

# Eurohealth

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Volume 13 Number 1, 2007

## Health worker migration in Europe: assessing the policy options



**Migrant health in the EU**

**England: payment by results**

**Albania: pharmaceutical reimbursement**

Spain: long-term care reform • Mental health policy in Europe: time to refocus  
Croatia : introduction of DRGs • Nicotine replacement therapy revisited

# COMMENT

## Train of thought: migration and health

As James Buchan writes in this issue of *Eurohealth*, the migration of health workers has now become a significant feature of the global health policy debate. It has particularly taken on prominence in Europe as the EU expands yet further. It is all too easy to see the international recruitment of health workers as a 'quick fix' short-term solution to the health professional skill shortages that can be observed in some European countries. Why invest scarce resources and many years in training up the domestic workforce, when it is much easier simply to launch overseas recruitment drives and free ride on the training efforts of others? Well this would be fine, if not for the consequences for those 'donor' countries; often low-income countries themselves with severe shortages of health care professionals.

Global problems require global solutions, yet it is remarkable that so little is still known about the impact of migration on the effectiveness of health systems in Europe; nor is there any system in place that can accurately measure the stocks and flows of migrant health care workers. This raises all manner of ethical and practical challenges for policy makers. Professor Buchan sets out here some of the potential policy options that the international community may wish to consider in their deliberations, including the greater use of international codes of practice, as well as bilateral agreements.

Of course, it is not just health care professionals that continue to migrate across Europe. When does the health status of immigrants become comparable to that of the local population? What steps can be taken to protect both the health of migrants and that of established residents. Again, as Philipa Mladovsky notes, European countries rarely collect health data by ethnicity, making it difficult for policy makers to address some of these issues. Carefully targeted policies would seem merited, given that in many instances first generation migrants may enjoy a better state of health than that experienced by subsequent generations.

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# Albania: The Health Insurance Institute and pharmaceutical reimbursement

*Florentina Gjeci*

## Health care in Albania

Albania has a population of 3.58 million. This is one of the youngest populations in Europe, with an average age of 28.9 years.<sup>1</sup> In 2005, total health expenditure was 6.6% of Gross Domestic Product,<sup>2</sup> putting the country in line with the average for lower middle income countries. Albania's health care system prior to this transition was characterised by strong central government control over all aspects of the system. This was based on the Semashko style, which in one manner reflected the relationship between countries in central and eastern Europe. A series of reforms were initiated in the mid-1990s, which included the decentralisation of primary care management, privatisation of the pharmaceutical sector and the establishment of the Health Insurance Institute (HII).

The government is the major provider of health care services. They are organised on three levels: (i) primary health care is provided at health centres and polyclinics; (ii) secondary health care is provided at districts hospitals (51 hospitals in 36 districts); and (iii) tertiary health care is provided at the University Hospital Centre (CHU) located in the capital Tirana, where more than one-fifth of the population lives.

The HII covers primary health care services, including general practitioner and

specialist visits, as well as the reimbursement of a list of outpatient pharmaceuticals ('positive list'). In contrast, hospital care remains under direct state administration. Established in 1995, it is an independent body funded by payroll tax contributions as well as contributions from the self-employed and farmers, and governmental budget contributions for the dependent (non-active) population.

## Pharmaceutical distribution and reimbursement

Patients treated at polyclinics and health centres who require a pharmaceutical product receive a prescription and collect it from a private pharmacy. Private pharmacies procure products from private wholesalers. If the patient is insured (covered by the HII), the pharmacy will be partially or fully reimbursed for the price of the medicine. The patient pays the remainder out-of-pocket.

Under the HII there is 100% reimbursement of prescription drugs for children 0–12 months, people with severe disabilities, military veterans, old age pensioners, as well as patients with cancer, tuberculosis, multiple sclerosis, anaemia caused by chronic kidney failure, major thalasaemia, and kidney transplantation.

There is partial reimbursement ranging between 50% and 95% of prescription costs, dependent on therapeutic class for employees, the voluntarily insured, those with mild and moderate disabilities, social welfare recipients, children aged one year and over, students, expectant and new mothers and soldiers. The levels of reimbursement were last approved by the Council of Minister in February 2007. The percentage of reimbursement is calculated using a reference price which represents the lowest retail price of a generic drug

(lowest CIF price\* + wholesale margin + retail margin). Moreover, military veterans can be prescribed any branded product (i.e. a registered drug, regardless of whether on the reimbursement list).

The current distribution margins in Albania are high compared to those of other countries - 18% for wholesale and 33% for retail. The current fixed margins create an incentive to distribute higher priced drugs. At the same time, a digressive margin system has been introduced for the most expensive drugs (about 20% of drugs on the reimbursement list), aimed at reducing this incentive to sell expensive drugs. For example, the drug Erythropoietin ampoule, has lower margins of 8% for wholesale and 15% for retail, (the higher the price – the lower the margins). There remains however scope for informal payments to be potentially linked to prescribing practices as highlighted by the HII.<sup>3</sup> There may also be perverse incentives for physicians and pharmacists to collude to process 'ghost' prescriptions, and then share the additional reimbursements received from the HII. A confidential telephone hotline has also been set up to allow the public to report instances where a patient has felt been pressurised to process their prescriptions in specific pharmacies.<sup>3</sup>

## The positive list and pharmaceutical expenditure

There are currently 341 drugs on the reimbursement list (that came into force on 1 April 2007), and some can only be prescribed under specific conditions or following approval from a specialist. In this case, the primary health care (PHC) physician completes a form in which he

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\* Cost, insurance and freight price.

**Table 1. Total Expenditure of Health Insurance Institute of Albania, 1995–2004 (€ millions)**

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Reimbursement of drugs	2.4	6.8	9.5	14.1	15.3	13.5	13.3	13.4	17.8	28.9
% of total HII exp	73.4	68.2	74	74.9	74.9	70	56.7	47	51.5	60.2
Doctors	0.6	2.5	2.7	3.4	3.8	4.2	4.8	6.9	7.8	8.7
Administration	0.2	0.5	0.6	1.1	1.2	1.4	1.8	2.4	2.5	2.8
Investments	0.1	0.2	0.0	0.2	0.2	0.2	0.2	0.6	1.0	0.8
Pilot project expenses	0.0	0.0	0.0	0.0	0.0	0.0	3.4	5.2	5.4	6.8
Total	3.3	10	12.8	18.8	20.5	19.3	23.5	28.5	34.5	48.0

Source: Health Insurance Institute of Albania, 2005.<sup>4</sup>

**Table 2: Top ten reimbursed drugs by value 2005**

INN Name	Indication	Quantity	Value (Leke)
Enalapril 20 mg	ACE Inhibitors, Hypertension	21,351,668	233,511,574
<b>Risperidon 2 mg</b>	Neuroleptic, psychosis, Angiotensin II antagonist	967,302	224,430,982
<b>Valsartan 80 mg</b>	Hypertension	1,747,126	195,308,163
<b>Interferon beta</b>	Multiple Sclerosis	14,730	137,119,170
Amlodipine 10 mg	Calcium antagonist, hypertension	3,991,451	127,660,162
<b>Fluvastatine 40 mg</b>	Cholesterol lowering	1,519,703	122,557,294
Finasteride 5 mg	Benign prostatic, hyperplasia Alpha-blocker	701,542	107,054,934
<b>Tamsulosin 0,4 mg</b>	Hyperplasia	576,959	106,183,326
<b>Olanzapine 10 mg</b>	Neuroleptic, psychosis	101,448	95,819,722
H-insulin bi-phasic	Diabetes	87,766	90,516,449

Note: Single source drugs in bold.

Source: Health Insurance Institute, 2005.<sup>6</sup>

recommends the specific drug to a specialist, for example, Ibuprofen 400 mg. The specialist may, however, prescribe another drug, different to that prescribed by the PHC physician, for example, Voltaren 50 mg.

In principle, all drugs prescribed by specialist doctors have to be endorsed by a PHC physician. Often, patients can get confused when they receive a different brand than that prescribed by the specialist and which they desired to have. To avoid

this confusion, some patients choose to visit the specialist first and afterwards go to the PHC physician to endorse the prescription. The pharmacists are allowed to substitute less expensive, branded and generic drugs. The positive list is updated every year by a committee set up by the Order of the Minister and is made available to PHC physicians by the HII.

Over the past few years, the HII has been facing the problem of growing pharmaceutical expenditure.

Expenditure on pharmaceutical reimbursement drastically increased during 2003 and 2004 (see Table 1). In 2004, HII expenditure on drugs was €28.9 million (3.66 billion Leke).<sup>\*</sup> This equated to 60% of total HII expenditure or 10.6% of total health expenditure (including all public and private spending on health).

The increase in expenditure is due to a combination of factors, including the expansion of the positive list and the new co-payment exemption. For example 72 new drugs were added to the list in 2004, many of which were very expensive. At the same time, the reimbursement committee decided that drugs for pensioners should be fully reimbursed. In 2004, the HII therefore ran up a deficit of €4.8 million, that increased to €8 million in 2005.

Another challenge in Albania is that physicians tend to prescribe expensive brand name drugs, which leads to high expenditure. As indicated in Table 2 out of the top ten reimbursed drugs by value, six are single source and these are also very expensive. Approximately 50% of expensive drugs in the reimbursement list are single source drugs.<sup>5</sup>

#### Challenges and measures for improvement

As drug distribution in Albania has been problematic and partially undermined by corruption, the HII has introduced a number of measures intended to improve

<sup>\*</sup> The average annual exchange rate for 2004 was €1 = 126.5 Leke.

**Box 1: Health economic indicators****Performance indicators**

1. Thirteen medical visits per doctor per day (rural) and sixteen visits per doctor per day (urban), with consideration for special cases, for example, physicians working in mountainous areas.
2. 60% of people registered in each health centre should be covered by insurance. Currently only 40–45% of the population benefit from coverage under the mandatory health insurance system, indicating that the majority of population still pay for medicines out-of-pocket.<sup>6</sup>

**Quality service indicators**

3. Planning of patient visits (all visits will be planned for chronically ill patients) aimed at avoiding the long waiting time and towards better organisation of physician time.
4. Maintaining the percentage level of immunisations in accordance with national standards
5. Improving the situation of chronically ill patients (aiming to monitor and keep under control the diagnosis of chronic diseases and reimbursement expenditures for these patients).
6. Obtaining direct feedback from the population (for example, patient questionnaires) at least twice per year. (This point has been largely neglected)
7. First time patient visits have to cover 60% of an area's population (this aims for doctor to know the epidemiologic situation at areas he/she works).
8. Child mortality rates to be under the average of the health centre (for each doctor these data will be compared with data of the health centre where he/she works, data of regional level/data of national level).
9. The average prescription value per diagnosis to be in the regional level (The regional average prescription value per diagnosis is considered as a benchmark).
10. Decrease the average prescription value per inhabitant by 5% (This value to be decreased up to 5% when compared with that of previous year).
11. Decrease in references given by PHC physician to the specialist doctors by 5%. (This requires more responsibility and professional skills of PHC physicians, who sometimes recommend patients to a specialist without having clearly motivated reasons).
12. Participation of the medical staff in continuing professional development.

Source: Health Insurance Institute, 2007.<sup>7</sup>

the situation and contain costs. First, certain drugs can now only be prescribed under specified conditions. In mid-2006, there was a revision of the positive list and contracts that HII have with family doctors and pharmacists. A drug budget is determined for each PHC doctor in order to control spending. The budget is individualised and differs according to historical spending and the number of war

veterans and people with disabilities seen by the physician. Also, additional controls are in place at polyclinics and in pharmacies to prevent the generation of false prescriptions that in fact are not dispensed. Furthermore, important steps have been taken to improve transparency along the pharmaceutical distribution chain. The HII is also looking into establishing treatment guidelines for primary care that

could then be used to monitor prescribing.

These measures are in themselves insufficient to curb the rapidly increasing expenditure, thus the HII is continuing to introduce new elements, including twelve health economic indicators, in an attempt to improve both the quality of primary health care and the efficient remuneration of physicians. These are thus divided between two performance and ten quality indicators (see Box 1).

**Conclusions**

The Health Insurance Institute is committed to consolidating efforts to strengthen the management of the health insurance system. The measures introduced, including these health economic indicators, are only the beginning of a long and complex process. Remaining challenges include strengthening control in the market; increasing transparency in the various commissions that make decisions; and revision of the level of pharmaceutical distribution margins. The success of these efforts will depend greatly on the future organisational model adopted as well as on the improvements in the rules and management capacities of the health system.

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# The introduction of DRGs in Croatia

Luka Voncina, Tihomir Strizrep and Aleksandar Dzakula

In Croatia, hospitals have been funded by monthly payments from the state health care budget, controlled by the state health insurance fund (Croatian Institute for Health Insurance, HZZO). Funds have to be accounted for through the issue of bills for medical services. These bills are a combination of fee-for-service (FFS) payments and charges levied under a Diagnosis Related Groups (DRG) system referred to as the PPTP (*Plaćanje po terapijskom postupku*).

Furthermore, hospitals have hard budgets. If a hospital exceeds its annual budget, it will not receive additional funding for any bills levied for further services provided. Conversely if hospitals do not provide enough services to account for all of their budgets in a given year, then, in accordance with their contracts with the HZZO, in the subsequent fiscal year their budgets should be reduced by an amount equal to these unspent funds.

Under the FFS reimbursement system, hospitals are reimbursed on the basis of inputs used. The payment system consists of three separate components: (1) hospital hotel services, paid via a flat rate per diem; (2) medical services provided; and (3) pharmaceuticals and other supplies that are paid for separately, depending on the cost of each item. Under the current FFS schedule, hospitals have an incentive to

maintain a high level of bed occupancy and extend length of stay, since this high occupancy rate results in stable funding through per diem payments, while the majority of costs tend in fact to be concentrated in the first few days of hospital stays. Low occupancy rates also increase the risk that the HZZO will lower the global budget ceiling.<sup>1</sup> The effects on service provision can be seen in Table 1, as average lengths of stay and bed occupancy rates in Croatian hospitals for acute care are significantly higher than in some neighbouring countries such as Slovenia, Hungary and Austria.

In 2002, the government started to introduce the PPTP, the parallel DRG-based element of the payment system for certain diagnoses that makes use of broad case groupings. By 2006, the number of services reimbursed via the PPTP system had grown to 118 selected diagnoses, with the remainder still being paid for by the point-based FFS schedule. Interventions for these PPTP case groupings were either costly or numerous and the prospective payment system was intended to provide hospitals with incentives to increase the technical efficiency of service provision. Both the use of broad-based case

groupings in the PPTP system, as opposed to more detailed DRGs, as well as the prices set for particular PPTPs, have made them quite unpopular with providers. This system has on occasion been accused of underestimating the intensity of resource use for more complicated medical cases.

Nonetheless, encouraged by reports of efficiency gains arising from the implementation of the PPTP schedule, including reductions in length of stay,<sup>3</sup> the government has now decided to gradually move towards a comprehensive prospective case-adjusted payment system based on DRGs. This will represent an important step in rationalising incentives in the health care system.

As in some other European countries, such as Ireland, Romania, Germany and Slovenia, Croatia has decided not to develop its own DRG system, but rather to import and modify the Australian Refined-DRG (AR-DRG) system (specifically, version 5.1), known locally as *Dijagnostičko terapijske skupine* (DTS). It has already been piloted in four Croatian hospitals since February 2006. As of April 2007, it has been introduced by the HZZO into all Croatian hospitals, initially

**Table 1: Average length of stay and bed occupancy rates for acute inpatient care 2003**

Country	Average length of stay (days) per hospitalisation	Bed occupancy rates
Croatia (2004)	8.20	89.90%
Hungary	6.65	77.15%
Austria	6.35	76.20%
Slovenia	6.10	68.12%

Source: HZJZ 2005.<sup>2</sup>

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running in tandem with existing billing systems. Until January 2008, all hospitals will continue to account for their budgets according to the old two-tiered FFS and PPTP schedule, but are now also obliged to keep track of cases according to the new DTS schedule. During this period, the HZZO plans to actively work with hospitals to ensure the appropriateness and quality of the coding used.

One of the greatest challenges to the introduction of this Australian system in Croatia still to be addressed is the difference in DRG costing between the two countries. The original ARG-DG system unsurprisingly made use of

Australian data on resources use, clinical practice and the monitoring of hospital billing. A second challenge related to the possibility of a form of 'gaming' known as 'code creep' in DRG systems, i.e. coding patients as having more serious/complicated conditions that they actually have. This issue will have to be closely examined once the DRG system is fully implemented, but as yet the system is still in too early a stage of development and the issue has not received sufficient attention. In Australia, in contrast, six different mechanisms are now employed to reduce this risk of upcoding.<sup>4</sup>

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## New Health Systems in Transition (HiT) profiles from the Observatory



### Croatia HiT

By: Luka Voncina, Nadia Jemai, Sherry Merkur, Christina Golna, Akiko Maeda, Shiyan Chao and Aleksandar Dzakula

Edited by: Sherry Merkur, Nadia Jemai and Elias Mossialos

Available at <http://www.euro.who.int/document/e90328.pdf>

Croatia's health system is based on the principles of inclusivity, continuity and accessibility. Since 1991, it has been subject to a range of organisational reforms, which have mostly relied on decreasing public and increasing private expenditure in the system. The Croatian health system has a well-trained workforce, a well-established system of public health programmes and health delivery system, and good health outcomes in relation to countries at comparable income levels.



### Bulgaria HiT

By: Lidia Georgieva, Petko Salchev, Rostislava Dimitrova, Antoniya Dimova and Olga Avdeeva

Edited by: Olga Avdeeva and Melinda Elias

Available at <http://www.euro.who.int/Document/E90023.pdf>

10-page summary <http://www.euro.who.int/Document/E90023brief.pdf>

This new HiT profile highlights some of the main reforms carried out to make the Bulgarian health system more efficient and responsive to patients' needs. In the new system, the role of primary care has been strengthened, especially that of the general practitioner operating as a gatekeeper. Also, inpatient care has been restructured and rationalised, reducing the number of hospital beds and the average length of stay.



### Armenia HiT

By: Tatul Hakobyan, Mihran Nazaretyan, Tatyana Makarova, Movses Aristakesyan, Hovhannes Margaryants and Ellen Nolte

Edited by: Ellen Nolte and Erica Richardson

Available at <http://www.euro.who.int/Document/E89732.pdf>

Since independence, the health care system in Armenia has undergone numerous changes that have effectively transformed a centrally run state system into a fragmented health care system that is largely financed from out-of-pocket payments. Armenia is increasingly reforming the health system from one that emphasises the treatment of disease and responds to epidemics to one which emphasises prevention, family care and community participation.



# Health worker migration in Europe: assessing the policy options

James Buchan

*Summary: The issue of the migration of health workers has become a more significant feature of international health policy debate in the last few years, in Europe and elsewhere. It has taken on additional prominence in Europe as more countries have joined the European Union. This paper examines trends in general migration in Europe, and highlights the key policy options for 'source' and 'destination' countries when monitoring and assessing the implications of health worker migration.*

*Key words: migration, workforce planning, international recruitment*

Polish physicians working in Germany. German physicians flying to England to work at weekends. Angolan nurses working in Portugal. Estonian pharmacists working in Finland. Doctors from the Kyrgyz Republic migrating to Kazakhstan. The issue of the migration of health workers has become a more significant feature of international health policy debate in the last few years, in Europe and elsewhere,<sup>1-4</sup> and has taken on additional prominence in Europe as more countries have joined the European Union (EU).<sup>5</sup>

The international recruitment of health workers has become a "solution" to the health professional skill shortages in some countries. It offers a "quick fix" which can be attractive to policy makers. It can take three to five years to train a nurse, and fifteen to twenty to train an experienced senior physician. Recruiting in other countries can deliver these staff much quicker - and with the training costs having been met by someone else. This active recruitment of nurses, doctors and other workers is in addition to any "natural" migration flows of individuals moving across borders for a range of personal reasons.

Just as international recruitment can be a solution to the staff shortages in some countries, it can also create the additional problem of skills shortages in others. Countries that lose scarce skilled staff may suffer a negative impact on the effectiveness of their health care systems. This issue has been debated at the World Health Assembly,<sup>6</sup> has received attention at EU level and in the Council of Europe, and has been identified as a critical human resources for health issue within the European region of the World Health Organization.<sup>4</sup>

Some European countries have been actively recruiting health workers from other countries. Others, particularly in the east, are concerned about the out-migration of health workers as a result of accession to the EU.

## General migration trends in Europe

In relation to the countries of the EU, and EU enlargement, a recent overview for the European Foundation for the Improvement of Living and Working Conditions<sup>5</sup> reported the following key estimates:

- There were thirteen million non-national citizens living in the fifteen EU member states in 2000, but half were nationals of other EU countries;
- the income gap between central and eastern acceding countries and existing member states is estimated at 60%,

which is much higher than in the previous enlargement of the EU;

- migrants from the accession states are likely to be relatively young and educationally well qualified, with women making up to 40-45% of the total, creating a potential 'youth drain' in the source countries.

## Assessing trends in the migration of health workers

How important is the migration of health workers to health system effectiveness in Europe? The simple answer is that we do not know, because of limitations in available data. There are two main indicators of the relative importance of migration and international recruitment to a country: by examining the 'inflow' of workers into the country from other source countries (and/or the 'outflow' to other countries), or by assessing the actual 'stock' of international health workers in the country at one point in time.

Many countries in Europe and elsewhere currently cannot monitor with any accuracy the stocks and flows of migrant health workers. This limits their capacity to assess the impact of policies and means that they cannot be clear about the impact of migration. This constrains any attempt to develop a clear Europe-wide picture of the overall flows of health workers. Many countries, both 'source' and 'destination', need therefore to improve their ability to

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assess the dynamics of migration, in order to decide if migration is a problem or a solution, and to identify the correct policy solutions.

### 'Source' countries

Governments and policy makers in countries that are experiencing a net outflow of health workers, such as some in the east of Europe and central Asia, need to be able to assess why this is happening and evaluate what impact it is having on the provision of health care in the country. It is important that the available information enables policy-makers to assess the relative loss of staff due to outflows to other countries in comparison with other internal flows, such as health workers leaving the public sector to work in the private sector, or leaving the health professions to take up other forms of employment. Migration may be the most obvious source of "loss" of health workers, but it may not be the most important.

In addition, for some of these countries, out-migration may be encouraged, either to reduce oversupply of specific types of worker, to encourage some workers to acquire additional skills or qualifications before then returning, or to stimulate the return of hard currency through remittances from these migrant workers. Other policy responses to reducing outflow relate to a more direct attempt to curtail the push factors, for instance by dealing with matters concerning poor pay and career prospects, poor working conditions and high workloads, as well as responding to concerns about security, and improving educational opportunities.

### 'Destination' countries

The first concern of stakeholders in destination countries should be the monitoring and assessment of inflow trends (in terms of numbers and sources), as this is vital if a country is to be able to integrate this information into its workforce and service planning process, as well as assess the relative contribution of international recruitment compared with other key interventions (such as home-based recruitment, improved retention, and the return of home-based non-practising health professionals).

A second element of the 'management' of migration for destination countries is that of efficiency and effectiveness. If there is an inflow of health workers from source countries, how can this inflow be moderated and facilitated so that it makes

**Table 1: International recruitment of health workers: opportunities and challenges**

	Opportunities	Challenges
Destination countries	Solve skills/ staff shortages. A "Quick Fix".	How to be efficient and ethical in recruitment.
Source countries	Remittances Upskilled returners (if they return)	Outflow causes shortages with negative impact on delivery of care. Costs of "lost" education. Increased costs of recruitment of replacements. "Manage" migration?
Internationally mobile health workers	Improved pay, career opportunities, education.	Achieving equal treatment in destination country
Static health workers	[If worker oversupply] Improved job and career opportunities	Increased workload as staff leave. Lower morale.

an effective contribution to the health system? Policy responses have included 'fast tracking' of work permit applications; developing coordinated, multi-employer approaches to recruitment to achieve economies of scale in the recruitment process and developing multi-agency approaches to coordinated placement of health workers when they have arrived in the source country. These may include the provision of initial periods of supervised practice or adaptation as well as language training, cultural orientation and social support to ensure that the newly arrived workers can assimilate effectively into the new country, culture and organisation. Another related challenge may be that of trying to 'channel' or direct international recruits to the geographic or speciality areas that most require additional staff.

The migration and international recruitment of health workers creates challenges for both individual health workers and policy makers in 'source' and 'destination' countries, and at European level. Some of the key issues are summarised in Table 1 which also highlights some of the potential opportunities created when health workers are, or can be, internationally mobile.

### Policy options

Essentially there are two viable policy stances for states and regions faced with the issue of in-migration and/or out-migration of health workers. Either non-intervention, or some level of intervention either to moderate flows via some type of framework or code, or to attempt to manage the migration process so that it is

nearer 'win-win', or at least is not exclusively 'win-lose', with the countries that can least afford to lose being the biggest losers.

One option is for individual countries to establish bilateral agreements to recruit health workers; one example was that between England and Spain to encourage Spanish nurses to work in England. Another option is to introduce a code of practice, either unilaterally or multilaterally, which sets down principles for effective and 'ethical' international recruitment. The Department of Health in England has a Code of Practice on International Recruitment.<sup>7</sup> The Code requires National Health Service employers not to actively recruit from developing countries, unless there is government-to-government agreement. It also lists approved recruitment agencies.

Another option would be for a regional bloc such as the EU as a whole to introduce some type of guidelines, code or framework. There is already an example of a multilateral code, which was introduced by the Commonwealth.<sup>8</sup> Some international health professional associations have also promoted codes and principles for international recruitment, as in the case of the European Federation of Nurses.<sup>9</sup>

Whatever the source of such a framework or code, its effectiveness will be based on three factors: content, coverage, and compliance. What is its content? What are the principles and practical details set out to guide international recruitment? What is its coverage? Does it cover all relevant employers and countries? Is compliance assured? Are there systems in place to

**Table 2: Examples of potential policy interventions in international recruitment**

Level	Characteristics/ examples
Organisational	
'Twinning'	Hospital in 'source' and 'destination' country develop links, based on staff exchanges, staff support and flow of resources to source country.
Staff exchange	Structured temporary move of staff to another organisation, based on career and personal development opportunities/ organisational development.
Educational support	Educators and/or educational resources and/or funding in temporary move from 'destination' to 'source' organisation.
National	
Government-to-government bilateral agreement	'Destination' country develops agreement with 'source' country to underwrite costs of training additional staff, and/or to recruit staff for a fixed period, linked to training and development prior to staff returning to 'source' country, or to recruit 'surplus' staff in 'source' country
Ethical recruitment code	'Destination' country introduces code that places restrictions on employers, in terms of which source countries can be targeted, and/or length of stay. Coverage, content and compliance issues all need to be clear and explicit.
Compensation	Much discussed, but not much evidence in practice. Destination country pays compensation, in cash or in form of other resources, to source country. Possibly some type of sliding scale of compensation related to length of stay and/or cost of training, or cost of employment in destination country possibly "brokered" via international agency?
Managed migration (can also be regional)	Country (or region) with outflow of staff initiates programme to stem unplanned out-migration, partially by attempting to reduce impact of push factors, and partially by supporting other organisational or national interventions that encourage planned migration.
Train for export	[Can be a subset of managed migration] Government or private sector makes explicit decision to develop training infrastructure to train health professionals for export market- to generate remittances, or up-front fees.
International	
International code	As above, but covering a range of countries. Its relevance will depend on content, coverage, and compliance, the Commonwealth Code is an example.

Source: [4]

monitor cross border recruitment activity, and what are the penalties for non-compliance?

Table 2 sets out some options for policy at organisational, state and international levels; some are relevant for 'source' countries, some for 'destination' countries, but few have been fully implemented or evaluated. The next round of policy research should focus on two aspects of migration. Firstly, there is a clear need to improve the available data so that the monitoring of trends in flows of health workers can be more effective. Secondly, it should assess the viability and effectiveness of the various possible policy interventions, to

identify which, if any, are relevant and may have the potential for mutual and beneficial impact in Europe.

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# Migrant health in the EU

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*Philipa Mladovsky*

*Summary: Across European Union countries, attempts to incorporate the needs of migrants into health systems have remained uncoordinated. The limited available data suggest that infectious diseases, accidents, injuries, musculoskeletal disorders and violence disproportionately affect certain migrant groups compared to long settled populations in the European Union. However, low birth-weight and some chronic diseases are relatively less prevalent in some migrant groups, known as the 'healthy migrant effect'. This advantage may diminish in subsequent generations. Legal barriers, communication, lack of information and mistrust are some obstacles to providing good quality care for migrants. Several research topics and policy considerations merit greater attention to address these inequalities.*

*Keywords: migrants, immigrants, inequalities.*

The thirty-five to forty million foreign-born people in Europe continue to face difficulties in becoming a full part of the economic, cultural, social, and political lives of their adopted societies.<sup>1</sup> This situation is undesirable both from the perspective of European integration and human rights. The right to health obliges governments to ensure that "health facilities, goods and services are accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds".<sup>2</sup>

## **Migrant health trends**

Unlike Australia, Canada and the United States, European countries rarely collect health data by ethnicity (the UK, Sweden and the Netherlands being exceptions). One difficulty in studying migrant health is defining the subject. At least five sub-categories of 'migrants' have been identified: students; economic migrants; asylum seekers; irregular or undocumented migrants; and displaced persons.<sup>3</sup> However, it is still unclear how long before a group of people thought of as 'migrants' begin to simply constitute a socially or culturally distinct or ethnic group of residents;<sup>4</sup> there are different understandings of what it means to be a 'migrant' across

Europe.

Another difficulty is a lack of data. The data that are available give rise to a complex and dynamic picture. A review of the literature suggests that infectious diseases (including sexually transmitted infections), accidents, injuries, musculoskeletal disorders, violence and drug abuse all appear to disproportionately affect certain migrant groups compared to what are referred to technically as the 'autochthonous' or long-standing resident European populations. These patterns are likely to be linked to increased exposure to risk factors, either in the country of origin and/or in European countries where migrants are forced to live and work in poor conditions.

Migrants are not necessarily disadvantaged in all areas of health though. Relatively low rates of low birth-weight infants have long been observed in migrant groups in the US and Europe. Many studies have shown that chronic diseases are less prevalent in some, though by no means all, migrant groups compared to indigenous European (and North American) populations. This is known as the 'healthy migrant effect'. It has been suggested that (self-) selective migration may play a role; such findings may also be explained by a difference in timing between the health benefits and the health risks of migration.<sup>5</sup>

However, this relative advantage does not translate across all countries and across all migrant groups. Also, research suggests

that the advantage may diminish over time (length of stay) or in subsequent generations. In short, a review of the literature suggests that it is not useful to make generalisations about the health of migrants, since mortality and morbidity patterns vary across space, time, age, gender, disease, different countries of origin and type of migration. Disaggregating mortality and morbidity data by cause, and by country of origin, is crucial.

Five explanations for the differences in health between ethnic groups have been identified:<sup>6,7</sup> genetic differences; cultural differences; socioeconomic position; short-term migration history; and ethnic identity. In terms of more proximal determinants, varying patterns in risk factor prevalence (smoking, inactivity, alcohol consumption and so on) account in part for the differences in health between migrants and the indigenous populations. Additionally, it seems that access to and utilisation of health services also plays a role. Findings that some immigrants are comparatively healthy and under utilise health services refute the simplistic assumption that immigrants represent a disproportionate burden on European health care systems.

## **Health care access and utilisation**

Most countries grant full equality of treatment to third country nationals after awarding them long-term or permanent residence status. So is access to health care still an issue? Data on this topic are relatively sparse, but several studies suggest

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migrants do experience unequal access to health care. One issue is that requirements for permanent status vary across Europe and obtaining this status may take several years.<sup>8</sup> Secondly, undocumented migrants in many countries are not granted equality of treatment. Besides the legal barriers, migrants also face other specific difficulties in accessing health care. In clinical encounters, language and literacy are the most obvious cultural obstacles to providing good quality care. In addition, miscommunication and dissatisfaction stemming from cultural differences and expectations can also contribute to sub optimal care. Categories and concepts used by migrants to explain health problems may differ significantly from Western understandings, as the field of medical anthropology has long demonstrated. This suggests there is a major role for user involvement in the design of effective services for migrants.

A lack of knowledge about the health care system may also be a serious obstacle to access, sometimes even despite tailored publications and orientation services. Mistrust of service providers may be an important issue for some, particularly undocumented migrants fearing detection. In countries with complex registration systems for social health insurance, administration and bureaucracy is a major barrier. Barriers to health care may result in worse health outcomes, as is suggested by the relatively high rate of avoidable mortality found among migrants in some studies, resulting in health inequalities. They also may result in increased consumption of more expensive emergency treatments.

Certainly, migrants are likely to face different barriers/inequalities in different European countries. There are also difficulties with measuring utilisation. Also, immigration may not always be the primary explanatory factor for differences in health care utilisation, with income being an important confounding variable. Nevertheless, in countries with immigrant populations, it does seem that language-adapted and culture-sensitive programmes are needed to decrease inequality in access for ethnic minority groups.

### Measurement and indicators

Measurement of migrant health and health care utilisation is challenging for a variety of technical and political reasons.<sup>7</sup> Medical research favours homogeneous samples, resulting in ignorance about the effec-

tiveness of treatments on ethnic minorities, while recording ethnicity in clinical records can be perceived as discriminatory. Ethnic minorities often have low response rates in epidemiological surveys, in part because monitoring undocumented immigrants is difficult and information cannot easily be validated. Moreover, immigrant mortality in the population may be underestimated in register-based studies because sizeable numbers of immigrants who subsequently leave their new homeland (the host country) fail to register this fact with the national registration authorities.

Several techniques have been developed to counter a lack of data on migrant health, for example linking datasets and developing algorithms to identify persons of ethnic origin by surname in registries. If surveys do include migration variables, they mostly depend on a broad 'social science' definition of immigrant status, employing country of birth, parental country of birth and length of stay in the host country as indicators to identify this population. Conceptually, there are two main problems with this. Firstly, the paradigm incorporates important sub-categories of persons, such as refugees, who may experience specific non-random patterns of health and health care that differ to those of non-refugee immigrants. Secondly, the paradigm does not capture legal status which may affect access to and utilisation of health services, which in turn may also affect patterns of disease in a non-random manner.<sup>9</sup> To make these indicators relevant to health research, an understanding of the way in which immigration law relates to eligibility in accessing public services is important. This may become complex when legal criteria on the eligibility of immigration subcategories change over time.<sup>9</sup>

Reflecting both these technical difficulties, but also political concerns, there are very few, if any, national or European surveys currently available to measure the health of first and second generation migrants relative to the health of the native population. There are also generally low levels of reporting on migrant health. Exceptions include the Netherlands and to some extent Sweden and the UK. Countries such as Belgium, Spain and Germany have only very recently started to introduce questions on migration into health surveys. New Member States, reflecting their relatively low levels of immigration, rarely include indicators of immigration in health surveys, but this may change in the

future as the numbers of immigrants to these countries are also increasing.

### Migrants and health policy

Across EU countries, attempts to incorporate the needs of migrants, in particular from non-EU countries (so-called third-country nationals), into welfare systems have remained scattered and uncoordinated. In terms of Europe's policy response, it seems there is an increasing effort at the supra-nationalisation of migration policy. This has affected the upgrading of many national anti-discrimination policies, but at the same time there is a concern that the focus of EC policy on the flexibility of the labour market may take precedence over concerns with social citizenship and the protections afforded by the welfare state.<sup>10</sup>

To some extent, however, diversity in policy is to be expected, since the way migrant health is approached to some extent depends on the type of immigration affecting the country.<sup>7</sup> A country's approach to migrant health issues will also depend on its welfare regime, with different nations responding to similar political challenges in idiosyncratic ways.<sup>10</sup> Furthermore, where migrant health policy is elaborated, implementation may not necessarily reflect this on the ground.

A consultation with country experts in health policy revealed that in France, social analyses by ethnic origin are not routinely carried out both for cultural and administrative reasons and migrant health policy has mainly focused on preventing the spread of infectious diseases. In Germany and Ireland, at the national level, the issue of migrant health and access to health care has also not yet been developed as a specific policy issue, though there is an increasing interest in tackling health inequalities. Politically, migration itself was a widely neglected policy area in Germany until very recently. In Italy, on the other hand, policy regarding the health of migrants is relatively developed, though how successful the government has been at implementation is not clear. At the central level, immigrant related health policy targets have been set since the 1990s.

As early as 1997, the Netherlands Organisation for Scientific Research (NWO) set up a working party on culture and health, and a programme to stimulate research and care innovations in this area was launched. Indeed, the Netherlands stands out in Europe for its sustained and systematic attention to the problems of migrant

health, although a closer look at the current situation suggests there is a danger of these initiatives stagnating. In Spain, migrant health and health care issues have recently started to feature in national and regional plans for the integration of immigrants. The general Swedish national health policy aims to create social conditions that will ensure good health, on equal terms, for the entire population with a special emphasis on vulnerable groups such as immigrants. The government has thus developed a multi-sectoral approach to coordinating services in a way that promotes health among newly arrived individuals.

In the UK, health policy relating to migrants is largely integrated into a policy framework addressing health inequalities in general (dating from the 1980s) and the health inequalities of 'black and minority ethnic' (BME) groups specifically. The Department of Health (in England) has commissioned a number of initiatives to generate or collate good practice in "race equality". However, as in most European countries, the lack of baseline data on ethnicity makes it difficult to evaluate the impact of such projects, which in turn makes it hard to identify good practice.

In light of this variability, there appears to be a significant role for the EU to play in facilitating the development and transfer of evidence and information on immigrant health policy. The upcoming Portuguese presidency, which is focussing on immigration, may be a timely opportunity for further policy development on this issue.

#### Potential policy considerations

Both this and previous reviews<sup>7</sup> throw up a number of concurrent potential policy considerations. The methodological problems associated with migrant health research indicate a need to increase funding and collaboration at the European level between national research centres to develop research techniques. This could include some focus on methodological barriers to the inclusion of data on migrants in national and European health surveys.

Nutritional and psychosocial problems among migrant children and youth signal a need for greater attention paid to multi-sectoral policies, particularly across health and education. While problems relating to

sexuality, reproduction and family life, might imply that there should be more attention devoted to the improved planning and provision of targeted preventive and curative sexual health services; ante and post natal care; and social services for vulnerable women. At the other end of the life course, the ageing of migrant populations requires the development of culturally appropriate long term care.

The access of illegal/undocumented migrants to health services remains a major problem, as much political as it is technical. Greater transparency in countries' approaches to responding to health and health care utilisation inequalities experienced by this population, within the framework of human rights, is merited.

As this review indicates, migrant groups can play an important role in the design and provision of services. This also resonates, and could be integrated, with many countries' more general attempts to improve empowerment through better access to information, strengthened patient rights and choice and enhanced complaints procedures. Linkages between sender and receiver countries could also be explored to provide insights into health norms, culturally relevant methods of research and treatment, and the expectations and health beliefs of migrants.

Preserving the health 'advantage' of some newly arrived migrants could potentially be a very important preventative strategy, particularly in terms of chronic diseases; focusing on healthy diets and other lifestyle related factors through targeted programmes is a possible way forward. Where individuals are at risk, such as in the workplace, multi-sectoral policies need to be developed to address this important area of migrant health. However, this is potentially a political issue since poor working conditions are often related to the exploitation of undocumented migrants. In settings where there is a need to prevent and control tuberculosis and HIV/AIDS among migrants, it may also become apparent with further research that interventions fully mainstreamed within the health care system are more effective both clinically and in terms of cost than vertical programmes (run at ports and borders for example).

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# Payment by Results in England

Seán Boyle

*Summary: Payment by Results (PbR) was introduced into the English NHS in 2003/04. The introduction of a system of regulated national tariff prices was a major change in the financial regime for public health care in England. In this article progress since 2005/06 is examined and some of the key features of the scheme as it currently exists are discussed.*

*Keywords: payment by results, health resource groups, efficiency, quality, England*

Payment by Results (PbR) was introduced into the English NHS in 2003/04. The introduction of a system of regulated national tariff prices was a major change in the financial regime for public health care in England. In an earlier article in *EuroObserver*<sup>1</sup> the implementation of PbR up to 2005/06 was discussed and some of its key features outlined. In this article progress since then is examined, and some of the key features of the scheme as it currently exists are discussed. It concludes with some remarks on issues concerning PbR that have emerged.

## How Payment by Results operates

In introducing the concept of Payment by Results in 2002, the Secretary of State for Health was clear that the policy was intended to address the need to introduce stronger incentives to ensure improved performance.<sup>2</sup> Primary care trusts (PCTs) – the commissioning agencies in the English NHS – would be free to purchase care from the most appropriate provider whether in the public, private or voluntary sectors. The driving force behind these changes, at least explicitly, was to give providers incentives that would reward better performance. This in turn required incentives for those making choices about where patients would be treated (the PCTs that commission services) to send patients to hospitals that performed better. At the same time the Government was looking to

hand over more choice directly to the patient. Eventually patients would go to their hospital of choice and ‘*money would follow the patient*’.

Instead of block contracts for activity (which are insensitive to the volume and nature of activity), providers are paid for the activity they undertake. This is done using national average NHS provider costs to establish a standard tariff for the same treatment regardless of provider. It is intended that over time the NHS will move to a system where all activity is commissioned against a standard tariff, using either Health Resource Group (HRG) benchmarks (an English version of Diagnosis Related Group – DRG) or other appropriate measures that differentiate activity according to casemix.

Local commissioning will focus on volume, appropriateness and quality not price, as this will be fixed using regional tariffs to reflect unavoidable differences in costs in different parts of the country. Thus the market created by PbR differs from that of the previous Conservative Government reforms of the early 1990s when providers were able to quote local prices based on their own local costs. Under PbR the intention is that competition on price is excluded.

## Implementation

The introduction of PbR has been slower than originally intended. Although by 2005/06 the national tariff was supposed to apply to around 80% of activity in acute and specialist hospitals, and almost all activity was to be commissioned using cost-and-volume contracts, this did not

prove possible. Instead, it was agreed that for most providers the mandatory national tariff would only apply to elective care. Non-elective cases, outpatients and accident and emergency (A&E) cases remained outside the scope of the scheme for most providers, although these were included for Foundation Trusts, a form of organisation introduced in April 2004 where existing, selected NHS trusts were given more financial freedoms and a different accountability regime.<sup>1</sup>

In 2006/07 the tariff was extended across all NHS providers to cover admitted patient care, outpatient and A&E attendances. However errors in the 2006/07 tariff published by the Department of Health on 31 January 2006 resulted in a greater overall average increase in the tariff than had been intended. The Department’s intention was an overall increase of 1.5% but some PCTs reported increases of 4% or more in the cost of activity.<sup>3</sup> As a result the tariff was withdrawn and reissued on 17 March 2006. This gave the NHS very little time to plan for 2006/07 on the basis of the new tariff.

The structure of PbR remained essentially the same in 2007/08.<sup>4</sup> The Department of Health has always recognised it would take time for providers to adjust to a set of national tariffs which would result, initially at least, in many of them receiving less income than their actual costs. Similarly, PCTs might find themselves paying a higher price than they had previously. Transitional arrangements – known as purchaser parity adjustments (PPA) in the case of PCTs – were introduced so that gains and losses would not be immediate

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**Table: Key features of PbR system in England**

Issue	Comments
Purpose	To improve efficiency, quality, choice
Start date	Apr 2003
Coverage – activity	Covers admitted patient, outpatient and A&E activity
Critical care	Currently treated outside the PbR system but work is ongoing to include
Mental health	Currently treated outside the PbR system but work is ongoing to include
Coverage – providers	Includes public, private and voluntary providers but differences in how PbR is applied
Tariff system	Uses national average NHS provider costs to produce cost per HRG spell, outpatient attendance, etc.
Regional adjustments	Yes, using the Market Forces Factor
Academic centres	Some funds dealt within PbR but education and R&D funds excluded
Quality of care	There is no evidence so far
Increased productivity	There is no evidence so far
Cream-skimming, up-coding	There is some evidence of overcoding and optimising coding but no evidence of fraudulent activity.

but would be achieved over a four-year period. In line with the aim to phase out these transitional arrangements by 2008/09, the level of purchaser parity adjustment (PPA) was reduced in 2007/08 to 25%. Moreover, it is intended that from December 2006 all practice-based commissioning would be based on PbR.

PbR, as it stands, has tended to reinforce the delivery of care in acute hospital settings. To enable the unbundling of the care pathways which equate to acute hospital spells, so that care can be delivered in a multitude of different settings, the Department of Health has issued a set of indicative unbundled tariffs relating to both care pathways and the use of diagnostics, and guidance in support of the unbundling of services. However unbundling is not a mandatory part of the system so far.

#### **Key features of the new system**

In 2007/08 the mandatory PbR tariff is payable for a large proportion of the activity carried out by NHS trusts, NHS foundation trusts, PCTs as providers and

Independent Sector Extended Care Network (ISECN) providers. Some key features of the system: coverage, calculating prices, the role of the independent sector and quality are now discussed here, while other points are highlighted in the accompanying table.

#### *Coverage*

The Government intends that almost all health care activity purchased by NHS commissioners will be covered by the PbR system. As already indicated, in 2007/08 the national tariff will cover almost all patients admitted for care – elective and non-elective, outpatient attendances, and A&E attendances. However a wide range of activity remains excluded (see other services). Hence in 2006/07 over £22 billion of services were delivered under PbR, representing around 35% of PCT revenue allocations, or over 60% of acute hospital income (source: personal communication, Department of Health).

The focus has been on getting it right for the existing tariff structure and hence over the last two years there have been a series

of adjustments to the way in which tariffs are calculated.

*Admitted patient care.* Tariffs have been set for patients who are admitted electively and non-electively. These are based on HRG spells, and there are now 548 separate HRG tariffs in use. For 2007/08, for elective care, these range in price from £200 to £20,165 with a mean price of £1,920 and a median of £1,255. For non-elective care the range is from £350 to £19,565 with a mean of £2,730 and a median of £2,180.

*Outpatient care.* Outpatient tariffs are set at specialty level for first and follow-up attendances. There are 39 specialty tariffs and these are based on the specialty of consultant responsible for the outpatient clinic. For 2007/08 these range in price from £155 to £288 for first attendance, and from £76 to £161 for follow-up attendance. The tariff has been structured to load the payment towards the first attendance so as to provide a financial incentive to minimise follow-ups. The tariff for children under the age of seventeen years is usually greater than that for an adult.

There are also tariffs for a small number of procedures that may be carried out in an outpatient clinic. Where these occur they replace the outpatient tariff. Currently there are just nine of these: colposcopy; hysteroscopy; flexible sigmoidoscopy; rigid sigmoidoscopy; epidural injections (for pain services); fine needle biopsy of breast; needle biopsy of prostate; and laser destruction of lesions of the skin. For 2007/08 these range in price from £180 to £408.

*A&E attendances.* A&E tariffs are set at three levels: high-cost, standard-cost and minor A&E /minor injury unit (MIU). Prior to 2006/07, the lowest level applied only to MIUs, but in that year a combined minor A&E and MIU tariff was introduced that reflected the average cost of minor attendances at A&E departments and attendances at MIUs. Attendances are costed at the same rate whether a patient is admitted or not. In 2007/08 the A&E tariff ranges in price from £55 to £101. Although the Department of Health has stated its intention to also include attendances at Walk-in Centres, these are currently excluded from the PbR scheme.

*Other services.* As indicated earlier there remain a considerable number of services that are outside the scope of the PbR scheme in 2007/08. In these cases the price paid is subject to local negotiation. These



include:

- Community services
- Mental health services
- Ambulance services (other than patient transport services)
- Well babies
- Private patients in NHS hospitals
- Chemotherapy
- Learning disabilities
- Critical care
- Continuing/intermediate care
- Respite care
- Regular attenders
- Radiotherapy
- Direct access radiology and pathology
- Renal dialysis
- Rehabilitation in discrete rehabilitation ward/unit
- Primary Care Services
- Walk-in Centres

Also a number of specific HRGs and outpatient specialties are outside the current scope of the PbR scheme, either because they have low volumes, volatile costs and/or are of a highly specialised nature, for example, heart, liver, lung transplant, and cystic fibrosis HRGs; neurosurgery and cardiac surgery outpatients.

The Department of Health intends to include critical care in the PbR scheme. However, the Department is not yet in a position to produce representative prices owing to the lack of appropriate data collection. Data are currently being collected but a considerable amount of work remains to be done. Critical care includes high dependency units, intensive care units and burns intensive care units; coronary care units are now included as overheads in tariffs for cardiac activity.

Similarly it is still not clear how mental health services will be treated. There are no obvious examples from other countries that easily translate to the NHS. So currently mental health services are commissioned as before. The Department of Health has undertaken a project to attempt to define mental health currencies that can be used to describe and cost mental health activity across inpatients, outpatients and community services for adults of working age and older people. This has required a special data collection. The Department hopes that a mental

health tariff can be published in late 2008, with its use beginning in 2009/10.

#### *Calculating prices*

The pricing system for PbR has become more complicated as each year more activity is added to the scheme. In this section the way in which prices are derived for the three principle types of care – admitted patients; outpatients and A&E attendances – is considered, as are any special considerations or exceptions that may affect the price paid.

There is a separate national tariff for admitted patients who are elective or non-elective. This tariff is derived from a weighted average cost of inpatient spells. These include all clinical costs, e.g. costs of diagnostics and monitoring interventions, and all non-clinical costs, for example, capital charges, food, cleaning and maintenance.

Admitted patients national tariffs for 2007/08 is based on a simple uplift of the 2006/07 tariff of 2.5%. This reflects changes in pay, prices and government policies that have been calculated to impact on costs, e.g. Agenda for Change, National Institute of Health and Clinical Excellence (NICE) appraisals and guidelines. The 2006/07 tariffs were based on reference costs for 2004/05 (which represented the average cost of an admitted patient spell) with uplifts to reflect the expected increase in the cost of NHS provision over the two intervening years, specific HRG adjustments to take account of NICE technology appraisals, and long-stay outlier payments (patients staying longer in hospital than a pre-determined cut-off point). Similarly outpatient tariffs, the nine outpatient procedure tariffs, and the three A&E tariffs for 2007/08 are a simple uplift of 2.5% of 2006/07 tariffs.

There are adjustments made to the tariff for emergency admissions. In 2005/06 Foundation Trusts had been paid the full tariff price for all activity undertaken. This placed all the financial risk of increased levels of emergency admissions on PCTs. When the tariff was extended to all providers in 2006/07, the Department of Health decided the risk should be shared and so introduced a reduced rate tariff of 50% for all emergency spells above a set threshold: 3.2% above the level in 2004/05. This was the Department's best estimate of the emergency activity level in 2005/06. If activity fell below the threshold, then 50% of the tariff would be withheld from the provider. This differential tariff for emer-

gency admissions above a set threshold has been retained in 2007/08, although the threshold will be based on the level of activity in 2005/06. Some emergency tariffs are also reduced where the actual length of stay in hospital is less than two days, and this is less than the average length of stay for that HRG.

There are top-up payments for some specific procedure and diagnosis codes in some specialist and children's activities, for example, in spinal surgery and orthopaedics. These codes are based on the second edition of the Specialised Services National Definition Set. There are also a number of exclusions from the calculation of tariffs: for example heart, liver, lung, and kidney transplant HRGs; and some high-cost drugs and devices, for example primary pulmonary hypertension drugs and implantable defibrillators.

There are adjustments made to the A&E tariff to take account of variations from planned activity. Providers are funded at tariff for their planned activity level. If actual activity is less than planned, their income is reduced by just 20% of the tariff; on the other hand if actual activity is greater than planned this will be paid for at the full tariff price.

*Regional adjustments to the national tariff.* HRGs are intended to take account of all legitimate differences in costs between trusts. To take account of geographically-determined unavoidable differences in local cost due to different costs of resources, tariffs for each provider are adjusted by the application of the market forces factor (MFF). The MFF has been used for many years to weight allocations of funds to commissioners. Over time its calculation has come to depend more on the specific circumstances of individual PCTs.

It comprises a weighted index of three separate cost indices: a staff index based on variations in wages in the private sector, and calculated at the PCT level; a buildings index based on a moving average of tender prices for all public and private building contracts, and calculated on a London Borough and county basis; and a land index based on the land value per hectare (10,000 square metres) for each individual provider or PCT location. Where a provider operates over many sites in different areas, this is taken into account by producing an index for this provider based on activity weights, where these relate to bed numbers in each location.

The MFF is rebased so that the provider with the lowest MFF has an MFF value of 1. All other providers receive a proportional increase in tariff relating to the value of their MFF. In 2007/08 the value of the MFF weighting ranged from 1.00 to 1.45, so the price received by one provider could be 45% more than another for what is essentially the same spell of care, but delivered in a different location. When PbR was first implemented MFF passed directly from PCT to provider but the potential for price competition that this introduced has now been eliminated. Each provider receives the same tariff price from its commissioning PCT, and the MFF uplift is paid to providers by the Department of Health from funds top-sliced from PCT budgets for this purpose.

*Treatment of capital.* Changes to forecast capital charges at a national level are reflected in the inflation uplift applied to the national tariff. Account is taken of local changes to capital and land costs through the MFF. However, the Department of Health has recognised that a tariff based on national average costs may not always reflect fully the local costs of a newly built facility. This is particularly true where there have been policy changes, for example, changes in the accounting rules that impact on the assumptions underlying some of the early PFI schemes. The Department of Health also acknowledges that new hospitals can be more costly, citing quality improvements such as a higher proportion of single rooms, more sophisticated equipment, as well as one-off procurement and double-running costs. The Department believes that "if funding is not provided outside of the tariff there is a risk that PbR would significantly disincentivise capital investment."<sup>5</sup>

Hence, until 2006/07 the NHS Bank distributed a centrally-held budget to support a number of major NHS capital investments. The Bank contributed to the costs of procurement for major PFI projects and also made some contribution in the first few years of operation of all major projects. These funds were provided directly to providers, though routed through the PCT where their primary site was located. From 2006/07 this central budget has been managed by the Strategic Health Authorities (SHAs).

*Research and Development (R&D) and teaching adjustments.* There are subsidies currently provided by the allocation of education/R&D monies to some trusts. Moreover, some work is undertaken as

research trials. These may lead to regional variations in the cost of service delivery. The Department of Health has considered both the amount and distribution of existing education and R&D levies with a view to eliminating any significant cross-subsidies between the patient care and levy funding streams. However, it has decided not to attempt to rebase these levies; at least until the end of the transition period for PbR.

#### *Independent sector*

Detailed policies on how the national PbR tariff will apply to new independent sector providers are not fully developed. The Department of Health intends to ensure new providers' costs converge with the tariff by the end of the PbR transition period. In August 2006 the Department stated that, "further work is needed before PbR can be extended to other sectors, including the voluntary sector and the independent sector... to assess the different economic factors affecting each of the different sectors to inform the development of the national tariff in a way that is consistent with achieving a level playing field."<sup>6</sup>

*"The government has argued PbR will provide incentives for levelling-up quality because prices will be fixed"*

However, in 2006 a number of private providers came under the scope of PbR with the introduction of the Extended Choice Network (ECN) offering choices to patients from NHS Foundation Trusts, Wave 1 Independent Sector Treatment Centres (ISTCs) and Wave 2 ISTCs that had bid specifically to be ECN providers. There have also been contracts with Wave 1 ISTCs and Wave 2 ISTCs, where PCTs pay for activity commissioned from the independent sector up to the level of tariff prices, with a central budget used to cover any differences.

#### *Quality*

The national tariff includes the cost consequences of general quality improvements, for example, NICE recommendations or National Service Framework requirements, that have occurred after reference

cost data were collected. But in general, quality standards are set by mechanisms outside the financial system and underpinned by appropriate clinical governance arrangements and regulation of quality standards. However it is expected that contracts or service level agreements will eventually include appropriate quality provisions agreed between trusts and commissioners.

#### **Concluding remarks**

The Government may see the PbR scheme as the solution for all the problems of the NHS. However it will be some time before PbR is properly bedded into the NHS. Meanwhile questions remain around the extent of coverage; costs, prices and efficiency, as well as the operation of the market.

#### *Extent of coverage*

PbR still applies to only a limited number of activities, and these are mainly in the acute hospital sector. This can cause distortions in provider behaviour. While the Government is committed to the 'unbundling' of care, so that eventually the care pathway for any particular patient's condition can be delivered by a wide range of providers, either individually or in combination, in practice this has proved difficult to deliver. This is seen as key to encouraging the introduction of new ways of delivering health care. However, the Department of Health's guidance<sup>7</sup> on contracting for acute hospital services serves as an illustration of how difficult this will be even in the acute hospital sector. Although the aim is to extend PbR so that national tariffs are set independently of the setting in which care is provided – hospital or community – difficulties experienced in setting acute sector prices suggest that this may prove an insurmountable task. Nevertheless, the introduction of some 'indicative' unbundling of activities is a move in the right direction.

#### *Costs, prices and efficiency*

The Government has argued PbR will provide incentives for levelling-up quality because prices will be fixed. Under a fixed national tariff providers will have to compete on quality. However anomalies remain in the system. Geographical variations in costs are recognised by the PbR scheme, and hence there are variations in prices paid. The NHS may be paying up to 45% more to deliver the same treatment to one set of patients, in inner London say, compared with the price for an equivalent

set of patients in rural Cornwall. A straightforward hip replacement may be priced at a level £2,500 higher if done in inner London. Competition on the basis of price is ruled out however, even though in theory an inner London PCT could save considerable sums of money if its patients could be persuaded, through incentives for example, to travel for their elective treatment.

There is also a wide variation in the costs of individual HRGs across different providers. The Government has argued that PbR provides an incentive to reduce these costs and also to improve quality. Cost differences may be due to inefficiencies but they may equally well be due to differences in quality. The effect of PbR could be to reduce quality in those providers that are better than average but which cost more. Providers end up competing on cost. There is evidence from other countries that where prices are fixed, quality is reduced in order to keep costs down.

The Audit Commission found little evidence of improvements in efficiency or increases in activity resulting from the introduction of PbR.<sup>8</sup> But there is evidence from other countries that the introduction of similar funding systems was accompanied by 'HRG-drift' where patients are 'up-coded' to more expensive procedures, or by better counting resulting in apparent increases in activity, or higher rates of intervention and higher levels of admission, all of which may push up total costs.<sup>9</sup> It has also been argued that some providers may cream-skim patients (choosing the easier ones within a particular casemix category). The consistency and quality of the activity and coding data on which national tariffs are based are therefore of fundamental importance.

There have been several disputes between PCTs and providers about the accuracy of coding and the source of activity inflation. The Government recognised that there may be issues around accuracy of coding and the potential for gaming in the system, and in January 2006 asked the Audit Commission to develop a data assurance framework for PbR. The purpose was to instill confidence in the data underpinning the whole PbR system. The Audit Commission report of November 2006<sup>10</sup> found evidence of clinical coding errors leading to inaccurate payments under PbR. It also found evidence of overcoding, i.e. recording more diagnosis and procedure

codes than is necessary, as well as trusts actively optimising their coding to maximise income, although as the Commission carefully stated this was all "within existing coding rules".

#### *Operation of the market*

It is not clear that, in the market for health care services introduced by PbR, both providers and commissioners are on an equal footing. Contracts depend very much on the information supplied by providers. PCTs may be short of the expertise to monitor these contracts closely. It could prove quite costly to remedy this situation, and the mechanisms for doing so may be quite complex (see the Department of Health's guidance<sup>7</sup> on contracting for acute hospital services).

#### *"The Audit Commission found little evidence of improvements in efficiency or increases in activity resulting from PbR"*

In its report in 2005 the Audit Commission found the costs of implementing PbR were greater than anticipated.<sup>8</sup> Another report in 2006 confirmed that costs increased by between £90,000 and £190,000 in organisations as a result of the introduction of PbR.<sup>11</sup> This was due to higher costs of negotiation, data collection, monitoring and enforcement. The complexity of the tariff system will require significant improvements in the production and use of detailed finance and activity information. However, this could be a good thing if it contributes to a better understanding of the health care business from the perspective of both providers and commissioners. It has been reported that individuals felt the higher administrative costs of PbR were justified by benefits such as greater clarity of payment rules and sharper incentives.<sup>11</sup>

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# Mental health policy:

## Time to refocus on promotion and prevention?

David McDaid

*Summary: The socioeconomic impacts of poor mental health are substantial and have an impact far beyond the health system. Their increasing recognition has helped drive mental health up the European health policy agenda. The Mental Health Economics European Network has, since 2002, been collating data on a range of issues, including funding, employment and the use of economic evidence. What is clear is that funding for mental health remains modest in many European countries. Moreover, investment is still largely focused on treatment and rehabilitation. There is growing evidence that more emphasis on a public health orientated approach to mental health not only would be effective, but also potentially cost effective, and consistent with the EU's Lisbon Process goals of economic growth and social cohesion.*

*Keywords: mental health policy, public health, cost effectiveness, Europe*

As many as one quarter of all European citizens may be affected by poor mental health in any one year. The human, social and economic costs are substantial, conservatively estimated to be between 3% and 4% of Gross Domestic Product in EU countries.<sup>1</sup>

These socioeconomic impacts reach far and wide. While health care system costs are clearly significant, the vast majority of costs are incurred outside the health sector because of lost employment opportunities. In total across Europe, the costs of depression were estimated to be €118 billion in 2004, of which €76 billion were due to productivity losses from poor health and premature mortality.<sup>2</sup> Although in absolute terms their number are much smaller, people living with psychotic disorders such as schizophrenia still have substantial non-health system costs. Many European studies, such as those in England and Hungary, report that health and social care costs account for just one third of all costs, with the other two thirds due to lost employment.<sup>1</sup>

Individuals with poor mental health are

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also more likely to have co-morbid physical health problems. Stigma, ignorance and subsequent discrimination may limit educational, employment and housing opportunities. There is also a greater risk of contact with the criminal justice system. Family relationships can suffer, there may be concerns about behaviour such as restlessness, hypochondria, sleep disturbances, or aggressiveness. In many cases, family members may find that they have to devote considerable time every day to providing support and informal care to a loved one. This may reduce their own opportunities to maintain employment and social activities. It may also place strain on their marital relationships. The children of people with mental health problems can also experience parental neglect and their schooling may be disrupted, again curtailing long-term opportunities.

These impacts raise major concerns for both national and European-level policy makers that have been reflected in both the World Health Organization (WHO) European Region Declaration and Action Plan on Mental Health endorsed by all Member States in 2005,<sup>3,4</sup> and the European Commission's Green Paper response.<sup>5</sup>

### **The Mental Health Economics European Network**

It is against this background that the Mental Health Economics European

Network (MHEEN), established in 2002 with the support of the European Commission, has been collating information, initially across seventeen, but now thirty-one European countries. Jointly coordinated by the London School of Economics and the Brussels-based NGO, Mental Health Europe/Santé Mentale Europe, the aim has been to develop a network of representatives, at least one from each country, with expertise and/or experience of health economics and with personal work or commitment to the economics of mental health (see [www.mheen.org](http://www.mheen.org)).

Activities in the first phase of work were grouped around a number of themes: financing; expenditure and costs; provision, services and workforce; employment; and the capacity for economic evaluation. A series of papers on these topics were published in an issue of the *Journal of Mental Health* in 2007.<sup>6</sup> The second phase of work includes detailed analysis of some of the issues involved in making the economic case, not only for interventions to treat and alleviate mental health problems, but also for the promotion of mental well being and the prevention of mental health problems.

This article reflects on some of this work, arguing that there is a growing evidence base indicating that a more public health orientated approach to mental health is

both effective, potentially cost effective, and consistent with the EU's Lisbon goals on economic growth and social cohesion.

### Fair funding for mental health?

Although mental health related health services are funded largely in an identical fashion to other health services, i.e. through taxation and/or social insurance, there is considerable variation in the levels of funding allocated to mental health across Europe. Although prevalence rates for psychiatric disorders vary very little, different health systems identify different levels of need, devote different levels of funding and choose different ways to deliver services. These variations in need, funding and response arise for many reasons, including differences in demography, socioeconomic and political structure and culture.

Another key factor is that the boundaries between what are considered to be health and social care services, which may be funded separately, can vary substantially between countries. Thus, cross national comparisons of investment in mental health are difficult.<sup>7</sup> These caveats notwithstanding, what is undoubtedly clear is that in many European countries mental health care remains grossly under-funded. The share of Gross Domestic Product spent on mental health in Latvia and the Czech Republic is approximately five times lower than that spent in Germany (See Table).

Even if there is sufficient political commitment to investment in effective interventions, implementation remains problematic. Multiple costs, not just to different agencies within the public or private sector, but also to individual service users and their families, raise a number of challenges. In particular, unless the full cost implications of mental health problems, and of changes to mental health systems are recognised, multiple costs raise the risk that any reform process will be seriously under-funded. They also give rise to the potentially very constraining problem of silo budgets: resources held in one budget cannot be allocated to other uses, to the general detriment of the pursuit of effectiveness.

There is also a risk that key opportunities to promote service user well-being will be missed, for example by denying individuals the opportunity to secure paid employment.

Some of these problems may be addressed

through the creation of joint budgets for mental health across sectors, as seen in England and Sweden. Resource implications and benefits are shared by sectors, increasing flexibility to deliver services that best address need.<sup>8</sup> The issue of resource inflexibility may also be addressed by a greater degree of partnership working with non-governmental organisations. If commissioned to deliver services, they may be able to respond more flexibly than the statutory sector and adapt to changing local circumstances.

### Mental health and economic wealth

Data collected by MHEEN also show a trend of increasing absenteeism and early retirement due to mental health problems (particularly depression) across Europe.<sup>9</sup> In Germany, for example, the number of long-term sick due to mental health problems increased by 74% between 1995 and 2002, compared with a 10% increase in sickness absence due to musculoskeletal or respiratory problems.<sup>10</sup>

In comparison to the impact on those at work, where it can be argued that the avoidance of mental health problems would help boost workplace performance and competitiveness, different issues are faced by those with long standing mental health problems. They are far less likely to be employed than the general working age population. The majority of European countries employ no more than 20%–30% of this group.<sup>9</sup> Individuals with mental health problems may also have a 40% lower chance of obtaining employment compared to other disability groups.<sup>11</sup> There are however substantial variations across Europe. Italy, for instance, reports employment rates of 46.5% for all those with mental health problems compared to 18.4% in the UK.<sup>12</sup> This suggests that different socioeconomic contexts, including the structure of disability benefit systems, account for some of this variation.

### Making the economic case for promotion and prevention

Although all EU countries now have a mental health policy in place, either at the national or regional level, much policy is still focused on the treatment, and to a lesser extent, rehabilitation of people with severe mental health problems. Comparatively little policy attention is paid to the promotion of good mental health and well-being at a time, conversely, when there is an increasing emphasis on the case for investment in health promotion more

### Public expenditure on mental health in selected EU countries (latest available year)

		% of GDP
1	Germany	1.11
2	Sweden	1.01
3	UK	1.00
4	Malta	0.92
5	Luxembourg	0.82
6	France	0.81
7	Netherlands	0.78
8	Denmark	0.72
9	Iceland	0.66
10	Hungary	0.62
11	Belgium	0.58
12	Ireland	0.50
13	Portugal	0.48
14	Cyprus	0.44
15	Italy	0.42
16	Spain*	0.41
17	Lithuania	0.38
18	Slovakia	0.30
19	Romania	0.24
20	Czech	0.21
21	Latvia	0.21

\* Spanish estimate based on data from three of the seventeen Autonomous Communities.

generally.

One criticism levied at mental health promotion/prevention interventions is that the supporting evidence base is, at best, weak. Certainly it is more difficult to conduct randomised controlled trials, with complex community-based interventions. This is not to say that the evidence base is absent; in fact there is a growing body of increasingly robust evidence to support the delivery of some of these interventions.<sup>13</sup>

In particular, the evidence base is strong for early interventions to support very young children and their parents, such as home visiting programmes for low income

women expecting their first child. Low cost parent training interventions can have a positive impact on child behaviour. If these impacts were to be maintained in the long run, then it might be possible to avoid some of the high lifetime public purse costs associated with behavioural problems. Studies have estimated these to be as much as ten times more than for the general population.<sup>14</sup> In another area, work undertaken by the WHO also suggests that the use of taxation instruments to dissuade individuals from the over-consumption of alcohol and subsequent alcohol related addictive behaviours can be highly cost effective.<sup>15</sup>

There is also a growing base of evidence on the effectiveness of various workplace-based programmes, both to promote good mental well-being and deal with some of the early signs of stress and mental health problems. There may well be substantial scope for economic as well as health benefits through companies investing in workplace mental health promotion strategies. In the US, one Employee Assistance Programme run by the McDonnell-Douglas company managed to reduce both work loss days (25%) and turnover (8%) for people with mental health problems.<sup>16</sup> Economic evaluation of such interventions in a European context remains limited: there is an urgent need for the robust evaluation of the cost effectiveness of models of workplace based mental health promotion.

Putting to one side the issue of access to social welfare benefits, there is also a substantial body of evidence suggesting that supported employment programmes, where individuals are placed in real jobs and then receive ongoing support, are highly cost effective.<sup>17</sup> Stable employment is just one outcome of supported employment programmes. In comparison to other employment related interventions, higher rates of employment can be associated with other benefits such as a reduced need for health care services, increased levels of social inclusion and improved quality of life.

One eleven year US evaluation following three thousand employment service clients for forty-eight months, reported that overall costs were lower because the use of health services was much lower during periods of stable employment.<sup>18</sup> A six-country European Commission supported study, EQOLISE, has now investigated the cost effectiveness of supported employment for people with severe mental

illness using the same approach. This is the first large scale study in Europe and published findings are anticipated soon (See <http://www.eqolise.sgul.ac.uk> for more information).

Perhaps remarkably, given the use of suicide rates often as the sole target of public mental health strategies, there remains little evaluation of the effectiveness, let alone the cost effectiveness of population-wide suicide prevention strategies. This is not to say that no European evidence exists. One Danish study suggests that a multi-faceted intervention strategy to tackle suicide over a twenty year period was instrumental in reducing the suicide rate by some 60%.<sup>19</sup> Another multi-faceted community based approach, first tested in Nuremberg, is now being rolled out and evaluated in a number of cities across the EU in a Commission funded study.<sup>20</sup>

Despite the limited evidence, the economic case for investment in effective population-wide suicide strategies may be compelling. Recent analysis in Scotland, where there are approximately 800 suicides per annum, suggests that a very small reduction in the rate of suicide (less than 1%) would, because of the high lifetime costs of completed suicides, make it highly likely that such a strategy would compare favourably with most health care interventions currently considered to be cost effective.<sup>21</sup>

### A timely opportunity

Poor mental health remains a major public health issue in Europe; it has many profound personal and socioeconomic consequences for individuals and their families. The economic costs to society at large are also substantial. Perhaps more than any other health issue, mental health requires an effective coordinated multi-sector approach to both the development of policies and the delivery of services. A comprehensive and holistic approach, as recommended by the WHO, should provide a range of interventions and strategies to promote positive mental well-being and take preventive actions to reduce the risk that mental health problems will occur.

The case for investment in a more public health orientated approach is also supported by an emerging evidence base on the effectiveness and potential cost effectiveness of this approach. Indeed, the mainstreaming of mental health within public health and health promotion

strategies will also be important; public health programmes to improve physical health have mental health benefits and the converse also applies.

The European Commission, now has a timely opportunity, through the development of its mental health strategy, to potentially play a highly significant role in facilitating the greater uptake of effective promotion and prevention interventions across the continent.

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# Long-term care reform in Spain

Joan Costa-Font and Anna García González

*Summary: Public funding of long-term care services in Spain has been limited; traditionally there has been a reliance on family members to provide informal unpaid care. The ageing of the population, coupled with changing family structures, have raised the issue of long-term care up the policy agenda. A new law, guaranteeing the right to long-term care services, funded through taxation but subject to means testing has now come into effect. While increasing public coverage for long-term care services, this new legislation raises challenges in respect of coordination and deliver of services within and across the seventeen Autonomous Communities that are responsible for the provision of social care services.*

*Keywords: long-term care, social care policy, Spain*

Long-term care (LTC) provides assistance, most typically to older people, with some of the most fundamental activities of daily living, including eating, washing, and dressing. Its financing is high on the policy agenda across Europe, given the ageing of populations across Europe;<sup>1</sup> the size of the dependant elderly population being expected to double over the next 50 years in countries such as Spain.<sup>2</sup>

Changing family structures,<sup>3</sup> for example smaller families and the greater participation of women, who currently make up 83% of all carers in the labour force, point towards a potential reduction in the availability of informal family caregivers and a consequent higher demand for paid formal care. European Commission supported

research concluded that with a few exceptions, social security or insurance coverage for LTC in the EU is insufficient.<sup>4</sup> Given this context, it is not surprising that over the last decade, much reform of LTC systems in Europe has begun to take place.

Spain stands out as one country where the ageing process is becoming more pronounced, access to informal care is decreasing, but only 6% of households receive some form of public support.<sup>1</sup> Despite this, it was only after some eight years of deliberation that a law for the promotion of independent living and help for dependent individuals (*Ley de Promoción de la Autonomía Personal y Atención a las Personas Dependientes*) was passed in 2006. This is expected to benefit approximately 3% of the Spanish population in the short term, and it has been publicised as being the ‘fourth pillar’ of the welfare state. It complements pensions, as well as existing health and social care services.

To date, public coverage of LTC has been insufficient; and dependent on the capacity of decentralised and under-funded social services. 70% of all funding has traditionally been allocated to residential care<sup>5</sup> with little made available for home care.<sup>6</sup> Only the most severe cases have been assisted within the health care system. This has led to ‘bed blocking’, that is an

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**Table 1: Publicly funded long-term care services**

	Places	Coverage (% Population over 65)
Home help	256,992	3.50
Telecare	208,107	2.84
Residential care	283,134*	3.86
Day care	39,554	0.54

Source: Libro Blanco de la Dependencia, 2005.

\* 57% private, 18% private with public sector contracts and 25% public.

**Table 2: Estimated number of future dependents by level of dependency**

	2005	2010	2015	2020
Category Three (Severe Dependency)	194,508	223,457	252,345	277,884
Category Two (Moderate Dependency)	370,603	420,336	472,461	521,065
Category One (Mild Dependency)	560,080	602,636	648,442	697,277
Total	1,125,190	1,246,429	1,373,248	1,496,226

Source: Libro Blanco de la Dependencia (2005).

**Table 3: Estimated central state allocation to the new long-term care system**

Year	Funding (€ millions)
2007	400
2008	679
2009	979
2010	1,160
2011	1,545
2012	1,674
2013	1,876
2014	2,112
2015	2,212
TOTAL	12,638

inability to discharge an individual from hospital who does not have medical care needs, because of a lack of appropriate social care services. Public funding for essential services such as home helps and LTC cover no more than 4% of the population (Table 1). More than 65% of care for older people is still provided informally by family members.<sup>5</sup>

#### Framework of new system

While some countries, including Germany, finance LTC through social insurance, Spain has opted for a tax funded approach, consistent with its tax funded health care system. A initial budget of €12.638 billion has been set aside for the 'National Long-Term Care System' that commenced operations in 2007. The system will be implemented in stages, with the aim of full operation by 2015.

Alongside the new funding, the government has introduced a "universal, but subjective" right to LTC. The scheme

can also apply to younger people who have LTC needs, for example, those with early onset dementia. Individuals are guaranteed access to a package of care services (subject to some cost sharing), regardless of place of residence, if they are deemed eligible following an assessment of care needs, income and financial assets. Although cost sharing schemes are still being defined, several forms of insurance coverage are also likely to develop, including both complementary and substitutive private insurance. There are also an increasing number of financial products being developed to facilitate the self-financing of LTC expenses, for example schemes to free up equity tied up in an individual's home.

Care packages will also vary, depending on which of three categories of dependency an individual may fall within. In the first (mild dependency), an individual would require assistance with one activity of daily living at least once a day. For those falling into the moderate dependency category, an individual would need help with at least one activity of daily living two or three times daily, but could still function independently without the constant presence of a caregiver. The highest level of assistance is made available to those deemed to be severely dependent, that is requiring help with the activities of daily living frequently and also in need of constant caregiver support. There will also be two gradations of support within each category, depending on the intensity of care needs. Determination of dependency level will be made by a newly established Territorial Council.

Assistance can take the form both of formal service provision, such as home helps, access to day and long term residential care, and/or cash payments to assist family carers. The system is expected to initially cover 1.125 million people (Table 2), 80% of whom will be over the age of 65.<sup>6</sup> Little change is predicted in the balance between different levels of need between 2005 and 2020, although the total number of individuals receiving support is projected to increase by one third to almost 1.5 million.

The first phase in introducing the new system began in 2007 with the provision of coverage to those qualifying individuals deemed to have the most severe level of dependency. In the subsequent three years coverage will be extended to those in category two, with coverage of those in category one complete by 2015. This will



increase total public expenditure on LTC from 0.33% of Gross Domestic Product in 2007 to 1% by 2015 (Table 3).

### Devolution and coordination

One of the chief characteristics of the 'modern' Spanish state is its decentralised political, and to a lesser extent, structure. The seventeen Autonomous Communities (AC) in Spain have progressively obtained responsibility for all areas of social policy, including education, health and social care. This means that they can design their own specific policies to tackle perceived priorities. Indeed, there is evidence of wide heterogeneity in preferences and attitudes towards the funding of health and social care.<sup>8</sup> The new law allows for flexibility in financing arrangements, so as to account for local variation in priorities, whilst maintaining a basic system for the whole country.

This has been achieved through a Territorial Council for the National Long-Term Care System (*Consejo Territorial del Sistema Nacional de Dependencia*) where the central government and the ACs will discuss and establish 'Integral Action Plans' and plan the organisation of the system. The legislation gives rise to some tensions between the national government guarantee (subject to means testing) on equal access to a basic package of services according to need on one hand, and regional responsibility for social care on the other. Complementary packages of care may also be provided by some ACs. However small these differences in coverage may be, they might arguably give rise to incentives for individuals to move between ACs in order to improve their access to services. Regulation may thus be required to counter these incentives, for instance ensuring that funding comes from the AC where the individual has paid tax.

One source of funding for long-term care, may be inheritance tax which is a AC responsibility. This issue has been heavily politicised, with ACs run by conservative administrations reducing the role of this tax. Given the structure of Spanish decentralisation, unless this tax is linked to the financing of LTC so that individuals may perceive some benefit from its retention, it is likely that one of the few instruments to guarantee federal financing of LTC will disappear.

Another key policy issue is that of coordination between health and social care, which is split between departments of health and social welfare respectively.

Moreover, social care is managed by municipal local authorities, who take responsibility for the day-to-day delivery of services. Unfortunately, with some notable exceptions (Catalonia, the Basque Country and Cantabria), coordination between health and social care has been limited and remains an important policy goal for the next decade. Institutional reform might be one obvious response, perhaps through the creation of independent coordinating agencies for LTC.

Overall, the progressive decentralisation of social policy responsibilities seems to have brought significant efficiency improvements, including the creation of incentives for policy innovation and replication of successful pilot welfare reform schemes across ACs with similar needs and characteristics.<sup>8</sup>

Finally, the new legislation also has sensitive political connotations, particularly for those mainstream political parties that campaign for greater devolution and ultimately independence in different ACs across Spain. This might potentially lead to some competition between regional and centrally mandated services, given the blurred distribution of policy responsibilities.

### Reflections

The law which sets out the framework for LTC coverage in Spain, is a first step towards an increased awareness that funding for social care will need to rise in order to cope with the demands of an ageing population. It makes clear the need for a highly flexible system for LTC. A pre-funded tax-based system guarantees a basic coverage but may also create incentives for private sector institutions to develop financial products and/or expand capacity to deliver care. Yet, a key challenge is how coordination and cooperation across the ACs will operate, without affecting efficiency and policy innovation.<sup>8</sup> Another key issue will be whether health and social care are coordinated through the creation of specific agencies, as is proposed in some ACs, or alternatively are integrated within inter-departmental programmes.

An important question, is the broader impact of the introduction of LTC systems on individual responsibility, regarding the way individuals save, invest and consider leaving assets to their relatives. Regarding savings, individual expectations that the public sector will, subject to means testing, pay for LTC, may create an incentive to

exhaust wealth (for example by selling property) in order to be eligible for public support. In southern European countries such as Spain, individual wealth is concentrated in housing; this has traditionally been seen as a way of financing LTC. One solution could be setting means testing mechanisms which account for wealth, not only at the later stage of life, but across the life span (inter-generational equity). Alternatively, one might argue in favour of a universal and uniform system resembling that for Spanish health care, but how then might this be financed? One possibility could be to draw on inheritance taxes, which in Spain are collected by the ACs; however, there is no uniform policy on such taxes. Some ACs, such as Madrid, have eliminated this tax, which will remain unpopular with much of the population unless some clear cut entitlement to care is offered in exchange.

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## Nicotine replacement therapy (NRT) revisited

One of the interesting aspects of looking at evidence is the effect of time. Initial results for new interventions or observations often look good, but then look less good as more evidence comes in. That is why a degree of caution is sensible. Time can also affect results in the sense that those results may look better or worse as duration of treatment or observation lengthens. Clinical trials have time limits, while clinical practice may have different time horizons.

It behoves us, then, occasionally to revisit the evidence, especially when time is a feature. This has

been done with nicotine replacement therapy,<sup>1</sup> reminding us that our judgements on efficacy and effectiveness can change with time.

### Systematic review

This systematic review of nicotine replacement therapy (NRT) for smoking cessation looked for randomised trials with endpoints beyond 12 months after the start of treatment. It had a terrific search strategy. The aim of trials was permanent cessation of smoking, and required that active and control arms differed only by use of NRT, so allowing supportive advice or counselling at various intensities. Use of any NRT product for any duration was allowed. Information on cessation rates at 12 months and at the longest time afterwards was abstracted.

### Results

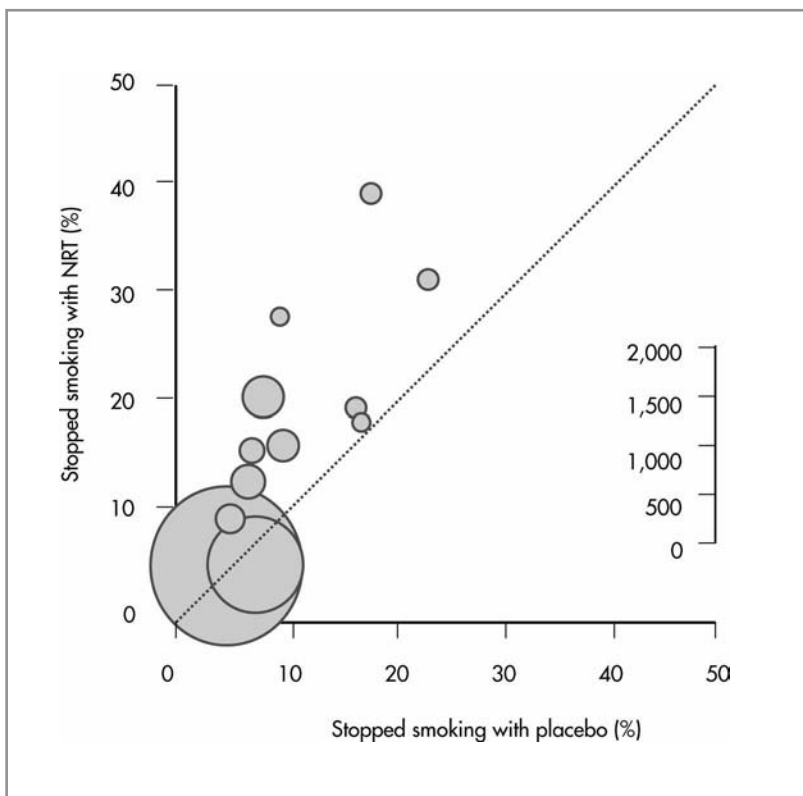
There were 12 trials with 4,792 patients reporting cessation results at 2–8 years, with a weighted mean of 4.3 years. Trials used nicotine patch, gum, or spray for 3 to 52 weeks, with most using NRT for 12 weeks or longer (weighted mean 22 weeks). All but one of the trials assessed smoking cessation by breath carbon monoxide or urine cotinine measurement. Trials predominantly excluded light smokers of fewer than 10–15 cigarettes daily. Support and advice on cessation was of varying intensity.

Figure 1 shows smoking cessation results of the individual trials at the longest time. Most of the trials were small, with two contributing over 2,600 patients, and having low quit rates with both NRT and placebo.

Table 1 shows quit rates and derived statistics for the trials both at 12 months and at the longest duration. The proportion of patients who were non-smokers fell between 12 months and the longest duration, as previous quitters began smoking again. A third of quitters had begun to smoke again (Figure 2) after both NRT and placebo. Figure 3 shows the results for 24 individual treatment arms of the 12 trials.

This adversely affected the efficacy of NRT as

**Figure 1: Smoking cessation rates at longest study duration with NRT and placebo**



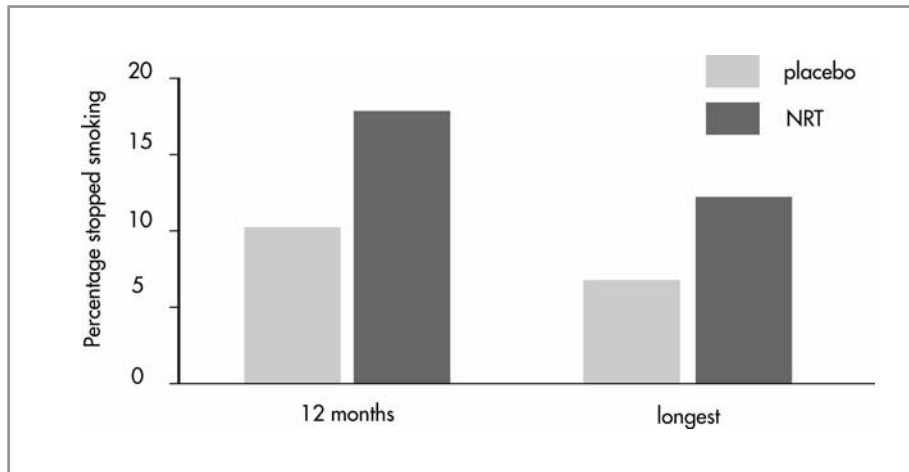
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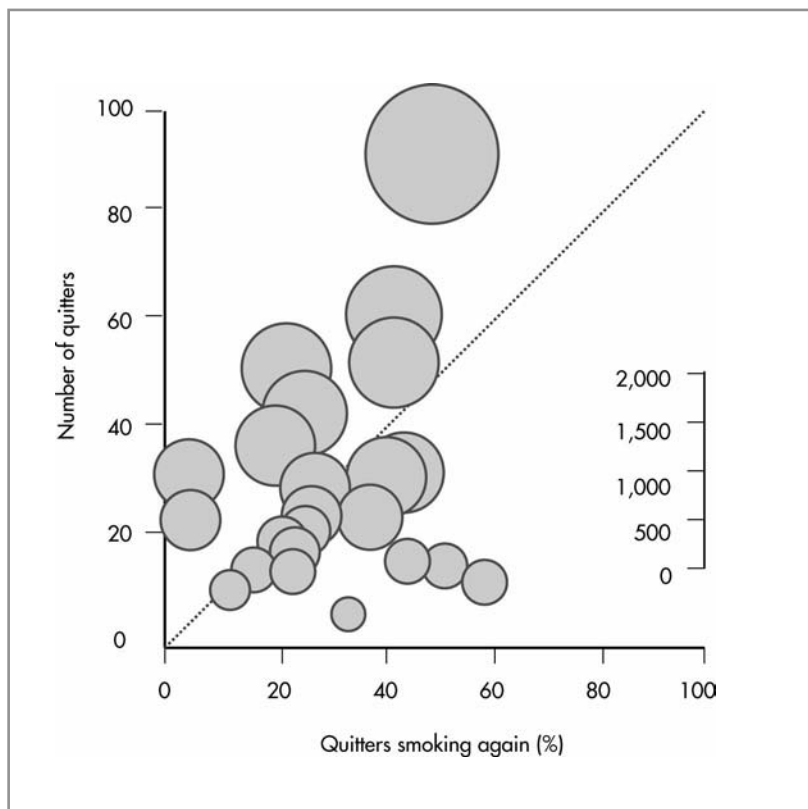
**Table 1: Results of trials at 12 months and at longest duration**

Duration of observation	Percent stopped smoking		Relative risk (95% CI)	NNT (95% CI)
	NRT	Placebo		
12 months	18.2	10.1	1.8 (1.6 to 2.1)	12 (10 to 16)
Longest	12.2	7.0	1.7 (1.5 to 2.1)	19 (15 to 28)

**Figure 2: Smoking cessation rates at 12 months and at longest study duration**



**Figure 3: Percentage of quitters at 12 months smoking again at longest duration months and at longest study duration**



measured by the number needed to treat (Table 1). NRT rather than placebo would have to be used in 12 patients to induce one more patient to quit smoking at 12 months. But NRT would have to be used in 19 patients for one more to be a non-smoker after an average of 4.3 years.

**Comment**

NRT has clear efficacy in helping some patients stop smoking over the short term. The effectiveness of NRT is eroded by the propensity of former smokers to begin smoking again. This study showed that at least a third of quitters began to smoke again after NRT or placebo.

In the case of NRT the argument of cost effectiveness is governed by how many people stop smoking because of NRT. At 12 months, after an average of 22 weeks of NRT treatment, the answer is 1 patient in 12. But at longer follow up, it is more like 1 in 19.

The real importance of this study is not, however, about smoking cessation, but about how duration of observation can affect how we perceive a result. In this case, there is an argument that an intervention that looks just about useful after one year, is tipping towards irrelevance by four.

What this does is to open something of a Pandora's box of cost effectiveness. If the effect of NRT in smoking cessation continues to diminish as recidivist quitters begin to smoke again, does the cost of the effort outweigh the health gains? It may just be easier to ban smoking in public places. In California, where bans began, smoking rates have halved.

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## AIR POLLUTION RISKS IN CHINA

Ying Zhou, Jonathan Levy, John S Evans and James K Hammitt

*"Our work suggests that intake fractions can facilitate risk-based priority-setting when resources are limited."*

### Introduction

As in many rapidly developing countries, energy generation capacity and consumption in China have increased tremendously over the past 25 years and will continue to increase substantially in the foreseeable future. Due to the use of coal for the majority of power generation, many cities are experiencing severe levels of air pollution and decision-makers are faced with the difficult task of mitigating pollution while supporting continued economic growth.

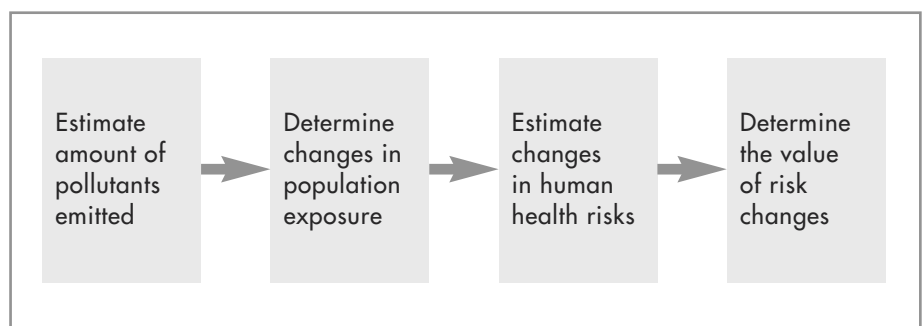
This edition of Risk in Perspective reports some results of the Harvard Center for Risk Analysis' work on these issues, undertaken as part of the University's China Project. The China Project is an interdisciplinary academic research program focused on the Chinese atmospheric environment and its national and international implications, bringing together faculty, researchers, and students from across Harvard's schools under the auspices of the University's Center for the Environment and Division of Engineering and Applied Sciences.\*

As indicated in Figure 1, ascertaining the benefits of air pollution control (i.e., of reducing the human health risks associated with energy generation) involves four main steps: estimating the quantities of pollutants emitted, determining the impact of these emissions on ambient concentrations and hence on population exposure, assessing the incremental damages to human health (for example, on mortality and morbidity) due to exposure, and determining the value of these damages using monetary or other measures. The analysis discussed in this article focuses on the second of these components, and estimates the impact of emissions on ambient concentrations and population exposure in a form that can be directly translated into human health risks. We also briefly summarise related work on the Chinese monetary values for these risk reductions.

### What is an intake fraction?

The link between emissions and exposures is often determined by running complex models that require significant time and resources. However, there are more than

Figure 1: Steps in estimating the benefits of pollution controls



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2,000 coal-fired power plants in China with capacity greater than 12 MW. The analytical cost of running detailed fate and transport models for each of them would be prohibitive, and the time needed to apply such models is likely to delay decision-making. Instead, we run a detailed long-range transport model (CALPUFF) for a subset of China's coal-fired power plants and use the outputs to develop simple yet meaningful measures of the emissions-exposure relationship. By building models to determine how this relationship depends on the geographic location of the source, we can estimate the relationship for sites not included in our sample.

For this analysis, we utilise the concept of an 'intake fraction', defined as the proportion of material or its precursor released from a source that is eventually inhaled or ingested by a population. For pollutants with linear concentration-response functions, population health risk will be directly proportional to the intake fraction. The intake fraction ( $iF$ ) can be calculated as:

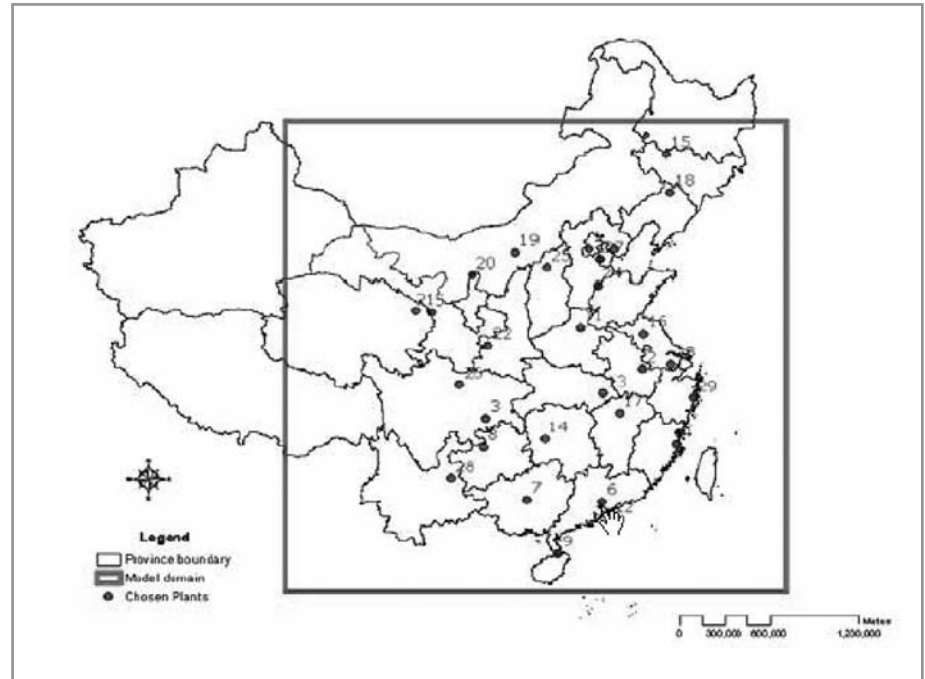
$$iF = \frac{\sum_{i=1}^N P_i \times C_i \times BR}{Q}$$

Our modelling domain covers all the heavily populated areas in China, and is divided into 14,400 grid cells indexed by  $i$ .  $P_i$  is the population in cell  $i$ , derived using 1999 county-level population data.  $C_i$  is the incremental concentration at location  $i$  ( $\text{g}/\text{m}^3$ ), estimated using CALPUFF.  $BR$  is the population-average breathing rate ( $\text{m}^3/\text{s}$ ), for which we assume a nominal value of  $20 \text{ m}^3/\text{d}$ .  $Q$  is the emission rate of the modelled pollutant or its precursor ( $\text{g}/\text{s}$ ).

### Pollutants modelled

Primary pollutants are formed directly during the combustion process, while secondary pollutants are formed in the ambient air by the chemical reactions of gaseous precursors during atmospheric transport. We calculate intake fractions for primary pollutants (particulate matter (PM) and sulphur dioxide ( $\text{SO}_2$ )), and for secondary pollutants (ammonium sulphate inhaled per unit of sulphur dioxide emissions and ammonium nitrate inhaled per unit of nitrogen oxide emissions).

Figure 2: Location of modelled power plants



The particle size distributions of primary PM can vary substantially for different combustion processes and control equipment and influence the fate and transport of particles in the atmosphere and therefore the intake fractions. For the purpose of this study, we define  $\text{PM}_{10}$  to be particles of  $1 \mu\text{m}$  in aerodynamic diameter, with parallel definitions for  $\text{PM}_{2.5}$ ,  $\text{PM}_{10}$  and  $\text{PM}_{10-2.5}$ . We calculate the intake fraction of total primary particles as the weighted average of the intake fractions of particles of different sizes.

### Power plant selection and source characteristics

For our analysis, we select power plants that allow us to evaluate geographic factors that influence intake fractions. We randomly choose one site from each of the Chinese administrative units covered by our modelling domain. Figure 2 shows the locations of the 29 selected sites.

Allowing plant characteristics to vary significantly between sites would make it difficult to identify the independent effects of population and meteorology on intake fractions. Moreover, newly constructed or proposed power plants in China follow the same engineering design guidelines and their source characteristics (for example, stack height, exit temperature, exit velocity) are usually within a narrow range. Consequently, we evaluate the intake fractions associated with locating a typical modern power plant in China at each of the 29 sites.

### Results

Table 1 lists the estimated annual average intake fractions for the 29 sites as well as the standard deviation and minimum and maximum values.  $\text{PM}_{10}$  has the highest mean intake fraction,  $1 \times 10^{-5}$ . This means that for every metric ton of  $\text{PM}_{10}$  emitted, 10 grams are eventually inhaled by people in the domain.  $\text{PM}_{2.5}$  has the second highest mean intake fraction, followed by  $\text{SO}_2$ , secondary ammonium sulphate,  $\text{PM}_{10-2.5}$ , secondary ammonium nitrate, and  $\text{PM}_{10}$ . Among the primary particles, larger particles have smaller intake fractions. Averaging the intake fraction estimates for PM yields an overall intake fraction for primary particles of  $6 \times 10^{-6}$ .

We also estimated how far from the power plant one would need to be to capture at least half of the intake fraction (and therefore half of the population risk). The average distance ranges from less than 200 km (for  $\text{PM}_{10}$ ) to nearly 500 km (for secondary nitrate particles). For primary particles, the distance from the source capturing a certain percentage of the total intake fraction decreases with increasing aerodynamic diameter.

We construct regression models to study whether variability in intake fractions can be explained using easily obtainable parameters that represent the effects of important variables, including meteorological conditions, source characteristics, and population distribution. We include general meteorology variables (such as

**Table 1: Annual average intake fraction estimates and summary statistics across 29 power plant sites in China**

	Sulphur dioxide	Sulphate	Nitrate	Primary PM <sub>1</sub>	Primary PM <sub>3</sub>	Primary PM <sub>7</sub>	Primary PM <sub>13</sub>
<b>Mean</b>	4.8E-06	4.4E-09	3.5E-09	1.0E-05	6.1E-06	3.5E-06	1.8E-06
<b>Standard deviation</b>	1.9E-09	1.5E-06	1.7E-06	3.7E-06	3.0E-06	1.8E-06	1.0E-06
<b>Maximum</b>	1.8E-06	7.3E-07	8.0E-07	2.8E-06	1.7E-06	1.1E-06	6.7E-07
<b>Minimum</b>	8.9E-06	7.3E-06	7.1E-06	1.9E-05	1.2E-05	8.2E-06	5.2E-06

Note: PM<sub>x</sub> = particulate matter with aerodynamic diameter equal to “x”µm.

climate zone and precipitation) and characterise population based on fixed distances from each plant (within 100 km, between 100 and 500 km, between 500 and 1,000 km, and beyond 1,000 km).

We find that population is a strong predictor of intake fractions, as expected. Generally speaking, the near-source population is more important for large primary particles while population at medium and long distances is more important for primary fine particles and secondary particles. We also find that intake fractions are generally lower for power plants in areas with more precipitation.

Sensitivity analyses indicate that stack height has a greater effect on primary than secondary particles, because secondary particles have long residence times, can travel further distances in the atmosphere, and are not as strongly influenced by the local population density as primary particles. The size distribution of primary particles has a large impact on their resulting intake fractions while the background ammonia concentration is an important factor influencing the intake fraction for ammonium nitrate. The background ozone concentration has a moderate impact on the intake fraction for ammonium sulphate and nitrate.

### Discussion and conclusions

The intake fraction estimates for China are about an order of magnitude higher than those in similar US analyses. Much of the difference appears to be explained by the higher population density in China. The findings from our regression analyses generally agree with similar analyses of intake fractions for US power plants. For example, population variables alone can explain the majority of the variability in the intake fractions. In addition, popu-

lation at medium distance (for example, between 100 and 500 km) significantly influences the intake fraction of primary fine particles while population at longer distances (for example, beyond 500 km) significantly influences the secondary ammonium sulphate intake fraction.

Because an individual power plant contributes a relatively small fraction to ambient concentrations, it is difficult to use monitoring data to “validate” the model outputs, an approach that is further impaired by the relative lack of monitoring data across China. However, we find that the relationship between emissions and modelled concentrations is consistent with aggregate measured PM emissions and concentrations. The correspondence between our results and previous intake

fraction estimates, when accounting for population patterns (at least for primary PM), provides some assurance that our estimates are reasonable. The fact that we have not varied power plant characteristics masks some of the true heterogeneity in intake fractions across China, although it allows us to better quantify the influence of geographic location.

The robustness of our atmospheric modelling coupled with the strength of the regression equations and the use of stack characteristics typical of new power plants suggest that our model could reasonably predict the total population exposure to pollution from power plants in China. By combining our findings on population exposure with estimates of emissions, human health damages, and the value of

### Valuing reductions in air pollution-related health risks

Determining the appropriate level of pollution control requires careful balancing of the benefits against the costs. Estimating the value of these benefits is a difficult and controversial task, since it involves ascertaining the monetary worth of effects on human health and the environment.

HCRA Director James K Hammitt and Dr Ying Zhou have been researching the value of air pollution-related risk reductions in China. Using a contingent valuation survey administered in three diverse locations, they estimate values for three health endpoints: colds, chronic bronchitis, and premature mortality. Averaged across the locations, they find that (in 1999 US dollars using the official exchange rate) median willingness to pay to prevent a cold episode ranges between \$3 and \$6; to prevent a statistical case of chronic bronchitis ranges between \$500 and \$1,000; and to prevent a statistical case of premature mortality ranges between \$4,000 and \$17,000. The mean values are between two and thirteen times larger because some respondents reported values significantly above the median.

The Chinese values are substantially smaller than those for more developed countries; for example, between about 10 and 1,000 times smaller than similar estimates from the US and Taiwan. These differences are more than proportional to the differences in income: Chinese per capita income is about 50 times smaller than in the US and about 20 times smaller than in Taiwan.

these damages, we can estimate the benefits of increasing pollution controls using different strategies. Our estimates have been incorporated into national-level models in China to determine priorities for pollution control as well as the relative merits of different control strategies (such as environmental taxes), as documented in a forthcoming book from MIT Press, *Clearing the Air: The Health and Economic Damages of Air Pollution in China*.

#### FURTHER READING

Zhou Y, Levy JI, Evans JS, Hammitt JK. Estimating population exposure to power plant emissions using CALPUFF: a case study in Beijing, China. *Atmospheric Environment* 2003;37:815–26.

Zhou Y, Levy JI, Evans JS, Hammitt JK. The influence of geographic location on population exposure to emissions from power plants throughout China. *Environment International* 2006;32:365–373.

Hammitt JK, Zhou Y. The economic value of air pollution-related health risks in China: a contingent valuation study. *Environment and Resource Economics* 2006;33:399–423.

Ho MS, Nielsen CP (eds). *Clearing the Air: The Health and Economic Damages of Air Pollution in China*. Cambridge, MA: MIT Press, 2007.

## HPROWOMEN Project

### Development of an Educational and Training Tool for Workplace Health Promotion focusing on Women

Women currently comprise 42% of the employed population in the EU. Gender issues in the workplace are of utmost importance, because of major differences in the way work affects the health of men and women. Health promotion at the workplace has neither addressed women as a separate group, nor taken into consideration factors such as gender segregation and the increased responsibilities outside the working environment.

#### The project

During the two years of the HPROWOMEN project, an educational and training tool for planning, implementing and evaluating health promotion for working women has been developed. The tool is valuable for all health professionals, particularly those specialising in occupational and public health as it constitutes a manual that presents occupational risks and hazards that are specific to women, or that women are most likely to encounter. The tool can facilitate the planning, implementation and evaluation of health promotion activities targeting women at the workplace.

Emphasis has been given to the ways healthy female employees can influence health behaviours in other environments, such as the family and community. Several health topics are covered such as: needs assessment and programme planning of worksite interventions; mental health and work-life balance; occupational health; musculoskeletal diseases; work-related violence; bullying and sexual harassment; female reproductive health and breast feeding; screening; communicable diseases; smoking; alcohol abuse; nutrition and physical exercise.

#### Project outcomes

One outcome of the project has been a *pilot course*, which took place in Athens, Greece in February 2007. The course summarised the expertise acquired during the implementation of the project and pilot tested this expertise with participants involved in teaching or coordinating workplace health promotion courses or who are working in the area of applied or theoretical workplace health promotion.

Because of wide-spread interest, the partnership is considering repeating the pilot course. Those interested in attending a pilot course or obtaining a CD-ROM containing the pilot course presentations can contact the project team by email at: [info@hprowomen.gr](mailto:info@hprowomen.gr)

The end product of the project is a book entitled *Promoting Health for Working Women* soon to be published by Springer Publications.

#### Coordination

The HPROWOMEN project is coordinated by the University of Athens Medical School. It is a project under the DG SANCO, 2003–2008 Public Health Programme co-funded by the European Commission. The project is also supported by a generous grant from the Stavros Niarchos Foundation. The project partnership consists of leading European experts in the field of occupational health, epidemiology, health promotion, and gender issues from the Technische Universität Dresden, the London School of Economics and Political Science, the Institut Municipal de Investigació Mèdica, Barcelona, the Finnish Institute of Occupational Health, the University of Erasmus Rotterdam, Prolepsis: Institute of Preventive Medicine, Environmental and Occupational Health, Kastri, Greece and the University of Sofia Medical School.



Project website: [www.hprowomen.org](http://www.hprowomen.org)

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](mailto:s.m.merkur@lse.ac.uk) if you wish to submit a publication for potential inclusion in a future issue.

## National Strategy for Quality Improvement in Health and Social Services (2005–2015)



Oslo: National Directorate for Health and Social Affairs, September 2005

ISBN 978-82-8081-073-0

52 pages

Freely available on line at:

[http://www.shdir.no/vp/multimedia/archive/00005/IS-1162\\_E\\_5484a.pdf](http://www.shdir.no/vp/multimedia/archive/00005/IS-1162_E_5484a.pdf)

With this strategy, the Norwegian National Directorate for Health and Social Affairs has drawn up guidelines for work on quality improvement until 2015. This is an overall strategy that is expected to be a common feature for many services, including municipal health and social services, county dental services, specialist health services and private services.

This strategy aims to ensure that users and patients of health and social services in Norway receive high quality support. The strategy also aims to ensure that the authorities' policy for high quality is implemented, and that quality improvement work initiated in different areas within health and social services is coordinated and strengthened.

*Contents:* Foreword; Who has participated?; Introduction; Two examples of service failure; What do we wish to achieve with this strategy?; What is high quality?; What is our theoretical approach?; Where are we heading?; How do we get there?; The way forward; How do we know whether we have reached our destination?; To you, the user; References and literature.

The report begins by providing examples of service failure. Then the vision, aim and target groups are identified. Next, six elements in the concept of quality are described, which include: effective measures, safe and secure services, involving service users and allowing them to have influence, good coordination and continuity in service supply, appropriate utilisation of resources and available services and fair distribution.

The latter chapters explain quality improvement theory, strategic directions, and target areas. There is a related web site, available at [www.shdir.no/kvalitetsforbedring/english](http://www.shdir.no/kvalitetsforbedring/english)

## Healthcare professionals' views on clinician engagement in quality improvement: A literature review

Huw Davies, Alison Powell and Rosemary Rushmer



London: The Health Foundation, April 2007

ISBN 0-9548968-6-6

90 pages

Freely available at:

<http://www.health.org.uk/document.rm?id=135>

It is widely accepted that the active involvement of staff is an essential requirement for quality improvement in any organisational setting. However, quality improvement initiatives in the NHS have not generally secured the full engagement of clinicians.

As a result, the Health Foundation is planning to commission new research to investigate the opinions of UK health care professionals on clinicians' engagement in quality improvement. To inform this research, the authors were commissioned to conduct a literature review to clarify what is already known about the views of UK health care professionals in this area.

This report is structured through the use of ten inter-related questions that emerged during the literature review as

to how health care professionals have responded to various quality initiatives in the UK since 1990.

These key questions address the following topics: How is quality defined? Does quality of care need to be improved? What are health care professionals' attitudes towards initiatives aimed at quality improvement? What are the concepts and methods of quality improvement? Where should responsibility for quality improvement lie?

Other subjects explored in this report include: clinical guidelines, evidence-based practice, quality measurement, accountability and barriers. The review draws predominantly on studies that rely on self-reported attitudes.

*Contents:* Introduction; Summary of key findings; Literature review; References; Technical appendix: a summary of the main empirical studies used in the review.



# Silent victories. The history and practice of public health in twentieth-century America

Review by Walter Holland

*Edited by John W Ward and Christian Warren.*

*Oxford University Press, 2006. £29.99 Hardback, 512 Pages ISBN-10: 0-19-515069-4*

This is a very interesting historical account of a large variety of public health activities in the United States. Ward is a former editor of the well-known “Morbidity and Mortality Weekly Report Series” published by the US Centers for Disease Control and Prevention (CDC) while Warren is a historian from the New York Academy of Medicine. The background of the editors has obviously been crucial both in the choice of topics as well as of chapter authors. The accounts of advances in infectious disease are fascinating and outstanding. Each chapter tackles the problems from a historical angle and most are revealing.

The book is divided into ten parts – control of infectious disease, control of disease through vaccination, maternal and infant health, nutrition, occupational health, family planning, oral health and dental fluoridation, vehicular safety, cardiovascular disease, tobacco and disease prevention. Each part has two or three chapters which describe the advances and improvements that have occurred in their particular area with the second (or third) chapter giving a fascinating historical account of the background, development of methods and campaigns before concluding with a brief note on future needs. Each chapter has a voluminous bibliography, including advice on further reading materials.

It may be invidious to select individual chapters for their excellence, but several are outstanding in the analysis of advances which have been made. Of particular note are the chapters on the contribution of René Dubos to the control of infection,

while the two chapters on poliomyelitis give a vivid account of the dread of this disease and the response by the government and public to its prevention, as well as the lessons that can be learnt from this for “biological warfare”. The account of the background to the First Surgeon General’s report on tobacco is illuminating and accurate in its conclusions of the effect that this has had on epidemiological thinking and practice.

Reviewing a book of such excellence is challenging – it is difficult to distinguish between different contributions. However it is important to consider whether any important areas have been omitted in order to put public health problems into perspective.

The provenance of the book from the CDC may have affected both the choice of problem/condition, as well as their descriptions. Although many of the chapters, particularly those on infant mortality and maternal health and nutrition, refer to the association with deprivation, none really deals in any depth with the recurring problems of poverty or the influence of ethnicity on health in the US.

It is tempting to identify gaps in any work – and there are some in this book. In the infectious disease field the omission of the work of Rammelkamp and his group on the control of streptococcal disease and rheumatic fever is surprising. The lack of analysis of influenza can, perhaps, be excused by the title “victories” since there has not been a victory, only a debacle with the mass immunisation against swine flu in the 1970s. There is also a relatively sparse account of environmental improvements in areas such as air pollution, or the abandonment of lead based paint and its effect on child health. A surprising omission is the work on tuberculosis in both Alaska (where it was a major scourge) and in the southern US. The conquest of syphilis is

also not described, perhaps in deference to the scandal of Tuskegee County where a population was kept in ignorance and not treated for many years when effective control measures were available.

An area of public health in which the US has excelled is in its programmes of education and its Schools of Public Health. It is a shame that the means by which the “victories” have been achieved receive so little recognition. It is also to be hoped that the fear expressed on page 228 that the US will, in the future, “reject science-based policies”, as is happening with the current Bush administration, will not come to pass.

The title “Silent Victories” has a subtitle – “the history and practice of public health in twentieth century America”. This work undoubtedly portrays well some of the major successes. The preface disclaims any suggestion of comprehensiveness, nonetheless the choice of subjects and the omission of such major scourges, as tuberculosis and rheumatic fever, where US public health has played an enormous role is unfortunate. Although both the swine flu vaccination debacle and the Tuskegee episode are referred to in passing in the introduction, the book would have been immensely strengthened if it had included analysis of these unfortunate events. Rather than being only a celebration it would have been an important source of reference for public health in the United States. But perhaps the most striking analytic omission is the difference in infant mortality rates between whites and other ethnic groups which has persisted throughout this century. This illustrates the problems of poverty in the US more vividly than any other public health problem. The willingness to tolerate Third World conditions in parts of the country is an unfortunate blot on the US. The neglect of this issue in the book may be due to its provenance from a US government agency.

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## German Institute for Quality and Efficiency in Health Care (IQWiG)

<http://www.iqwig.de>

Established in June 2004, IQWiG is an independent scientific institute that assesses the quality and efficiency of health care in Germany. The Institute evaluates pharmaceuticals, surgical procedures, diagnostic tests, clinical practice guidelines and aspects of disease management programmes, following the principles of evidence-based medicine. It communicates its findings to the health care professions, patients and the general public. The website provides, in both English and German, information on the role and structure of the Institute (including a mandate to assess the cost-effectiveness of drugs), details of commissions undertaken, information on methods and tools, and publications for download, including final reports and other documents produced by the Institute as well as original articles and reviews produced by scientific staff members.

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## Quest for Quality and Improved Performance (QQUIP)

<http://www.health.org.uk/qquip>

QQUIP is a five-year research initiative of the Health Foundation in England, which brings together data from a wide range of sources to reveal national and international trends on disease and quality of care. Its three main aims are: to assess the current state of quality and performance of health care, to identify what works to improve quality and performance and to measure value for money criteria regarding NHS spending. QQUIP also collects, analyses and updates data from outside sources, such as OECD Health Data, the Department of Health, the Healthcare Commission, Royal College databases and clinical publications. The website collates evidence on the impact of various interventions designed to improve the quality of health care internationally, supplies charts that provide at-a-glance data on quality topics (effectiveness, safety, access) and highlight priority areas (cancer, heart disease, diabetes, mental health). Publications also available for download.

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## Belgian Health Care Knowledge Centre (KCE)

<http://www.kce.fgov.be>

Created in December 2002, KCE is in charge of conducting studies that support political decision-making on health care and health insurance in Belgium. It is a public interest organisation under the supervision of the Minister of Public Health and Social Affairs. Recent studies have addressed various topics, including: financing hospital nursing care, chronic care of people with acquired brain injuries, cardiovascular primary prevention, and chronic low back pain. Its website provides details of mission, press releases, outcomes of studies, publications for download and useful links to other organisations. The website is in Dutch and French, with some publications also available in English.

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## GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries

<http://www.socialhealthprotection.org>

The Consortium is a joint effort to coordinate the work of several organisations working in the field of social health protection: GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit (German Society for Technical Cooperation), International Labour Organisation (ILO), and the World Health Organization (WHO). It collaborates at country, regional and global level and supports increases in the quality and scope of sustainable and comprehensive health care financing in partner countries, strengthens technical support by joining resources and creates synergies and savings through complementary activities. The website provides details of the Consortium's aims and work, presentations from past conferences, as well as publications for download in various languages including English, French, German and Spanish.

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## Insight & Action: A new digest from the CHSRF

[http://www.chsrf.ca/other\\_documents/insight\\_action/index\\_e.php](http://www.chsrf.ca/other_documents/insight_action/index_e.php)

The Canadian Health Services Research Foundation (CHSRF), which supports the evidence-informed management of Canada's health care system by facilitating knowledge transfer and exchange, has launched a new weekly digest called *Insight & Action*. Available in both English and French, the digest aims to link those individuals who practice knowledge transfer and exchange with relevant evidence-informed resources. This series provides insights into important concepts of knowledge transfer and exchange, including networks, brokering, dissemination and research use. It is available for download, or can be received by email following subscription.

## EUROPEAN MONITOR

**60th World Health Assembly**

The 60th session of the World Health Assembly took place in Geneva between 14 and 23 May. Member States agreed a resolution which will help all countries better prepare for the global public health threat which an influenza pandemic presents. The resolution, *Sharing of influenza viruses and access to vaccines and other benefits*, restates the general principles of the necessity of sharing, both in the preparations for an influenza pandemic, and in the benefits that will flow from improved international cooperation and preparation, such as greater quantities of and equitable access to H5N1 and pandemic vaccines.

In her closing remarks, the Director-General Dr Margaret Chan told delegates, “all countries need to be aware of their obligations under the revised International Health Regulations (IHR). When collective security is at stake, public opinion can carry great weight. After very considerable discussion, you have adopted a resolution on the sharing of influenza viruses and access to pandemic vaccines and other benefits. I want to underscore the importance of this decision. My responsibilities in implementing the IHR depend on this sharing.”

The resolution requests WHO to establish an international stockpile of vaccines for H5N1 or other influenza viruses of pandemic potential, and to formulate mechanisms and guidelines aimed at ensuring fair and equitable distribution of pandemic-influenza vaccines at affordable prices in the event of a pandemic.

It also tasks an interdisciplinary working group with drawing up new Terms of Reference (TORs) for the WHO Influenza Collaborating Centre Network, and its H5 reference laboratories, for the sharing of influenza viruses. The new TORs will take into account

the origin of influenza viruses going into the WHO Global Influenza Surveillance Network, and will make their use more transparent. Once finalised, these TORs will be submitted to a special Intergovernmental Meeting of WHO Member States and regional economic organisations.

The Assembly also reached a last-minute agreement on public health, innovation and intellectual property. The resolution expressed appreciation to the Director-General for her commitment to the process of the Intergovernmental Working Group on the issue and encouraged her to guide the process to draw up a global strategy and plan of action. The resolution also requested the Director-General to provide technical and policy support to countries. Dr Chan said that she is “fully committed to this process and have noted your desire to move forward faster ... We must make a tremendous effort. We know our incentive: the prevention of large numbers of needless deaths and suffering.”

Norwegian Prime Minister, Jens Stoltenberg, gave a keynote address to the Assembly, focusing on two of the Millennium Development Goals that Norway has paid particular attention to: child mortality and maternal health. He announced that a draft *Global Business Plan* to accelerate progress on these two goals is under preparation, with the intention of being launched in September 2007. He hoped that the plan “will help mobilise additional resources that will help successfully achieve the goals on child mortality and maternal health” and that “it may provide the political impetus at the highest level to facilitate country-led action.”

The Health Assembly approved the largest-ever budget for the WHO for 2008–2009 of US\$4.2 billion, an increase of nearly \$1 billion from the \$3.3 billion approved for 2006–2007. For the first time, this budget is part of a

six-year strategic plan for WHO, which Member States also adopted at the Assembly.

Among the other issues discussed, Member States expressed their concern that malaria continues to cause more than one million preventable deaths every year. The Assembly passed a resolution to intensify access to affordable, safe and effective antimalarial combination treatments, to intermittent preventive treatment in pregnancies, to insecticide treated mosquito nets, and indoor residual spraying for malaria control with suitable and safe insecticide. Member States requested that donors adjust their policies so as to progressively cease to fund the provision and distribution of oral artemisinin monotherapies, and to join in campaigns to prohibit the marketing, distribution and use of counterfeit antimalarial medicines.

The Assembly also endorsed the Global Plan of Action on Workers' Health, which aims to devise policy instruments on workers health; protect and promote health at the workplace; improve the performance of, and access to, occupational health services; provide and communicate evidence for preventive action; and incorporate workers health into other policies. The Assembly adopted a resolution on emergency trauma care systems, which draws the attention of governments to the need to strengthen pre-hospital and emergency trauma care systems (including mass casualty management efforts) and describes a number of steps governments could take. It also invites WHO to scale up its efforts to support countries.

Member States approved the resolution on the strengthening of health information systems and enhancing WHO's work on health statistics in general. They also called on the DG to strengthen the information and evidence culture of WHO itself, and ensure the use of accurate

and timely health statistics in order to generate evidence for major policy decisions and recommendations within WHO. Member States approved a resolution and reiterated the importance of a coherent research strategy for WHO which will help to disseminate the outcomes of research and its utilisation in decision- and policy-making for more effective health policies.

Other issues discussed included smallpox eradication; non-communicable diseases; better medicines for children; and progress in the rational use of medicines

*More information on the World Health Assembly is available at <http://www.who.int/mediacentre/events/2007/wba60/en/index.html>*

### **G8 Summit: Commitments to Africa “will be honoured”**

The G8 have vowed to deliver on their existing pledges to Africa. The discussions with African representatives were “very honest, very open” German Chancellor, Angela Merkel, said after the first working session on the last day of the Summit in Heiligendamm, Germany. The Chancellor’s message to the countries of Africa was this: “We are aware of our responsibility and we will honour our commitments.” The G8 needed to “fulfil the promises we made,” she said.

US\$60 billion has been pledged over the coming years to combat HIV/AIDS, malaria and tuberculosis. This is to be used to safeguard universal access to comprehensive HIV/AIDS prevention programmes, treatment and care, and to develop health systems at local level. Particular attention in the fight against infectious diseases is to be paid to the needs of adolescent girls, women and children. G8 hosts, Germany, will be providing €4 billion to support efforts to combat these illnesses, while overall half of the budget will come from the United States.

The vow for action, comes after the acknowledgement that the G8 members had not met their 2005 commitments. Anti-poverty campaigners were decidedly unimpressed. “This wasn’t serious, this was a total farce... I won’t have it spun as anything else except a farce”, said Bob Geldof. He added that instead of re-committing to the promises made two years ago, the G8 leaders had to get “serious and deliver”. However he

singled out, UK Prime Minister Tony Blair for pursuing the anti-poverty campaign “to the point of exhaustion”.

A policy advisor from the UK NGO, Oxfam, said only \$3bn of the money was new, “We must not be distracted by big numbers. What the \$60 billion headline means at best is just \$3 billion extra in aid by 2010”. “Before this summit, Oxfam showed the G8 were set to miss their 2010 target by a massive \$30 billion. Today’s announcement may only close that gap to \$27 billion” he added. Steve Cockburn of the Stop AIDS Campaign said the pledge fell short of UN targets obliging G8 nations to spend \$15 billion per year to combat AIDS alone through to 2010.

This is not to say that no progress has however been made since the 2005 summit in Gleneagles, Scotland. This has included the write off of the debt of eighteen African nations. In the case of Zambia, free health care in rural areas has been expanded as a result.

In their final declaration, the G8 affirmed their commitment in Africa to “focus on promoting growth and investments in order to combat poverty and hunger, to foster peace and security, good governance and the strengthening of health systems, and to assist the fight against infectious diseases.”

The G8 countries also pledged to support their African partners in meeting the challenges they face when it comes to climate policy. They also want to contribute to strengthening political structures, to promote investments and to development the local economy. The Summit Declaration “Growth and Responsibility in Africa” lists the 63 commitments which cover a wide variety of issues.

*More information on the G8 summit is available at <http://www.g8.de/Webs/G8/EN/G8Summit/g8-summit.html>*

### **Global health: launch of the first advance market commitment for new vaccines**

In Rome on 9 February, at a ceremony attended by Her Majesty Queen Rania Al-Abdullah of Jordan, then President of the World Bank, Paul Wolfowitz, and Ministers from Italy, Canada, Russia, Norway, the UK, Malawi and Ghana, the first step was taken to accelerate the development of new vaccines for

diseases that afflict the poorest countries with the launch of the Advanced Market Commitment (AMC).

The AMC is an innovative, market-based mechanism with the potential to save millions of lives by accelerating access to vaccines in the world’s poorest countries; vaccines that would not otherwise be available for many years. The first AMC will target pneumococcal disease, bringing potentially life-saving vaccines more quickly to one hundred million children and preventing over five million deaths by 2030.

Speaking at the launch of the AMC, then UK Finance Minister, Gordon Brown, said, “we have come together in a unique and historic global alliance to put innovative finance fully at the service of innovative medicine and to save millions of lives. The advanced market mechanism we launch today means that – instead of high costs, low volume drug production as in the past – we can have high volume, low cost production of drugs in the future and ensure that the many will not be denied the medical advances available to the few.” He added that “we call on other countries to join us to put finance fully at the service of innovative medicine.”

The AMC concept was developed in response to a tragic dilemma, noted Italian Finance Minister Tommaso Padoa-Schioppa, whose ministry led the drive to adopt the AMC pilot. “The AMCs are an absolutely innovative approach which combines market-based financing tools with public intervention. This innovative instrument opens a new frontier in the financing of the fight against poverty and endemic diseases.” He went on to add that “international projects such as this one will make it possible to save millions of human lives and demonstrate that development can and must go together with the need to ensure equality and guarantees of a better future for the poorest and the weakest.”

The AMC for pneumococcal disease will provide \$1.5 billion in future financial commitments to the poorest countries, giving them the purchasing power to buy a suitable vaccine at discounted prices when one becomes available. By creating a market for vaccines in the poorest countries, the AMC creates incentives for the pharmaceutical companies to invest in research,

development and production capacity for new vaccines that serve the poor. Commitments to the pneumococcal AMC have so far been made by Italy \$635m, UK \$485m, Canada \$200m, Russia \$80m, Norway \$50m and the Gates Foundation \$50 m.

Julian Lob-Levyt, executive secretary of the Global Alliance for Vaccines and Immunisations (GAVI), said new pneumococcal vaccines would reach developing countries by 2010 thanks to the project, at least ten years earlier than they would have done otherwise. However, he added, manufacturers lack the capacity to provide a vaccine well-suited to the developing world on a large scale, and extended protection vaccines are needed to bring pneumococcal disease under control in developing countries. The then World Bank President, Wolfowitz, also noted that “on average vaccines take fifteen to twenty years to get to the poor, AMC breaks that vicious circle.”

Her Majesty Queen Rania pointed out that in the poorest regions of the world, two to three million children die of preventable diseases every year. Her Majesty took particular note of the donor nations that are helping to meet the goal of reducing by two-thirds the number of deaths among the world’s most vulnerable children. “You are giving the gift of health, and, more than that, the gift of hope” said the Queen. “Thanks to you, more families will have a fighting chance to see their babies survive, to see their boys and girls grow up, their sons and daughters live productive lives. Thanks to you, entire communities may find the strength to push back against poverty and entire countries may take a step up the ladder of human development.” Pope Benedict has also given his support to the project following a meeting at the Vatican.

An independent expert committee, with representation from developing and industrialised countries, was instrumental in recommending that pneumococcal disease be the target of the initial AMC pilot. Pneumonia is the leading infectious cause of child mortality worldwide, causing an estimated 1.9 million child deaths each year, almost 20% of all child deaths. Pneumococcal disease is also the second leading cause of childhood meningitis deaths. This kills more than 1.6 million people including nearly one million children

under age five every year. HIV/AIDS is increasing the rate of infections, with HIV-infected children twenty to forty times more likely to get pneumococcal diseases.

Going forward, the AMC will be overseen by an independent assessment committee, which will set and monitor standards for the vaccines. The World Health Organization will facilitate the establishment of the target product profile and assess the quality, safety and immunogenicity of AMC vaccines. The GAVI Alliance and the World Bank will be responsible for supporting the programmatic and financial functions of the AMC.

#### **Ulla Schmidt: Good progress on health policy under German Presidency**

The EU Council of Health Ministers met in Brussels on 31 May. German Minister of Health, Mrs Ulla Schmidt, appreciated the agreement reached by the EU Health Ministers concerning the regulation of medicinal products for so-called advanced therapies. Mrs Schmidt said that “the regulation decisively contributes to the competitiveness of the EU in key areas of biotechnology and supports the growth of this upcoming sector of industry. At the same time appropriate attention is paid to ethical issues.”

The revision of the Medical Devices Directives was also completed. Mrs Schmidt emphasised that “the public is right to expect that these products meet the highest safety standards and comply with the relevant standards through out the European Union. This is guaranteed due to the amendments of the Medical Devices Directives.”

After five months of the German Council Presidency, Mrs Schmidt, also reflected more generally on progress achieved so far. “For the German Council Presidency, ‘innovation, prevention and access to health care services’ have been our priorities in health policy. We achieved decisive progress in all of these areas and they are followed up within the scope of the Triple Presidency with Portugal and Slovenia.”

She added that “the permanent and serious threat to public health by HIV/AIDS in Europe is the reason why Health Ministers committed themselves in the Council Conclusions adopted

today to new initiatives to combat HIV/AIDS in the European Union and in the neighbouring countries”. Thus the Council endorsed the results of the ministerial conference held under the German Council Presidency in March, in which Federal Chancellor, Angela Merkel, had also participated. In this context Minister Schmidt confirmed that she had intensive conversations with pharmaceutical industry and the European Commission with the aim of enabling patients to have access to expensive antiretroviral drugs in all European states by an appropriate country-specific pricing.

She also warmly welcomed the conclusions which had been adopted regarding the planned Community framework on health services. During an informal meeting in April, the European Health Ministers expressed their support for a comprehensive legal framework guaranteeing access to health services for all patients throughout the whole European Union. Together with Federal Minister Horst Seehofer, Ulla Schmidt also welcomed the “Council conclusions on health promotion by means of nutrition and physical activity”. They are based on the key results of an expert conference in Badenweiler, which had been jointly organised by the Federal Ministry of Health and the Federal Ministry of Food, Agriculture and Consumer Protection under the German Presidency.

*Further information on health policy under the German Presidency can be found at [www.eu2007-bmg.de](http://www.eu2007-bmg.de)*

#### **Commission proposes EU-wide efforts to tackle the obesity epidemic**

On 30 May, the European Commission adopted a White Paper setting out a wide range of proposals on how the EU can tackle nutrition, overweight and obesity related health issues.

The prevalence of obesity has more than trebled in many European countries since the 1980s, according to the World Health Organization. In the majority of Member States more than 50% of the adult population is overweight or obese. Child obesity is of particular concern. An estimated three million European school children are now obese, and some 85,000 more children become obese each year. Young people tend to retain excess weight throughout their adult lives and are more likely to become obese.

The White Paper stresses the importance of enabling consumers to make informed choices, ensuring that healthy options are available, and calls upon the food industry to work on reformulating recipes, in particular to reduce levels of salt and fats. Stressing the benefit of physical activity and encouraging Europeans to exercise more is another area to develop.

The need for EU action in the area of nutrition and physical activity stems from the fact that poor diets and low levels of physical activity in Europe account for six of the seven leading risk factors for ill health in Europe.

#### *Stronger partnerships*

The White Paper calls for more action orientated partnerships across the EU involving inter alia private actors and public health and consumer organisations. This builds on existing mechanisms such as the EU Platform for Action on Diet, Physical Activity and Health and calls on the range of stakeholders across the EU to work together to establish fora at national and local level within Member States. It aims to strengthen links with Member States, the World Health Organization and other important stakeholders. To ensure high level political support, and cross sectoral cooperation within Member States, the White Paper proposes the creation of a new High Level Group focused on nutrition, overweight and obesity related health issues, comprising a representative from every Member State.

The Commission also calls for stronger action on the part of private actors across the EU in a number of areas. These include the development of stronger advertising codes, greater efforts by the food and retailing industry, and initiatives by sporting bodies to develop advertising and marketing campaigns to encourage physical activity and focusing on target groups such as children

#### *Commission action*

The White Paper clarifies the range of Commission policies that can be marshalled towards these objectives, such as health and food safety policies, regional policy in the form of structural funds, transport and urban policies, sport policy and research programmes. Areas where the Commission proposes new actions include a revision of

nutrition labelling, programmes to promote the consumption of fruit and vegetables, a White Paper on Sport and a study to explore the potential of food reformulation to improved diet.

The Commission will monitor the progress and performance of all actors with a first report due in 2010 and will collaborate with the World Health Organization to improve surveillance of nutrition and physical activity actions and health status in the EU.

#### *Reaction*

There has been a mixed reaction to the White Paper. Director of the European Consumers' Organisation (BEUC) Jim Murray, stated that it contained a "disappointing, unambitious and minimalist response to the problems of obesity and diet related diseases." He went on to say that "reading the White Paper it seems that Mr Kyprianou and the Barroso Commission have already decided to leave much of the work to their successors – who will no doubt themselves wish to 'review the situation' before deciding what to do," urging the Commission to do "much more before they go" and to at least bring forward a "robust proposal for simplified nutritional labelling". In contrast both the Confederation of the Food and Drink Industries of the EU (CIAA) and the Association of the Chocolate, Biscuit and Confectionery Industries (CAOBISCO) welcomed the Commission's strategy.

The trade association of Television and Radio advertising sales across Europe, egta, also welcomed the White Paper. Michel Grégoire, Secretary General of egta stated that "the European Commission offers a comprehensive and balanced approach to the fight against obesity in this Strategy. The marketing of food products is part of the political debate but the Commission acknowledges that it must be treated in a proportionate way". He went on adding "with the European Commission's support of self-regulation, all stakeholders within the advertising industry must now amplify their efforts to make sure that self-regulation is really made effective across Europe; that it properly addresses the issue of healthy lifestyles and, not least, that it deals with new marketing communications and not only the already-regulated television and radio advertising."

*The White Paper on Nutrition and Physical Activity can be found at: [http://ec.europa.eu/dgs/health\\_consumer/index\\_en.htm](http://ec.europa.eu/dgs/health_consumer/index_en.htm)*

#### **Renewed commitment for cooperation on cross-border electronic health services**

On 19 April, at the 2007 eHealth Conference, representatives of European Union Member States and Members of the European Economic Area adopted a common Declaration. They agreed to pursue close interaction and collaboration in the area of cross-border electronic health services throughout Europe.

This conference had *From Strategies to Applications* as its guiding theme, focusing on the implementation of electronic health-service applications and infrastructures such as electronic prescriptions, electronic patient files and other services made possible with an electronic health card.

Dr Klaus Theo Schröder, State Secretary at the German Federal Ministry of Health declared, "by adopting today's Declaration, we seek to ensure that, in the future, electronic health services for Europe's citizens do not stop at national borders. We want to give patients access to their medication records and patient summaries from everywhere within the European Union. This not only serves the continuity of care but also affords safety in an emergency."

The declaration included an understanding that national well-organised eHealth infrastructures are a prerequisite to cross-border solutions, but that European standardisation will open up market opportunities. Implementation of eHealth services will however require greater synergies between research and education, and agreement on common standards by all EU Member States is essential. The Declaration identifies the next steps required for European cooperation, in the shape of large scale pilots to test the application of improved patient summaries in different health contexts such as medical emergencies or prescription dispensing.

Frans de Bruijne, Director, European Commission, Directorate-General Information Society and Media, remarked that "the 2007 eHealth Conference has deepened the cooperation among the Member States and all stakeholders. The

Commission welcomes the Declaration on European cooperation in the field of Europe-wide electronic health services. The European Commission is supporting the first steps towards their concrete implementation by means of Large Scale Pilots.”

Dorjan Marušič, State Secretary at the Ministry of Health of the Republic of Slovenia added, “we now have the opportunity to further the main theme of the German EU Presidency *Europe – succeeding together* and make it tangible on the ground in our citizens’ everyday life. We intend to continue the initiative of Germany’s Council Presidency. Our national activities provide a sound basis for achieving this aim.”

*The full declaration can be accessed at [http://ec.europa.eu/information\\_society/activities/health/docs/events/ehealth2007/eh\\_declaration20070417](http://ec.europa.eu/information_society/activities/health/docs/events/ehealth2007/eh_declaration20070417)*

### **Commission proposes actions to increase organ donations and transplants**

On 30 May, the European Commission adopted a Communication proposing actions for closer cooperation between Member States in the field of organ donation and transplantation, and announcing plans for a European Directive on the quality and safety of organ donation. The Communication includes ideas to raise public awareness so as to increase organ donation, such as the creation of a European organ donor card.

Every day ten people die in Europe while waiting for an organ. The mortality rate of patients waiting for a heart, liver or lung transplant is between 15% and 30%. Currently, there are around 40,000 patients in Europe on waiting lists. Across Europe, there are huge disparities in the number of organ donors, ranging from 34.6 donors per million people in Spain to 13.8 in the UK, 6 in Greece and 0.5 in Romania.

A new Eurobarometer survey shows that while 81% of European citizens support the use of an organ donor card, only 12% of Europeans currently have one. The shortage of legally-donated organs can, unfortunately, encourage illegal trafficking in human organs, which creates both serious ethical problems and health dangers.

The Communication sets out ideas to increase organ availability, such as

creating organ transplant coordinators in hospitals and expanding the use of living donors. The Commission will also promote the exchange of best practices between Member States to make organ transplant systems more efficient and accessible. EU Health Commissioner Markos Kyprianou said that “thousands of lives are saved every year in Europe by organ transplants. Yet many more lives could be saved if we could reduce the current shortage of organs in many European countries. A European organ donor card, and common EU standards on the quality and safety of organ donations and transplants, could add value to national efforts to secure a sufficient and safe supply of organs.”

#### *Increasing organ availability*

Public awareness and opinion has an important role to play in increasing organ donation. In 2006, 56% of Europeans declared themselves ready to donate their organs after death, but this readiness varies considerably from country to country. The Communication argues that creating a European organ donor card which indicates the willingness of the holder to donate organs will contribute to increasing public awareness. The Commission will promote cooperation between Member States to increase public awareness, and the creation of such a donor card, or its incorporation into the existing European health insurance card, should be considered in this context.

In order to increase organ donation, learning from the best models using living donors or the so called expanded donors (donors that can be used only for specific recipients) will be promoted. Cooperation between countries will be the best way of defining practice guidelines for those cases.

#### **Directive on quality and safety**

Every year, a number of organs are exchanged between hospitals in different EU Member States, carried out by hospitals or professionals falling under different national requirements with regard to safety and quality. These quality and safety measures currently vary widely.

A European Directive on quality and safety of organ donation, based on Article 152 of the EC Treaty, would create common standards for quality and safety at every stage of the transplant

process across the Community, without affecting organ donation rates in the EU.

The Directive, expected to be proposed in 2008, would establish oversight authorities in Member States, a common set of quality and safety standards, and a system to ensure the traceability and reporting of serious adverse events and reactions. It would also establish inspection and control measures, and incorporate a mechanism to characterise organs, so that the transplant teams can undertake the appropriate risk assessment.

*The Communication on organ donation and transplantation can be found at: [http://ec.europa.eu/health/ph\\_threats/human\\_substance/oc\\_organ/oc\\_organ\\_en.htm](http://ec.europa.eu/health/ph_threats/human_substance/oc_organ/oc_organ_en.htm)*

*The Eurobarometer survey on attitudes towards organ donation is available at [http://europa.eu.int/comm/health/ph\\_publication/eurobarometers\\_en.htm](http://europa.eu.int/comm/health/ph_publication/eurobarometers_en.htm)*

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## **NEWS FROM THE ECJ**

### **ECJ rules against a priori exclusion of reimbursement of treatment received abroad**

On 19 April, in case C444/05, Aikaterini Stamatelaki versus NPDD Organismos Asfaliseos Eleftheron Epangelmaton (OAE – Insurance Institution for the Liberal Professions), the European Court of Justice ruled that excluding a priori reimbursement of treatments abroad is contrary to Community law.

The case concerned Dimitrios Stamatelakis, a Greek national, who had paid £13,600 to obtain health care from a private hospital in London between May and June 1998. The OAE refused to reimburse him, as under Greek law reimbursement of treatment in private hospitals abroad is not permitted for those over fourteen years of age. Mr Stamatelakis’ widow argued that this law was not consistent with the principle of freedom of services within the EU (article 49 of the EU Treaty).

The ECJ, in its judgement, stated that Article 49 was applicable to Mr Stamatelakis, regardless of whether the treatment received was provided in the public or private sectors. Referring to previous judgements (Case C-157/99 Smits and Peerbooms [2001] and Watts,

(Case C-372/04 Watts [2006]), the Court noted that national legislation must comply with Community law, in particular the provisions on the freedom to provide services. Those provisions prohibit the Member States from introducing or maintaining unjustified restrictions on the exercise of that freedom in the health care sector.

The ECJ argued that the Greek legislation was not proportionate, as less restrictive protections against any threat of seriously undermining the financial balance of the Greek social security system, such as a prior authorisation scheme could have been put in place.

The Court also dismissed the Greek government's argument relating to the fact that Greek social security institutions do not check the quality of treatment provided in private hospitals in another Member State, and to the lack of verification as to whether hospitals with which an agreement has been entered into are able to provide appropriate, identical or equivalent, medical treatment. Private hospitals in all Member States, the Court deemed, are subject to quality controls. Doctors who operate in those establishments provide professional guarantees equivalent to those of doctors established in Greece, in particular since the adoption and implementation of Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.

*More information at*

<http://curia.europa.eu/en/actu/communiqués/cp07/aff/cp070031en.pdf>

### **ECJ rules against Swedish alcohol restrictions**

Under Swedish law beverages that contain more than 3.5% volume of alcohol can only be bought in Systembolaget, a government owned retail monopoly. Only Systembolaget and wholesalers authorised by the State may import alcoholic beverages. Private individuals are prohibited from importing alcoholic beverages. That prohibition means that an individual wishing to import alcohol from other Member States must do so exclusively through Systembolaget. Systembolaget is required to obtain any alcoholic beverage on request at the consumer's expense, provided that it sees no

objection to doing so.

Klas Rosengren and several other Swedish nationals ordered, via a Danish website, a number of cases of Spanish wine. The wine was imported into Sweden, without being declared to customs, by a private transporter. The wine was then confiscated by the customs authorities at Göteborg. Criminal proceedings were brought against Mr Rosengren and other individuals for unlawful importation of alcoholic beverages.

The Högsta Domstolen (Swedish Supreme Court), dealing with the case at final instance, asked the Court of Justice of the European Communities whether the provisions of the Swedish legislation are compatible with Community law, in particular with the principle of free movement of goods guaranteed by the Treaty.

In a preliminary ruling, on 6 June, the Court stated that the rules at issue must be assessed in the light of the Community provisions relating to the free movement of goods and not in the light of the specific provisions relating to State monopolies; the latter apply only to rules relating to the existence or operation of monopolies. The importation of alcoholic beverages is not the specific function assigned to the monopoly by the law on alcohol, which rather confers on the monopoly the exclusive right to retail sales of alcoholic beverages in Sweden.

Accordingly, the Court took the view that the fact that Systembolaget may refuse an order from a consumer to import alcoholic beverages amounts to a quantitative restriction on imports. Furthermore, the Court noted that consumers, when making use of the services of Systembolaget to secure the importation of alcoholic beverages, find that they face a variety of inconveniences with which they would not be faced if they imported the beverages themselves. These include additional administrative costs and a profit margin which might be avoided if the individual imported those goods himself. This also in the Court's view amounts to a quantitative restriction on the free movement of goods.

The Swedish government argued that this restriction was justified on the grounds of public health. In its ruling, the Court recognised that measures

which amount to quantitative restrictions on imports can be justified on the grounds of protection of the health and life of humans. Rules which seek to prevent the harmful effects of alcohol and to combat alcohol abuse may therefore be justified in that regard. These rules however must be proportionate.

Even though it is indeed possible for Systembolaget to refuse an order, it was not apparent from the information available to the Court that Systembolaget has, in practice, refused an order by reference to maximum quantities of alcohol. In those circumstances, the prohibition of importation is less a method of limiting alcohol consumption generally, than a means of favouring Systembolaget as a channel for the distribution of alcoholic beverages. Thus, the prohibition of importation must be considered unsuitable for attaining the objective of protecting the health and life of individuals.

With regard to the claim that the prohibition is justified on the ground that it achieves the objective of protecting young persons from the harmful effects of alcohol, the Court notes that the prohibition applies to all persons, irrespective of age. Accordingly, it manifestly goes beyond what is necessary with regard to the objective pursued of protecting young people from the harmful effects of alcohol.

Finally, taking into account the methods of distribution of the goods and the checks on the age of purchasers, the Court took the view that, in all the circumstances, an effective check on the age of people to whom alcoholic beverages are supplied is not fully guaranteed. Furthermore, it is not established that age checks could not be carried out using methods which are at least equally effective and less restrictive. For example, the Commission submitted, without being contradicted, that a declaration system by which the recipient certifies, on a form accompanying the goods, that he is over 20 years of age would achieve the same objective. Thus, the prohibition is not proportionate for achieving the objective of protecting young persons against the harmful effects of alcohol.

In those circumstances, the Court ruled that the prohibition of importation of alcoholic beverages cannot be justified



on grounds of protection of the life and health of humans.

The issue will now return to the Swedish Supreme Court for further consideration. Commenting on the judgement Public Health Minister, Maria Larsson told the press that “Sweden’s alcohol policies stay firm, with our goals to reach decreased alcohol consumption.”

According to the English language Swedish on-line newspaper *The Local*, Public Health Minister, Maria Larsson, said a ruling by the EU court in November stating that goods imported to Sweden are to be taxed according to Swedish regulations was of greater importance in maintaining the country’s restrictive alcohol policy. “As taxes are just as high when making purchases over the internet the interest (in importing privately) will be moderate,” Larsson said. Swedish Customs were reported to have temporarily stopped confiscating alcohol imported via the internet, according to Lennart Nilsson, the head of the customs agency’s crime unit speaking to Swedish radio. The Swedish Tax Board’s position remains that customs have the right to confiscate alcohol purchased on line.

*More information on the ECJ judgement is available at*

<http://curia.europa.eu/en/actu/communiqués/cp07/aff/cp070038en.pdf>

### **Advocate General Opinion on German advertising rules**

On 13 February, in case C374/05, Gintec International Import-Export GmbH v Verband Sozialer Wettbewerb e.V., the Advocate General of the European Court of Justice gave an opinion on the consistency of the German Act of Advertising within the area of health care with that of EC Directive 2001/83 (Medicinal Products Directive).

Directive 2001/83 prohibits the advertising of unauthorised medicinal products. The advertising of prescription-only medicines is permitted when directed to professionals. Medicinal products which are intended to be used without a prescription may be advertised, subject to various conditions. These include the prohibition of the direct distribution of medicines for promotional purposes. They also stipulate that advertising should not refer to improper, alarming or misleading terms, to claims of recovery of health status.

The specifics of the case concerned a German company, Gintec International Import-Export, that marketed several medicinal products containing ginseng. In May 2005, it undertook a mailing campaign including promotional material containing positive results from a public opinion poll regarding its products. Moreover, the company on its web page also offered readers the opportunity to win boxes of Gintec products in monthly draws.

The German Association for the Prevention of Unfair Competition (Verband Sozialer Wettbewerb) embarked on a course of legal action against the company. They claimed that this advertising campaign violated sections of the German Act on Advertising within the area of health care. Under this law, the use of testimony from third parties or prize draws are prohibited from advertising campaigns.

As these rules are more restrictive than those of the EU Directive, on 12 October 2005, the Bundesgerichtshof (German Federal Court of Justice) sought a preliminary ruling from the European Court of Justice as to whether the standards set under EC Directive 2001/83 should prevent a Member State from adopting stricter legislation. If the answer to this question was yes, the Bundesgerichtshof wanted the Court to consider two further questions. First, whether public opinion polls on medicinal products should be banned as abusive “patient claims of recovery”; and secondly whether the placing of such prize draws on the internet is prohibited by EC Directive 2001/83.

The Advocate General gave the Opinion that the Medicinal Products Directive does indeed set a maximum standard, and thus no Member State is allowed to make any additional prohibitions or restrictions. Directive 2001/83 is intended to safeguard public health by means which will not interfere with free trade to harmonise national laws. These goals would not be met if discrepancies between the laws of Member States were allowed. Thus national laws, such as those that impose a general prohibition on adverts containing third party statements or prize draws, are inconsistent with the provisions of the Directive.

Second, the advertising of medicinal products by the use of generally positive public opinion polls findings, without

indicating precisely the medicinal products’ therapeutic properties, does not operate as improper, alarming or misleading claims of recovery in terms of Article 90. Thus, such advertising should not be prohibited.

However, an internet advertisement by means of a monthly draw where the prize is the advertised product itself, violates Article 87 paragraph 3 of the Directive because it encourages the public to use the medicine in an unreasonable way. Moreover, such advertising is prohibited under Article 88 paragraph 6, because it qualifies as a direct promotional distribution of a medicinal product to the public.

*The Opinion can be accessed in several languages via <http://curia.europa.eu>*

## **COUNTRY NEWS**

### **Russia: Putin cites progress on health in annual address to Federal Assembly**

On 26 April, President Vladimir Putin made his annual address to the Federal Assembly in Moscow. In his address, President Putin gave an assessment of the situation in the country and set out policy priorities for the economy, social sphere, science, defence and security, and for domestic and foreign policy. In reference to health, he spoke of achievements made so far in the priority national health project established in 2005 stating that “it had brought results in the form of victories, small victories, yes, but victories nonetheless, represented by the lives of thousands of our fellow citizens. The reduction in the death rate and rise in the birth rate that we achieved in 2006 and that has continued in the first months of this year are clear evidence that we are working in the right direction.”

He also pointed to investment in providing health care establishments with state-of-the-art equipment, and providing financial support to universities using new teaching methods and concepts. He went on to declare his support for 2008 to be the *Year of the Family in Russia* saying that he hoped that “this decision will consolidate the efforts of the state and the business community to help strengthen and support the institution of the family and basic family values.”

*The full text of the President's speech is available at*

[http://www.kremlin.ru/eng/speeches/2007/04/26/1209\\_type70029\\_125494.shtml](http://www.kremlin.ru/eng/speeches/2007/04/26/1209_type70029_125494.shtml)

### **Moldova: World Bank Health Services and Social Assistance Project**

In Washington, on 7 June 2007, the World Bank approved a US\$17 million interest free loan for a Health Services and Social Assistance Project for Moldova. The project will assist the government in reducing premature mortality and disability, and in improving the targeting of social transfers and services to the poor.

Moldova has made notable progress in reforming its health sector, including the introduction of mandatory health insurance and the consolidation of the health infrastructure, while extending the primary care network and decentralising its management to local governments. However, important challenges remain and the authorities need to further the reform process if the country's health and social assistance systems are to offer effective and sustainable care, particularly to the country's poor.

Health sector reforms undertaken in recent years by the government risk being undermined as the population continues to face low average life expectancy, high mortality rates, and the re-emergence of tuberculosis and other illnesses. Access to quality health care services remains skewed in favour of the largely better-off urban population. The country still lacks universal health insurance coverage, and informal payments to obtain medical treatment are commonplace. In addition, poor conditions in many hospitals and polyclinics, and the widespread lack of nurses and doctors lead to inadequate health care.

In the area of social protection, the Government has established a National Social Insurance House to improve the administration of pension and social insurance, and to eliminate arrears in the payment of pensions. However, Moldova currently has fifteen social assistance benefits with a range of eligibility criteria and processing procedures, which are not applied using poverty-related instruments. This fragmentation of social assistance transfers limits their ability to reach the poor and much of social assistance ends up benefiting the

middle and upper-income groups.

Rekha Menon, World Bank Task Team Leader for the project, said that it "builds on the ongoing reform process outlined in the government's Medium Term Expenditure Framework and will be implemented in close coordination with other donors. It aims at addressing the most prevalent health concerns, including reducing the high rates of premature mortality, modernising the hospital sector, and improved targeting of social services for Moldova's poorest people."

The project has three main components. The first component, Health System Modernisation, builds on on-going reforms in the health sector that form part of the National Health Strategy 2007–2017. The second component, Social Assistance and Welfare, supports government plans to improve the effectiveness of cash benefits and social welfare services in combating poverty. The third component, institutional support, relates to the provision of institutional support for the implementation of the reform strategies.

The project is an integral part of a larger and longer-term programme of the government to improve the efficiency and effectiveness of social spending in Moldova. It is jointly supported by other donors, including the European Union, the Swedish International Development Cooperation Agency, the United Kingdom's Department for International Development, the Council of Europe Development Bank, and relevant UN agencies. The project will be run over a four-year period, from September 2007 to February 2011, and will be implemented by the Ministry of Health as well as that of Social Protection, Family and Child.

*More information on the World Bank's work in Moldova is available at* <http://www.worldbank.org.md>

### **UK: Branded medicines regulations enter into force**

New legislation requiring pharmaceutical companies to provide the UK Department of Health (DoH) with information on income from the sales of each branded medicine supplied to the NHS, has taken effect.

On 25 May, the Health Service Medicines (Information Relating to Sales of Branded Medicines Etc.) Regulations

2007 came into force in the UK. They place additional requirements upon members of the voluntary Pharmaceutical Price Regulation Scheme (PPRS), which was negotiated by the DoH and the Association of the British Pharmaceutical Industry to control NHS expenditure on branded medicines. Under the Regulations, PPRS members must now supply information on the sales of each pack size and strength of branded medicines to the DoH on a quarterly basis, in order that the data be analysed for the NHS.

The PPRS regulates the prices of branded prescription medicines and the profits that manufacturers are allowed to make on the sales of these medicines to the NHS, and covers approximately £8 billion of the value of medicines used in the NHS in both primary and secondary care. A new five year scheme started on 1 January 2005, providing for a 7% reduction in price for branded prescription medicines to the NHS, which is thought to be saving the NHS an estimated £1.8 billion over the five years. The new Regulations, by requiring PPRS members to give information on the discounts they give for branded medicines, will make it possible for the DoH to assess whether it is in the NHS's best interests to continue the 7% reduction. This is particularly important in light of revisions by several large pharmaceutical companies to distribution arrangements for their branded medicines, changes which could potentially affect the NHS's discount savings.

*The Statutory Instrument can be viewed at* <http://www.opsi.gov.uk/si/si2007/20071320.htm>

### **England: vote of confidence by patients in care provided by NHS hospitals**

Patients have given a vote of confidence to the overall care provided by NHS hospitals with nine out of ten people surveyed by the Healthcare Commission rating it as "excellent", "very good" or "good". The Commission is the health watchdog in England. It keeps check on health services to ensure that they are meeting standards in a range of areas. The Commission also promotes improvements in the quality of health care and public health in England through independent, authoritative, patient-centred assessments of those who provide services.

The findings are from the Commission's

inpatient survey, the biggest test of the experiences of patients in NHS hospitals in England. In autumn 2006, 80,000 patients at 167 acute and specialist trusts responded to the survey, coordinated on behalf of the Commission by the independent Picker Institute.

Just 2% of patients said the overall care they received in hospital was "poor". More patients said they waited six months or less for planned admissions, 84% in this survey compared with 78% in 2005. Compared with the previous inpatient survey, more people also responded positively to questions about cleanliness and efforts to control infection through handwashing.

The results also highlighted considerable variation in the performance of acute trusts on a range of issues relating to dignity in care. Of patients who indicated that they needed help eating, 20% said they did not get enough. There were 30 trusts where one in five, or more, patients rated the food as "poor". But in most other trusts, few patients rated the food as "poor", just 2% in one trust. Looking at planned admissions only and excluding those who stayed in critical care units, 11% of patients nationally said they shared a room or bay with a patient of the opposite sex. Almost one in three said they had to share a bathroom or shower area with members of the opposite sex.

Commenting on the publication of the survey, British Medical Association consultants' committee chairman, Dr Jonathan Fielden, said that "it is gratifying that this survey reflects the immense efforts from doctors to improve the quality and experience of care for their patients despite the financial pressures placed upon the health service."

Anna Walker, Chief Executive of the Healthcare Commission, said "we all hear a lot of negative comment about the NHS, but we must never forget that most patients have consistently rated the overall quality of their care as good or excellent. Staff should remember this as it shows that patients value the good work they do. The results also suggest that we need a fresh drive to tackle a set of issues related to treating patients with dignity. But, where there are problems it seems as if there are a minority of trusts that are letting the rest down."

She also commented that "patients have

the right to expect all hospitals to get the basics right, like offering help with eating and answering calls for assistance. It is also clear that for a significant minority of patients, the NHS is performing below standards on segregated accommodation."

The Commission will feed the results of the inpatient survey into its annual assessment of NHS trusts, which uses information to target inspections and ultimately leads to an annual performance rating.

*Further information on the survey can be found at <http://www.healthcarecommission.org.uk/nationalfindings/surveys/patientsurveys/nhspatientsurvey2006/inpatients.cfm>*

### **Northern Ireland: Survey on satisfaction with health and social care services**

Eight out of ten people in Northern Ireland are happy with the health and social care services they received last year. The latest public attitudes survey was carried out in 2006 and involved interviews with around 1,500 people. Newly appointed Health Minister, Michael McGimpsey, welcomed the generally positive findings but said that the survey also highlights scope for improvement.

He said that the survey "shows that progress has been made and that standards are high across many aspects of health and social care provision in Northern Ireland. Health and social care staff are to be commended for their dedication in achieving these standards, particularly during a time of change and upheaval in the health service." However, he cautioned that "there is still much to be done, both in making further progress in areas showing a high level of satisfaction and in tackling the issues which the public have clearly said are of concern to them"

For the first time, the survey sought public views on tackling health care-associated infections, such as MRSA. Mr McGimpsey said that the "findings highlight the public's concern and a sense that not enough is being done. This is another important area in which progress must be made"

The survey also indicated that the public had been responding to health promotion messages, with 65% indicating some positive changes to their behaviour in the last twelve months,

such as eating more fruit and vegetables, other improvements to diet, taking more exercise, reducing alcohol consumption and stopping smoking. The Minister recognised the importance of the cross-departmental 'Investing for Health' strategy in this achievement, given its emphasis on preventing illness through healthier lifestyles.

*More information at <http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-010607-survey-reveals-high.htm>*

### **Ireland: Health Information & Quality Authority established**

The Health Information and Quality Authority, Ireland's first independent Authority to drive continuous improvements in Ireland's health and social care services was formally established on 15 May.

Speaking on the establishment of the new Authority, Mary Harney, Minister for Health and Children said "this is a major step forward in ensuring safety and standards for patients and a very significant day in the development of the reform programme in the Health Services. I am certain that the work of the Authority will yield real and tangible benefits. It will help to ensure that all persons receiving health services will have them delivered in accordance with the highest quality and safety standards.

The establishment of the Authority will have a positive impact on public confidence generally by enabling people to have confidence in the safety and quality of the health care they and their families receive, including the safety and quality of the residential services being provided to older people, persons with disabilities and children in need of care and protection."

Mr Pat McGrath, Chairman of the Health Information and Quality Authority, said that "Ireland is unique in the world in establishing an independent Authority with the powers to set, monitor and investigate health care standards, to evaluate the effectiveness of the medications and treatments being used and to advise on the collection and sharing of information across the entire health and social care services.

The key drivers of quality are all contained within the functions of the Authority, which reflects the government's ongoing commitment to

continuous improvement in our health system. The Health Information and Quality Authority will be a powerful driver of reliable, safe and quality services. It will take time but all of us in the Authority are determined to play our part in helping Ireland achieve the health and social services it deserves”.

Dr Tracey Cooper, Chief Executive of the new Authority, said that “the Health Information and Quality Authority will support the further development of a culture in our health and social services where learning takes place when things go wrong; where staff are developed, supported and feel comfortable to share concerns; where people using the services are involved in their own care and the planning of their services; where services are quality assured to provide high quality, safe care and where best practice is shared and celebrated.”

As an independent Authority, we are committed to an open and transparent relationship with those working in health and social services and with people using these services so that people can, and will, have confidence in the quality and safety of care being delivered and received. Our independence within the health system will be key as we grow the organisation and begin our work over the coming months”.

The Social Services Inspectorate and the Irish Health Services Accreditation Board have been incorporated into the new Authority. The functions of the Social Services Inspectorate have been expanded to include the inspection of residential homes for older people and people with disabilities. The Health Information and Quality Authority is currently developing the National Standards for Residential Care Settings for Older People.

*More information on HIQA is available at <http://www.hiqa.ie>*

#### **Austria: INCB warning on counterfeit medicines**

On 1 March 2007, the Vienna-based International Narcotics Control Board (INCB) warned that the flood of counterfeit medicines now available in many countries could have fatal consequences for consumers. In its Annual Report, the Board also called on Member States to enforce legislation to ensure that narcotic drugs and psychotropic

substances are not illegally manufactured or diverted from illicit manufacture and distribution channels to unregulated markets.

The danger of unregulated markets is the theme of chapter one of the Annual Report. The Board is calling for it to be addressed on a priority basis. The existence of unregulated markets means that substandard, and sometimes even lethal medication is sold to the unsuspecting consumer. Unregulated markets are often supplied with stolen and diverted drugs, illicitly manufactured pharmaceuticals or through illegal sales on the internet and distributed through the mail and courier services.

Apart from consumers who purchase pharmaceuticals containing controlled substances on the unregulated market because of limited access to health care facilities or lower prices, persons dependent on and abusing such medications make use of unregulated markets to obtain them without prescription. “Besides the fact that the existence of unregulated markets, the sale of diverted and counterfeit drugs and the purchase of drugs containing controlled substances without prescription contravenes international treaties on drug control, it is important for consumers to realise that what they think is a cut-price medication bought on an unregulated market may however have potentially lethal effects whenever the consumed drugs are not the genuine product or are taken without medical advice. Instead of healing, they can take lives,” said Dr Philip O Emafo, President of the INCB.

This danger is real and sizeable. The World Health Organization estimates that 25–50% of medicines consumed in developing countries are believed to be counterfeit. The problem is further compounded by the fact that counterfeit drugs are easy to manufacture – they can resemble genuine drugs in packaging, and labelling. Unknowing clients have experienced serious health or even lethal consequences; for instance, in Africa, the use of counterfeit vaccines in 1995 resulted in 2,500 deaths.

Narcotics, benzodiazepines, amphetamines and other internationally controlled drugs are easily available in street markets in several developing countries. In developed countries, these drugs are sold via illegal internet

pharmacies, without the mandatory prescriptions.

“The problem of counterfeit medication and abuse of pharmaceuticals containing controlled substances bought without prescriptions, has been in existence for some time. However, the rapid expansion of unregulated markets has dramatically worsened the situation,” said Dr Emafo.

The unregulated market broadly covers two scenarios: unlicensed individuals and/or entities conducting illegal trade of pharmaceutical products containing controlled substances – for instance, a street vendor selling a controlled drug, such as a narcotic drug, a stimulant or a sedative in a village fair; and, licensed individuals and/or entities contravening laws to sell controlled drugs, such as a pharmacist who sells controlled drugs without asking for a prescription.

The Board has called on Member States to enforce existing legislation, to impede this menace, and also take appropriate measures to increase the availability of medicinal drugs through legitimate channels, particularly in areas where there is lack of access.

*The report is available at [http://www.incb.org/incb/en/annual\\_report\\_2006.html](http://www.incb.org/incb/en/annual_report_2006.html)*

#### **Netherlands: Cabinet approves compulsory health insurance excess**

On 23 May, the government of the Netherlands announced plans to abolish the no-claims scheme under the Health Insurance Act from 1 January 2008. This will be replaced by a compulsory excess of €150 a year, which will be collected by the health insurer. People with unavoidable long-term health expenses, for example due to chronic illness or disability, will be compensated financially. The Cabinet agreed to Health Minister, Ab Klink’s, proposal to approve the bill.

Like the no-claims bonus, the compulsory excess will only apply to people aged 18 and over, and the same forms of health care will also be excluded. The no-claims scheme will still cover bills for 2007, which means the bonus for 2007 will be paid out in March 2008. Health care insurers will still be entitled to reclaim incorrectly made payments until 1 April 2009. The Cabinet has agreed to pass on the bill to the advisory Council of State. The text

and the Council of State's recommendation will only be made public when they are submitted to the House of Representatives. This is expected to take place in June.

### **Poland: government fails to tighten abortion laws**

On 13 April, Poland's parliament rejected constitutional amendments that would have strengthened the country's anti-abortion laws. Poland's current 1993 abortion law is already one of Europe's strictest, allowing abortions only when the woman's health is threatened by pregnancy, the baby is likely to have severe disabilities, or the pregnancy is the result of rape.

The conservative ruling League of Polish Families and Law and Justice parties proposed these amendments, which would have either banned abortions altogether or made it harder to weaken existing anti-abortion legislation. The amendments failed to achieve the two-thirds majority required by the Polish constitution.

The vote also exposed divisions between the coalition partners, with the League of Polish Families voting for a total ban, while most members of Law and Justice sought just to bolster the existing legislation. The centrist and leftist opposition voted against the proposed changes. Piotr Gadzinowski of the Democratic Left Alliance told Polish television the vote was a "victory of reason over backwardness."

The issue of abortion is highly charged, in this very conservative Catholic country. In March, protesters rallied across Poland in support of a complete ban on abortion. The European Court of Human Rights (ECHR) awarded damages of €25,000 in the same month to a Polish woman who had been refused an abortion despite fears that she might lose her sight as a result of childbirth.

When Alicja Tysiac became pregnant in February 2000, three eye specialists told her having another baby could put her eyesight at serious risk. But neither the specialists nor her GP would authorise an abortion. After giving birth, Ms Tysiac suffered a retinal haemorrhage and now wears glasses with thick powerful lenses and cannot see objects more than a metre and a half away. The ECHR ruling will not however affect the

current abortion laws. Polish women's rights groups estimate there are just 200 legal abortions performed every year.

### **Norway: National strategy to reduce social inequalities in health**

Social inequalities in health are a public health concern and an expression of unacceptable systematic injustices, says Sylvia Brustad, Norwegian Minister of Health and Social Affairs. The Ministry of Health and Care Services has in a report to the Storting (Parliament) made recommendations for a national strategy to reduce social inequalities in health.

The Norwegian population enjoys good health. However, averages conceal major, systematic inequalities. Minister Brustad said that "we have to acknowledge that we live in a stratified society, where the most privileged people, in economic terms, have the best health. These inequalities in health are socially determined, unfair and modifiable. The government has therefore decided to initiate a broad, long-term strategy to reduce social inequalities in health. A fair distribution is good public health policy."

The Norwegian policy will continue to build on the Nordic tradition of general welfare schemes and at the same time implement special measures to help the people with the most problems. In keeping with the identified need for a broad approach, the strategy operates with four priority areas for the next ten years. First, to reduce social inequalities that contribute to inequalities in health and second, those social inequalities in health-related behaviour and use of the health services. Social inclusion will be promoted through targeted initiatives while another objective will be to enhance knowledge and develop cross-sectoral tools.

*The report is available in English at <http://www.regjeringen.no/en/dep/hod/Documents/regpubl/stmeld/2006-2007/Report-No-20-2006-2007-to-the-Storting.html?id=466505&epslanguage=EN-GB>*

### **Hungary's health fund in surplus after reforms**

On 12 April, health officials reported that Hungary's national health insurance fund had a surplus in the first quarter of the year after reforms which curtailed the rise in spending on drug subsidies and health care provision. The insurance

fund recorded a Ft 17 billion (\$93.13 million) surplus in the first three months, said Zoltán Major, general director of the National Health Insurance Fund. "This is negligible compared to the total 1,600 billion forint health budget, but it gives reason for definite optimism," Major told the Hungarian newspaper *Napi Gazdaság*. The number of hospital outpatient visits has dropped by 60% since the 15 February introduction of physician visiting fees and hospital fees, another daily, *Magyar Hirlap*, reported.

Health reform is one of the key planks of the Hungarian government's plans to reduce its budget deficit, which in 2006 hit almost 10% of GDP. Further cost-cutting measures have been announced, with the closure of almost 9,000 of 80,000 hospital beds. Other measures are planned, although some have met with fierce opposition in the Socialist Party, the main partner in the governing coalition.

Health Minister, Lajos Molnár, resigned in early April saying he could not accept any further delay in the decision about transforming the insurance system. Molnár's party, the liberal Alliance of Free Democrats are in favour of a multiple insurer model so as to reduce the costs for the state, but Prime Minister Ferenc Gyurcsány's Socialist Party wants to slow changes, fearing a market-based model would hurt their older, poorer voters.

As Health Minister, Molnár, drastically cut subsidies on medicines, closed hospitals, raised pharmaceutical manufacturers contributions to the health budget and imposed fees for visits to doctors. Commenting on the event, János Kóka, Minister of Economy and Transport, as well as chair of the left-wing SZDSZ party and junior coalition partner entitled to nominate the health minister under the coalition agreement, said that continuation of the health care reform and introduction of a multiple payer insurance regime were his party's prerequisites for remaining within the government coalition. Kóka said Molnár resigned because he felt that professional conflicts had become personal and were slowing the coalition's decision making on the insurance system. He stated that his party would retain the health ministry and would choose a new minister committed to the proposed system.

# News in Brief

## EU signs new treaty on disability rights

On 30 March, in New York, the EU signed up to a new UN treaty on disability rights. The Convention aims to ensure that people with disabilities enjoy human rights and fundamental freedoms on an equal basis with everyone else. It will provide protection for 50 million EU citizens and 650 million people with disabilities worldwide. The Convention will enter into force when ratified by 20 countries.

*More information on the EU's Disability Strategy is available at*

[http://ec.europa.eu/employment\\_social/disability/index\\_en.html](http://ec.europa.eu/employment_social/disability/index_en.html)

## International conference on mental health promotion

The IMHPA (Implementing Mental Health Promotion Action) network, in cooperation with the Catalan Ministry of Health and with the support of the European Commission, is hosting a conference in Barcelona from 13–15 September. This is in support of the forthcoming European Commission Strategy on Mental Health and will also build on mental health promotion and mental disorder prevention components of the WHO Declaration and Action Plan for Mental Health. The conference aims to share examples, barriers and opportunities encountered throughout Europe in implementing prevention and promotion actions for mental health. Outcomes will include a set of recommendations and suggested proposals to support implementation of actions for mental health promotion and mental disorder prevention across Europe.

*Registration details and further information are available at*

[www.imhpa.net/conference](http://www.imhpa.net/conference)

## Report on euthanasia in the Netherlands

According to a new report, published by the Ministry of Health, Welfare and Sport in the Netherlands, there has been a considerable fall in the number of cases of euthanasia between 2001 and 2005. In 2005 there were more than 2,300 cases of euthanasia and 100 cases of assisted suicide, compared with 3,500 and 300

cases respectively in 2001. Doctors are now reporting cases of euthanasia more often, with the proportion of cases reported rising from 54% to 80%. The number of express requests for euthanasia or assisted suicide fell from 9,700 in 2001 to 8,400 in 2005, but the number of cases of palliative sedation rose from 8,500 to 9,600. The increase in the use of palliative sedation probably explains, in part, the decrease in the number of cases of euthanasia and assisted suicide. One recommendation of the report is that better information should be provided on the possibilities and limitations of euthanasia declarations. It appears that there are still misunderstandings about this among both doctors and the general public.

*An English language summary is available at*

[http://www.minvws.nl/images/evaluatie-euthanasiewet-engels\\_tcm20-147320.pdf](http://www.minvws.nl/images/evaluatie-euthanasiewet-engels_tcm20-147320.pdf)

## Disability trends among older populations

A new working paper, written for the Organisation of Economic Cooperation and Development by Gaétan Lafortune, Gaëlle Balestat and Disability Study Expert Group Members, assesses the most recent evidence on trends in disability among the over 65s in twelve OECD countries: Australia, Belgium, Canada, Denmark, Finland, France, Italy, Japan, the Netherlands, Sweden, the United Kingdom and the United States. The focus is on reviewing trends in severe disability (or dependency), defined where possible as one or more limitations in basic activities of daily living.

*The report is available at*

<http://www.oecd.org/dataoecd/13/8/38343783.pdf>

## Comparison of US and international health care systems

A new report, from the New York based, independent foundation, the Commonwealth Fund, reports that despite having the most costly health system in the world, the United States consistently under performs on most dimensions of performance, relative to other countries. This report, an update to

two earlier editions, includes data from surveys of patients, as well as information from primary care physicians about their medical practices and views of their countries' health systems. Compared with five other nations, Australia, Canada, Germany, New Zealand and the United Kingdom, the US health care system ranks last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity, and healthy lives. The US is the only country in the study without universal health insurance coverage, partly accounting for its poor performance on access, equity, and health outcomes. The inclusion of physician survey data also shows the US lagging in adoption of information technology and use of nurses to improve care coordination for the chronically ill.

*The report is available via*

[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=482678](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=482678)

## UK survey on public expectations of long-term care funding

A new survey reveals that there are three times more people who think that individual need should determine how care services are funded than those (23%) who think it should be based on their income or assets, as is currently the case in the UK. The YouGov survey was commissioned by a partnership of fifteen health and care organisations to generate a national debate on the future of long-term care funding. The partnership, called *Caring Choices*, aims to consult older people, carers, professionals, care providers and commissioners of care services on options for reforming the current system of paying for long-term care in old age.

*More information on the survey and the Caring Choices partnership at*

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

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## Health Economics, Policy and Law

International trends highlight the confluence of economics, politics and legal considerations in the health policy process. HEPL serves as a forum for scholarship on health policy issues from these perspectives, and is of use to academics, policy makers and health care managers and professionals.

HEPL is international in scope, and publishes both theoretical and applied work. Considerable emphasis is placed on rigorous conceptual development and analysis, and on the presentation of empirical evidence that is relevant to the policy process.

The most important output of HEPL are original research articles, although readers are also encouraged to propose subjects for editorials, review articles and debate essays.

HEPL invites high quality contributions in health economics, political science and/or law, within its general aims and scope. Articles on social care issues are also considered. The recommended text-length of articles is 6–8,000 words for original research articles, 2,000 words for guest editorials, 5,000 words for review articles, and 3,000 words for debate essays.

Instructions for contributors can be found at [www.cambridge.org/journals/hep/ifc](http://www.cambridge.org/journals/hep/ifc)

All contributions and correspondence should be sent to: Anna Maresso, Managing Editor, LSE Health, London School of Economics and Political Science, Houghton Street, London WC2A 2AE, UK. Email [hepl@lse.ac.uk](mailto:hepl@lse.ac.uk)

### INTERNATIONAL HEALTH CONFERENCE:

## RECENT ADVANCES IN CLINICAL MEDICINE, PUBLIC HEALTH AND HEALTH POLICY

South-eastern European countries, and the European Union as a whole, are presented with a very particular set of challenges in the domain of health care delivery.

This three-day conference will address recent medical advances in areas of high public health significance in South-eastern Europe, and the implications of these in local and Europe-wide health policy development.

Speakers will include international authorities in relevant medical fields, public health and health policy, representatives from the WHO, European Commission, medical press, local governments, medical associations and the global pharmaceutical sector.

This is the first time that a meeting attempts to address this combination of themes, from clinical medicine through public health to health policy, which, though intimately linked, are rarely addressed together in an inter-professional fashion.

The conference will be of interest to a wide audience, from clinicians to public health physicians, health managers, policy researchers, civil servants and politicians.

Further information is available on the website:  
[www.internationalhealth2007.com](http://www.internationalhealth2007.com)

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