approach and the responses from stakeholders reinforced many WHO recommendations, but the continued investment in the EU Common Agricultural Policy, which generously subsidises the production and consumption of animal fat, tobacco and wine in contrast to healthy fruit and vegetables, clearly does not concur with WHO recommendations.

“Many national policies identify the private sector as the key partner in influencing dietary behaviour”

Europe-wide actions include the WHO European Ministerial Conference on Counteracting Obesity, that took place in Istanbul, in November 2006. At the conference representatives of EU Member States, together with the WHO Regional Office for Europe, adopted a European Charter on Counteracting Obesity.⁷ It aims to give policy guidance and provide a strategic framework for strengthening action on obesity throughout Europe. The draft Charter will be discussed and submitted for adoption by Member States at the conference.

National level actions

At the national level, there has been renewed attention for obesity. Belgium, Bulgaria, the Czech Republic, Denmark, Germany, Ireland, Latvia, Spain, Turkey and the United Kingdom have all established specific policies, programmes or published recommendations aimed at reducing obesity in the last three years. The Nordic countries (Denmark, Finland,

Iceland, Norway and Sweden) have also put into action a joint policy on obesity.⁸ Several countries, including the Nordic states, have set quantitative targets for obesity control programmes, while others use aspirational targets. Many recognise that monitoring systems, as well as buy-in at the regional and local level, are needed to meet such targets.

Most national policies are multi-sectoral, reflecting the diverse causes of obesity. They involve the health and education sectors in addition to the food industry. For example, the 2005 Belgian National Food and Health Plan, launched by the Federal Minister of Social Affairs and Public Health, was developed in partnership with many stakeholders including the food industry, consumer groups, patient organisations, health professionals and scientists. The Plan includes a media campaign, national food guide, school meal regulations, professional education for the food and hospitality industries, implementation of a national policy promoting breast feeding, increased use of ionised salt, the appointment of food committees in hospitals and further scientific research on nutrition and dietary behaviour.

Many national policies identify the private sector as the key partner in influencing dietary behaviour. For example, as part of the Spanish 2005 National Strategy for Nutrition, Physical Activity and Prevention of Obesity, the private sector signed six partnership agreements with government. This brought together governmental partners from the Ministries of Health and Consumer Affairs, Agriculture, Fisheries and Food, and Industry, as well as the governments of the seventeen Autonomous Communities, with representatives of the food, hotel and catering industries.

What do we know about the effectiveness of obesity policies?

Obesity treatment studies have yielded some evidence to inform policy aimed at curbing the epidemic. Evidence on the use of surgical, pharmacological and lifestyle-based interventions (including counselling and behavioural therapy) to treat adult excess weight and obesity suggest only moderate weight loss.⁹ Mechanisms of greater importance in the uptake of interventions, such as building doctor-patient trust, prove more difficult to measure.¹⁰ The effectiveness of fiscal instruments such as pricing policies, taxes and subsidies

require careful evaluation. The limited available evidence provides only tenuous support for a cause-and-effect relationship between such interventions and changes in the consumption of unhealthy foods. Some of the limitations relate to an inability to demonstrate causality, while others concern the difficulty of generalising findings from one or more studies to different national or regional settings in Europe.¹¹

Research on the treatment and prevention of obesity in children is particularly limited and what is conducted is often poor in quality.⁸ Some of the difficulties identified in monitoring the impact of childhood obesity programmes in Europe can apply equally to adult focused interventions including small sample sizes, limited longitudinal data, a continued reliance on US-tested approaches and variation in data collection methods used across countries.¹²

Policy recommendations to decrease obesity prevalence

To sum up, the evidence to inform clinical and public health interventions to control obesity is still emerging.⁹ Notwithstanding the recent attention to the issue at the EU-level, the means for coordinating obesity policy amongst EU Member States also remains underdeveloped. Useful lessons might also be drawn from other areas of public health where successful measures to influence behaviour have been introduced, most notably tobacco control.¹³ There are many areas for action; four areas that would benefit from urgent attention are highlighted.

1. Evidence on effectiveness and cost effectiveness of obesity prevention

Policies have focused on food marketing regulations, an endeavour that the food, drink, vending and advertising industries have resisted. Additional research is needed on how voluntary self-regulation by these stakeholders might compare with mandatory measures in influencing eating behaviours. Moreover, the role of new methods of communication, such as the internet and the mobile phone, require greater understanding.

2. Harmonisation of data

Greater harmonisation in data methods may improve trans-national evaluation of policy and programmes.

3. EU-wide policy development

EU-wide policy holds a particularly

important place because of the trans-national nature of some key factors, including the food industry. Careful development of EU-wide policies in areas of competence are well merited.

“as many as three quarters of all overweight or obese children will become overweight or obese adults”

4. Greater focus on obesity in children

We noted that as many as three quarters of all overweight or obese children will become overweight or obese adults, thus the problem of childhood obesity requires particularly urgent attention. Actions targeted specifically at children need to be implemented and evaluated. One step would be to set guidelines on appropriate nutrition and physical activity targets. Countries could also curtail advertising targeting children and support more active methods of transportation through the development of dedicated cycle networks which are safe from the hazards of motor vehicles. Public health campaigns could focus on providing health-related information direct to children, while the education sector might encourage the introduction of health promotion education into the school curriculum.

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French health system reform: recent implementation and future challenges

Chantal Cases

Summary: This article provides a brief overview and an introduction to several contributions in this issue on recent reforms within the French health system. While the initial results appear promising, more questions than answers remain as to the long term impact of reform measures. One less obvious, but critical element for the success of the reforms, is the need for robust information systems.

Keywords: France, Health policy, Health reform

The French health system has some strong characteristics: a satisfactory level of access to care and service utilisation, an abundant availability of choice without any significant waiting lists and a high level of life expectancy. Indeed, the World Health Report 2000 ranked France as having the best health care system in the world.¹ Yet, not many people in France took particular pride in this ranking despite a general recognition of the distinctive role played by the mixed public and private system.

The health system faces numerous challenges, many of which are common to neighbouring countries. First, health expenditures continue to increase, leading to sizeable budget deficits for the social security fund. Second, there will likely be a significant decrease in the number of doctors per head of the population in the near future. Coupled with the persistent unequal distribution in existing medical professionals across the country, this could create tensions in respect of the supply of care, as equal access to care remains a core system objective. The ageing of the population also contributes to uncertainties over future health care workforce needs. Third, given the excessively high rates of mortality in those under 65, there is an urgent need to develop preventive actions within a coherent public health framework. Last, but not least, the

continuous need, to not only maintain, but also improve the quality of care and ensure access to innovative medicines, remain major challenges for the health authorities.

Major reform

To tackle these challenges, several major reforms have been introduced from summer 2004. In August of that year, two laws were adopted: the Public Health Policy Act and the Health Insurance Reform Act, followed in 2005 by new agreements between the national health insurance funds and medical trade unions on rules governing private practice. A year before, 'hôpital 2007' aiming to reform the hospital sector had been launched and the Social Security Act also was revised to implement new rules on funding hospital patient care. In January 2006, a new strategic plan was also introduced to foster health workforce development, reinforcing measures announced in previous years.

This issue of *Eurohealth* contains a number of articles reflecting on some key dimensions* of those recent reforms which have significantly altered the governance and regulation of the health system. In an interview, Xavier Bertrand, our Minister of Health, discusses some of the major strengths and weakness of the French health system, the rationale for the latest reforms, their initial results and future prospects. Isabelle Durand-Zaleski looks at both the Public Health Policy and the

Health Insurance Reform Acts, questioning priority setting for health care, while Carine Franc and Dominique Polton comment on the evolution of French health insurance governance. Gérard de Pourville and Zeynep Or present developments in hospital reform and set out the key issues that need to be resolved if success is to be achieved. Regulation of the pharmaceutical sector, a major driver of health care costs, is analysed by Nathalie Grandfils and Catherine Sermet, while Yvon Berland and Yann Bourgueil sum up recent health care human resource policies. Given the current demographic pressures on health care professionals, they question the extent of opportunities related to the future supply of the health workforce.

Governance and structure

According to the Minister of Health, the main objectives of the recent reforms have been to improve health system organisation and management. They aim to change the behaviour of key actors and place a special emphasis on the monitoring of health care expenditure by health care professionals. The reforms focus both on the renewal of the organisation and management of the health system on one hand, and financial measures and incentives on the other. Moreover, the reforms will have strong implications for health information systems.

First of all, the two major laws of the

Chantal Cases is Director, Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France. Email: Cases@irdes.fr

* See also Com-Ruelle L, Dourgnon P. Can physician gate-keeping and patient choice be reconciled in France? Analysis of recent reform. *Eurohealth* 2006;12(1).

reform change significantly the governance and organisation of the health care system. The Public Health Policy and Health Insurance Reform Act insist on the role of the state and parliament in priority setting in the health sector. They give more power to local and/or dedicated structures for implementation. The Health Insurance Reform Act also renewed the governance of national health insurance by reinforcing still further the position of the government in national insurance fund management, something that has been increasing since the mid 1990s. Beyond these measures, a new branch (the fifth) of the social security system was created in 2005 to provide support to people living with disabilities.

Elsewhere the 'new hospital governance' permits more flexibility and relative internal organisational freedom to public hospitals, despite relatively strict controls on hospital management. The organisation and planning of health care facilities has also been simplified. Hospital regulatory power was shifted, to some extent, from the central to regional level. The controlling role of regional hospital agencies in charge of defining targets through contracts with individual hospitals has been reinforced. At a higher level, a strategic plan for health workforce development promotes group practice and also experiments with the transfer of tasks away from doctors to paramedical staff.

Financial incentives

Financial instruments are increasingly used as incentives to promote behavioural change by health system actors. Beyond the traditional, but substantial level of assistance to boost investment in hospitals, the implementation of activity-based payments in both the private and public sectors will significantly change the landscape and supply of hospital services. The implementation of a French-type non-mandatory gatekeeping system is also built on a system of financial incentives mainly directed towards patients.* This is intended to encourage them to move along recommended coordinated care pathways. Pharmaceutical regulations also include financial incentives for pharmacists to substitute generic products for original medications when these are prescribed by doctors, as well as charging levies on the pharmaceutical industry related to advertising, sales promotion expenditures and

* A small annual capitation based income was also introduced for the 'preferred doctors' providing primary care.

turnover. Last but not least, there are special fee-for-service patterns and financial support to encourage doctors to relocate and practice medicine in more deprived areas of the country.

Need for robust information systems

Another cross-cutting, albeit less obvious, feature of these reforms is the general need for robust information systems at every level. The creation of a comprehensive electronic patient record, coupled with the preferred doctor system in primary care, is presented as a core component of the Health Insurance Reform Act, while quantitative targets and indicators are the backbone of the Public Health Policy Act. A comprehensive set of data on private and public hospital costs are essential for designing fair activity-based tariffs, as well as for a series of quality of care and performance indicators to evaluate the effect of the new system on hospital results. Intensive use of health insurance reimbursement data are vital for the monitoring of anticipated changes in health care consumption; moreover, another planned measure is the implementation of joint data files on compulsory and complementary health insurance.

Though the implementation of all these reforms has not as yet been achieved, the High Council on the Future of Health Insurance (*Haut Conseil pour l'Avenir de l'Assurance Maladie*), set up in 2003 by the Prime Minister, provides some initial idea of their impact in its 2006 evaluation report.² It states that the health insurance budget deficit reduced in 2005, to (a still substantial) €9.1 billion compared with €11.2 billion in 2004. A deficit of €7.3 billion was forecast for 2006. The improvement is in part due to an increase in income and a decrease in reimbursed outlays. In fact, much of this reduction is due to a reduction in overall health care spending, rather than a drop statutory health insurance reimbursement. Nevertheless, the High Council noted that in 2005 that there was a modest increase in the share of health expenditures directly paid out of pocket by private households (from 8.47% of expenditure on medical services and goods in 2004 to 8.74% in 2005), reversing the trend of previous years.

Growing opposition

Some aspects of the reforms have received genuine support, or at least no strong opposition from stakeholders. In particular a large contingent of health care professionals were behind the reforms, in

so far as funding methods for free practice were not threatened. Opinions are now changing. There is increasing scepticism among professionals about the administrative burden faced, the relative complexity of coordinated care pathways, and a measurable decrease in activity and income for some specialists. The recent vote by professionals for regional liberal medical unions' illustrates that the popularity of those unions who participated in the implementation of the reform have waned. In public hospitals planned reforms impacting on the status of salaried doctors now face strong opposition, while both the public and the private sectors have expressed concern (for different reasons) as to the implementation of the convergence of activity-based tariffs.

Questions to address

Given that past reforms only have had a temporary impact, the first question that comes to mind is on their expected long term impact on health care expenditure. It is clearly too early yet to provide an answer. This will largely depend on the likelihood of structural change in the prescribing and consumption behaviours of health care professionals and consumers. So far, patients seem to complied with the access restrictions introduced under the preferred doctor reform, with 80% of the insured signing up to contracts. The most difficult challenge is for doctors to change their practising habits in favour of less expensive and better quality care; the fee-for-service payment is still preserved and no noteworthy financial incentives have been introduced. Whether activity-based hospital financing can improve hospital efficiency without damaging quality or equal access to care, including innovative therapies, will be major concerns of future evaluation, as will be the consequences of the reforms for health inequalities.

So at present, while the initial results are promising, more questions than answers remain on the long term impact of the reforms.

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Interview with Xavier Bertrand, French Minister of Health



This interview was conducted and edited jointly by Chantal Cases, Karine Chevreul, Nathalie Meunier, Julien Mousques and Zeynep Or at IRDES – Institut de Recherche et Documentation en Economie de la Santé.

In your opinion what are the strengths and weakness of the French health care system today?

The strength of our health and welfare system is the French people's adherence to the fundamental principle of contribution based on the ability to pay, and the receipt of care on the basis of need. This type of system ensures solidarity and freedom; for patients, freedom in choice of physician and for health care professionals, the freedom to set up practice and prescribe. Today, our health system is at a pivotal point for which we must determine a number of priorities. Three seem crucial to me: the future health system workforce (medical demography), the modernisation of hospitals, and the prevention of ill health.

The future supply and geographical distribution of health care professionals is an essential issue for us all. I hope that we start from now on to show our commitment to a new path, one where equal access for all becomes a requirement and a reality. Modernising hospitals and other health facilities is equally an important question that we have recently begun to tackle as part of the 2007 Hospital Plan.* The plan has several tiers: firstly, a new approach to hospital provision in regionally organised schemes, based on a key concept – complementarity; secondly, an important reform of hospital

funding with activity based payment; and finally, structural reforms placing more emphasis on clinical services in hospitals. These will take time to implement.

Another challenge, in my opinion, is more strategic: the prevention of ill health. In terms of curative care, the World Health Organization considers the French health system to be one of the best in the world. In terms of prevention however, I believe that we can, and we must, make real progress. We can meet this goal not only by providing increased coverage of preventive activities within our health insurance,** but also by promoting health education and better awareness on health issues, as well as taking more responsibility for those risk factors that can affect health such as excess drinking and smoking. In my opinion, prevention is the key challenge, and the key driver, improvements in quality, led by the training of health care professionals and accreditation of health care facilities.

Since 2004, several reforms have been implemented, in particular the Health Insurance Reform Act. What are their

major objectives? How do they differ from previous reforms?

The reforms stem from a strong and consensual report¹ by all the main health care actors united in the High Council.*** This report on the future of statutory health insurance advocated reform and modernisation to ensure improved organisation and management. In order to organise our health system better, we need to have better integration between primary and secondary care, and also ensure that this care is coordinated around individual patient records and the preferred doctor or '*médicins traitant*'. Many European countries have already been on this track for years, unlike France prior to 2004.

Introducing new governance arrangements for statutory health insurance, alongside better enforcement of these changes will also help improve management of the health system. We have decided to take great efforts to clamp down on abuse and fraud within the system; this is not a trivial issue. I believe that in a welfare state characterised by solidarity, we must at all costs ensure that this sentiment applies to all. Better management aims, before all else, to

* See Article by Zeynep Or and Gérard de Pourvoirville in this issue.

** For example, bone density measurement techniques have been included since 1 July 2006.

*** Includes representatives from the State, Statutory Health Insurance, Complementary Insurance, Parliament, health care professionals, social partners, trade unions and individuals. The Council, created in 2003, is responsible for evaluating the health care system and formulating recommendations.

reduce and eventually eliminate superfluous spending in the health system. This amounts to approximately €5 to €6 billion per annum, including redundant consultations. Thus these measures should not affect the quality of care, on the contrary they should improve it.

I am also interested in changing behaviour, because it is this change which will guarantee a healthier future for all. We are particularly concerned with monitoring the reforms from their planning to their implementation. As you are aware, the excessive delay in publishing decrees has been a continuing French malaise. I am committed to responding swiftly to this problem: 85% of decrees published by the end of 2004 were linked to an Act published on 13 August that year. I believe that today politics is all about delivery, particularly when it comes to health policy.

How would you currently assess the preliminary impact of the Health Insurance Reform Act?

Today, the reform is progressing and is making a difference. We have been hearing about reforms in France for more than twenty-five years. However, this is the first time in ten years that the Statutory Health Insurance has stayed within its expenditure limit. This is a historical achievement. This moderating tendency in health expenditure can be seen during all of the past eighteen months, particularly in urban areas. Without the reforms introduced in 2005, the deficit would have amounted to €16 billion. Instead, it now amounts to €8 billion. I have made a commitment to reduce the deficit still further to €6 billion by the end of 2006. This will however leave room for some flexibility, for example to continue to reimburse €1 billion worth of new drugs per year. This equally enables us to face the challenge of the health care workforce through concrete measures,* to move the system in a direction more focused on prevention, starting this year with more initiatives within the health system. Reducing the deficit through reform will allow us to move along the path towards improved quality and modernisation.

Coming back to the issue of coordinated care, will introducing gatekeepers risk hurting our country's traditional principle of free access to specialists? Also, is it

possible to reconcile the increase in fees seen in the reforms with the aspirations of specialists to preserve their revenues. Already, we are observing a decrease in the revenues of dermatologists as well as ear, nose and throat specialists?

First, we should look at the facts: in the twelve months since the reform, three quarters of French people over sixteen, some thirty-seven million people, have voluntarily chosen their '*médecin traitant*' (preferred doctor or gatekeeper). The '*médecin traitant*' in fact has the same logic as the long standing concept of the family doctor, that is seen in the provinces. Thus the reforms are reinforcing already existing good medical practice/habits for some patients. Others are now entering a system that has better coordination of care. The '*médecin traitant*' has a dual role: to ensure the coordination of care to improve quality and also to eliminate superfluous activity. In France, the numbers are constant: one out of every six medical examinations is undertaken twice, leading to greater expenditure without any additional benefit. I would prefer that this 15% share of expenditure, some €1.5 billion, be used in a much better way to improve health through the funding of new activities. It is true, certain specialties today have seen their activity levels reduced. Reinforcing communication and information on this issue is essential for both health system professionals and patients.

Today, one of the issues that remains somewhat unclear is the place of hospitals in the health care pathway.

Hospitals are part of the reform process. The health care pathway, monitoring health care patterns, for example in regard to the development of generic medicines and the use of personal medical records, affects both primary care services and hospitals. Let us not forget that just one and a half years ago, a very ambitious reform was also implemented. Hospital policy today needs some stability, with follow-up and adjustment if necessary.

Let us come back to hospitals and the new activity based payment for public and private establishments. This type of reform has also been implemented in most other European countries to increase efficiency. However, the objectives vary among countries (for example,

reducing waiting times or containing hospital expenditure). In your view, is there a productivity problem for French health care facilities? How does this manifest itself?

Above all else, I believe that we can and that we must improve organisation among and within both public and private facilities. I think the principal challenge for hospitals today, other than modernisation, is the way in which work is organised and the working conditions for health system personnel. Currently, the activity based payment gives us complete transparency between funding and activity levels. In my opinion, this can improve still further hospital efficiency. The convergence of tariffs between the public and private systems is clearly drawn up by legislation, with an intermediate target set for 2008 and a final goal to be realised in 2012. We are currently working on this. We need to define what responsibilities should be devolved to the different public and private facilities. It is important not to forget to account for their particularities and accordingly include these in remuneration, so as to ensure that we are not misled over convergence criteria.

We have noticed that the introduction of activity based payment has led to an increase in activity...

I am not aware of any other country which has not been through this initially. This is why we have taken the decision to decrease hospital fees this year, knowing that, compared to last year, the increase in activity will still result in an additional €2 billion for health care providers.

Precisely, does it not worry you that this decrease in fees will be difficult for the key stakeholders to understand?

The situation has always been clear, adjusting fees is not a new tool. Last year, there was considerable overspending which we have integrated into our new expenditure targets, so as to ensure there are no further excess expenditures. We are starting from a position with a predicted increase in activity of 2.6%. With only a 1% decrease in fees, revenues for health care organisations will thus continue to increase this year. However, it is important to note that if the primary care sector can be successful in its efforts to meet objectives, then the hospital sector should be capable of doing the same, notwithstanding the risk of course, that a major public health crisis might necessitate an increase in activity.

* See Article by Zeynep Or and Gérard de Pourville in this issue.

If some health care institutions are found to be managed inefficiently, how much room for manoeuvre will they have to restructure?

We have made available greater financial assistance to support the contracting process between the regional hospital agencies and local health care facilities. This will leave real room for manoeuvre for those health care facilities in difficulty who wish to undertake restructuring in order to return to balanced budgets. It is the first time that such important resources have been distributed at the local level.

Do you think that regional hospital agencies will have enough flexibility to determine the choice of specialist services provided by hospitals? This might possibly increase hospital efficiency, but may also imply a drift away from the underlying principles of the health system?

A word of caution. Hospital activity will always be dependent, first and foremost, on health care needs rather than on efficiency concerns. I suspect that the only way to achieve lasting success is to monitor medical practice within a better organised health care system. Indeed, in a system underpinned by managed care, providing greater access to scanners for instance, will not lead to an increase in the number of scans conducted. But on the other hand, it could reduce some costs. The fact is that if we comply with health and safety regulations, but do not have access to appropriate technological support, additional medical transportation costs will be incurred moving patients to facilities where procedures can be performed. When health care needs are justified, we must provide all necessary means. In this way, we reduce waiting times and provide more timely diagnoses, treatment and reassurance to patients.

For example, this would imply that you would be able to adjust fees if drifting was noticed in the choice of activities provided in some health care facilities?

The rules of the game are clear, fees can be adjusted up and down. This also assumes that there will be monitoring, which the Statutory Health Insurance [Agency] would carry out.

To try to summarise, general services and contract support provided to Regional Hospital Agencies would be one of the means used to ensure

geographic equity of access to hospitals?

Equity of access to care in France is a fundamental and non-negotiable principle. If a health service provider faces difficulties, it is appropriate to examine how they envisage their own future. If necessary, significant help with the contracting process can be provided. We are not solely relying on a fee-based system. Some health care services focus on geriatrics, follow-up care and rehabilitation and therefore will not necessarily gain any greater benefits from activity based payment. However, we are not going to end these services!

Previously, we spoke about the transparency of fees, but is it not particularly difficult to evaluate costs for services of general interest?

This is the reason why this year I have decide to greatly increase (12.1%) the funding for both services of general interest and contract support. I believe that this was not accounted for last year. Now we must agree on the real financial needs of these services. This should reassure and instill confidence in the future and in our commitment to modernise the hospital sector.

In all European countries the definition of the publicly funded package of health care services is a major issue. We must reconcile containment of health care expenditure, support for innovation, protecting jobs in the local pharmaceutical industry, against responding to the principal public health issues, particularly chronic diseases. What is your vision for achieving this?

The real issue at stake is to be able to succeed in moderating, medically speaking, health expenditure so that its progress, which is both unavoidable and desirable, is compatible with our growing national economy. This should be achieved without encroaching upon the share of national resources needed for older people, education, research, etc. The real challenge is to control expenditures by monitoring and improving medical practice; this is what I wish for and am working towards.

We must find the answers to taking greater responsibility for our health, to determine for example which drugs should be prioritised in terms of cover by Statutory Health Insurance, without forgetting that currently in France we reimburse some very costly drugs. For example, we reimburse breast cancer drugs which cost

€1,500 per month. I am proud that the French system provides for this. We have, nonetheless, as a result of removing some drugs from the list of reimbursable items, generated savings of some €300 to €385 million to the Statutory Health Insurance. This does not however compensate for the additional €1 billion in expenditure that is due to new drugs that will be covered by Statutory Health Insurance.

Since 1999, we have all known that some drugs have not necessarily provided the added clinical benefits expected. Today, we must make it clear that some conditions would benefit more from the use of alternative therapies. Sometimes drugs are not the most appropriate treatment. For example, nasal irrigations are at least as effective as expectorants or other similar products to treat child colds. In another example, support stockings provide a real alternative to more complex therapy for varicose veins. We must change our individual behaviours, while industry must direct innovation towards public health priorities. To respond to the health challenges we all face, research and development should be one of the first priorities for industry.

In comparison to our neighbouring countries, France still remains in a favourable position in terms of nutrition and obesity. Are there any lessons we can share on this with other European countries?

I would caution against giving lessons to anyone else. Each country has its own solutions which are dependent on history and local practices. We have taken a number of initiatives under the national nutrition plan. For example, we no longer allow the sale of sugary products and carbonated drinks in schools. We are working with an agro-food industry which understands that there must be change. We are also working to improve communication in terms of food advertising and in strengthening actions at a local level, as I truly believe that these will be more effective. We will also work to improve food quality and presentation. By working with health professionals and general practitioners we will better deal with obesity, especially among disadvantaged groups. These actions must be taken on behalf of people of all ages, not just children. There is much exchange of information on these issues at the European level.

Do you feel that Europe can have some influence over decisions on interventions

to prevent ill health?

It is important to be aware that health care does not fall within the competence of the European Union. Unlike animal health, human health truly is the responsibility of each Member State. Europe cannot impose policy in this area.

We were thinking of the discussions that have recently taken place on the future prohibition of smoking in public places.

Let us also talk about the harmonisation of policies on the price of tobacco. There is a lot to do on this subject.

To conclude, what in your view are the principal challenges for European health systems to confront in the coming years?

First, we must take into account the real challenge of dependency and ageing. This will have many consequences, not only for health policy. Decisions on social welfare policy will be a major factor which will have impacts elsewhere: the future supply of medical professionals, coverage of new forms of treatments and the introduction of an information technology system to benefit both the patient and the health care professional. A second challenge is to empower patients to have a greater say on health matters. This is a legitimate aspiration.

We must also plan for new health challenges. At the beginning of this new century there are no certainties about future health risks. We have already seen this with avian influenza, as well as with a number of emerging or re-emerging illnesses which particularly affect us because of our overseas links. I believe that today, with global warming and climatic imbalances, (for instance because of deforestation), coupled with the increase in global travel, viruses no longer know any borders. We must raise awareness among Europeans on these subjects and adopt a common approach to much research, for example on cancer. We can then be much more effective, in particular in the fight against HIV/AIDS and infectious illnesses, which are, in my view, the real public health priorities.

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Pharmaceutical policy in France: a mosaic of reforms

Nathalie Grandfils and Catherine Sermet

Summary: Pharmaceutical policy was one of the key components of the 2004 Health Insurance Reform in France. Regulatory measures being implemented focus on measures to reduce levels of expenditure, including greater use of generics and the introduction of reference pricing, as well as measures to promote access to innovative therapies and the provision of better information to both medical professionals and patients on the most appropriate use of medications. By 2007, more than €2 billion in savings are expected as a result of these reforms.

Keywords: France, Pharmaceuticals, Health policy, Health reform

France has the highest level of per capita expenditure on pharmaceuticals in Europe. Expenditure has been rising at an increasing rate: it has more than doubled since 1990, while pharmaceutical consumption as a share of total health care consumption has also increased from 18% in 1990 to 21% by 2004;¹ this is evidence of more rapid growth in the pharmaceutical sector. Pharmaceutical policy was one of the key components of the 2004 Health Insurance Reform; this was reinforced by the government's decision to establish a 'drug plan' running from 2005 to 2007.

Regulatory measures being implemented are targeted at both supply and demand side factors and take three forms:

- Strict state regulatory measures intended to reduce the costs generated by the health insurance system without modifying entitlement to services.
- Promoting better clinical control of costs on one hand through measures for more efficiency and patient safety, while on the other being in favour of

better access to innovative therapies.

- Providing better information to both doctors and patients, so as to ensure both a better understanding of what drugs are available on the market, and improve patients' understanding of medicines.

Measures to reduce expenditure*Use of generics*

Encouraging the greater use of generics constitutes one of the key levers of pharmaceutical policy. Since the right to substitute generic for branded drugs was enacted in 1999, pharmacists have become key players in the spread of their use in France. This right is also accompanied by financial incentives for wholesalers to maintain a margin equal to that of the original medicine.* Only those drugs appearing on an approved list of generics can be used as substitutes. A small number of active drugs that are heavily used (for example, paracetamol) do not appear in this list for policy or legal reasons.

Specific agreements signed in January 2006 between the Statutory Health Insurance and pharmacists refer to the twenty most

Nathalie Grandfils is a Research Fellow and Catherine Sermet is Research Director, Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France.

Email: grandfils@irdes.fr

English translation by David McDaaid at LSE Health

* In making the margin calculation, the margin of the original medicine is generally higher than that of the generic equivalent, except in the case where the original price is linked to that of the generic.

expensive medications (statins, proton pump inhibitors, and angiotensin II receptor antagonists). The objective is to achieve a prescribing rate for generics of 70% by the end of 2006 (compared with 35% in 2002), with an intermediate target of 60% by mid 2006; this appears to be on track, the intermediate target had already been achieved by the end of 2005.

Doctors, culturally accustomed to prescribing branded drugs, committed themselves to INN (International Non-proprietary Name) prescribing (i.e. prescribing using the international chemical name of the medicine) during the medical convention (used to make agreements between the doctors and the Statutory Health Insurance) of 2001. Despite the subsequent change in prices, only 8.5% of all pharmaceutical prescriptions were made using INN by the end of 2005. In March 2006 however, doctors committed themselves to prioritising the prescription of drugs for which generic alternatives were available to pharmacists.

To provide information and accustom patients to the use of generic medicines, the Statutory Health Insurance launched a major public campaign in 2003 across different media outlets, followed in 2005 and 2006 by two campaigns targeted specifically at those patients who still used little or no generic medicines. Today nine out of ten French people say they are in favour of generics.

The global impact of this policy favouring the increased use of generic medicines, has slowly begun to bear fruit; in 2005 the increased use of generics allowed the Statutory Health Insurance to save over €500 million. On the horizon by 2007, more than €1 billion in savings will have been realised as a result of these measures, which culminate in the 'natural' extension of the list of medicines with generic equivalents and an envisaged decrease of 13% in the price of generic medicines.

Introduction of reference prices

In France the price of reimbursable ambulatory medicines are fixed by the Economic Committee for Medical Products (*Comité Economique des Produits de Santé*, CEPS) based on three essential criteria: the price of treatments already available on the market, the

increased effectiveness of new products and predicted sales volume. When a drug does not have any additional effectiveness its price is fixed in such a fashion as to generate savings for the Statutory Health Insurance. It is the case, for instance, that generic medicines have their price fixed at a rate between 30% and 40% lower than the price of the original equivalent.

Parallel to this framing of pricing policy in favour of generics, a law on the financing of social security in 2003* introduced reference prices (*tarifs forfaitaires de responsabilité*, TFR). This scheme, which applies to seventy chemical entities, reimburses both generics and their original equivalents based on the price of the generic is becoming *de facto* a mechanism for price regulation: 70% of these original medicines have realigned their prices to those of the generic alternatives. Pharmacists have however registered a protest against a decrease in their profit margins by making fewer switches to generic alternatives. The generics manufacturers have equally opposed what is a relatively neutral measure from the patients perspective, since the difference in price between the two is covered by complementary health insurance schemes.

Marketing of larger packets of medicine

The health insurance reform of 2004 envisaged a move to more efficient package sizes in respect of prescription medicines for some chronic diseases. Manufacturers must make a request for market authorisation for packet sizes that allow three months treatment for four classes of drugs: anti-hypertensives, lipid lowering drugs, oral anti-diabetics and treatments for osteoporosis. The CEPS have committed themselves to ensuring that the drug manufacturers' price per dose of medication will remain the same regardless of packet size. The savings generated will instead result from the automatic reduction in the margins enjoyed by pharmacists.

Fixed prices for some hospital drugs

The reform and its ensuing measures initiated a profound change in regulatory measures for hospital drugs. In effect, while the price of ambulatory drugs were the subject of regulation, the price of hospital-based drugs remained entirely uncontrolled until 2004.

In the absence of a legal framework, an increasing number of medicines purchased by hospitals were resold by hospital pharmacies to outpatients at very disparate price levels. These products were nonetheless reimbursed by the Statutory Health Insurance on the basis of actual expenditure incurred by patients. In 2004, a limited list of drugs which can be sold by hospitals was established; these specialist drugs are subjected to a process known as '*dépôt de prix*' – which requires the drug manufacturers to propose a reasonable price to CEPS. This procedure permits higher reimbursable prices for innovative patented drugs. This price is then used as the reference for reimbursement. Medicines not currently on this list that are essential for the treatment of outpatients must, from now on, much to the disadvantage of their manufacturers, be registered on this list of reimbursable drugs where prices are fixed by the CEPS.

Optimising expenditure

A second series of measures are based on a concept introduced in 1994 and broadly reaffirmed in the 2004 reforms: 'clinical control over health expenditure'. It is a question of maximising efficiency, clinical appropriateness and quality in prescribing; these behavioural changes would then lead to better control of wastage and a decrease in expenditure.

Improving access to innovative drugs in ambulatory as well as hospital care

For ambulatory care, a series of measures have been brought together in one framework agreement, signed in 2003 between the LEEM (*Les Entreprises du Médicament*), an umbrella body for the pharmaceutical industry, and the CEPS, followed by a hospital agreement in 2004. These agreements anticipate an acceleration in the pace of licensing and reimbursement of innovative drugs thanks to the procedure of *dépôt de prix*: the industry makes a proposition to CEPS to have one coherent price similar to that seen in Germany, Italy, Spain and the United Kingdom, anticipating the first four years of sales volume. Subsequently the CEPS would then ratify this price.

Furthermore, a list of innovative but expensive drugs are now reimbursable within hospital budgets. This allows all hospital departments to benefit from

* This law was first established in 1996 with the target of determining the general conditions to financially balance social security, based on anticipated revenue and fixed expenditure objectives.

increased access to innovative medicines. The approach seems to have led to an increase in the prescription of such medicines.

The framework agreement of 2003 furthermore required an annual agreement to be signed between the industry and the State. Under the terms of these agreements, the industry is committed to making payments if growth in reimbursable ambulatory drug sales exceeds a ceiling fixed annually under the law on the financing of social security.* Highly innovative drugs and all generics are exempt from this rule. Those companies that have not signed up to these agreements are today very few in number and they fall within the terms of a 'safeguard clause' which makes them liable to pay a tax on their sales turnover which is at least equivalent to that which would have been paid had they signed up to the agreement.

In June 2006 the LEEM and CEPS went further by signing a hospital master framework agreement; this extended the agreements and safeguard clauses to all hospital drugs sold to all non-hospitalised patients in the same way as those drugs receiving specific financing.

Establishing agreements between doctors and the Statutory Health Insurance

In 2005, the Statutory Health Insurance signed a number of specific agreements with doctors associations covering the years 2006 and 2007. These had the aim of improving efficiency in prescribing, whilst containing expenditure related to five classes of pharmacotherapy: antibiotics, statins, anxiolytics and hypnotics, proton pump inhibitors and anti-hypertensives and anti-coagulants. Moreover, doctors are committed to respecting a 'prescribing book' which allows them to separately prescribe drugs that have a long lasting effect (at full price) from other medications (which are priced at 65%, 35% or 15% of full price depending on circumstances).

Revision of the positive list

All ambulatory drugs reimbursable by the Statutory Health Insurance have been the subject of a re-evaluation of their clinical use in order to determine whether they should be kept on the list of reimbursable drugs (positive list). The basket of care has been changed in two ways by this re-evaluation:

- Approximately two hundred specialist drugs have disappeared from the positive list since 2003. These de-reimbursements were apparently very unpopular and the chance of prescriptions being transferred towards those medications remaining on the positive list have been largely symbolic with little to show until now.
- Sixty-two other specialities (including treatments for varicose veins) have seen their rate of reimbursement decrease over a transitory period from 35% to 15%. These products will be de-listed by the beginning of 2008. This fall in the rate of reimbursement has however only served to transfer the costs between statutory and complementary health insurance.

Increasing benefits via more deductions from the pharmaceutical industry

Since the first law on the financing of health insurance in 1996, the pharmaceutical industry has been subject to various additional charges. One of these levies a tax on advertising expenditures and has been the subject of numerous revisions. The law on the financing of social security in 2006 envisages a further increase in this tax. Another charge is based in sales turnover and its increase in relation to the previous year. In addition to this contribution, the 2004 law on the financing of social security included a one off charge of 0.6% for the pharmaceutical industry. This was linked to the sales turnover of each company. The 2006 financing law has made this an annual charge and also included a one off increase to 1.96%.

Improving the quality of information and prescribing

The High Authority for Health (*La Haute Autorité de Santé*, HAS), established as part of the 2004 reforms, has been given a major role in the promotion of good practice and better utilisation of health care services. It ensures, along with the French Agency for the Safety of Health Products (*Agence Française de Sécurité Sanitaire des Produits de Santé*, AFSSAPS) the publication of numerous guidelines on clinical practice. At the same time, the reforms wished to organise the role of health visitors when putting in place a charter for home visits.

As part of this charter, companies have

begun to provide objective and free information to doctors that is in the best interest of patients. Improving information for patients is being achieved primarily through media campaigns. Using the campaign model previously used to promote generic prescribing, the Statutory Health Insurance has developed two other national information campaigns. One is in respect of antibiotics: "*Les antibiotiques c'est pas automatique*" (antibiotics are not an automatic option), and the other focusing on the "INN – the real name of the drug".

Conclusion

Despite a succession of reforms over the last ten years, pharmaceutical policy has encountered many difficulties which have slowed the pace of implementation considerably. The public authorities are caught between the need to contain health expenditure and the need to support a pharmaceutical industry which makes an important economic contribution to the country.

Doctors are not very receptive to measures intended to change their practice: thus prescribing patterns that do not conform with guidance are still very numerous and INN prescription is still not part of the medical culture. Many doctors reject the very notion of financial responsibility. The system for financing health care, by taking full responsibility for prescribed drugs does not encourage patients to take more responsibility, which can be seen in particular through the low level of self-medication.

Nonetheless, and despite an impression of expansion, successive reforms have piece by piece progressed towards a more coherent policy for the regulation of pharmaceuticals. In total, until now (in 2005 and 2006) only about €1 billion in savings have been linked to these policies because of the delays in implementation of certain measures. But savings for the year 2007 are expected to be more than €1 billion, mainly due to the promotion of generics.

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* This rate, known as rate K, was equivalent to 4% in 2003, 3% in 2004, and 1% in 2005–2007.

Health targets in France: role of public health and social health insurance reform laws

Isabelle Durand-Zaleski

Summary: Two major laws were passed within a few days of each other by the French Parliament in August 2004. The first set public health priorities and targets; the second reformed the financing, organisation and regulation of the health care delivery system. The purpose of this article is to examine the consistency between the two and to identify possible factors in this prioritisation process which resulted in the publication of 104 distinct health targets.

Keywords: Health targets, France, Health policy, Public health, Priority setting

Public health targets

In 2004 for the first time, the French Parliament discussed and endorsed a Public Health Law¹ which listed 104 health targets for the years 2005–9. This law thus allows for planning and budgeting for public health actions over a five-year period, rather than confining planning to the traditional one-year period. The political need for such a law can probably be traced back to the different crises that reduced public confidence in the health authorities: AIDS-contaminated blood, so called ‘mad-cow’ disease and, more recently, the August 2003 heat wave that killed an estimated 15,000 older people.

Back in the late 1990s, the Ministry of Health launched a series of ‘public health conferences’, one in each region, involving different stakeholders: patients’ representatives, payers, professionals and (to a certain extent) the general population. Those conferences produced, in each region, a list of health priorities or targets. They were periodically summarised and

integrated into reports produced by the High Committee of Public Health for the Minister of Health. As limited action was taken after each report, targets and priorities tended to pile up, which may also be an explanation for the very comprehensive list of 104 targets now presented in the public health law!

When selecting those 104 health targets, the law considered both diseases and determinants of health. Targets were defined either for the total population or for specific population sub-groups and they were included in the list (along with their accompanying programmes) if they could meet nine criteria (see Box 1).

The methods used to select health targets

followed the usual pattern of firstly taking account of estimates of the magnitude of health problems using mortality and morbidity data (such as Disability Adjusted Life Year (DALY) estimates published by the World Health Organization). This initial identification of major health problems was then followed by an analysis of the current scientific information on prevention and treatment strategies available, bearing in mind existing resources within the French health and social care systems.

Targets were presented with one or more measurable indicators that would reflect an evolution in the health states of the population or selected population sub groups. Priorities were given pragmatically to

Box 1 Criteria for health targets

Achievable within five years

Measurable given the current level of scientific knowledge and availability of resources

Would contribute to a reduction in health inequalities

Gender-specific

Gives priority to improvements in the health of infants, children and adolescents

Gives priority to actions for the prevention of disease or any worsening of a given health condition

Cost-effective

Favours cooperation between health care, social welfare professionals and other relevant stakeholders

Includes elements of appraisal/assessment of effect on population health

Isabelle Durand-Zaleski is Head of Department at the Department of Public Health, APHP hôpital Henri Mondor, Paris, France.

Email: isabelle.durand-zaleski@hmn.apbp.fr

Acknowledgement: the author gratefully acknowledges the contribution of Professor Didier R Tabuteau

Box 2 Categories for health targets

1. **Determinants of health (alcohol, tobacco, nutrition and exercise, health in the workplace, environmental health)**
2. **Reducing iatrogenic (doctor induced) risks**
3. **Reducing antibiotic resistance**
4. **Improving pain management**
5. **Reducing the burden of disability**
6. **Reducing the burden of communicable diseases**
7. **Improving maternal and child health**
8. **Reducing the burden of malignancies**
9. **Improving management of diabetes**
10. **Reducing the burden of psychiatric disorders**
11. **Reducing sensory deficiencies**
12. **Reducing the burden of cardiovascular disorders**
13. **Reducing the burden of respiratory diseases**
14. **Improving quality of life of people with chronic inflammatory bowel disease**
15. **Reducing the burden of non-malignant gynaecological disorders**
16. **Reducing the burden of end-stage renal disease**
17. **Reducing the burden of rheumatic diseases (osteoporosis, rheumatoid arthritis, low back pain)**
18. **Reducing infant mortality and improving access to prenatal screening**
19. **Ensuring equal access to prevention and care for patients with rare diseases**
20. **Improving dental health**
21. **Reducing the burden of suicide and accidents**
22. **Specific population groups: Learning disabilities and dyslexia, improved access for women to contraception and terminations, older people.**

actions for which data and evidence of positive effect were available. In other cases, the law specified that more data or knowledge needed to be generated. Programmes were prepared to deal with specific health problems identified by the High Committee of Public Health:² cancer, violence and addictive behaviour, environmental hazards, chronic diseases and ageing, and orphan/rare diseases. All 104 targets were placed within 22 different chapters (see Box 2). For each target, the law indicates whether additional information/data are still required.

This attempt at health targeting is marked by the willingness of the government to delegate power to the regional health authorities, as they are considered to be the most capable of identifying health needs and providing care to their populations. This empowerment in fact started with hospital care as the regional authorities are

now responsible for hospital budgets, while welfare and social services are also, to some extent, financed through regional budgets. Following the April 2004 regional elections, which led to socialist party majorities in 20 of the 22 regions, discussions on the financial empowerment of regions took a new, more political, turn.

Consistency between laws

Only a few days after the approval of the Public Health Law, French parliamentarians approved another law reforming the regulation and financing of health care (the Social Health Insurance Reform Law). This law also responded to a major financial crisis, as the total deficit of the Social Health Insurance was then almost €10 billion. The consistency between both laws has now been examined.³ Each law affects both the code of public health and the code of social health insurance.

Both laws consistently emphasise and enforce requirements for information systems, for regional decision-making, for quality assurance and for more preventive measures. The Public Health Law states the possibility of using claims data to help inform public health policy, while the Social Health Insurance Reform Law permits electronic medical records and has created a public institute to consolidate and manage health databases. Moreover, the Public Health Law instituted regional planning for the implementation and monitoring of the 104 health targets. The Social Health Insurance Law meantime enabled changes in financial administrative structures to create financial incentives for professionals in underserved areas and also created agencies to coordinate the supply of health care at a regional level. This does not, however, concern ambulatory care or services yet, although both laws allow for pilot projects by regional health authorities (in contrast to the current regional hospital authorities).

Quality assurance is another important element in both laws; the Public Health Law, for instance, created a National Cancer Institute, while the Social Health Insurance Reform Law mandated health technology assessment, the development of guidelines and review criteria, hospital accreditation and professional practice appraisal, all under the responsibility of a single national health authority.

Prevention had traditionally been left out of reimbursement, possibly under the unspoken assumption that this should be the responsibility of the individual. Both new laws however explicitly cover prevention; the Public Health Law alters the social health insurance code to make the financing of public health programmes possible at the regional level.

Disconnection between priority setting and financing

There are however inconsistencies, most notably the disconnection between priority setting and financing. The above-mentioned targets do not constitute a binding obligation for financing organisations. Also noteworthy is the fact that such primers for a public health policy as an electronic medical record system and a common regulatory authority appeared in the social health insurance reform law. This can be seen as an illustration of the ongoing rivalry between the administrations in charge of public health and health financing.

Reflections on priority setting

The simultaneous publication of both laws created an occasion to reflect upon the relationship between priority setting and financing. Priority listing and setting should take account of the available budget and, in turn, the budget should be made available to finance the government's health priorities. Governments that have followed an explicit priority setting approach have rejected a cost-effectiveness or cost-benefit dominated approach but instead attempted to define the boundaries of individual versus collective responsibilities.⁴ In the case of the French Public Health Law, the leading principles (final goals) stated in the preamble to the law were not to maximise health gains but rather to reduce inequalities (including gender disparities), protect the young and favour primary prevention. The processes to reach these goals were the promotion of evidence-based and cost-effective interventions, as well as quality assurance and coordination of care.

Some elements of utilitarianism could be found in the emphasis on the young and on cost-effective interventions, but economic evaluation alone cannot account for all priorities selected. Following the approach of Goddard et al.,⁵ political economy models were examined to see if they could shed any light on the health priorities chosen and on the apparent inconsistencies between the public health and the social health insurance reform laws. Goddard and colleagues suggest that priority setting in health does not correspond to predictions of economic rationality, but not because of errors or haphazard decisions, but rather because policy makers also have to serve their own interests in addition to those of the population.

Several models of political economy can be drawn into this discussion of health priority setting. In addition to the maximisation of health gains, the majority voting model, the role of interest groups, the economic theory of bureaucracy and the rent-seeking models have all been proposed.

The majority voting model explains why 'policy makers seek to direct resources toward key population groups', for example, towards votes in important constituencies or notoriously volatile voter groups. The focus on health for the young and on primary prevention may be the result of such thinking from the government. Most citizens are not ill, (for example in France 10% of the population

consume 60% of total healthcare resources) but would support preventive services for themselves and for their families. The same applies to the chosen objectives of: (i) reducing iatrogenic (doctor induced) risks – any person may receive a treatment for a minor ailment and therefore become at risk; (ii) reducing low back pain – affecting an estimated one million plus people in France; or (iii) reducing the burden of non-malignant gynaecologic disorders, which may concern a large population of women.

“One lesson perhaps is that priority setting and financing laws should not be separate”

Interest groups and bureaucratic decision making may also be a factor in the disconnection between priority setting and financing. According to the interest group model, 'individuals that have the lowest costs of organisation' are most effective in securing health care resources for their own purpose. This can be seen in the case of cancer care where both professionals and patients have well structured organisations, as well as for rheumatoid arthritis, HIV and Hepatitis C infections and the prevention of hospital-acquired infections (one of the most active patients' association in France). The rivalry between the bureaucracies in charge respectively of public health policy and health care financing has resulted in a double steering system at the regional level, as well as the curious fact that one institution in charge (among other tasks) of evidence-based practice and quality assurance in cancer care was created by one law, while the institution with the same duties for the rest of medicine was created by the other.

The rent-seeking model may explain why it was necessary to state that better coordination between ambulatory and hospital care, as well as between preventive and curative medicine, is necessary. The time spent by professionals either in hospital or in private practice to educate and coordinate care for patients with chronic diseases is not valued by social health insurance. The rent-seeking model explains why such important elements of the quality of the health care system have been long neglected because of the imper-

fectly competitive market created by social health insurance. Both the rent-seeking model and the role of professional interest groups provide an explanation for the very strong emphasis on the reduction of demand (rather than supply) to control health care expenditures.

Conclusion

The simultaneous publication of the public health and social health insurance reform laws enabled the population (including researchers) to reflect upon the principles and theories that govern priority setting in health care. The French government, unlike others,⁴ did not explicitly define which principles of justice were used to define priorities; priorities however were indeed set while the financial reforms to the health care system were being voted for separately.

This legislative activity has taught us firstly that the connections between priorities and financing are so strong that each law resulted in major changes to the codes of the other; another lesson to be drawn perhaps is that the priority setting and financing laws should not be separate. Secondly, that there was common ground between both bills, such as the need for better information systems, reinforcement of preventive systems, development of quality assurance and empowerment at the regional level for the implementation of health policies. Thirdly, that priority setting in democratic societies is not done solely to maximise societal health gain but also results from bureaucratic and political negotiation.

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French hospital reforms: a new era of public-private competition?

Zeynep Or and Gérard de Pourville

Summary: In 2003, the French government launched an ambitious reform plan, known as 'Hôpital 2007', with the objective of improving overall efficiency and management within the hospital sector. A major element of the reform was the introduction of an activity-based payment system both for public and private hospitals which were previously paid under two different schemes. While this reform is a step in the right direction, further measures are required that will regulate carefully the conditions for competition between public and private providers without discouraging quality improvement and risking large increases in expenditure.

Key words: France, Hospital reform, Activity-based payment, Competition.

The hospital sector in France is a real mix of public and private provision where private-for-profit hospitals account for about one third of all hospital beds and almost half of those for surgery. French patients have complete freedom of choice to be treated in either sector and, unlike most other European countries, long waiting times are not a problem on the political agenda. However, given that it absorbs almost half of total health care expenditure, the hospital sector has been under increasing pressure in recent years to improve efficiency. Moreover, the sector's funding arrangements and organisational structure are complex with little transparency as to the efficiency and productivity of individual health care facilities. Therefore, the current government launched in 2003 an ambitious reform plan, known as 'Hôpital 2007', with the objective of improving overall efficiency

and management within the hospital sector.

Hôpital 2007

The measures introduced by this reform plan, aimed on the one hand at improving overall efficiency and organisation of all health care facilities and on the other at modernising the organisational and management structures within public hospitals by giving them more autonomy. The plan had three major planks:

1. Modernisation of healthcare facilities and simplification of hospital sector planning.

This first phase of the reforms put the emphasis on the modernisation of hospitals by boosting investment to improve their general infrastructure. This was also necessary to support national health priorities including improving cancer treatment, perinatal care and mental health. Total investment in hospitals has doubled between 2003 and 2006, while in parallel, the organisational structure and planning of health care facilities have been simplified.

The sanitary chart (an index of local health needs) which used to control, among other things, the number of beds and medical equipment authorised for each hospital has

been discontinued. Regulatory powers have been shifted from the central level to the regions by reinforcing the role of regional hospital agencies (ARH – *Agences régionale d'hospitalisation*) in controlling hospital activities. The regional organisation plans (SROS – *Schéma régional d'organisation sanitaire*) which placed an emphasis on the demographic and epidemiological characteristics of each region's population became the only tool used to guide hospital planning.

2. Renewal of the hospital financing system.

The second and most important measure was the introduction of an activity-based payment system both for public and private hospitals. Previously, public and private hospitals were paid under two different schemes. On the one hand, the public and most private not-for-profit hospitals had global budgets with funds allocated by the ARHs. These allocations were mainly based on historical costs, making little adjustment for hospital efficiency or specific public health targets. Private for-profit hospitals, on the other hand, had an itemised billing system with different components: daily tariffs covering the cost of accommodation, nursing and routine care, and a separate

Zeynep Or is Senior Economist, Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France. Gérard de Pourville is Research Director, Centre National de la Recherche Scientifique and also at Institut National de la Santé et de Recherche Médicale, Paris, France.
Email: Or@irdes.fr

payment based on the diagnostic and therapeutic procedures carried out, with separate bills for costly drugs and medical devices. In addition, doctors working in private hospitals are paid on a fee-for-service basis unlike those working in public hospitals, who are salaried.

The new activity-based payment system has been implemented progressively in the public sector (for public and private not-for-profit hospitals) from January 2004. A payment is made for each patient treated in acute care (rehabilitative, long-term and psychiatric care are not as yet included) based on the *Groupes Homogène de Séjour* (GHS – the equivalent of diagnosis related groups) prices for the public sector. The activity-based element of the payment will increase gradually each year: 10% in 2004, 25% in 2005, 35% in 2006 and so on.

Private hospitals on the other hand have been paid entirely using the new case-mix based system since 1 March 2005. However, a transition period was allowed where ‘national prices’ have been adjusted, first taking into account the prices for the private sector, and second using a transition coefficient for each provider based on its own historical costs/prices. The objective is to harmonise the prices for all providers (public and private) by 2012.

3. A new governance structure for public hospitals.

Following the first two steps of the reform process, the last phase has been to give public hospitals the flexibility they need to deal with this new financial environment. The idea is to simplify the administration of public hospitals and give more autonomy to medical staff over managerial decisions. Hospitals will also have the opportunity to create large clinical departments (hubs of medical excellence) in order to organise their medical activities in a more efficient way. These centres, under the responsibility of a doctor, will enjoy organisational and administrative autonomy, subject to an internal contract with hospital management.

While public hospitals now have obtained some freedom over their internal organisation (number of centres, departments, etc.), their autonomy is still strictly limited in other ways. The boards and executives of hospitals are still under the control of the Ministry of Health and the ARHs. Resource allocation is still the result of a mixture of predefined rules and bureaucratic negotiations. Most of the management rules concerning recruitment,

investment strategy and the use of new interventions are also set through this bureaucracy. One striking example of this is the fact that hospital managers still do not have the power to layoff staff, whether medical or non medical.

Issues to be resolved

It would not be an exaggeration to say that rarely has a health reform in France received as much support as this reform. Both public and private hospitals and all of the medical organisations involved agreed with the major principles and the proposed new method of financing. The differences in treatment between the public and private sectors have long been a subject of debate in France. The private sector has claimed that global budgets reward inefficiency and have prevented a real benchmarking process which would demonstrate that private hospitals are more efficient. Public hospitals conversely saw the global budgets as an instrument of rationing which strangled the most dynamic of hospitals and did not give them any room to respond to changes in demand.

“rarely has a health reform in France received as much support as this reform”

The government stated that the “equal treatment of the public and private sectors” was a major objective of the reform. Ironically the word “competition” was hardly ever mentioned in this context, even though implicitly one of the rationales for the reform was to increase competition within the hospital sector and hence foster efficiency. Increasingly, however, attention is being paid to the implications of a unique payment system with one price (price competition) and the initial consensus on the need for more transparency and efficiency has since been peppered by some scepticism and questions concerning issues of implementation.

Quantifying the cost of ‘public missions’

For public hospitals (and private hospitals participating in so called ‘public missions’) there are three types of additional payments to compensate ‘specific missions’. These include research and education, assuring the continuity of care,

which means providing 24 hour emergency care, an obligation to non-discriminatory practices, that is to accept any patient who seeks treatment, and taking part in activities related to national/regional public health priorities.

There will be fixed yearly grants, plus a fee-for-service element, to cover the standard costs of maintaining emergency care and related activities. Budget ‘envelopes’ are determined taking into account the yearly activity of providers. There are two separate ‘envelopes’: one for education, research and innovation related activities (MERRI – *Missions d’enseignement de recherche, de référence et d’innovation*) and one for financing activities carried out for the ‘public good’ (MIGAC – *Missions d’intérêt général et d’aide à la contractualisation*) to meet national or regional health priorities (for example, prevention) or specific public missions (for example, providing care for at-risk groups). These ‘envelopes’ are funded from regional budgets and distributed by the regional hospital agencies on a contractual basis following nationally defined rules. It is still not clear what specific activities are covered or how the cost of different elements (such as research) will be assessed.

Finally, a closed list of expensive drugs and medical devices (*Médicaments et dispositifs médicaux implantables*) is paid retrospectively, according to the actual level of prescriptions made. This decision was taken for two reasons. First, there is a strong political consensus to offer equal access to innovative technologies, and including such costs within a fixed price per case could push hospitals to switch to cheaper and less innovative drugs. Second, the private sector was already billing for expensive drugs retrospectively, whereas they were included in the global budget for public hospitals. However, this mode of payment for ‘innovation’ encourages the use of innovative drugs while potentially reducing the budget envelope for innovation in other areas. Given the global cap on hospital expenditures a large increase in drug expenditure would need to be compensated by a reduction in GHS tariffs which cover the cost of innovative diagnostics, surgical or organisational procedures.

The construction of the MIGAC budgets is also an issue of concern as the decision on the size of these envelopes seems to be political rather than evidence based (see interview in this issue with Xavier

Bertrand). Both the public and the private sectors have expressed concern as to the future size of this budget. The private sector fears that this budget may be used as a mechanism to make up for inefficiencies in public hospital performance, while the public sector has concerns that the value of their 'public mission' will be underestimated. Hopefully, the need to assess the cost of different public activities will help improve transparency within public hospital budgets.

One price for all?

Currently the GHS prices for private and public hospitals are calculated differently. In particular, the prices in the public sector include 'all costs' (fixed and variable) linked to medical care, while in the private sector fees for medical staff and devices such as MRI scanners are paid separately over and above GHS tariffs. Although the new funding system recognises the distinctiveness of public hospitals and their missions, there are still a number of questions as to the rationale for applying the same tariffs to both public and private facilities. The fact that public hospitals also have to carry out a number of additional activities of a very different nature might have an indirect impact on their cost functions.

For instance public hospitals, by law, cannot select their patients and are more likely therefore to treat those patients that are more expensive to treat than what is covered by an 'average cost' payment. Even for the same DRG, the technical procedures performed and the severity of the disease treated are not the same in each sector with, on average, the public sector dealing with more severe or technically complicated cases. Moreover, the obligation of providing emergency care incurs not only reimbursable direct costs, but also indirect costs and consequences. For instance the management of non-planned care disrupts the scheduling of elective surgery, with lower bed occupancy rates etc.

The activities of the private sector are highly concentrated on surgery, maternity care and highly technical specialties, unlike public facilities that provide a comprehensive package of care. The average number of case-mixes making up hospital activity in private hospitals is therefore only half of those in public hospitals. Thus, the economies of scope that the private sector benefits from through its ability to specialise are not considered in cost

comparisons.

More fundamentally, to be able to compare costs or introduce cost-based competition between the public and private sectors, it would be necessary to have costs calculated in the same manner in both sectors. Surprisingly, for a country where the private sector provides more than half of all surgery and one third of maternity care, little is known about the actual costs or inputs used by private hospitals. Very little progress has been made in producing comparable cost information between the two sectors.

Adjustment for quality

One acknowledged shortcoming of activity-based payment is that there is no link between the prices set and the quality of services provided. The facilities where costs are higher than average might be less efficient, but they might alternatively be providing a higher quality of care. Indeed, there are inherently perverse incentives to increase the volume of activity at the expense of quality, unless there are specific regulatory safeguards.

Currently, very little information is available to compare the quality of care between and within public and private facilities. One recent study shows that (while this is not a direct indicator of care quality) the qualifications of medical personnel are significantly higher in the public sector.¹ It should also be noted that public and private facilities are not currently subject to the same rules of health care security and safety. Such rules are better established in the public sector, although, because of their growing number and complexity, this should not be interpreted as meaning that they are better enforced.

Containing cost v. increasing productivity

In order to contain the overall costs of hospital care, the new system introduces national and regional level expenditure targets for social security concerning acute care expenditure (with separate targets for the public and private sector). It was announced that if the actual growth in volume of activity produced exceeded the target, prices would subsequently go down. Not surprisingly, in 2005, both public and private sectors exceeded their targets (by more than 3.5%) costing an additional €650 million to the health insurance fund. While the government let this go unchecked in 2005, it decided to reduce GHS prices by 1% in 2006, as the

rate of increase in activity is already higher than the targets set. We note that part of this increase was actually due to a large increase in expenditures on expensive drugs and medical devices.

This type of regulatory mechanism is problematic. Adjusting prices depending on the volume of activity assumes constant productivity gains without taking into account the type of activity produced. When this is not the case, depending on the impact of new technologies on costs, there is a risk of setting prices (progressively) not linked to costs at all. This would encourage health care facilities to opt for less expensive care/therapies.

Conclusion

The implementation of *Hôpital 2007*, especially the introduction of a new financing regime for hospitals in France, will result in significant change in hospital behaviour and resource allocation. While the core measures introduced by the reforms are based on sound principles, there are a number of issues that need to be resolved if their expected impact is to be achieved.

Activity based payment schemes are intended to increase productivity and efficiency. In the French context however, (where there is no gatekeeping for hospital care) improving the efficiency of individual hospitals does not forcibly require an overall increase in activity in the hospital sector. However, the introduction of a prospective activity-based payment system introduces strong incentives for this to occur, albeit with all the problems of unjustified hospitalisation that this may imply. In order to offset any such negative incentives, regulation of access to hospital care, both public and private, should be enhanced.

In addition, because of the hybrid funding system in the public sector, with a mix of prospective (for care) and retrospective (special missions, expensive drugs and devices) payments, there is a high risk of cross-subsidisation. This could lead to an increase in expenditure (or a decrease in tariffs) that are not related to productivity gains, thus threatening the financial viability of even the most productive of public hospitals.

At the same time it is not clear what will happen to good and bad performers. In a truly competitive market, those hospitals where costs are higher than tariffs must reduce their unit costs, or they will go bankrupt and close. However, this would

be politically unacceptable in France. Moreover, since public hospital managers do not have much room for manoeuvre – they cannot layoff staff or close down certain services – their main strategy can only be an increase in volumes to reduce unit fixed costs. Given that productive hospitals will also increase their activity to gain more revenues, the overall effect is a total increase in expenditures, which will jeopardise the national spending target. It is also not clear if the good performers will be allowed to retain surpluses, nor how they might be used.

Finally, if the issues that have been dealt with above are not settled, and if the convergence process moves on towards the same average tariff for both sectors, then the private sector will have huge opportunities to increase profitability and gain market share from the public sector because of their greater flexibility. One consequence may be that they will offer better career and remuneration opportunities to doctors and nurses compared with the public sector, thus aggravating the problems in recruiting medical staff in under-served areas, with implications for access to care. Thus, while recent French hospital reforms are a step in the right direction, further measures are required that will regulate carefully the conditions for competition without discouraging quality improvement and risking large increases in expenditure. In France as elsewhere, assuring fair competition between public and private hospitals is not an easy task.

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Health care human resource policy in France

Yann Bourgueil and Yvon Berland

Summary: The number of full-time doctors in France is decreasing. Inequalities in the distribution of the health work force are of concern with some regions in the north having medical density rates 60% lower than those found in the south. Mechanisms used to regulate the supply of medical professions appear to have been ineffective and general practice remains an unattractive career option. A new strategic plan was announced by the government 2006. This includes opportunities for training in general practice in medical school, the development of financial incentives to encourage doctors to locate in areas of most need, and delegation of some clinical activities to other health professionals.

Keywords: France, Health workforce, Health reform, General Practice

The number of full-time doctors in France is decreasing. This is due to a combination of factors, including the decline in the numbers of medical students between 1971 and 2001; the introduction of the 35-hour working week in France; and the EU working time directive limiting the maximum working week (Directive 93/104/EEC). Moreover, the increasing number of women (60% of all new medical students in 2002), and a change in younger professionals' attitudes towards work will lead to significant reduction in the actual worked time of health professionals.

In France, the number of doctors is currently relatively high at 3.4 per 1,000 inhabitants. This compares well with countries such as Germany (3.4 per 1,000), Denmark (3.2 per 1,000), Finland (2.6 per 1,000) and the United Kingdom (2.2 per 1,000); however, it is rather lower than that of Italy (4.1 per 1,000).¹ Moreover, in

France, the geographical distribution of doctors across the country is uneven. There is more than a two-fold difference between the north and south. Furthermore, the large number of doctors reaching retirement age in the near future will exacerbate the situation (see Figure). Yet, despite this general trend, it is still unclear as to what the actual shortages of staff might be as there is no single source of comprehensive data available on the actual distribution of the different types of health professionals.

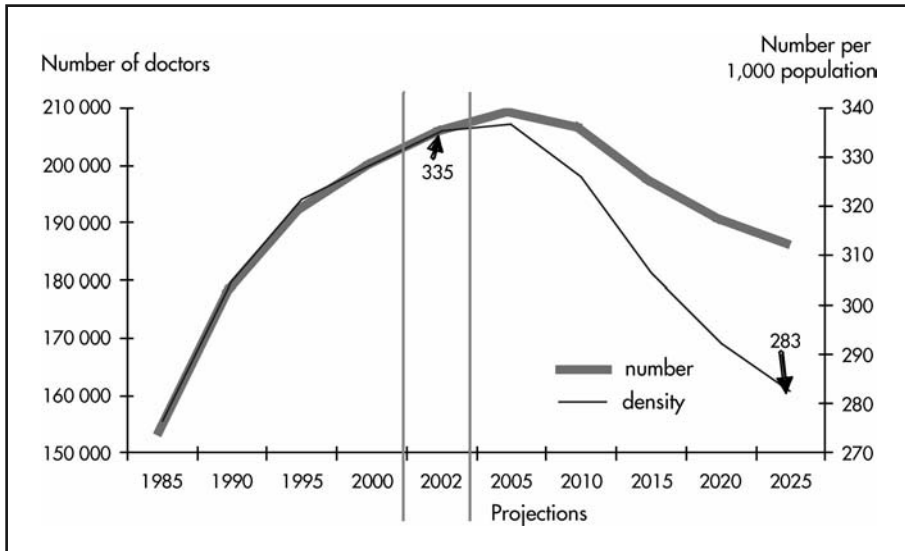
Background

Following several public reports and surveys in the 1990s pointing to the need for better information on health workforce demographics, the Ministry of Health created a National Observatory of Health Professions (*Observatoire National de la Démographie des Professions de Santé*, ONDPS) in 2003. Its major responsibilities are to collect, analyse and communicate precise and objective information relating to all categories of health care professionals. The ONDPS also engages in research on working conditions, planning needs for health professionals and professional development. It also works in cooperation with Observatories of Health Professionals found in each region. They bring together local representatives of doctors, the state authorities, sickness

Yann Bourgueil is a Research Director, Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France.

Yvon Berland is Professor of Medicine and President of the National Observatory of Health Professions (ONDPS). Email: bourgueil@irdes.fr

Figure: Predicted total number of doctors and number per 1,000 population assuming 7,000 new students per annum.²



funds, hospital agencies and medical schools. They also coordinate surveys and other initiatives to help ensure the health workforce matches demand.

Two reports published by the ONDPS in 2005 and 2006 concluded that, compared to other countries, the number of doctors is currently not a cause for concern in all areas.^{2,3} However, the declining numbers will be most acute between 2008 and 2015. Concentrating on primary care catchment areas (30,000 to 50,000 population) that were defined as being deprived of health care professionals (see later section in article) these reports concluded that very few areas currently fell within these criteria; nonetheless, those that do encompass 2.6 million inhabitants (4% of the population) and affect 1,600 GPs (3% of the workforce). Inequalities in the distribution of the health work force are of greater concern with some regions in the north having medical density rates 60% lower than those found in the south.

Mechanisms used to regulate the supply of medical professions, appear to have been ineffective in ensuring access to an adequate number of various specialists. Currently, there are two main tools of medical demographic regulation: *numerus clausus*, which limits the number of students allowed to enter medical school, and the *Examen Classant National*, which ranks medical students after six years of study. These rankings determine what medical speciality a student may pursue. Regional inequalities are also partly explained by the freedom both specialists and GPs have to work in any part of the

country they choose.

Moreover, general practice is not attractive for medical students, and consequently they have developed strategies to avoid this career option. Indeed in 2005, 600 training posts in general practice remained unfilled. Students who were not ranked high enough to access a specialist training position preferred to repeat their exams in 2006, rather than enter general practice training. The poor opinion that students may have of general practice may be due to only working in hospitals, with little opportunity to learn about primary care work. General practice commonly considered exhausting due to patient demands.

The ONDPS has made a number of recommendations to address this situation:

- Promoting a single register for all professionals
- Regionalising the *Examen Classant National*
- Making changes to the curriculum in medical and paramedical education, including a more robust generalist education for doctors before any specialisation, training outside teaching hospitals, better promotion of general practice, and the reinforcement of paramedical skills.
- Restructuring the health workforce supply by grouping practice both in primary and secondary care and redefining health professions.

However, the ONDPS did not propose any policies restricting the geographical

locations where doctors might practice. A special committee chaired by the president of ONDPS suggested a number of measures to reduce regional inequalities, but expressed their respect for the 'free settlement' of doctors.⁴ This implies that there are no real disincentives for those doctors who want to locate in areas where there is already a high density of health professionals.

Because the ONDPS is recognised in the health sector as a reliable source of data, analyses and recommendations, its recommendations have been received with great interest by both professionals and the media. They have also raised knowledge and awareness of this issue. Subsequently in response to the growing expectations for policy development, the current government announced a new strategic plan in January 2006 aimed at improving health workforce development.⁵ This includes the development of incentives to encourage doctors to practice in medically deprived areas, improvements in working conditions and actions to increase the supply of doctors. Another feature is the promotion of the greater delegation of clinical activities from doctors to other medical staff such as nurses.

Developing incentives to practice in medically deprived areas

Deprived areas are defined by two criteria: low medical density (an area where the number of doctors is 30% below the national average) and high professional activity (an area where the per capita medical activity in terms of patient visits is 30% above the national average). The precise list of deprived areas is set by regional authorities after consultation with regional stakeholders.

Stating that doctors working in medically deprived areas face unattractive working conditions, including long hours and a lack of time for continuing medical education discourages young doctors from locating in such areas. Thus, the plan provides several incentives to encourage group practices and to improve working conditions in these areas:

- The health insurance fund will pay a 20% higher rate of remuneration to doctors working in a group practice in medically deprived areas.
- Local authorities in rural areas will be able to provide financial aid to doctors who wish to set up a practice (for a minimum period of three years) in

deprived areas, or provide them with professional facilities or personal housing. They can also give a study allowance of up to €24,000, offer a housing grant up to €400 per month or provide accommodation to medical students in their sixth year of study if these students commit to locating for a minimum period of five years in a medically deprived area.

- Doctors participating in out-of-hour services in such areas will benefit from a tax revenue rebate on their income from this activity for up to a maximum of 60 days or €9000 per year.

A single regional office will be in charge of disseminating all available information on these incentives in order to increase doctors' knowledge and understanding.

Improving working conditions

It is generally accepted that operating in group or multidisciplinary practices would improve both the quality of health care and the quality of life for doctors. A special fund (*Fond d'Aide à la Qualité des Soins de Ville*, FAQSV), which was set up within the national health insurance budget to finance innovations in ambulatory care organisations among other things, will be used to make capital investments to set up multi-speciality group practices.

Additionally, a new status of 'associated partner' has been created for young doctors. This will allow them to join a practice without having to make a capital investment. The plan also has abolished the difference in the maternity leave period permitted to female doctors compared to that enjoyed by other employed women. This will facilitate a better balance between family and professional life, and is essential given the increasing number of female doctors.

Increasing the number of doctors and the proportion of GPs in workforce

The plan also increased the *numerus clausus*, which restricts the number of entrants to medical schools from 4,700 students in 2002, to 6,300 in 2005, and to 7,000 per year for the period 2006 to 2010. Furthermore, from 2006, a two-month training period in general practice has been offered to medical students in at least third year of study, in order to improve their knowledge about general practice. Previously, as we have noted, French medical students did not have any training period in general practice before choosing their speciality. The proportion of students

entering medical school, as well as the number of junior doctors, will also be increased in the medically deprived areas.

The plan also introduces measures to encourage doctors to continue to practice for more years and to dissuade early retirement. The 2003 law reforming retirement rules allows individuals to have an activity based income on top of their pensions. The cap on the additional income has also been raised from €30,000 to €40,000 for doctors retiring beyond age 65. Moreover, doctors older than 60 are exempt from out-of-hour shifts.

Delegation of medical tasks from physicians to other medical staff

Skill mix and especially the delegation of tasks from physicians to other health care professionals are considered an important issue by the Ministry of Health. The plan aims to improve cooperation between doctors and these professionals. Evaluations first begun in 2005 looking at sharing or transferring tasks from doctors have now been extended from five to fourteen pilot schemes.⁶ These projects have been limited to very precise situations in a few practices, impacting on a very limited number of patients and professionals e.g. looking at the role of nurses in dialysis or radiotherapy as well as the conduct of eye sight tests by ophthalmologists/orthoptists.

The ONDPS has supervised these pilot evaluations.⁷ Initial results confirm their feasibility in terms of safety and quality. General recommendations for a widening and further generalisation and development of advanced practice nurses will be produced by the end of 2007 under supervision of the HAS (*Haute Autorité de Santé*), a body similar to the National Institute of Clinical Excellence (NICE) in England and Wales in its functions.

Conclusion

The demographic pressure on the health care workforce may have a dramatic impact on future health care supply and organisation in France. In one sense, this situation is a threat to the equilibrium between health care professionals. In another, it offers an opportunity to support restructuring policies, both in the hospital and ambulatory sectors. This implies, for instance, a re-definition of the roles of specialists and general practitioners in the ambulatory sector.

The recent reform of the *médecin traitant* which introduced a preferred doctor scheme, while not clearly oriented towards

a gate keeping model as in the English NHS, confirms a more important role for GPs.⁸ This policy could be enhanced if there are decreasing numbers of specialists in ambulatory care. A greater recognition of GPs in the provision and teaching of primary care could become more acceptable to specialists if they work in collaboration rather than in competition. From this perspective, the challenge will be to define a new contract for doctors working in the ambulatory sector in order to guarantee equal access to care for all of the French population.

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New governance arrangements for French health insurance

Carine Franc and Dominique Polton

Summary: This article traces the development of statutory health insurance in France, highlighting challenges in governance and power arrangements between the state and the health insurance funds. The impact of the 2004 Health Insurance Reform Act is also discussed. This introduced new governance arrangements that on the one hand can be seen as a reinforcement of the power of the state in the management and regulation of the health system. At the same time significant decision making powers have been shifted from the state to UNCAM, the new National Union of Health Insurance Funds.

Keywords: France, Health policy, Health insurance, Governance

Background

The French national health insurance scheme was established in 1946,* just after the Second World War, as an employment based statutory system. The three main objectives inspired both by the 'sozialpolitik' of Bismarck (1881) and the famous report of Beveridge (1942) were: unity (a unique national fund), universality (equal access) and uniformity (equal treatment). At the end of 1946, the French social security system covered health insurance including accidents at work, maternity allowances, disability insurance, a pension scheme, and family allowances for workers and their families.

Statutory health insurance was only extended to farmers in 1961 and to self-employed non-agricultural workers in 1966. By then the objective of unity had been abandoned and independent schemes were created for these two professional groups.

Carine Franc is a Researcher at the Institut National de la Santé et de Recherche Médicale and the Institut de Recherche et Documentation en Economie de la Santé (IRDES), Paris, France.

Dominique Polton is Director of Strategic Research and Development, Caisse Nationale d'Assurance Maladie (CNAMTS), Paris, France.

Email: Carine.Franc@kb.inserm.fr

Today 95% of the population is covered by three schemes providing a uniform package of benefits: the general health insurance scheme (*Régime Général*), the agricultural scheme (*Mutuelle Sociale Agricole, MSA*) and the national insurance fund for self-employed non-agricultural workers (*Régime Social des Independents, RSI*). In addition, there remain several insurance systems for some professional groups who already had insurance coverage in 1945, including civil servants, mariners, miners, railway-workers, and employees of the national bank.

Health insurance in France has, therefore, always been more concentrated and uniform than that seen in other 'Bismarckian' systems (such as the German system). Universality was achieved in 2000 through the Universal Health Coverage Act (*Couverture Maladie Universelle, CMU*), which enshrined the right to statutory health insurance coverage on the basis of residence, thus providing coverage to the non-insured fraction of the population.**

* The edict of 19/10/1945 concerned among others risks, the risk of illness and the law passed on 22/05/1946 worked on the principle of the continued spread of social security to the whole population.

** Estimated at about 1% of the population. Before the CMU Act a system of personal insurance existed and premiums were financed by local governments for those with low incomes.

*** The same principles of professional representation apply to the governance of the two other main funds, but they will not be analysed in detail here.

The governance of the health care system: problems and past reforms

The social security system created in 1945 was associated with the idea of social democracy; the Régime Général (covering 85% of the population) was thus organised as a network of health insurance funds headed by elected boards of directors comprising representatives of employees (the majority) and employers.*** It included 129 local funds, 16 regional funds and a national fund (*Caisse Nationale d'assurance Maladie, CNAMTS*). Employees and employers were to manage the sickness benefits, financed through payroll contributions.

Since 1945, the governance of the health care system has been the subject of numerous debates and several reforms, the most recent of which were part of the health insurance reforms of 2004. Two issues are at stake: (1) the division of power between the state and the health insurance funds over governance of the funds and the relationships between the two, and (2) the internal management of the health

insurance scheme itself. These two issues have always been considered to be problematic, especially in respect of the recurring problems of cost containment and deficit management found within the French health care system.

The respective roles of the Government and the sickness funds

From the very beginning, the system was hampered by the fact that although the social security scheme was to be managed by representatives of both employers and employees, in the health care sector the extent of these management responsibilities was limited, especially in terms of financial responsibility. This is another key difference to other social insurance systems, such as the German system. In fact, the French health care system has from the beginning been a hybrid system (in between the Beveridge and Bismarkian models). This historical feature partly explains the difficulties that it has encountered ever since.

In the initial division of powers between the state and the sickness funds, fundamental decisions about the level of contributions, the extent of the benefit package and the fee schedules* belonged to the state. The state also handled policy concerning public hospitals (planning and budgets) and drugs (price setting), while the health insurance funds negotiated collective agreements with professionals in private practice, including the level of prices (nevertheless these agreements had to be approved by the government).

In addition, there was also a division of power across different geographical entities, both within the state and the sickness funds. For instance, up to the 1990s hospital planning was designed by the regional directorates of the state while the budgeting process was at the *département* level. For a period of time, tariffs for private-for-profit hospitals were set independently by each regional fund (with its own boards of directors).

Several reforms have attempted to address the conflicts and contradictions arising from the complexity of this institutional landscape. Over time, this balance has tended to shift towards increased state intervention, particularly since the issue of balancing the public accounts, and thereby controlling public expenditure, has figured

prominently on the political agenda. An important step was taken in 1996 with the Juppé reform: notably it addressed the issue of legitimacy and democratic control of state decisions by reinforcing the role of parliament.¹ Thereafter, the parliament has set a projected target (ceiling) for health insurance spending for each subsequent year, known as the national ceiling for health insurance expenditure. However, up to 2005, this objective has only been attained once, in the first year 1997. The reform also created regional hospital agencies linking the state and the sickness funds at the regional level, but in practice giving pre-eminence to state influence.

“state authorities and the health insurance funds were increasingly in conflict”

The Juppé reform was thus seen by many as giving the state more control of the health care system. This trend was further reinforced by the Social Security Funding Act of 2000, which gave the state responsibility for the whole hospital sector, including private for-profit hospitals that previously were regulated by the insurance funds. In return, a more clear delegation was given to CNAMTS regarding the ambulatory care sector budget (professional fees and prescriptions). However, again in practice, this delegation of responsibilities was only implemented during the first year.

The internal management of the health insurance funds

The issue of organisation structure and decision making power within the health insurance funds is also linked to the relationship between the funds and the government. Historically, social insurance managed by employers and employees and based on payroll contributions, was seen as a more coherent and legitimate mechanism than direct state intervention.

This ‘social democracy’ was to rest upon direct elections to the funds’ board of

directors. But in 1967, in the first major reform of social security these elections were replaced by a system of trade union appointments. This also meant that there was parity in representation between employers and employees, whereas before employees had been in the majority. In 1982, with the political left coming to power, the intention to return to the original principles of 1945 was announced, with a return to elections and employees majority boards. In practice, however, such elections only took place once, in 1983.

The 1996 Juppé reform reversed the policy and returned to the 1967 position again appointing board members and reintroducing parity between employers and employees. In addition, parliamentary involvement from 1996 also raised questions about the legitimacy of employers and trade unions as a source of democratic control. The links between professional status and health insurance were also relaxed: wage contributions were replaced by a tax on income in 1996 with coverage based on residency in 2000.

At the beginning of the new millennium governance of the health care system remained a burning issue. After several attempts at clarification, the division of responsibilities still remained unclear. The state authorities and the health insurance funds were increasingly in conflict, with the trend towards state control regularly denounced by the health insurance funds.

This tension reached a critical point in September 2001, when the main employers union withdrew from the boards of all the health insurance funds, on the grounds that the funds did not have the ability to effectively regulate health care expenditures; the legitimacy of these boards thus became even more questionable. At the same time, the deficit of the general scheme was soaring (€6 billion in 2002, more than €11 billion in 2003 and 2004), increasing still further demands for a strong cost containment policy.

Thus, in August 2004 the Health Insurance Reform Act introduced changes in the institutional arrangements, addressing both the issue of shared decision making power between the state and the health insurance funds, and the status and management of the latter.

New governance arrangements

The reforms have been largely inspired by a consensual report from the High Council

* Setting reference values for health care services provided by the various categories of professionals in private practice.

for the Future of Health Insurance, which stressed the necessity to redesign responsibilities in the management of the health care system by identifying a 'chief' in charge to pilot and to insure the coherence of the system.²

The three main insurance funds (Régime Général, MSA and RSI) are now federated in a National Union of Health Insurance Funds (*Union Nationale des Caisses d'Assurance Maladie*, UNOCAM). This new federation has become the sole representative of the insured in negotiations with the state and health care providers.

The director-general of the UNOCAM is also the director of the CNAMTS. He is nominated by government and his executive power has been strongly reinforced at the expense of the board, whose role is now limited to strategic matters. For example, collective agreements with doctors and other organisations of professionals in private practice are now negotiated and signed by the director-general alone. He also nominates the directors of local and regional funds; thus operational management is clearly in his hands.

This is thus a new step in the process of the withdrawal of employees and employers unions from the management of the health insurance system. But is it a reinforcement of the state's power? The answer is ambivalent as the reforms reinforce indirectly the power of the state to the detriment of employees and employers unions by entrusting much power to the director-general of UNOCAM. Yet, at the same time, important responsibilities have been shifted from the state to this new managed health insurance fund. These concern the financial governance of the health care system, the definition of the health care package and the regulation of prices and tariffs, as well as the negotiation of collective agreements with service providers. This shift of power is discussed further below.

New responsibilities

For instance, in order to regulate ambulatory health care expenditure, the director-general of UNOCAM now has more power than the health insurance funds had previously, to negotiate with the doctors' unions and other professionals in private practice. Previously, the government could decide to approve or refuse the result of the negotiations, taking into account various factors including the

impact on health expenditures. From now on, the government can only refuse the approval on legal or public health grounds. This means that the sickness funds are fully responsible for the economic consequences of the agreements that they negotiate and sign. In respect of hospital care and drugs, UNOCAM is more involved in the decision making process than previously was the case, although the state retains a leading role.

"The ability to define levels of co-payment now rests with the health insurance funds"

The health insurance funds are now responsible for defining the package of care to be covered (for procedures performed by health care professionals). This was previously a state responsibility. The sickness funds are assisted in their decisions by the High Authority of Health (*Haute Autorité de Santé, HAS*), which is in charge of the scientific evaluation of diagnostic and therapeutic procedures and the development of clinical guidelines. Consultation should also take place with the Union of Voluntary Health Insurers (*Union Nationale des Organismes Complémentaires d'Assurance Maladie, UNOCAM*), a new institution created by the reform.*

The ability to define levels of co-payment also now falls under the jurisdiction of the health insurance funds. Prior to these reforms, most user charges were co-insurance fees, fixed by the state. Now, some co-payments may be levied in addition to co-insurance rates for each consultation with a health professional. All these user charges are now fixed by the sickness funds and no longer by the state (although it can oppose decisions taken on public health grounds). Again the

voluntary insurers body, UNOCAM, has to be consulted on decisions related to co-payments.

The health insurance funds are also now responsible for meeting the financial objectives for ambulatory care expenditure. They are assumed to have the capacity and tools to control their health care costs and stay within the limits of the national target/ceiling set by parliament. An independent committee monitors the evolution of health expenditures during the year in order to inform the state and UNOCAM if there is a risk that this target will not be met. If this is the case, UNOCAM is obliged to take measures (notably concerning user charges) to balance the budget.

Conclusion

On one hand, the new governance arrangements implemented following the 2004 reform can be seen as a reinforcement of the power of the state in the management and regulation of the French health system at the expense of employees and employers unions. In comparison with the past, the national health insurance fund (general scheme) has moved towards being an independent agency under state control. On the other hand, some decision making powers have been shifted from the state to this newly organised insurance fund: the notion being that increased autonomy and responsibility will lead to improved performance in system management. Only time will tell as to whether this promise will be kept and these new institutional arrangements will operate in a more coordinated and efficient manner.

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* The underlying idea was that in the French health care system, given the role of voluntary insurance, which covers co-insurance and co-payments for more than 90% of the population, effective stewardship of the health care system requires coordination between statutory and complementary insurance. The mutual benefit movement, which is an important force in French political life, has strongly advocated the involvement of supplementary insurers in the collective regulation of the health care system. UNOCAM was inspired by this proposal.

A new policy agenda in Sweden: choice and deregulation

Anna Melke

The September 2006 general election gave Sweden its first centre right government since 1994. In fact, the Social Democratic Party (SDP – *Sveriges socialdemokratiska arbetareparti*) has been in power since 1932 with the exception of just nine years. The new government is comprised of four different parties. The new prime minister, Fredrik Reinfeldt, has managed to obtain a majority of seven seats in the parliament (*Riksdag*) by successfully building a coalition between his 'new' Moderate Party (*Moderata samlingspartiet*) and competing parties on the right: the Folk Liberals (*Folkpartiet liberalerna*), Centre Party (*Centerpartiet*), and Christian Democrats (*Kristdemokraterna*). While this may seem a very narrow majority, it represents a remarkable change in a country where the SDP has long been able to run minority administrations, relying on support from Left and Green parties. Local elections were also held on the day of the general election and the right wing parties were also successful in many of the regional (county councils) and local (municipalities) governments.

Health policy in Sweden on the national level will be determined by officials from two different parties. Göran Hågglund (Christian Democrat leader) has been appointed Minister for Health and Social Affairs, Maria Larsson (Christian Democrat vice president) is the Minister for Elderly Care and Public Health, and Christina Husmark Pehrsson (Moderate) is the Minister for Social Security. Although opinion polls indicate that Swedes, like others in Europe, are concerned with the future of their health care system, it was only a marginal issue

during the election campaign. (In Sweden, much of the responsibility for health and social care lies with the county councils and municipalities rather than central government.) Nonetheless, the new government's first budget presented to the Riksdag in October 2006 will have significant consequences for health policy.

Unemployment and sickness benefits

The election campaign focused heavily on the economy and, in particular, on the need to reduce the high levels of unemployment and challenges arising from long-term absence from the workforce. The centre-right coalition also campaigned on a platform which would incentivise individuals on long term sick leave to return to work. One way of doing this was to reduce the maximum monthly sick pay by about €1,000 for high income earners. Moreover, a new system for calculating sickness benefits will be introduced and measures taken to combat supposed irregularities, such as overuse, abuse and inaccurate authorisation of sick leave by general practitioners. There will also be changes to unemployment insurance resulting in higher contribution rates and lower benefit levels. Additionally, more thorough changes have been announced including making the self-employed contribute to the unemployment insurance and incorporating this into the general social security system.

Increasing emphasis on choice

One key theme in the new budget is the emphasis on the freedom of choice of care provider, partly through fostering private sector alternatives. The so-called national 'care guarantee' is to be further developed, placing particular attention on freedom of choice for health care consumers. The guarantee was first introduced in 2005 as a means of reducing waiting lists and ensures that anyone in need of care is guaranteed contact with their GP or other relevant

specialists and subsequent appropriate treatment within a specified time period. If care cannot be provided within an individual's local catchment area, then he would be free to seek treatment elsewhere. At present, this guarantee is for guidance only, but proposed new legislation would enshrine it in law. Furthermore, additional private sector institutions will be included in the list of approved health care providers that can be funded by the public purse.

In addition, state grants will encourage providers to move care out of the hospital setting and provide privately managed services. The Minister of Health has also proposed the potential privatisation of some aspects of hospital services in the country, i.e. permitting private management and the accrual of profits.¹ He has also announced potential reforms to the dental care system, such as decreasing user charges, which may help increase access.²

Focus on older people and mental health

One of the main areas of proposed additional spending is on health and social care for older people. The government plans to invest in many areas, including promoting an increase in the number of residential care beds and doctors, better use of drug treatment, and improved care for people living with dementia (and their family carers). Older people will also be encouraged to make active choices regarding their care and service providers.

Since 2003, mental health has also been high on the agenda, most notably because of the high profile murder of the SDP Foreign Minister, Anna Lindh, by Mijailo Mijailovic, a man acknowledged in his trial to have significant mental health problems. Subsequently, a national coordinator was appointed to look at the system and see how it might be improved. One key conclusion was the need for substantial additional funding; this is reflected in the new budget. The emphasis will be on enhanced professional training as well as an increase in inpatient beds. Preventive actions are also being considered, specifically related to child mental health including increased access to psychologists and social welfare officers in primary care. Specific funding will also be dedicated to care management.

State monopolies

Turning to public health issues, taxes on tobacco will increase, while taxes on alcohol will not decrease. The latter had previously been suggested in one report as

Anna Melke is a former journalist and currently a PhD candidate, School of Public Administration, University of Göteborg, Sweden.

Email: anna.melke@spa.gu.se

being beneficial in reducing alcohol imports,³ and had been endorsed by the Moderate Party. However, the new Public Health Minister confirmed that it would not be possible to reach a common position on tax reductions within the four-party coalition.⁴ Instead, the focus will be on measures to reduce illegal sales of imported alcohol. There has also been no mention of any reform to the state monopoly on the sale of alcohol; something that has often been challenged by the centre-right. The two national institutions responsible for the prevention of alcohol and drug use are to be abolished by 2008. It remains unclear who will now take on these roles.

In contrast to alcohol, the current retail monopoly of the state-owned pharmacy chain *Apoteket AB* in the distribution of both prescription and non-prescription medications will end and the market then opened up to other suppliers. A bill setting out how the new arrangements will operate has yet to be published, so the precise nature of deregulation in the pharmaceutical sector remains unclear.

Another broader policy issue with potential health impacts is that of gambling. The national betting agency, *Svenska Spel*, is due to be dismantled and according to comments from the Minister for Local Government and Financial Markets, Mats Odell, foreign companies may be allowed to enter the market.⁵

Conclusion

Considering the turbulent history of some coalition governments, it will be interesting to observe how well the parties making up the new government will be able to work together. After only a few weeks in office, two Moderate ministers have been forced to resign as media investigations revealed some inappropriate personal actions, including the employment of illegal workers, alleged tax evasion, and failure to pay the television license. Furthermore, other ministers are being investigated by the Riksdag for potential conflicts of interest in respect of their personal investments.

It also remains to be seen how the new coalition will succeed in its internal negotiations. Moreover, with Sweden being a country where almost all parties constantly 'crowd the centre ground' of the political spectrum, it will be interesting to observe how the new government will in practice differ ideologically from its predecessors.

More information on the new government's policy at <http://www.sweden.gov.se>

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Health care reform in Germany: is Bismarck going Beveridge?

Melanie Lisac and Sophia Schlette

Chancellor Angela Merkel declared health care reform a top priority in March 2006. At the time, high expectations were placed on the new grand coalition between the CDU/CSU (Christlich Demokratische Union Deutschlands/Christlich-Soziale Union in Bayern) and the SPD (Sozialdemokratische Partei Deutschlands). The country anticipated far-reaching reforms that would promote competition to address the pressing problems of rising expenditure, poor efficiency and evidence-free variations in the quality of care.

New legislation

Due to come into force in April 2007, the 'Statutory Health Insurance Competition Strengthening Act' (SHI-WSG) aims to strike a balance between the need for reform and the explicit commitment to safeguard universal access to essential health care regardless of the ability to pay. Key elements of the reform are:

A guaranteed right to health insurance

In recent years, Germany has seen the number of uninsured individuals climb to 200,000. With no obligation to buy or sell health insurance coverage, both public and

private health insurers can currently reject individuals who have no coverage or have lost their insurance due to unemployment, divorce, or low-income jobs. From April 2007, insurers must offer at least a basic benefit package to these individuals.

Care coordination incentives

To encourage the integration of health care providers, as well as better cooperation between health, social and long-term care, the government will extend financial incentives for integrated care contracts that focus on population-oriented care initiatives. Facilitating selective contracting legislators hope will make sickness funds and health care providers raise efficiency and foster competition based on the quality of care.

Contribution rate and tax funding

From 2009, the contribution rate will be determined centrally by ministerial decree, replacing the rates currently set separately by each of the 250 sickness funds. In addition, contributions will be supplemented by tax revenues covering the health insurance needs of children.

Portability of private coverage

The reform bill contains a portability provision allowing individuals with private health insurance to change insurer without undergoing a new risk assessment. This provision is also aimed at increasing competition among private health insurers.

Melanie Lisac is Project Manager and Sophia Schlette Project Director, International Network Health Policy & Reform Coordinator, Bertelsmann Stiftung, Gütersloh, Germany. Email: sophia.schlette@bertelsmann.de

Debate comprises technical solutions

The grand coalition holds a comfortable majority in the Bundestag and could thus easily legislate for substantial reform. The recent health policy making process has, however, turned out to be anything but smooth. Social and Christian Democrats differ strongly in their ideas for health care reform which makes consensus building between the coalition partners difficult. Moreover, the technical dispute about the challenges and solutions for health reform and the political dispute about the right balance between solidarity and individual responsibility have been overshadowed by a battle for resources and political influence. Leaders of the wealthier Bundesländer have repeatedly opposed federal government proposals for health financing reforms, such as the new risk adjustment mechanism, because they fear that the additional financial burden will fall on their states. Since the CDU/CSU have a majority in the Bundesrat (upper house representing the federal states), this peculiar power constellation, with opposition coming from the Chancellor's own party, threatens ratification of any new health care bill in the current circumstances.

The regional politicians' protests have so resembled a preliminary electoral race among would-be candidates for the chancellorship at the next general election that the Chancellor's image and her party's popularity have plummeted, as frequent opinion polls clearly show.

The bottom line for the coalition centres around one fundamental ideological question: is competition the remedy for the ailing system, or is 'state medicine' the answer? How can they possibly be aligned? When it comes to the issue of how to raise revenue to secure health care financing the coalition partners have little common ground.

The health fund

The ongoing debate around the proposed health fund vividly illustrates the differing political views:

The health fund, a new health insurance tool,¹ would combine these different financing approaches. The fund would centrally pool income-related employer and employee contributions as well as federal tax revenues. Through the health fund, sickness funds would receive a risk-adjusted flat-rate amount for each insured person. The sickness funds would be transformed from payers to players and thus have to manage their resources wisely.

They could "compete" over the quality and efficiency of contracted services or choose to merge with their rivals to generate major efficiency gains. If, however, the sickness funds could not purchase all necessary health services with their fund allocation, they would be permitted to charge their policy holders an extra contribution. The debate did not however end there.

The idea of an extra contribution, whether flat-rate or income-related, has led to feelings running very high within the SPD. The left of the party worried about the unfair distributive effects that these extra charges would have on low-income earners. Therefore, the SPD wanted to limit any contribution to just one percent annual income. The CDU/CSU opposed such a ceiling, arguing that it would restrict competition between sickness funds. Because of this and other unresolved questions, the grand coalition decided to postpone the health fund until 2009, which happens to be the year of the next general election.

As if coalition quarrels weren't enough, the various lobby groups also want to have their say. Their influence on policy makers further complicates the development of reforms that are based on health care needs and technical evidence-based assessment. Not unexpectedly, the original reform proposals of June 2006 met with strong opposition from of all those who still lived comfortably under the status quo.

Winners or losers?

These players do perceive the risks, i.e. how the reform touches upon their particular interests, but not the opportunities (or choose to ignore them):

Sickness funds that might under the health fund be forced to merge will have more freedom to selectively contract with providers.

The imminent abolition of statutory physician associations as collective negotiating bodies, will mean that providers will be free to directly negotiate (improved) contracts with sickness funds.

There are also those private health insurers who have won at least a temporary victory. Much of the original reforms have been watered down or abandoned altogether thanks to their successful lobbying of regional politicians. While the June 2006 proposal would have brought private full-cover health insurers into the health fund and compelled them to compete with the

sickness funds (or sell complementary policies), private health insurers managed to remain outside of the health fund and stay in the business of providing private comprehensive health insurance. However, requirements for purchasing private coverage have been tightened. To opt out of the statutory health insurance scheme, earning a lot is not enough any more; instead, individuals need a three-year record of income above the opting-out ceiling. Furthermore, private health insurers have to offer a social health insurance-like comprehensive benefits package to their clients and thus enter into competition with the public sickness funds.

Competition? Yes but...

Finding a consensual solution to health care financing has thus been tricky. All in all, the proposal as laid down in the official cabinet's draft for the "SHI-WSG" (25 October) does not live up to the expectations of health policy experts or the public. The irony is that those who most loudly called for competition as the ultimate means of achieving a sustainable, affordable health care system are the very same players who are now opposing any change. Competition is fine as long as it affects everybody except oneself. The compromise put forward now does have some incentives to improve the quality and efficiency of health care and aims to put patient needs and care requirements ahead of the vested interests of long-standing institutions. Nonetheless, especially in the area of financing, power games and the need to find an arrangement that suits both governing parties, have postponed any far-reaching structural reforms.

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Stem Cell Politics

Anne-Maree Farrell

Summary: In recent years, the use of human embryonic stem cells (HESC) for research or other purposes, has generated significant political conflict at EU level, which has been mirrored in a number of Member States, as well as in other western countries, such as the United States. This article, identifies the key parameters of such conflict in an EU context, the strategies employed by EU decision-makers to reach political compromise on a range of issues involving HESC use, and considers some of the wider implications of managing stem cell politics at EU level.

Key Words: Stem cells, Politics, Biotechnology, European Union, Ethics

Ethical concerns

Ethical fault lines in stem cell politics at EU level have focused predominantly (but not exclusively) on research involving HESC use. Unlike adult or 'multipotent' stem cells which can be used to make a limited range of specialised cell types, embryonic or 'pluripotent' stem cells are not limited in this way and therefore are much more attractive for research purposes. The key ethical dilemma which has emerged to frame political debates in relation to HESC research has centred on protection of human life from the moment of conception on the one hand, and the promotion of research leading to new medical treatments which could alleviate human suffering and/or promote human potential on the other hand. At the heart of this dilemma are differing and deeply held views over what constitutes a human being.

Within the EU context, a powerful ethical discourse around notions of 'human dignity' has emerged in policy and regulatory debates over the use of the human body and its parts generally, and stem cells in particular. In this regard, the need to preserve human dignity has been used as a

'signifier' to cover a range of ethical concerns at EU level over HESC use, including upholding the sanctity of human life from conception, preserving the integrity of the person, and preventing the instrumentalisation and/or commodification of human beings. Such discourse draws inspiration from a number of international human rights instruments, and in particular from the EU's Charter of Fundamental Rights. Although the Charter is not currently recognised as legally binding under Community law, it has nevertheless been relied upon at an institutional level in relation to a wide range of administrative and policy activities, as well as to inform political debates involving ethical and/or rights issues.

"At the heart of the dilemma are differing and deeply held views over what constitutes a human being"

Institutional conflict

Opportunities to express ethical concerns over HESC use have arisen on a number of occasions at EU level in recent years, most notably in relation to research funding programmes, and in legislative debates over human tissue. Political

conflict over ethical aspects concerning the funding of HESC research erupted in inter-institutional debates over the 6th Framework (FP6) Programme for Research in the years 2002 to 2003. Despite the Commission attempting to lay the groundwork for agreement on the issue through obtaining an expert opinion on ethical aspects of human stem cell use, bringing key stakeholders together, and issuing a position paper on the matter, political consensus proved elusive leading to a moratorium on HESC funding under FP6.

Although the European Parliament subsequently passed a resolution permitting such funding under tightly controlled circumstances, the Council was unable to reach political agreement on the matter. In the absence of such agreement, the Commission was made responsible for the management of the FP6 programme, issuing guidelines which permitted research into supernumerary human embryos (i.e. surplus embryos resulting from in vitro fertilisation treatment that were subsequently donated for research purposes) created prior to 27 June 2002. Any unresolved questions on potential funding involving HESC research were to be resolved on a case-by-case basis.¹

A further opportunity to debate ethical concerns over HESC use presented itself during inter-institutional negotiations over the adoption of the Tissue/Cells Directive.² In the context of such negotiations, conflict arose between the European Parliament, the Commission and Council over whether Community legal compe-

Anne-Maree Farrell is Lecturer, School of Law, University of Manchester, Manchester, UK.

Email: a.m.farrell@manchester.ac.uk

This article was written while the author was on a Leverhulme Trust Research Fellowship. The Trust's support is gratefully acknowledged.

tence to set standards for quality and safety in relation to the use of human tissue/cells under Article 152(4)(a) EC could encompass ethical concerns over HESC use. In the absence of a general political consensus, a compromise was eventually reached whereby it was agreed in non-legally binding terms in the Recital to the Directive that there would be no interference with the decisions made by Member States regarding HESC use. In circumstances where individual Member States did permit HESC use, however, they were to ensure public health protection and respect for fundamental rights in relation to such use.³ Although such an approach resulted in a political compromise, which enabled the Directive to be adopted, it nevertheless resulted in EU-wide quality and safety standards in relation to HESC use that were less than comprehensive.

Notwithstanding the political compromises reached in relation to HESC research and use under FP6 and the Tissues/Cells Directive, ethical fault lines over the issue remain, and have recently resurfaced in inter-institutional debates over the proposed 7th Framework (FP7) Programme. Despite strong differences of opinion within the European Parliament, limited funding for HESC research was agreed in relation to the proposed FP7 programme in June 2006, and the matter came before the Council in July 2006. Within the Council, a potential blocking minority of Member States composed of Austria, Germany, Italy, Lithuania, Malta, Poland, Slovakia and Slovenia, had formed around objections to the funding of HESC research. In the end, Germany, Italy and Slovenia agreed to a compromise on limited funding for HESC research, with the other five Member States maintaining their objections. The compromise reached acknowledges that the terms under which funding for HESC research was granted under FP6 will continue. Certain fields of research will be specifically excluded, such as human cloning for reproductive purposes and the modification of the genetic heritage of human beings. Although any research activities involving steps which lead to the destruction of human embryos will not be available for funding, it will still be available for subsequent steps involving HESC.⁴

Economic potential

While ethical concerns about HESC research loom large in inter-institutional debates, EU decision-makers also

recognise the economic potential to be derived from successful commercial applications resulting from such research. Such recognition is underpinned by a commitment to the Lisbon strategy adopted by the European Council in 2000, which aims to make the EU the 'the most competitive and dynamic knowledge-driven economy by 2010.'⁵ Supporting innovation and the development of new medical treatments and commercial applications derived from stem cell research (whether involving HESC or not) represents an opportunity for the EU to position itself as a global leader in the field.

Although the United States has traditionally dominated research and innovation in biotechnology, President George W. Bush's ongoing opposition on moral grounds to providing federal funding for HESC research,⁶ presents EU decision-makers with an opportunity to create a research environment, which is more conducive to innovation and research in this field, furthering its leadership ambitions in the area.⁷

“EU decision makers also recognise the economic potential from successful commercial applications of research”

Scientific research and expertise

Scientists claim that stem cell research offers the opportunity for the development of promising new medical treatments in relation to diseases, including Alzheimer's, Parkinson's and diabetes. The use of undifferentiated cell lines, such as those derived from HESC, offers much more scope for scientists engaged in such research to investigate the potential application of stem cells to treat a range of diseases, than does the use of adult stem cells. The potential offered by such research, however, largely remains to be realised at the present time and a long-term view needs to be taken of the prospects of success resulting from such research.

Revelations of scientific fraud and misconduct by South Korean Woo Suk Hwang, formerly recognised as a leading

international stem cell researcher, demonstrates the high stakes involved for those working in the area, challenges the idea of the neutral and objective pursuit of scientific 'truth', and lends weight to ethical concerns voiced by those opposed to HESC research and use.⁸ The current approach at EU level is to acknowledge the potential offered by HESC research, but to adopt a cautious approach to its funding. Such an approach involves ethical and scientific oversight of researchers granted funding in line with guidelines specified by the Commission. While such guidelines are clearly designed to address ethical concerns, it is equally clear that the intention is to avoid the occurrence of any similar incidents in the EU context of the type that arose in the case of the South Korean scientist.

What is absent from the current approach taken by the Commission in this regard, however, is any recognition that the provision of scientific advice or oversight in policy-making and regulatory processes can be problematic, particularly when they involve politically contentious issues; something of which EU decision-makers were made painfully aware in the context of the BSE crisis of the late 1990s.⁹ On the basis of the Commission's current guidelines on HESC research, however, the assumption appears to be that the scientific advice/oversight is value-free and objective. Given the contentious nature of HESC research and use, and in the light of past difficulties experienced with the provision of scientific advice, it would no doubt assist in the building of public trust by EU decision-makers if transparency or accountability mechanisms in relation to expert advice and oversight on the issue were clearer.

Public views

Differences of opinion at an institutional level over HESC research and use at EU level are also mirrored among European citizens, as was evident from the findings of a recent Eurobarometer survey, which canvassed views on biotechnology, including stem cell research.¹⁰ Of those polled, 59% said they approved of HESC research, and 65% of the use of non-embryonic sources of stem cells, provided that it was tightly regulated. Particular questions directed towards eliciting their views on ethical aspects of such research, however, revealed significant differences of opinion. When questioned over whether an embryo can already be considered to be a human being immediately after fertili-

sation, 54% of those polled agreed with this statement, while 32% disagreed.

When presented with the ethical dilemma of the potential offered by such research for new medical treatments against the need to protect human embryos, those polled were divided with approximately 40% of the view that it was wrong to use embryos in medical research notwithstanding such potential, compared with 40% who approved of such use. When this ethical dilemma was posed another way and those polled were asked about the duty to pursue research that might lead to new medical treatments, even if this involved HESC research, then 53% agreed with this approach, while 29% did not. Although religious views on what constitutes a human being clearly influenced the views of those polled on the merits of HESC research, a clear majority in this category nevertheless supported such research, provided that it was tightly regulated. What came through clearly from those polled was that they wanted more information about the benefits and risks of HESC research, as well as to whether regulation and ethical oversight were sufficient in this regard.

Managing stem cell politics

A political consensus on HESC research and use at EU level has not been achieved to date, and it is questionable whether this is possible, or even desirable. The intensity of current political conflict over the issue reflects deeply rooted cultural values, religious beliefs, and ethical concerns over the value and potential of human life. Such diversity needs to be respected in the search for political compromise. In the context of such a search, however, account also needs to be taken of the fact that policy-making and regulatory activities at EU level take place in a complex multi-level governance environment, which often necessitates the employment of a range of strategies aimed at achieving agreement between relevant stakeholders, institutions and Member States on contentious issues.

In this context, the intensity of disagreement over HESC research and use has necessitated the use of a diverse range of strategies by EU decision-makers, including: obtaining expert opinions on ethical concerns; bringing key stakeholders together; publishing position papers on the issue; crafting carefully-worded political agreements; devising strict ethical and funding guidelines; and standard-setting through regulation, where agreement was

possible. Some strategies have been more successful than others, and there are gaps in policy and regulatory initiatives, some of which are more serious than others.

Regulation of HESC use is not as comprehensive as it could be given the absence of EU-wide quality and safety standards in this area in the Tissues/Cells Directive. Transparency and accountability mechanisms in relation to the use of scientific advice and oversight which underpin policy-making and regulatory activities in relation to HESC could be made clearer. While recognising that the scientific and economic potential offered by stem cell research (whether through the use of HESC or not) needs to be given serious consideration and supported where appropriate, a more critical evaluation of the risks and benefits of such research also needs to be given greater public and political space at EU level.

“EU-wide quality and safety standards for embryonic stem cell research are absent from the Tissues/Cells Directive”

In recent years, EU decision-makers have trodden a fine line (and often torturous path) between a range of ethical, institutional, economic, scientific and public concerns on stem cell research, particularly in relation to HESC use. What has become apparent is that while political consensus may not yet be possible, political compromise is nevertheless achievable through employing a range of different strategies which show respect for differing views over HESC use, while at the same time seeking to find a way forward which recognises the scientific and economic potential of such research in a multi-level governance environment. In the search for political consensus, however, EU decision-makers need to remain focused on the need to cultivate public trust in their capacity to manage HESC use in way that is ethically acceptable, strictly regulated, and recognises the importance of ongoing public dialogue and critical evaluation of stem cell research and its applications.

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The challenges facing mental health reform in Romania

Jack R Friedman

Summary: This article discusses early research findings of an ongoing multi-year fieldwork project exploring the culture of mental health services and mental illness in Romania. In 2005, during two research visits, interviews were conducted with scores of patients and staff at three psychiatric hospitals in Romania – ‘Alex Obregia’ in Bucharest, ‘Socola’ in Iași, and the psychiatric ward in the Policlinic of the Emergency Hospital in Petroșani (Jiu Valley).

Keywords: Romania, Mental health policy, Health system reforms, Psychiatric hospitals

Mental health reform and EU accession

On 16–17 December 2004, a summit of the European Council of Heads of State met to discuss the prospects for the admission of Turkey, Bulgaria, and Romania into the European Union. At the conclusion of the summit, the Council submitted a 47-point list of Romania’s progress toward accession. While there were many ‘congratulations’ in the Council’s report on Romania’s reforms, there were also many core concerns that alarmed the Council. Two of the 47 points on Romania’s progress towards accession concerned failures in regards to the treatment of people with mental illness or intellectual (learning) disabilities (Points 19 and 20) while another insisted that Romania pursue “a comprehensive reform of mental health care” (Point 26).

This stress on problems in Romania’s mental health care system in such a public statement around such a highly anticipated and charged issue as EU accession was anything but a coincidence. During the summer of 2004, Amnesty International reported on the terrible conditions in Romanian psychiatric hospitals.¹ These reports were prompted by investigations into the deaths by exposure of over a dozen patients in Romania during the winter of 2003.

The reports, however, went well beyond

concerns about the safety of psychiatric patients and included wide-ranging condemnation of everything from issues of the lack of enforcement of the laws protecting patients under circumstances of involuntary psychiatric commitment, to the lack of specialised mental health care training for nurses. Other issues raised included economic concerns about the lack of sufficient quantities of basic psychopharmacological medications, and problems with the physical layout due to overcrowding in Romanian psychiatric hospitals.

While much of the Amnesty International report was undoubtedly accurate, it also made it perfectly clear that the weight of blame for these problems rested on the state rather than on individuals or groups of mental health care workers. For the most part, mental health care workers have struggled to maintain some semblance of a therapeutic space for their interaction with people with mental illness, despite the lack of basic resources and a collapsing clinical infrastructure.

The mental health care system receives a disproportionately small share of the total health care budget, just 3%, given that mental health problems (excluding dementia) account for 12% of the overall burden of disease.² This covers a mere 35–45% of that which is budgeted for

most other medical specialities, heightening the feeling that mental illness not only carries a social stigma for patients, but also is stigmatised in the broader health care system.³ While the stigma against mental illness has been fought, with limited effectiveness, by a handful of NGOs,* it has proven especially difficult for the medical community itself to lobby for greater support from the state due to the almost complete lack of good epidemiological data.

These burdens – the socio-cultural stigma of mental illness, the economic competition for limited resources, the political struggle to draw attention to the plight of the mental health care system – make the study of the mental health system and mental illness in Romania particularly fertile ground for understanding how Romania will respond to the demands of the international community and requirements for accession to the European Union.

The study of, and concern for mental health issues in Romania, has remained almost entirely unstudied by Western scholars, as well as remaining a notable and seemingly shameful topic of discussion among Romanian scholars themselves. Part of the reason for this, certainly, is the infrastructural and institutional state of Romanian psychiatry and mental health

*Jack Friedman is a Post Doctoral Fellow, Department of Comparative Human Development, University of Chicago, Chicago, Illinois, USA.
Email: jrfriedm@uchicago.edu*

* Most remarkable of these advocacy NGOs is ‘The Romanian League for Mental Health’ (Liga Română Pentru Sănătate Mintală) run out of a single, crowded apartment flat in Bucharest, and the Aripri Association which is a client-run advocacy group that works out of a community-based rehabilitation center attached to Bucharest’s ‘Al. Obregia’ psychiatric hospital.

care. During the state socialist period, psychiatry and psychology were profoundly complicit with the former-dictator Nicolae Ceaușescu's state and acted as another arm for the medical policing and disciplining of the Romanian populace. However, since 1989, there has been almost no evaluation of the nature of the Romanian mental health system.

This research gap has also been reflected in state policies and in the planning of international aid to Romania for health care reform. Part of the reason for the neglect of this issue can be attributed to a combination of factors including: (1) the reluctance of international aid to consider mental health reforms as 'cost effective' interventions in many developing nations, (2) a 'triage mentality' on the part of the government that placed immediate primary care concerns above, and to the near exclusion of, mental health care reforms; (3) the social stigma of the mentally ill patient/client population in Romanian society; and (4) the fear that a full policy evaluation of mental health care in Romania would reveal the fundamentally pathological structure of the system to the world.

Background to the current state of Romanian psychiatry

Romania's psychiatric system has suffered from diverse and serious problems over the last several decades. During the state socialist period, psychiatric hospitals, along with their regular medical duties, became spaces for the political repression of dissidents and others who were deemed too problematic to simply be jailed by the Ceaușescu regime. In addition, under Ceaușescu, the field of clinical psychology – an essential complement to psychiatry in the treatment of mental illness – was marginalised to the point where mental health care was almost completely subsumed by a biological model of care. Little or no talk therapy (cognitive or psychodynamic) existed for patients who suffered from mental illnesses where psychotherapy would be indicated. Instead, the liberal use of psychiatric medications tended to be the only treatment available to patients, leading to

frequent over-medication of people who might otherwise have benefited from a combination of more conservative medications, talk therapies, and social interventions.

Since 1989, Romania's psychiatric system has suffered from the economic stagnation and institutional challenges that have plagued most of the country's state-provided services. While the people who are involved in the treatment of patients with mental illness – psychiatrists, psychologists, social workers, nurses, and others – are deeply committed and professional individuals, they face profoundly challenging obstacles to the efficient and efficacious treatment of their patients. In particular, the psychiatric system has been overwhelmed by three interacting factors.

“there is no community care system for those who leave the inpatient setting”

First, due to the financial problems facing all of state-run sectors, psychiatric institutions have been increasingly under-funded and over-extended by demand for the services that they are expected to provide. These funding woes have been seen in the downsizing of the number of beds at many hospitals, despite the fact that most doctors and administrators with whom I spoke insisted that they are seeing more patients today than in the past. This downsizing is part of a broader effort towards deinstitutionalisation and a transfer of patient care to community-based initiatives; a goal made explicit in the health care reform legislation passed in January 2006.

Regardless, economic shortfalls have meant that basic medications are frequently either in short supply or are quickly depleted in these psychiatric hospitals – a fact that frequently contributes to the relapse of patients under even the best physical conditions and medical care. The state had traditionally subsidised or

paid for psychiatric medication for outpatients; however, today, this support has dwindled to the point where most people with mental disorders (especially since they are almost always unemployed due to their illness) cannot afford their medications.

In addition, the desire to limit the cost to the state of the burden of long periods of hospitalisation, has meant that doctors are increasingly pressured to convince patients to leave hospital, even when they do not necessarily think that it is in their best interest.* This is particularly difficult for many psychiatrists since (1) there is no community mental health care system for these individuals once they leave the inpatient setting, (2) most cannot afford the medications that the psychiatrists have prescribed, making relapse and social problems (with the patient's family, the community, the law, etc.) almost assured, and (3) inefficiencies in the disability laws mean that these individuals will return regularly whether or not they need to be hospitalised so that they can continue to receive their only source of income from their disability payments. While all of these budgetary problems have a dramatic impact on the care of patients, the understaffing and increased work load on psychiatrists mean that they rarely have the time to see patients for more than a few minutes each week and they have no time (or access) to pursue the newest medical treatment options or research.

The second major challenge to the Romanian mental health system since 1989 comes from the fact that psychiatric hospitals have recorded increasing numbers of patients with mental illness – particularly, major depressive disorder and various anxiety disorders. Romanian medical specialists and social workers universally associate this increase in patients with mental illnesses with increasing unemployment and economic stress, particularly since the late-1990s when economic reforms began to take their greatest human toll.

This increase in the rate of mental illness has meant that many of the very services that are most essential to those who are out

* In-patient care is limited to 17 days for acute patients and 90 days for chronic patients. Acute patients must wait 24 hours before they can be re-admitted for another 17 days, but they cannot be re-hospitalised in an acute ward, then, for another 30 days. Chronic patients can be continually re-admitted after each 90-day period. In addition, due to a curiosity in the nature of the budgetary system, if a patient is transferred at any point to another hospital, it is the *last* hospital that sees the patient that will receive reimbursement for the *entire* period of the patient's illness. This budgetary oddity means that there is a strong disincentive to transfer a patient even when it might be in his/her best interest.

of work and living with mental illness have been doubly impacted by the increasing population of people with mental illness and the simultaneous cuts in services. One point of caution though: the increase in the number of people suffering from mental illness reported to me by psychiatrists does not seem to be supported by good epidemiological data. This is not to say that this increase in the number of cases of mental illness is untrue or inaccurate; rather it is, at this point, anecdotal and demands a richer epidemiological foundation to influence policy decisions related to mental health service provision. To address this epidemiology problem, the January 2006 health reform legislation called for the creation of a national mental health institute to collect data on psychiatric illness.

The third, and perhaps most problematic, factor challenging the Romanian mental health system is the problem associated with various legislation (or the lack thereof) related to disability rights, workers' rights, and the 'mental health laws' in place in the country.* A person with mental illness is multiply challenged by these institutional inefficiencies. Due to a lack of workers' rights, any worker who must leave her place of employment for medical reasons is not guaranteed employment upon resolution of that medical problem. While most employers *will* re-employ workers who have been physically injured in some way, workers who suffer from mental illness are stigmatised and tend to find that it is impossible to maintain their job after a period of hospitalisation for mental illness. (The only exception to this rule found during fieldwork was in the Jiu Valley, where workers who have still been able to hold on to their jobs in the mining industry have tended to find a more sympathetic relationship with their employers, such that time spent in treatment for mental illness is simply treated as any other period of medical leave.)

Recent attempts to use a medical coding system borrowed from the Australian medical system have been instituted in order to address concerns about confidentiality and reporting on disability, medical, and employment documentation; however,

the lack of legal reforms and privacy laws continue to undermine these attempts to limit the impact of the stigma of mental illness on workers' employment opportunities. Ultimately, this problem with the legislation surrounding employment and mental illness puts one of the heaviest strains on the already buckling mental health system because many patients who suffer from an acute mental illness find that they must 'become' chronically mentally ill in order to receive enough support through regular state disability payments just to survive.

*“stigma means workers
tend to find that it is
impossible to maintain
their job after
hospitalisation”*

Some early observations

My observations and interviews revealed the deeply entwined connection between the experience of mental illness and the new forms of poverty in Romania. Specifically, the increasing rate of unemployment, particularly among those who are 40 or older, has taken a catastrophic psychological toll that has, for many, led to and/or contributed to the emergence of mental illness. In particular, all of the physicians with whom I spoke in Romania stressed the increasingly central place of women in their late-30s to their late-50s on the burden of illness in psychiatric settings. Most of these psychiatrists pointed out that, while, from an epidemiological standpoint, this is the key age for women to begin to experience major depressive disorders, the increase in the number of patients in this demographic category seemed to be more strongly correlated with the increased rate of *unemployment* among these women rather than appearing as a generalised increased rate of illness among *all* women in this age range. My qualitative interviews bore out much of these observations.

At the same time, doctors stressed that men are suffering a double-burden connected to economic stress and the increasing threat of downward mobility. They have historically tended to compose the heaviest burden on the psychiatric system because they have tended to show a much higher rate of the most severe, chronic, and debilitating of the mental illnesses, particularly psychotic disorders (especially schizophrenia). In contrast to this, historically, fewer men have been hospitalised or treated for mood disorders (especially depression) than would be predicted by epidemiological data. Psychiatrists, however, have stressed that, since the late-1990s, they have seen an increase in the number of both psychotic disorders *and* mood disorders among men.

While rich epidemiological data is lacking to support some of these claims, if this anecdotal evidence is true, this would seem to point to at least three possible explanations. First, for the psychotic disorders, it would seem to support some of the recent medical literature that has pointed to the increased prevalence of active psychosis among people who suffer from extreme social, cultural, and economic marginalisation. Second, for mood disorders, this might suggest that there is an increased rate of mood disorders associated with the environmental stressors of unemployment and increasing poverty.

Third, the increased rate of mental illnesses associated with mood disorders might be a function of *both* the new forms of poverty in Romania *and* how the new poor are forced to interact with the disability welfare system. In this case, what we might be seeing is a kind of 'performance' of one's illness. It is probably most likely that the real reason for the increased rate of mental illness can be found in the confluence of all three of these factors; however, each would demand its own policy-orientation to address each of these factors.

Policy recommendations

Romania's mental health system has suffered terribly from the economic stagnation and government-directed austerity measures associated with the need to rein in the inefficiencies of state-controlled

* A core concern for some scholars and international observers is the nature of 'involuntary commitment' legislation. Romania has very strict involuntary commitment legislation; however, this legislation is rarely observed. This is not for lack of interest on the part of most psychiatrists, but is mostly a function of the impossibly over-strained legal system that must be brought in to adjudicate each case of involuntary commitment.

sectors of the economy and service industries. Cuts in the budget for medical care have been accompanied by increasing numbers of patients in need of mental health care, frequently stemming from the repercussions of the very economic policies that have left these individual patients doubly impacted.

Regardless, many in Romania's mental health system recognise the need for reforms that can both provide the necessary services, while doing so in as efficient and cost-effective a manner as possible. Several important and broad-ranging policy suggestions come out of my preliminary research, some of which have become central parts of Romania's January 2006 health care reform legislation.

One recommendation is an *increased commitment to deinstitutionalisation and a simultaneous commitment to community mental health care*. Large psychiatric hospitals have proven to be highly inefficient. While initially designed to take advantage of an economy of scale, the shift to out-patient care – the least expensive type of mental health care – has become almost impossible as large, centralised hospitals consume all of the resources set aside for mental health in the state's budget.

Deinstitutionalisation would allow for the establishment of community mental health centres that can help patients who do not need to be hospitalised. It is essential, however, that any deinstitutionalisation be simultaneously met with a community health care* option in order to avoid any disruption in services to people living with mental illness. This will keep these people healthy enough to avoid relapse (and the subsequent need for in-patient care) as well as concentrating in-patient resources in such a way that they will be best used for the treatment of those who have chronic, severe mental illnesses that demand hospitalisation.

A second recommendation is an *increased commitment to reforming the legal system to combat institutionalised stigmatisation of those with mental illness*. Improving the legislation related to confidentiality and privacy, as well as reforming the laws related to disability eligibility and workers' rights, will allow more people with mental illness to be better integrated into

Romanian society. When people with mental illness are given the same rights as any other citizen, especially in terms of employment, they are less likely to relapse and are more capable of living a healthy life. This can help avoid the substantial burden that mental illness can place on the state sector, as well as in families and communities. It also implies that the individual can both contribute to the economy through their employment, as well as avoid using the limited resources of the mental health system that might better be used to assist low-functioning patients.

“Romanians tend to have a particularly harsh view of mental illness”

A greater commitment is also needed to reform the mental health educational system. While psychiatric education is well-developed and relatively modern in Romania, the lack of talk-therapy training, the limited availability of specialist mental health training for nurses, the limited training in basic psychiatry among primary care physicians, and the lack of a well-developed core of mental health-oriented social workers, all undermine the effectiveness of frontline psychiatrists in their battle with mental illness. In addition to these broader professional reforms, a greater emphasis must be placed on the special ethical problems that arise in mental health settings.

Increasing public awareness campaigns to educate the public about mental illness and to fight the stigmatisation that accompanies the cultural models of mental illness in Romanian society are also important. People living with mental illness are stigmatised almost everywhere. Romanians, however, tend to have a particularly harsh view of mental illness – a cultural understanding of “madness” that views it as a combination of evil (in the moral and religious sense), genetic weakness (eugenics), and stupidity (a conflation of mental illness with learning disabilities).

Families are known to simply abandon people at psychiatric hospitals once they

learn that their loved one does indeed have a mental illness. Priests frequently advise families and patients that it is the devil working through them that gives form to their mental illness. Even within the professional field of social work, young social worker trainees tend to avoid choosing the mental health track of social work because they see working with people with mental illness as somehow “dangerous” and “tainting.” These cultural beliefs must be addressed with a strong public education campaign in order to insure that families, communities, and professionals alike can provide the support that a person suffering from a mental illness might need.

A final recommendation is that a *national institution for gathering, analysing, and publishing the findings of mental health statistics be established* in order to gain a better understanding of the epidemiological trends in Romanian mental illness. At this point, there have been almost no broad-based epidemiological studies of mental illness in Romania, and, yet, everyone from policy makers to community leaders to religious leaders to physicians seem to believe that mental illness is more prevalent today than it was in the pre-1989 past. If this is the case, there needs to be a mechanism in place to document any trends in mental health epidemiology so that resources can best be brought to bear on different problems, in different regions – ultimately with an eye toward recognising the correlation between epidemiological trends and various environmental (especially economic) factors.

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Examples of a few innovative and successful community mental health initiatives can be found in Bucharest, Timișoara and Câmpulung Moldovenesc.



RISK COMMUNICATION: A NEGLECTED TOOL IN PROTECTING PUBLIC HEALTH

Davik Ropeik and Paul Slovic

“Decision-makers must realise, and accept, that the dangers of misperception of risk are real, and pose both a threat to public health and an impediment to policy making that will provide the greatest benefit to public health.”

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Harvard Center for Risk Analysis,
Harvard School of Public Health,
Landmark Center, 401 Park Drive,
PO Box 15677, Boston,
Massachusetts, 02215 USA.
The full series is available at
www.hcra.harvard.edu

Do we live in riskier times than humans have ever faced? This is a common question in these days of terrorism, SARS, weapons of mass destruction, climate change, ozone depletion and HIV/AIDS.

The answer is resoundingly equivocal. There is both good risk news, and bad. But despite the mixed evidence, many people say they think the risks we modern humans face are greater than they've ever been. The implications of this apprehension are immense for public and environmental health and for the global economy.

We write to offer insight into how human risk perception is both analytical and affective, which offers an explanation of why the public's fears sometimes don't seem to match the facts. We suggest that, empowered by such insight, governments can and must do a more effective job of risk communication, through both their policies and what they say about them. Understanding and respecting the analytic and affective ways people make risk judgments can help governments help citizens keep their sense of risk in perspective. This, in turn, will not only help individuals make wiser, healthier decisions for themselves. It will also help focus social concern on the relatively greater risks. That will allow governments, businesses, and other social institutions to invest in optimal protection of public and environmental health with the most efficient use of limited resources.

Some current risk realities

Just how risky is the world in which we live? Consider some data from the United States, which reflect similar trends in developed nations worldwide. In 1900, the average life expectancy was about 45 years of age. Today it is nearing 80. In just the

last 40 years, infant mortality has dropped from 26 per thousand live births, to 7. In 1918, the influenza epidemic killed 600,000 Americans. In 1999, influenza killed about 36,000 Americans. By major measures, this is a far healthier, safer world than it has ever been.

But new risks have arisen. Worldwide more than 22 million people have died of AIDS since 1984. The postwar industrial/technological/information age has given us both the benefits and the risks of nuclear power, pesticides, and many new technologies. Under the burden of a global population that in the last 100 years has exploded from 1.65 billion people to more than 6 billion people, environmental risks such as climate change, water and air pollution, and mass extinction of species have added to a growing litany of new perils.

On top of this new host of new hazards, we live in a time of unprecedented media availability and information immediacy. Whenever something is discovered that may even possibly be perilous, we learn of it, worldwide, within days. It is also a new phenomenon that a majority of our sources of information are owned by a small number of large corporations. Seeking to maximise profits, the media outlets of these global firms often make new risks sound as dramatic as possible in order to grab attention and attract us to buy their next newspaper, magazine, or television broadcast.

These are the modern realities of what seems like a risky world. But it is not by careful rational analysis alone that we interpret information about the risks our modern world presents. Such conscious analysis is relatively slow and effortful. In addition we use ancient intuitive processes

that are instinctive, fast, and often not completely accessible to conscious awareness. We apply a series of affective criteria to perceive and respond to danger. Essentially, several decades of research on risk perception suggests that humans tend to fear similar things, for similar reasons. To understand the characteristics of risks that trigger these responses is to gain some insight into why people are commonly more afraid of some relatively small risks, and less afraid of some that in certain ways cause greater harm.

Risk perception factors

Dread

What's worse, being eaten by a shark or dying of heart disease? Both kill you, and heart problems are far more likely to do you in. But the dreadful death often evokes more concern. Despite the fact that heart disease kills roughly 25% more Americans each year, cancer evokes more fear in most people because cancer is perceived as a dreadful way to die. This helps explain why hazards that might cause cancer, such as radiation and industrial chemicals, evoke strong fears. Dread is a clear example of the more general way we think about risk in terms of our intuitive feelings, a process that has been labelled 'The Affect Heuristic'.

Control

Do you feel pretty safe when you drive? Most people do. Having the wheel in your hand gives you the feeling that you can control what happens. But switch to the passenger seat and you're a little more nervous because you are no longer in control. This also applies to process. If you feel as though you have some control over the process determining a risk you will face, the risk probably won't seem as big as if it was decided by a process over which you felt you had no control.

Is the risk natural or is it human-made?

Anthropogenic sources of radiation like nuclear power, mobile phones, or electrical and magnetic fields frequently evoke greater concern than radiation from the sun, which is a vastly greater risk (1.3 million skin cancer cases, 7,800 melanoma deaths, per year in the US) but less worrisome to many because it is natural. This factor helps explain widespread concern about many technologies and products, and offers important insights into one key factor in the debate over the 'Precautionary Principle'.

Choice

A risk we choose seems less risky than if that risk is imposed on us. If you use a mobile phone while driving, you may have on occasion noticed a driver next to you, using his or her mobile, and felt upset about the risk that other driver was imposing on you, even while you voluntarily took the same risk, albeit with less concern. (Of course, you have control over your car, so the factor of control also contributes in this example.)

Children

In addition to the genetic imperative to survive (which is, after all, the underlying impetus of our risk perceptions and responses) humans are genetically driven to reproduce. Survival of the species depends on survival of our progeny. So it is not surprising that research has found that a risk to children, like asbestos in a school or the abduction of a youngster, seems worse than the same risk to adults, such as asbestos in a workplace or the abduction of an adult. During last year's sniper attacks in Washington D.C., after five adults had been murdered, the sniper wounded a 13 year-old boy. The local police chief, tears in his eyes, declared of the sniper "He's really getting personal now!"

Is the risk new?

At the time bovine spongiform encephalopathy first showed up in Germany, an opinion survey found that about 85% of the public thought mad cow disease was a serious threat to public health. But the same poll done at the same time in the UK, where it had been around for years and killed many more animals and more than 100 humans, found that only around 40% of the public thought mad cow disease was a serious threat. New risks, including everything from SARS and West Nile virus to new technologies or products, tend to be more frightening than the same risk after we've lived with it for a while and our experience has helped us put the risk in perspective.

Awareness

The more aware of a risk we are, the more available it is to our consciousness, and the more concerned about it we are likely to be. SARS is currently evoking far more new coverage, attention, and concern than influenza, which kills an estimated 36,000 people a year. In the Washington D.C. area last fall, fear of being shot by a sniper was much higher than the greater risks of heart

disease, cancer, or stroke. The other risks weren't gone, but conscious concern about them was lower, because awareness of them had been reduced.

Can it happen to me?

Any risk seems larger if you think you or someone you care about could be a victim. Consider terrorism in the United States. Prior to 11 September 2001, the Americans who were victims of terrorism were "someone else". Yes, they were Americans. But they were in foreign embassies, or on foreign military assignment. After 11 September 2001, however, Americans at home felt they too were possible targets, and fear of terrorism grew.

This helps explain why statistical probability is often irrelevant to people and an ineffective form of risk communication. Imagine that someone hands out one million bottles of water, one of which carries a poison. You get one of those bottles. Now imagine taking a drink from that bottle. Your risk of dying from that water is only one a million, but it still feels risky to drink it, because you could be that one. This helps explain why the acceptable level of risk to many people is zero.

The risk-benefit tradeoff

Some risk perception researchers and many risk analysts believe that the risk-benefit tradeoff is the major factor that makes us more or less afraid of a given threat. If we perceive a benefit from a behaviour or choice, the risk associated with it seems smaller. If there is no perceived benefit, the risk seems larger. When measles and polio were prevalent, the benefits of vaccination were perceived to outweigh the risk of the side effects. But now, with these diseases rare, the perception of some parents is that the risks of those side effects, as low as they are, outweigh the benefits of vaccines. Many American health care workers, 'first providers', are refusing a smallpox vaccination because the risk of the treatment, low though it may be, seems larger than the benefit, which is protection from a disease they aren't convinced is a threat at all.

Trust

Research has found that the less we trust the people who are supposed to protect us, or the people or government or corporate institutions exposing us to the risk in the first place, or the people communicating to us about the risk, the more afraid we'll be. The more we trust, the less concern we'll

feel. Imagine you're in a desert, nearly dead of thirst, and someone appears and offers you two glasses of a clear liquid. She won't tell you what is in either glass, only that one comes from Pope John Paul and one comes from a tobacco company. Which one would you take?

The implications

But what of all this? What is the utility of understanding the underpinnings of our fears? We suggest that by realising and respecting the realities of affect and other heuristic processes, and by accepting that they are apparently deeply rooted and reflect intrinsic human techniques for survival, policy makers can incorporate these values, as well as fact-based analysis, into their risk management decision making. Further, by understanding the reasons people perceive risk as they do, policy makers can communicate with various audiences about these issues in terms and language relevant to people's concerns. Risk communication which acknowledges and respects the affective motivators which underlie people's concerns, rather than dismissing such perceptions as "irrational" because they are not solely fact-based, is likely to be more successful in helping people make more informed choices about the risks they face.

This is directly a matter of public health. People who are either too afraid of relatively low risks, or not afraid enough of relatively big ones, make dangerous choices. People afraid of flying choose instead to drive, a much riskier behaviour. People afraid of terrorism or other crimes take the risk of acquiring firearms. In 2001 people afraid of anthrax took antibiotics prophylactically, increasing the proliferation of drug-resistant bacteria.

Further, chronic stress, by altering blood levels of adrenaline and cortisol, impairs the immune system. Worrying too much about getting sick may actually increase the likelihood that you will get sick, or sicker, or stay sick longer, or die, from any infectious disease. Chronic stress is also associated with the likelihood of type-II diabetes, accelerated osteoporosis, and causes decrements in learning and long term memory. Fear is, in itself, a risk.

Not enough fear can also be dangerous. People unafraid of natural risks like solar radiation, or risks they think they can control like driving, or risks that are associated with benefits, such as smoking or alcohol consumption or fat and calorie-

rich diets, fail to take adequate precautions, and they too face a greater likelihood of premature death. Lack of appropriate caution can be dangerous too.

At a societal level, elevated concern about relatively low risks, and too little concern about relatively big ones, is also potentially harmful. People afraid of a risk that triggers their intuitive fears demand government protection from that risk, though it may not actually be as much of a threat as they feel. Conversely, if a threat is indeed high but does not trigger affective alarm, demand for protection will be low. This drives allocation of resources that is suboptimal for public health. Time and money spent protecting people from relatively low risks are not available to protect people from greater risks. As a result, some of the people left unprotected from those higher risks will suffer. Some will surely die.

Conclusion

One solution to the dangers that arise when the analytic and affective sides of our risk perception don't agree is effective risk communication, informed and empowered by an understanding of risk perception. This must become a priority at the highest levels of policy making in government, in business, and in international affairs. More must be done to help people keep their sense of risk in perspective. Decision-makers must realise, and accept, that the dangers of misperception of risk are real, and pose both a threat to public health and an impediment to policy making that will provide the greatest benefit to public health.

Effective risk communication requires recognition by policy makers that there are risk perception implications in what they do, that communication is not just what they say and how they say it. Setting a threshold for acceptable exposure to a pollutant, allowing or disallowing a product or process, requiring or not requiring labelling – indeed all risk management decisions – have risk communication meaning and impact. At the most senior level, government agencies must consider the risk perception and communication implications of their actions as policy choices are being made. Risk communication must be thought of as more than just press releases, news confer-

ences, and public service campaigns. It is substance, not just spin.

Some call this pandering to irrationality and emotion, and suggest instead that a benevolent technocracy should be empowered to manage societal risk in order to ensure intelligent, rational and effective policies. But this fails to recognise the sensitive and pivotal issues of trust and control. Even the most benevolent process, if removed from the input of citizen values, will feel like one over which the public has too little control, and will not likely be trusted. The policies of such a process are more likely to provoke resistance than support. Further, the very idea of such a rationality-based technocracy fails to accept that risk perception is at least as much an affective and intuitive process as it is analytical, and that fear itself, either too much or not enough, is a significant risk that also must be factored into decisions about public and environmental protection.

Risk communication, informed by the insights of risk perception, is a powerful yet neglected tool in helping people make more informed and ultimately healthier choices for themselves. More informed individual decision making will in turn free the leaders of social institutions to make reasoned risk management choices that will maximise public and environmental health with the most efficient use of limited resources.

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Delivering Better Health Care 2

“Seeing the wood for the trees. Taking a systematic approach to implementing change in clinical practice.”

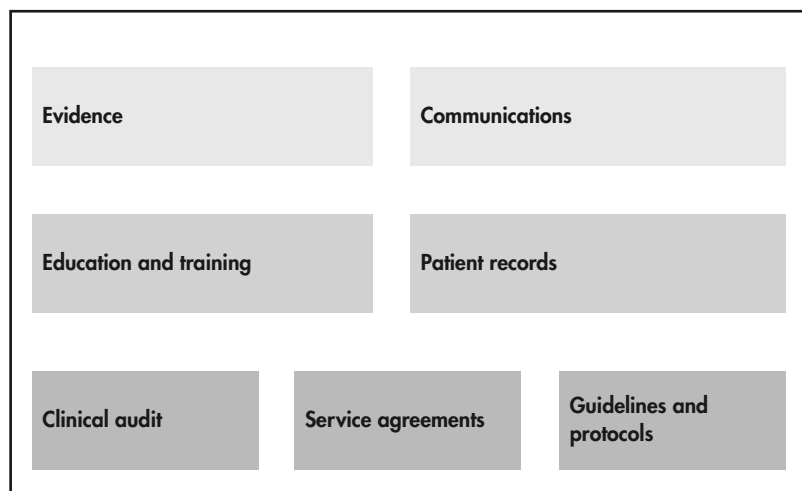
Michael
Dunning,
Editor, *ImpAct*

The starting point

The separate aspects of achieving change are familiar to most people in the NHS. Change is a way of life. The terms used form a common language. People talk freely about clinical guidelines, care pathways, clinical audit, critical appraisal, patient involvement etc (see Figure 1). Getting the right connections and balance between these separate activities is essential. Experience has shown that achieving these connections and this balance is not easy. In the first paper we identified things that can go wrong. Often this is simply because people do not have a good grasp of the work overall. They may spend too much time on the familiar, such as the preparation of guidelines and not enough on the unfamiliar: those they perceive as difficult.

The work in the West Midlands built on the success of the established model for critical appraisal training (CASP) workshops. These short two-hour sessions concentrate on getting the fundamentals over to participants. We wanted to explore whether we could design and deliver a similar short (two hour) session that could plant in people’s mind a practical picture of the task of implementing change in clinical practice. A two-part programme was

Figure 1: Delivering better healthcare – the right connections



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

This paper was first published in 2001. © Bandolier, 2001.

designed for a multi-disciplinary group of about fifteen people from each NHS Trust including clinicians and managers. Ideally, participants would be drawn from different levels within the organisation. An opening session, to present information about the task, was followed by small group discussions on a local implementation issue. The aims were to:

- Create groups of people in organisations with shared understanding of implementing change in clinical practice.
- Be practical and draw on real examples to illustrate the task.
- Support the development of clinical governance in NHS Trusts and Primary Care Groups.

Build on work on critical appraisal in the region

There are countless educational opportunities that seek to tackle all aspects of implementation and individual activities such as the formulation of clinical guidelines or the preparation of project plans. We were not trying to replicate these training opportunities. Our starting point was the belief that most people had some knowledge of managing change, but they would benefit from a better understanding of the overall process.

- Pilot trials indicated support for idea behind the workshop. On-going evaluation was positive, participants:
- Valued having time with other members of their organisation for discussion about clinical issues including multi-disciplinary approaches.
- Felt they gained an understanding of the planning process and time scales for preparation, planning, sustaining and delivering a change initiative.
- Liked the opportunity to rationalise the ethos of managing change in a less than ideal world.
- Reported a better understanding of clinical governance and evidence based health care was reported.

Nevertheless changes seemed necessary and more time was needed. The session proved to be too busy and too short. We were trying to handle too much detail in the limited time available. We subsequently

tried a more focused model for the workshop: this was better received. This paper is based on the concise version of the session. The third paper in this series will describe the more detailed version and be based around a series of slides that could be used in a workshop setting.

The starting point for the session was a set of four questions:

What do you need to know? The knowledge which should influence the work.

What needs to be done? A broad picture of the range of tasks involved.

How to make it happen? The range of skills and scale of resources required.

Where can you find help? Don't be alone, seek advice and share experiences.

What do you need to know?

Interest in evidence-based practice has sparked many questions about clinical behaviour and the ways to influence people. Anyone starting out to implement change needs to be familiar with the wide range material now available – but not necessarily all of it! It is sensible to be aware of the main points from this literature and aim to keep up to date. A framework of four types of knowledge can help you recognise what you don't know!

Evidence: from research on changing clinical behaviour

Theory: models of behaviour change

Lessons: about change management

Experience: from implementation projects

First, evidence from research on questions about changing professional behaviour. It is a complex field with many significant research programmes in hand. It is an international activity with collaboration through the Cochrane Collaboration bringing together people from across the globe. This work is starting to point to change strategies that have been proven to work – and importantly those that don't.

Second, theories about behaviour change and the way people learn. Many people may be familiar with is the work of Rogers who suggested a classification of people such as innovators, early adopters, early majority, late majority and laggards. Other work has explored how people learn and what motivates them to change.

Third, lessons from studies of change management and initiatives to improve the quality of services. Many of these come

from non-NHS settings but have useful lessons. They point to the need for clarity of purpose and a systematic approach.

Fourth, experience which has been learned by those leading and being involved in implementation projects. All of these confirm the complexity of the process and the need for flexibility as the work is taken forward.

What does all this tell us?

The wealth of material shows that implementing change is possible, but it is a complex business that takes time, resources and stamina. The important points are:

- Know where you are starting from.
- Build on what works, such as educational outreach and reminder systems.
- Multi-faceted approaches are more likely to be successful.
- Good project management is essential.

What needs to be done?

Clarity about what needs to change is a pre-requisite for success. Two dimensions require attention. First, an analysis of current practice to determine the gap between what is done now and the practice indicated by research evidence. Clinical audit is the key here but bear in mind that what is needed is a broad understanding of what needs to change – not extensive detail of current practice.

Second, an assessment of the likely attitudes of those you may seek to change: it will help you decide how best to involve and work with them. The Rogers analysis talks of identifying laggards, innovators etc. Others talk of the merit of identifying barriers or a contextual analysis. The important point is to determine where to start and identify whom is likely to support your initiatives and work with you in the initial stages – and who might oppose you! Early success is a good morale booster. Remember pharmaceutical companies devote significant resources to understanding their market. This task should be much easier for people working in the NHS.

While the assessment of the people likely to be affected by the work is in hand it is important to assess how the initiative will affect current services: will it prompt a need for more or less of something. Experience has shown that tackling these resource consequences may be as time consuming as changing clinical behaviour.

There is little point in encouraging GPs to refer patients for physiotherapy if that department is already under severe pressure. A link with planning and budgeting timetables and the early engagement of the appropriate managers in the discussions will help.

Making change possible

People cannot change unless they have space and the time to understand and absorb the evidence you are promoting. Research has shown that (simply) circulating information is normally ineffective. Design of suitable training and education programme should take account of the needs of those you seek to change. Do not expect people necessarily to attend organised training sessions, unless you have taken action to make attendance easy for them. It may be more sensible to take the training to the workplace. Educational outreach programmes are well proven.

Finally, it is sensible to be flexible and plan for the long term. No matter how well implementation programmes are planned, they are unlikely to adhere to timetables. People may not react as expected and support may come from unexpected quarters. Allow for this. As the process is costly in terms of time and resources it is important from an early stage to explore how the changes you are implementing will be sustained in the longer term – after the project spotlight has faded. Make sure that patients' records reinforce the changes you are implementing. How will you hand over responsibility to those charged with monitoring clinical standards?

Delivering better health care: what needs to be done?

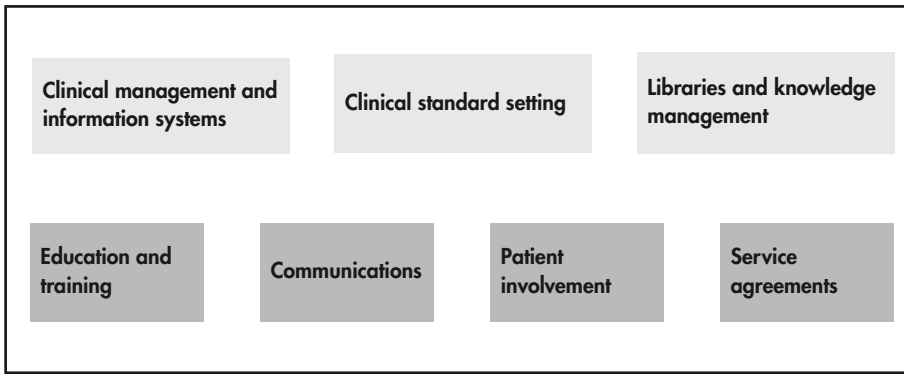
- **Be clear what and who needs to change**
 - **Tackle resource consequences**
 - **Provide practical training and education**
 - **Be flexible and plan for the long term**
-

How can you make it happen?

Choice of project leader is critical and should be guided by the need for someone with a reputation with his or her peers – rather than necessarily their position within the organisation. It is helpful if they have:

- Experience of managing change in the health service – an understanding of the range of activities involved.

Figure 2: Delivering better healthcare. An approach to clinical governance – creating links



- Awareness of the emerging research evidence about changing clinical behaviour.
- Knowledge and understanding of local organisational policies and structures and working relationships.

Given the complexity of the task and the range of activities involved, the recruitment of a team with the necessary skills should be an early task. The analysis of what and who needs to change will indicate the skills required. It is important to assemble the right team rather than simply rely on colleagues – people with whom you feel comfortable. Managerial and clinical skills will be required.

The scale of change required could be a reliable indicator of the resources required to make the change happen. The support and commitment of senior staff within the organisations will help ensure that sufficient people and resources are available to deliver the project's objectives.

Keeping people in touch

Communications must be taken seriously. Agree at an early stage a communications strategy to let people involved know what is happening. It's wise to share responsibility across the project group so that each member takes on the task of keeping their discipline in touch. Wherever possible existing communications systems should be used to avoid the need to create new meetings and paper work. Clarity about the message – what are you trying to say? – and the role of the messenger is essential.

For most people involvement in work to change clinical behaviour is a learning experience. Manage project meetings so that the collective learning of the group is captured. Allow time in the meetings for reflection so that those activities that have been a success and those that have not can be discussed. An honest approach where successes (and failures) can be openly

discussed is essential: asking a team member to take on a facilitation role can be helpful. Taking steps to ensure that the learning is used to influence other local initiatives will ensure that there is a better return on costs of initial project. It will also represent an important contribution to the development of local clinical governance systems.

Delivering better health care: how can you make it happen?

- Find a suitable leader
 - Recruit the right team
 - Secure adequate resources
 - Take communications seriously
 - Learn as you go!
-

Where to find help?

There is growing number of people across the NHS who have experience of creating and leading projects to implement improvements in clinical practice. Most are keen to share their experiences with colleagues across the NHS. This sharing used to be difficult and had to rely on personal networks – such as people you met at professional conferences.

The creation of the NHS Learning Network in 1999 has changed this and stimulated a range of activities designed to help people share experience and good practice across the NHS. ImpAct is one element of that activity; another is the network of NHS Beacons.

Delivering better health care: where can you find help?

- Don't try to re-invent the wheel
 - Share successes and failures
-

An approach to clinical governance – creating links

The introduction of clinical governance has the potential to streamline the process for implementing change in clinical practice. The experience from managing implementation projects suggests that the key task for organisations is to put in place linked systems covering the monitoring, improving and maintaining the quality of health care. Failure to make the right connections between different strands of work means that people have to spend countless hours working against the systems.

Seven linked systems could form the basis for managing clinical governance (see Figure 2):

1. Providing information to enable clinical staff to review, routinely, the quality of their current practice and identify areas where improvement is needed.
2. Providing access to the breadth of knowledge required to establish local standards of care.
3. Reviewing current practice and setting local clinical standards.
4. Ensuring that patients are at the centre of work to develop and monitor local clinical standards.
5. Providing education and training to support the development of individuals and clinical teams.
6. Ensuring that implementation is managed within service agreements.
7. Ensuring that information is communicated promptly and accurately within the organisation.

And, in conclusion

Experience has shown advantages from a systematic approach to the management of programmes to improve the quality of health care. Not least, because it ensures that scarce resources to be used to the best effect. But don't adopt a rigid approach where adherence to the plan and timetable is all-important.

Expect the unexpected and learn to coax and cajole the different aspects along together. A good analogy is trying to juggle several balls at once – difficult but not impossible. Keep trying!

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

Health in all policies: prospects and potentials

Edited by Timo Ståhl, Matthias Wismar, Eeva Ollila, Eero Lahtinen and Kimmo Leppo

Finnish Ministry of Social Affairs and Health, 2006



ISBN: 952-00-1964-2

279 pages

Freely available at:
<http://www.euro.who.int/document/E89260.pdf>

Health in All Policies (HiAP) was the main health theme of the Finnish Presidency of the European Union (EU). This accompanying volume published by the Presidency, under the auspices of the European Observatory on Health Systems and Policies, aims to highlight how and why the health dimension can and should be taken into account across all government sectors. As Finnish Minister of Health and Social Services, Liisa Hyssalla, writes, "HiAP highlights the fact that the risk factors of major diseases, or the determinants of health, are modified by measures that are often managed by other government sectors, as well as by other actors in society."

In his foreword, Robert Madelin, Director-General, Health and Consumer Protection Directorate of the European Commission, notes "health is a key foundation stone of the overall Lisbon strategy of growth, competitiveness and sustainable development" and that "a healthy economy depends on a healthy population." Particular emphasis is placed on the unique mandate and obligation of the EU to protect health in all its policies.

Examples from specific areas such as agriculture and workplace are examined. A key focus throughout is on the potential use of Health Impact Assessment (HIA) in policy

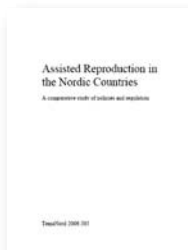
making. John Kemm, Director of the West Midlands Public Health Observatory, in England, contributes an overview chapter on this issue. He notes the critical importance, if HIA is to become ever more useful, of "strengthening the logic used for predicting consequences of decisions so as to improve estimates of the magnitude of outcomes and to develop forms of participation that meet the needs of both HIA and policy making." Other chapters look at the use of HIA in the EU and provide an illustrative case study.

Contents: Principles and challenges of health in all policies; Moving health higher up the European agenda; The promotion of heart health; Health in the world of work; Public health, food and agriculture policy in the European Union; Health in alcohol policies; Environment and health; Opportunities and challenges for including health components in the policy-making process; Towards closer inter-sectoral cooperation; Health impact assessment and health in all policies; The use of health impact assessment across Europe; Implementing and institutionalising health impact assessment in Europe; A case study of the role of health impact assessment in implementing welfare strategy at local level; Towards a healthier future.

Assisted reproduction in the Nordic Countries: A comparative study of policies and regulation

Riitta Burrell

Nordic Council of Ministers,
Copenhagen, 2006



ISBN: 928-93-1272-6

97 pages

Freely available at
<http://www.norden.org/pub/ovrigt/ovrigt/uk/TN2006505.pdf>

After five decades of intermittent attempts, the Nordic countries still have very different policies in the field of assisted reproduction. In the absence of a comprehensive policy design Finland has, by default, the most permissive regimen of assisted reproduction technology (ART) practices in the Nordic region, while Norway has the strictest ART regulation in place. The ART policy design in Iceland and Denmark places those two countries in the intermediate category. While the policy design in the other Nordic countries has remained relatively constant, Sweden has, through several redesigns, moved from a rather restrictive policy design to a more permissive one.

What is the nature of these differences and how did they come about? This report, by Riitta Burrell and commissioned by the Nordic Committee on Bioethics, examines the use of ART in the Nordic countries at a policy-making level. It traces the policy designing process in each country from

governmental committees or working parties to parliamentary proceedings. It describes formative events and debates. The one definitive conclusion that the report reaches is that there is no such thing as a Nordic policy on ART.

The report ends by identifying some of the factors that have accounted for the divergence in ART policies across the five countries. There are no simple explanations. Some factors are related to the timing of decision-making, actor beliefs, the policy-making arena, and the broader context. This, for instance, includes scientific developments such as the impact of in-vitro fertilisation and embryonic stem cell research. Cultural factors also are important, yet countries such as Denmark, with a tradition for liberalism, do not have the most progressive of approaches to ART.

Contents: Foreword; Introduction; Sweden; Norway; Iceland; Denmark; Finland; Conclusion; References.

Direction de la recherche, des études, de l'évaluation et des statistiques (DREES)

<http://www.sante.gouv.fr/drees>

DREES, or the Department of Research, Studies, Evaluation and Statistics, is a division of the French Ministry of Health and Solidarity. It commissions and publishes many evaluations, statistical analyses and policy overviews of all aspects of the French health care system. Many of these studies have a strong health economic component. Recent reports include a review of regional health inequalities and the annual health status of the population. In addition to working papers, there are also several periodical publications, including *Etudes et Resultats* which publishes two individually themed reports each week. The website is predominantly French only, although there is some limited English content.

European Foundation for the Improvement of Living and Working Conditions

<http://www.eurofound.ie>

Based in Dublin, the Foundation is a European Union body, one of the first to be established to work in specialised areas of EU policy. Specifically, it was set up by the European Council (Council Regulation (EEC) No. 1365/75 of 26 May 1975), to contribute to the planning and design of better living and working conditions in Europe. Its role is to provide information, advice and expertise – on living and working conditions, industrial relations and managing change in Europe – for key actors in the field of EU social policy on the basis of comparative information, research and analysis. The Foundation has explored the area of health, in the broader sense, by examining the physical, mental and social well-being of workers. In relation to workplace health, there are three main issues to be considered: health problems; risk exposure; and work organisation. Foundation studies have identified that the two most frequent work-related health problems are musculoskeletal disorders as well as stress, depression and anxiety problems. The Foundation also looks at the provision of social care: recent research includes a publication on employment patterns in social care across Europe.

Haute Autorité de Santé – French National Authority for Health

<http://www.has-sante.fr>

The Haute Autorité de Santé (HAS) was set up by the French government in August 2004 in order to bring together under one roof a number of activities designed to improve the quality of patient care and guarantee equity within the health care system. HAS activities are diverse. They range from assessment of drugs, medical devices, and procedures to publication of guidelines to accreditation of health care organisations and certification of doctors. All are based on rigorously acquired scientific expertise. Training in quality issues and information provision are also key components of its work programme. HAS is an independent public body with financial autonomy. It is mandated by law to carry out specific missions on which it reports to government and parliament. It liaises closely with government health agencies, national health insurance funds, research organisations, unions of health care professionals and patients' representatives. While most of the website is only available in French, there are some English language pages including a catalogue of more than 122 HAS publications available in English.

Institute for Public Policy Research

<http://www.ippr.org>

The Institute for Public Policy Research is a UK based think tank, undertaking research and policy innovation across all areas of public policy, including health and social care research. A wide range of reports are produced, all freely downloadable from the website. Recent publications include an analysis of hospital reconfiguration, as well as public expectations and the NHS. Detailed information on current research and flagship areas of work are also provided.

Scottish Medicines Consortium

<http://www.scottishmedicines.org.uk>

The remit of the Scottish Medicines Consortium (SMC) is to provide advice to NHS Boards and their Area Drug and Therapeutics Committees (ADTCs) across Scotland about the status of all newly licensed medicines, all new formulations of existing medicines and any major new indications for established products (licensed from January 2002). Assessments consider not only whether it is more effective than existing treatments, but which patients will benefit, what is costs and whether it is worth investing NHS money to prescribe it. The website provides information on on-going and completed assessments, detailed minutes of meetings, press releases and methodological documents.

NEWS

EUROPEAN MONITOR

New WHO Director-General

Dr Margaret Chan of China was appointed as the next Director-General of the World Health Organization (WHO) on 10 November 2006. In her acceptance speech, Dr Chan told the World Health Assembly that as Director-General she wanted WHO performance to be judged by the impact its work has on the people of Africa and on women. She also stated that her focus will be on six key issues, including health development, security, capacity, information and knowledge, partnership, and performance. Furthermore, she emphasised the importance of global health security in her vision of the Organization's role and praised health workers for their "impressive dedication, often under difficult conditions".

She also paid tribute to her predecessor. "We are all here because of the untimely death of Dr Lee Jong-wook. We are also all here because of many millions of untimely deaths. I know Dr Lee would have wanted me to make this point. He will always be remembered for his 3-by-5 initiative. That was all about preventing untimely deaths on the grandest scale possible".

Dr Chan obtained her medical degree from the University of Western Ontario, London, Canada and a degree in public health from the National University of Singapore. In 1987, she joined the Hong Kong Department of Health and was appointed Director of Health in 1994. In this capacity she launched new services focusing on the prevention of disease and promotion of health and introduced new initiatives to improve communicable disease surveillance and response, enhance training for public health professionals, and establish better local and international collaboration. Previously she

was WHO Assistant Director-General for Communicable Diseases and Representative of the Director-General for Pandemic Influenza. Anders Nordström, who was appointed by the Executive Board as Acting Director-General of WHO in May 2006, will continue in this role until the new Director-General officially takes up office.

More information at <http://www.who.int/mediacentre/news/releases/2006/pr66/en/index.html>

European Charter adopted to reverse the obesity epidemic

On 16 November in Istanbul, at the WHO European Ministerial Conference on Counteracting Obesity, Dr Marc Danzon, WHO Regional Director for Europe, and Professor Recep Akdag, Minister of Health of the Republic of Turkey, signed an historic charter on behalf of all of the Member States in the WHO European Region. The European Charter on Counteracting Obesity sets the ultimate goal of curbing the epidemic and reversing the current trend in the Region.

Dr Danzon said "we are all aware that obesity is one of the most serious public health challenges facing Europe today. Evidence exists on what needs to be done to reverse the trend. This Charter commits Member States to put obesity high on their political agendas and calls on all partners and stakeholders to do the same. It is a guide, an opportunity, and gives us the tools to take effective action".

The Charter declares that "visible progress, especially relating to children and adolescents, should be achievable in most countries in the next 4-5 years and it should be possible to reverse the trend by 2015 at the latest". It notes that specific, targeted action across many sectors is needed to achieve this. Among measures that should be included are: the adoption of regulations to substantially

reduce the extent and impact of the commercial promotion of energy-dense food and beverages, particularly to children, with the development of international approaches, such as a code on marketing to children in this area; and the adoption of regulations for safer roads to promote cycling and walking. Other key actions needed to encourage healthier diets and more physical activity include promoting breast-feeding; reducing the amount of fat, sugar and salt in manufactured products; and establishing opportunities for daily physical activity and for good nutrition and physical education in schools.

Earlier, at the opening of the conference, Turkish Prime Minister Tayyip Erdogan stressed the need for actions across many sectors stating that "obesity is an epidemic peculiar to this century...comprehensive changes to the way we live have led to this problem, and we are all aware that action in the field of health alone is not enough".

The charter is available at <http://www.euro.who.int/Document/E89567.pdf>

More information and access to working papers and background documents related to the Ministerial Conference can be found at <http://www.euro.who.int/obesity/conference2006>

Health Ministers Council calls for broad action on health determinants

On 30 November in Brussels, EU health ministers called for a broad package of measures to tackle the lack of physical activity, smoking, unhealthy diets and other 'societal' health determinants, as individuals' capacity to control them is sometimes limited. They also adopted conclusions on Health in All Policies (HiAP) – the main priority of the Finnish EU Presidency in the health sector. These conclusions call for "broad societal action to tackle health determinants, in

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

particular unhealthy diet, lack of physical activity, harmful use of alcohol, tobacco and psychosocial stress, since the individual capacity to control these determinants that account for major public health problems, is strongly associated with broader societal determinants of health, for example the level of education and available economic resources”.

Accordingly, the Council have invited the Commission to set out a work plan for HiAP and to consider related activities in the future EU health strategy. The Member States are invited to undertake, where appropriate, “health-impact assessment of major government policy initiatives with a potential bearing on health”.

The Council also reached a political agreement on the Commission proposal for the EU Health Programme 2007–2013, which aligns future EU health action with the overall EU objectives of prosperity, solidarity and security and aims to further exploit synergies with other policies. A formal “common position” will have to be adopted by the Council in early 2007, and the Programme will have to go through the European Parliament in second reading. The Programme sets the framework for the Commission’s funding of projects relating to health between 2007–13 and will be part of a broader EU health strategy to be put forward by the Commission next year. The proposed budget is €365.6 million. The Programme’s objectives are: improving citizens’ health security; promoting health; generating and disseminating health information and knowledge.

Under the first objective, actions to be taken will include developing EU and Member States’ capacity to respond to cross-border threats, including preparing for coordinated EU and international responses to health emergencies. This objective will also address patient safety and EU legislation on blood, tissues and cells.

Under the promoting health objective, the Commission will foster healthy active ageing and help bridge health inequalities. It will also continue action on the determinants of health such as nutrition, alcohol, tobacco and drug consumption as well as the quality of social and physical environments.

Under the third knowledge and infor-

mation objective, the Commission will foster the exchange of knowledge and best practice in areas where the EU can provide added-value in bringing together expertise from different countries, for example, rare diseases, children’s health or any other important area. It will promote EU health monitoring and develop indicators and tools as well as ways of disseminating information to citizens, such as the health-EU portal.

Welcoming the agreement, European Health and Consumer Protection Commissioner, Markos Kyprianou, said “improving health is important in its own right. But it also plays a key role in addressing challenges such as population ageing, security threats or labour shortages. Health has a role to play in achieving Europe’s full potential for prosperity, solidarity and security. The new Health Programme will be instrumental in reaching these goals. I look forward to working with the Council and Parliament to help discussions to progress rapidly”.

The Council conclusions can be viewed at http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lsa/91975.pdf

Further information on the proposed work programme can be viewed at http://ec.europa.eu/health/ph_Overview/pgm2007_2013_en.htm

Commission adopts Communication on reducing alcohol related harm in Europe

On October 24, the European Commission adopted a Communication setting out an EU strategy to support Member States in reducing alcohol-related harm. The Communication addresses the adverse health effects of harmful and hazardous alcohol consumption in Europe. Fifty-five million adults are estimated to drink to hazardous levels in the EU. Harmful and hazardous alcohol consumption is a net cause of 7.4% of all ill-health and early death in the EU. The Commission estimate overall alcohol is the cause of the deaths of 195,000 people a year in the EU. Other adverse consequences can include child abuse and neglect, while approximately one accident in four can be attributed to alcohol consumption, and about 10,000 people are killed in alcohol-related road accidents in the EU each year.

The priorities identified in the Commu-

nication were: to protect young people and children; reduce injuries and deaths from alcohol-related road accidents; prevent harm among adults and reduce the negative impact on the economy; raise awareness of the impact on health of harmful alcohol consumption; and help gather reliable statistics. In cooperation with Member States and stakeholders, the Commission will develop strategies aimed at curbing under-age drinking, by exchanging good practice on issues like selling and serving, marketing, and the image of alcohol use conveyed through the media. Through its Public Health Programme, the Commission will support projects that will contribute to reduce alcohol-related harm in the EU, and especially the harm suffered by children and young people, as well as gathering and disseminating data. It will support the monitoring of young people’s drinking habits, with a focus on the increased drinking of alcohol among girls and binge-drinking.

The Commission will explore, in cooperation with Member States and stakeholders, the usefulness of developing efficient common approaches throughout the Community to provide adequate consumer information. Such reflections are particularly important as some Member States are planning to introduce warning labels (for example, on alcohol and pregnancy). It will support Member States and stakeholders in their efforts to develop information and education programmes on the effect of harmful drinking. Through the EU Research Framework Programme, the Commission will launch research on young people’s drinking habits in order to analyse current trends and motivations for drinking, as well as the wider determinants of youth drinking.

The Communication also mapped out actions which Member States are taking, with a view to promoting good practice, proposed an Alcohol and Health Forum by June 2007 of interested parties and also set out areas where industry can make a contribution, notably in the area of responsible advertising and marketing. However acknowledging the role of Member States in this policy area the Commission stated that it does not intend to propose legislation at European level.

Health and Consumer Protection Commissioner Markos Kyprianou said of the strategy: “binge drinking, under-

age drinking and drink-driving are real public health issues in Europe, especially among young people. The Commission is not targeting moderate alcohol consumption, but seeks to actively support Member States measures to reduce the harm caused by alcohol abuse”.

Mixed reactions to the strategy

Responses to the publication of the strategy have been mixed. The alcohol industry have broadly welcomed the Communication, given its focus on alcohol abuse rather than alcohol consumption per se. Jamie Fortescue, Director General of the European Spirits Organisation (CEPS) welcomed “the recognition the Communication gives to the role the alcohol industry can play in reducing alcohol related harm, most notably in terms of promoting responsible consumption. The priority themes proposed are entirely consistent with CEPS’ Charter on Responsible Alcohol Consumption”.

Alan Butler, Chairman of the Europe Forum for Responsible Drinking (EFRD), an alliance of leading spirits organisations, said that “there is much to be welcomed in this Strategy, in particular a focus on alcohol misuse rather than alcohol per se and the reassurance that different cultural habits are respected through recognition of Member State subsidiarity”. He went on to applaud the Commission for “rejecting attempts to hijack the strategy by those who advocated a biased view of the evidence base and for recognising the positive role that industry can play in being part of the solution to alcohol-related harm”. However, he also said that “concerns remain that warning labels and de facto restrictions on commercial communications could surface during the implementation phase. We urge the Commission to exercise caution in compiling the evidence base in support of these policy options and reject such arbitrary measures”.

In contrast some in the public health community are disappointed with the final text agreed. The European Alcohol Policy Alliance (Eurocare), an alliance of fifty-five voluntary and non-governmental organisations “welcomed the strategy and stated that it would continue to support the Commission in its efforts to reduce the harm done by

alcohol in Europe”. However they argued that the final text of the Communication was watered down heavily due to intense industry lobbying.

Andrew McNeill, Honorary Secretary of Eurocare said “we regret to see the industry’s paw prints are all over the Communication”, and added “given that the industry has made it abundantly clear that it is opposed to the whole idea of a public health strategy on alcohol, how can it possibly be seen as a main collaborator in implementing it?”

Peter Anderson, the author of the recent report *Alcohol in Europe*, stated that “the alcohol industry has lobbied to put their own profits above the needs of the European people, with commission officials, other than those directly involved with health issues, surrendering to its pressure”. He said the proposed EU alcohol policy is “much weaker than the first draft and has a much greater focus on education as the answer to solving the problems of alcohol, when the evidence shows that it does not work”. He regretted that measures that could have made a real difference such as a “better regulation of the product and its marketing”, were no longer in the text of the Communication.

One week after the publication of the Communication, Commissioner Kyprianou in a speech in Stockholm to the EFRD also expressed his frustration with the attitude adopted towards the strategy by some in the alcohol industry and challenged them to do more to cooperate on alcohol-related harm. He said “to be frank, I have been disappointed to see that some senior players in your industry have deliberately painted a false picture of what the Communication is about, and about what we are trying to achieve. Indeed, some of you have used the media to give the impression that the Commission is hell-bent on spoiling the pleasure of those who enjoy alcohol in moderation. You know very well that this is not the case”.

He went on to say that “it is however clear that the alcohol industry must make an active and significant contribution towards measurable progress”. Referring to the planned Forum on Alcohol and Health, he said “I should emphasise right from the start that the Forum will not just be a talking shop. I want to see meaningful and verifiable commitments from all its members – and

obviously expectations on the alcohol industry to deliver will be high”. He also stated that there was an ethical obligation on the industry not “to specifically target young people through the design of alcoholic beverages, or through advertising, sponsoring and marketing”.

The alcohol strategy can be viewed online at http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/alcohol_com_625_en.pdf

Commissioner Kyprianou’s speech to the EFRD on 30 October can be viewed at <http://europa.eu/rapid/pressReleasesAction.do?reference=SPEECH/06/645&format=HTML&aged=0&language=EN&guiLanguage=en>

EUROPEAN COURT NEWS

ECJ looks again at duty on alcohol and tobacco imports

In the EU, excise duty is chargeable in the Member State of final destination; however, a provision allows for excise duty on products “acquired by private individuals for their own use and transported by them” to be charged in the Member State of purchase. The issue under question in the European Court of Justice centred on where duty on alcohol and cigarettes should be charged, specifically for goods bought for personal use over the internet or via mail order. In the present case (*Staatssecretaris van Financiën v. BF Joustra*), a private individual from the Netherlands purchased duty-paid wine in France for his own use. He did not transport the wine himself, but engaged a transport company to do so. The Dutch tax authorities now wish to levy excise duty on the wine, and the UK government is supporting them in their action.

Advice from Advocate General Jacobs in his December 2005 Opinion, confirmed that the rules should mean that shoppers can buy at local excise duty rates when ordering from abroad. The Dutch and UK authorities wanted the Court to reject this Opinion. On 23 November 2006, the European Court ruled that consumers are allowed to buy alcohol and cigarettes online at lower duties from abroad, but they will have to accompany the goods back themselves.

This judgment comes six months after the European Commission decided to

end legal proceedings against the UK for cracking down on shoppers bringing in excessive quantities of alcohol and tobacco. The UK Treasury crackdown was triggered by fears that shoppers were bringing in much more cheap alcohol and cigarettes than was justified by private consumption, then selling it on and worsening revenue losses.

Furthermore, the British Retail Consortium argued that if the Court had taken the Opinion of the Advocate General, British business could have been hit hard unless excise duty rates were harmonised across the EU.

COUNTRY NEWS

Access to cancer-treatment varies across Europe

Access to cancer care, such as surgery and radiotherapy, the availability of anti-cancer drugs and medical training differ throughout the EU, according to a study published by the Swiss based European Society for Medical Oncology (ESMO) on 3 October 2006. Even access to information is said to vary from country to country.

The Medical Oncology Status in Europe survey studied and compared countries, for example, on education and training, sub-specialisations of oncology, patterns of care, national guidelines on cancer and clinical research. The study does not provide for a clear ranking of the European countries on the matter, but shows that Iceland, Switzerland, Italy and Germany have the highest number of both oncologists and facilities relative to population size, whereas eastern European nations have fewer specialist units. ESMO President Håkan Mellstedt, hopes that the report, by providing more information on the European infrastructure, will help reduce some of the inequalities seen in access to services.

The report is available at
<http://www.esmo.org/resources/surveys>

Ireland: New hospital units and older people priorities in €14.5bn package of funding

On 16 November the Minister for Health and Children, Mary Harney, announced the agreed estimates of expenditure on health in 2007. Total public spending on health will amount to €14 billion gross current plus €657

million gross capital. The Minister said, "the government is again providing for a substantial annual increase in public spending on health, of over €1.1 billion". Eight new units in acute hospitals around the country will be opened at a cost (along with other developments) of €75 million.

The Minister also confirmed that spending on older people would be one of the key priorities in 2007, stating that she wanted to "ensure that our commitment to fully fund the largest expansion in services for older people is met in 2007". She noted that "€110 million was added to services for older people in 2006. This funding has been well-used to treble home care packages, to expand home help hours, to increase nursing home subvention and to support palliative care, for example. The €40 million required to fund this expansion in a full year is now provided for. Effectively, this means that these additional services will be provided for the full 12 months of the year, rather than 9 months on average in 2006, and this will mean more older people will receive new support in 2007 than in 2006".

There will also be an additional €8 million in funding to allow the nationwide rollout of Breastcheck, the national breast cancer screening programme, while €5 million will be made available to help prepare the national cervical screening programme. The National Treatment Purchase Fund, which sources treatment for patients who have been waiting for more than three months, will also see its budget increased by €10 to €88m. Commenting on the Fund the Minister said, "the Fund has shortened waiting times and improved responsiveness for 50,000 public patients. I am very supportive also of its expanding work to provide outpatient appointments in areas and specialties where waiting times have been longest".

Full information on the 2007 health estimates are available at
http://www.dohc.ie/publications/pdf/estimate_increases.pdf?direct=1

Italy: Senate investigates medical malpractice claims

The Italian Senate has called for further information on controversial claims that as many as ninety people a day die in the country due to medical malpractice and poor organisational procedures. The

claims were made at a conference organised by the Italian Association of Oncological Medicine (AIOM) held in Milan on 23 October. In response to the claims, Ignazio Marino, president of the Senate Hygiene and Health Commission, underlined that "the figures given to the press are alarming and need in-depth explanation and have to be analysed by experts active in evaluating clinical risk inside medical facilities."

Widely reported in the media, the AIOM report estimated that about 33,000 people die each year, far higher than the number of people killed on the roads. Speaking to the BBC, AIOM spokesman Mauro Boldrini said that they were "convinced that there is a serious problem that no-one has properly studied. If no-one talks about it, then it won't be addressed". In response, a health ministry spokesman said that the claim seemed "exaggerated". However Health Minister, Livia Turco, said that "whatever the correct numbers are...the data given by AIOM confirms the urgent need to face up to the issue of errors in medicine in order to guarantee maximum safety for citizens who turn to our country's health services every day".

Around one third of the alleged errors occurred on the operating table. Other areas for errors were patient wards (28%), emergency rooms (22%) and out-patient clinics (18%). The report suggested that many errors involved giving patients the wrong medication because of the similarities between generic and brand names.

Media coverage of the event has been criticised for being sensationalist and not grounded in science. Maurizio Maggiorotti, head of the Association of Doctors Unjustly Accused of Malpractice commented that "this is not only false but it has no scientific foundation or statistical credence". Measures to avoid the likelihood of medical errors in Italy have included the establishment of a Commission for Clinical Excellence and the National Centre for Patient Safety.

Germany: Parliament votes to ban tobacco advertising

The lower house of the German parliament on 9 November voted overwhelmingly in favour of a ban on tobacco advertising that would finally bring Berlin in line with European Union directives. Under the bill, ciga-

rette manufacturers will still be able to advertise on billboards and on cinema screens after 7:00 pm. But it will bring an end to tobacco in the print press, on television and the Internet and at sports events which are broadcast on television.

The Free Democrats, a free-market liberal party, voted against the ban. They claimed that it patronised consumers and forbade advertising for a legal substance. Advertisers and publishers also generally condemned the decision. Newspaper publishers see it as a restriction to their freedom to advertise, while the German Association of Magazine Publishers (VDZ) said the government capitulated with its “overly-hasty” decision. The vote to ban tobacco advertising shows the increasing influence of the EU over national questions, the VDZ told news channel Deutsche Welle.

Germany has long been considered a haven for smokers and cigarette manufacturers, while rules on public smoking and tobacco advertising grew stricter elsewhere in Europe. The ban was highly controversial and Berlin went to the European Court of Justice to fight the EU directive on forbidding tobacco advertising. But the government realised the challenge was doomed in June when an advocate general of the court recommended dismissing it. (See news section in *Eurohealth* 12 2).

Consumer Affairs Minister Gerd Müller has also held out the prospect of further anti-smoking legislation to protect individuals against the effects of passive smoking; a working group made up of representatives from the Social Democratic Party (SPD), the Christian Democratic Union (CDU) as well as from the health and consumer protection ministry is currently exploring ways of introducing a Germany-wide anti-smoking regulation.

Berlin to press ahead with local smoking ban

Meanwhile, Berlin’s local government wants a ground-breaking ban on smoking in the city’s public buildings as well as in all bars and restaurants, further stoking debate on outlawing smoking across the country. Berlin Mayor Klaus Wowereit’s Social Democrats and their designated coalition partners, the Left Party, said in early November that they are pressing ahead with plans to make the German capital smoke-free as early as 2007.

This would mark a sharp departure from the rest of Germany’s federal states, which have to varying degrees resisted national restrictions on tobacco. A previous effort to introduce a nationwide ban on smoking in restaurants, cafes and bars, aimed at bringing Germany into line with other European nations, was blocked in September by Chancellor Angela Merkel’s Christian Democrats.

Spain: Investigation into alleged illegal late term abortions

In October an investigation was launched in Barcelona into allegations made on a Danish television (DR1) documentary that doctors in one clinic were providing late terminations, for women from all over Europe; in some cases as late as eight months into pregnancy.

According to the documentary, which used video footage taken in September and also sent to local news agencies, the centre is alleged to be systematically and fraudulently using a legal loophole which allows abortions without time limits in cases of serious mental or physical risk to the mother.

In the documentary, filmed with a hidden camera, a DR1 journalist in her eighth month of pregnancy appeared to be offered a chance to abort her healthy foetus for a fee of €4,000. She met with the director of the centre, who assured her that the procedure was legal and carried no risks. The director explained before the hidden camera that the foetus would be injected with dioxin, which would make the baby’s heart stop before being extracted from the uterus. The female journalist, who alluded to the break-up with her partner being the reason for the abortion, was asked to fill in a questionnaire about her physical and mental health. Then she completed three psychological tests, being told that the only way of having a legal abortion (under these circumstances) was to allege physical or mental problems, in spite of the fact that she had already stated during an interview that her health was ‘good’.

Minutes later, the journalist returned to the clinic to reveal her true identity, accompanied by a television camera. In an interview with the director, he claimed that the operation had not been authorised and that further psychological tests were needed. He continued

to claim, however, that the abortion was completely legal. Moreover, the doctor, who has run clinics specialising in voluntary terminations for 30 years, underlined that he had rarely practiced abortions on women whose pregnancies had gone beyond 30 weeks.

The deputy director of the Catalan health ministry, Lluís Torralba, said his department was now collecting information on the clinic. The case has led to a political outcry in Denmark with the head of the Danish parliamentary committee on public health, Birthe Skaarup, a member of the far-right Danish People’s Party which is a key ally of the government, saying that she was “scandalised and shocked” by what she termed the “outright murders”. Opposition MPs also urged the Danish government to put pressure on the Spanish government. A spokesman for Denmark’s ruling Liberal Party, Joergen Winther, said meanwhile it was necessary to “discuss common regulations within the European Union on abortion”.

In Spain, abortion was decriminalised in 1985 for certain cases: up to the first twelve weeks of pregnancy following rape and up to twenty two weeks in the case of foetus abnormality or if the pregnancy represents a threat to the physical or mental health of the woman. Interviewed in the documentary, Jesús Silva, professor of criminal law at the Universidad Pompeu Fabra in Barcelona stated that the application process “was a theatre, a lie with false tests”, and that “it was fraudulent in Spanish law and as a whole”, and should – in the cases of illegal abortions being carried out – imply prison sentences and the disqualification from practice of those involved.

More information (in Spanish) at http://actualidad.terra.es/sociedad/articulo/reportaje_tv_barcelona_1174449.htm

Portugal: Parliament approves abortion referendum

On October 19 Portugal’s parliament voted to hold a national referendum allowing voters to decide on making abortion legal up until the 10th week of pregnancy. Current Portuguese abortion law allows the procedure up until the 12th week of pregnancy, but only in cases of rape, foetal abnormality, or risk to the mother’s health. Parliamentary approval of the referendum comes only a month after the ruling Socialist Party first proposed it. Before a date for the

vote is set, both the conservative President Cavaco Silva and the Constitutional Court of this very Catholic country must formally approve it.

Portugal, which has one of the most restrictive abortion laws in Europe, has made several unsuccessful attempts in the last ten years to ease restrictions on abortion, so success is by no means guaranteed. In 1998, a referendum on legalising abortion was declared void due to low voter turnout, yet there was a slight majority voting against the referendum. A second referendum was proposed in November 2005, but the Constitutional Court held that the vote could not be held before September of this year, because the same referendum had been rejected in the current legislature by the now-former president. A referendum result can only be valid if 50% of Portugal's registered voters cast ballots. One recent opinion poll conducted by the firm Marktest suggests that 63% of the population would be in favour.

Although affluent Portuguese women can travel to abortion clinics in Spain, abortion rights groups estimate that approximately 10,000 Portuguese women are hospitalised each year from complications from failed backstreet procedures. Prime Minister Jose Socrates said "we have to end this blight of backstreet abortions, it makes Portugal a backward country". The opposition Christian Democrats said they would campaign against the legalisation of abortion. "Once again, the Christian Democrats will be the only party that will campaign against (it), defending the fundamental right to life," MP Pedro Mota Soares told parliament.

In Europe, only Poland and Ireland have such restrictive rules on abortion, while Malta forbids abortion altogether.

Hungary: Proposed act on supply and distribution of medicines and devices

The Hungarian Minister of Health has submitted draft legislation to parliament on the Safe and Economical Supply and Distribution of Medicines and Medical Devices. Parliamentary debate began on 25 October 2006, and it is proposed that the Bill will enter into force on 1 January 2007. It will impose new payment obligations on pharmaceutical manufacturers and make amendments concerning various aspects of pharmaceutical regulation, particularly related to promotion,

pricing and reimbursement and distribution of pharmaceuticals, as well as the operation of pharmacies.

The Bill contains provisions on the pay-in obligations of marketing authorisation holders (MAH). A MAH shall pay a certain percentage (14% for fixed-subsidised products and 16% for non-fixed subsidised products) of the total annual amount of reimbursement for each product reimbursed by the national health insurance system. In order to cover the overspending of the health budget on the reimbursement of medicines, MAHs shall also comply with a band-based pay-in obligation (up to 9% of the overspending, the MAHs shall pay jointly with the State, above 9%, the MAHs shall be solely responsible for the remaining amount).

The Bill also permits the temporary fixing of pharmaceutical prices for a maximum of two years; currently the duration of such a price freeze is nine months. The Bill would allow for a review annually to determine whether any price freeze was still justified. Such factors would include the need to provide access to a key patented treatment for a disease or if the costs of manufacturing were in excess of the government's fixed price. Registration fees with the National Institute of Pharmacy for medical sales representatives will be increased to approximately €19,000 with an annual renewal fee of almost €4,000. The Bill also proposes that limits on hospitality and sponsorship of conferences per participant be slashed from 50% to just 5% of the monthly statutory minimum income.

A new authority will be responsible for approving contracts with health service suppliers. It will be able to recommend to the National Health Insurance Fund Administration to suspend or terminate the financing contracts of healthcare service providers. The Bill will also liberalise rules concerning pharmacies and the sale of medicines and will allow some over the counter medicines to be sold outside pharmacies.

Netherlands – Drug initiatives

Launch of nationwide Drugs Awareness Campaign

On 6 November, Health Minister Hans Hoogervorst officially launched the annual nationwide Drugs Awareness Campaign. During one month, young

people will have the opportunity to publish photographs or video clips on a web site (www.drugsinfo.nl), together with a message explaining why they do or do not smoke cannabis.

Figures published by the Netherlands Institute of Mental Health and Addiction show that cannabis is still the most widely used drug among young people in the Netherlands. Moreover, data collected by the Drugs Info Line show that most of the questions received by that service concern the use of cannabis. Yet four out of five young people have never smoked cannabis, which contradicts the commonly held belief in this age group that at least 80% are cannabis users.

The new campaign tackles misconceptions about cannabis use. It prompts young people aged between 14 and 18 to search for more facts about cannabis. The campaign was developed by the Trimbos Institute, in cooperation with addiction care institutions and municipal/regional health authorities, under the auspices of the Ministry of Health, Welfare and Sport.

Cash rewards for drug addicts

Meanwhile over the summer there has been some controversy over a pilot fourteen-month scheme involving hard drug addicts in three Dutch cities, estimated to cost of more than €500,000. The pilot schemes will give free heroin and cash rewards (up to €56 per week) to heroin addicts if they do not use cocaine at the same time. Participants will be required to prove that they are cocaine-free by taking regular urine tests. The Central Commission for the Treatment of Heroin Addiction believes that the experiment is worthwhile, as research has shown that cocaine is the preferred drug for most addicts.

Some in the Dutch media have however condemned the pilot schemes. In a written reply to Parliament, Minister of Health Hans Hoogervorst stated that he fully understood concerns over the use of a system of financial rewards, but stressed that this approach has been effective in the United States. Nonetheless, he acknowledged that this might be seen to send the wrong signals to addicts and as a result he has asked the Central Commission for the Treatment of Heroin Addiction to investigate suitable alternatives to cash. Potential options might include the

distribution of vouchers for services such as personal grooming, health and sports.

Russia: Chief Medical Officer calls for state monopoly on alcohol

On 14 November, Russia's Chief Medical Officer, Gennady Onishchenko, urged the government to introduce a state monopoly on alcohol, amid the rising death toll from bootleg vodka in the country. Russia has recently been swept by media reports of large-scale outbreaks of alcohol poisoning in several regions as bootleg vodka and poisonous substitutes have been sold at low prices in the country. Dr Onishchenko noted that while "in the 1990s, per capita consumption of alcohol stood at 7.6 litres; by 2005, the figure had reached 9.7 litres". He went on to say that his department and the Interior Ministry were taking active measures to expose bootleg vodka and alcohol substitutes.

Dr Onishchenko's call comes in the wake of the news that approximately 10,000 cases of toxic hepatitis caused by surrogate alcohol have been registered in Russia. He said that toxic hepatitis had been seen in eighteen regions, with a dramatic surge of alcohol-related cases in the Irkutsk, Chelyabinsk and Belgorod regions, where 107 people have been affected. There have been more than 400 deaths in recent months, the majority of which appear to be due to the consumption of sub-standard and illegal bootlegged alcohol.

The introduction in July of a new alcohol regulation policy, has been criticised for causing widespread confusion leading to a shortage of legal supplies of alcohol.

Russia: Corruption scandal hits insurance fund

A criminal investigation into alleged major corruption at the Federal Medical Mandatory Insurance Fund has been launched, following the arrest of fund director Andrey Taranov and deputy director Dmitry Usenko on suspicion of accepting bribes and misusing funds from the federal budget. Further arrests have followed. The Russian Prosecutor General's Office has released a statement saying that officials of the agency took bribes from regional medical insurance funds, pharmaceutical companies and medicine suppliers. The amounts involved have not been disclosed.

The scandal has been linked to the state

supplemental medicines programme, and may arise out of the fierce competition to win the next year's rights to supply medicines to Russians who receive state assistance and benefits. In this year's programme three companies were awarded 70% of the 29 billion rouble (€835 million) fund, with the remainder of the funds distributed to more than 50 companies. Next year's budget for the fund is expected to be in the region of 42 billion roubles (€1.2 billion).

The supplemental medicines programme has however been problematic; this year running out of funds by July and anticipated to incur a substantial debt of more than 20 billion roubles (€576 million) by the end of 2006. The case has also led to calls for the resignation of Minister of Health and Social Development, Mikhail Zurabov. The supplemental medicines program is seen as one of his most important projects. It was heralded as the largest state social programme and the beginning of the reform of state social assistance when it was launched.

At a press conference shown on Russian television on 20 November he said that "our understanding of how events will develop is rather limited at the moment, but it evidently is not a question of additional supplies of medicine". He did not rule out that people were using the scandal to drive him from his job, but he said that resigning would be too easy.

Mr Zurabov has courted unpopularity ever since his appointment in March 2004. He has tried to push through reforms to Russia's pension and health systems, seeking to replace many benefits with a cash payment system. He has faced stiff opposition from doctors and local officials and there have been calls for demonstrations from pensioners faced with charges for benefits that were previously free.

Tajikistan: Rapid increase in HIV infection rates.

Doctors at Tajikistan's Republican AIDS Prevention Centre have reported a sharp rise in the number of newly registered cases of HIV infection in their quarterly bulletin. 121 new cases have been officially registered in just the first ten months of 2006. This brings the total number of officially registered cases to 627 as of 1 October 2006, although doctors in Tajikistan estimate the total number of people living with HIV/AIDS in the country to be over

6,000. The largest number of officially registered people living with HIV/AIDS, 218, is in the capital city Dushanbe.

Although Tajikistan is still considered a country with low HIV prevalence, the dramatic rise in new cases since 2004 is a cause for concern. In Tajikistan, as in Russia, Ukraine and Belarus, the vast majority of new cases are among injecting drug users. The spread of HIV in this group has been rapid. They now make up two-thirds of officially registered HIV-positive cases.

Financial and technical support from international donors for HIV prevention and improved surveillance increased dramatically in 2005, as Tajikistan is one of the countries covered by the Central Asia AIDS Project.

For more information see:
<http://eng.caap.info>

Turkmenistan: Reforms focus on importing medical technology

The official news agency for Turkmenistan reported on 7 November 2006 that a new contract with Siemens has been finalised with the Ministry of Healthcare. This will provide a tele-medicine network across the country. The government have been collaborating with the German high-technology company Siemens on a number of health care projects and reforms in the country have focussed on the importation of 'big ticket' medical technologies.

The flagship hospital is the International Medical Centre in the capital, Ashkhabad, which specialises in cardiology. The aim has been to provide clinics and hospitals in Turkmenistan with the equipment to bring facilities up to 'western' standards. Estimated life expectancy in Turkmenistan was just 60 years in 2003, one of the lowest in the WHO European region.

While this project constitutes a major investment in health care facilities in Turkmenistan, there are concerns that investments in technological hardware have not been matched by commensurate investments in human capital and training for staff.

More information at
http://www.turkmenistan.ru/?page_id=3&lang_id=en&elem_id=8810&type=event&sort=date_desc

News in Brief

New HEN report on mobile phone use and health

Written by Emília Sánchez from the Catalan Agency for Health Technology Assessment and Research, this new report from the WHO Regional Office for Europe's Health Evidence Network looks at the use and health effects or risks of mobile phones. The study analyses epidemiological studies in the general population that have looked at the links between mobile phone use and the development of tumours. Although weak and inconclusive, most of the evidence available does not suggest that there are adverse effects on health attributable to long-term exposure to radio-frequency and microwave radiation from mobile phones. Recent studies have however reported an increased risk of acoustic neuroma and some brain tumours in people who use an analogue mobile phone for more than ten years. The report concludes that if there is a risk, it is small, but that there are still gaps in our knowledge.

The report is available at
<http://www.euro.who.int/Document/E89486.pdf>

Health in Scotland annual report

A Scotland in which lung cancer is virtually wiped out is a real possibility in years to come if the reduction in deaths speeds up as expected, Chief Medical Officer, Harry Burns, said on 6 November in his first annual report. The smoking ban, which has reduced passive smoking rates and is showing early signs of encouraging more people to quit, will reduce lung cancer rates to just a few hundred cases a year in the future, said Dr Burns. The smoking ban and other public health measures outlined in the report are also having an impact on driving down the incidence of conditions like heart disease and stroke.

More information at <http://www.scotland.gov.uk/Publications/2006/10/30145141/0>

World Drug Report 2006

Some two hundred million people, or 5% of the global population age 15–64, have used illicit drugs at least once in the last twelve months. Among this population are people from almost every country on earth. More people are involved

in the production and trafficking of illicit drugs and still more are touched by the devastating social and economic costs of this problem. Partially a consequence of its pervasiveness and partially a consequence of the illicit and hidden nature of the problem, reliable analysis and statistics on the production, trafficking and use of illicit drugs are rare.

The World Drug Report 2006, published by the United Nations Office on Drugs and Crime, endeavours to fill this gap. It provides one of the most comprehensive overviews of illicit drug trends at the international level. In addition, it presents a special thematic chapter on cannabis, by far the most widely produced, trafficked and used drug in the world.

More at http://www.unodc.org/unodc/en/world_drug_report.html

Public-Private Partnerships and collaboration in the health sector

Written by Irina Nikolic and Harald Maikisch, this World Bank brief is intended to provide an overview of the topic of public-private partnerships (PPPs) and public-private collaboration (PPC) in the health sector, the key types of PPPs and PPC encountered in practice, the associated benefits and risks, and good practices for ensuring success. Also included are nine recent case studies from experience in Romania, Germany, Austria, Denmark, Sweden and Portugal that illustrate these considerations under specific project circumstances.

The report is available at
<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/NikolicPPP&CintheHealthSectorfinal.pdf>

EHMA conference – call for papers

The European Health Management Association's scientific advisory committee is now seeking oral presentations and posters on the theme 'Managing values in health care' to be presented at its annual conference. The aim of the conference is to explore the relationship between values and performance measures, going beyond the ideological dichotomy of public-private, and state versus market. Instead of increasing the gap between a market and efficiency-oriented approach on the one hand, and

a caring and serving approach on the other hand, they want to focus on the possibilities and practices of more effective combinations of these two sets of values. The conference seeks to explore how the clash between value sets can be addressed. Is it possible to reconcile both sets of values and look for a common denominator?

The submission deadline is 15 January 2007. The event will take place in Lyon, France on 27–29 June 2007.

More information at
http://www.ehma.org/_fileupload/File/EHMA_2007_Call_for_papers.pdf

EC work plan confirmed

The European Commission has published its work plan for 2007, listing a range of new initiatives in addition to its ongoing programmes. Health related actions include strategic communications on nutrition, mental health, health care services and health in all policies.

More information at
http://ec.europa.eu/atwork/programmes/index_en.htm

Regions: Statistical Yearbook

Eurostat, the EU statistics body, has published the 2006 edition of Regions: Statistical Yearbook. Covering the 266 regions of the 27 EU member states from 2007, it includes chapters on health and other data.

It is available in paper, CD-Rom or DVD formats from
<http://epp.eurostat.ec.europa.eu>

WHO violence survey

The WHO Regional Office for Europe has published a European survey on violence and injury levels to better understand how ministries are operating in terms of policy frameworks and infrastructures.

Further information at
<http://www.euro.who.int/violenceinjury>

Additional materials supplied by
EuroHealthNet

6 Philippe Le Bon, Brussels.
Tel: + 32 2 235 03 20
Fax: + 32 2 235 03 39
Email: c.needle@eurohealthnet.eu

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

European
Observatory 
on Health Systems and Policies

LSE Health

ISSN 1356-1030