

Eurohealth

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Volume 13 Number 4, 2007

Meeting the health care needs of tourists

Health care needs of UK pensioners in Spain

Genomics as a priority for public health

Pay-for-Performance in the US: what lessons for Europe?



Restructuring municipal health services in Finland • Kaiser Permanente revisited – what can Europe learn? Choice and competition • Migration of Polish doctors in the EU • Assessing the performance of health services

COMMENT

Health on the move

At this time of year many of us start planning our summer holidays. But it was not that long ago that the notion of a foreign holiday was a luxury reserved only for the very rich. Only in the post war period did the concept of the low cost package holiday become a reality for many Europeans. Change continues apace. In addition to the annual holiday, we now have the phenomenon of multiple short-breaks planned and arranged independently. Health care systems are not immune from these evolving patterns of tourism and travel. In this issue of *Eurohealth* Simona Bellometti and Luigi Bertinato provide an overview of measures used in the Veneto region of Italy to cope with mass tourism.

Another consequence of the greater exposure of Europeans to international travel, coupled with an increase in disposable income, has been the upturn in the number of individuals choosing to spend their retirement outside of their home countries. Again, this phenomenon can have impacts on both health and social care systems, but as Helena Legido-Quigley and Daniel La Parra illustrate, many UK migrants to Spain do not avail of local health care services and instead rely on private services because of language and cultural difficulties.

This experience is by no means unique. The lack of local social support networks can make older migrants very vulnerable after the onset of debilitating conditions. To adapt, local health care systems require better information on their EU migrant populations; many still do not register with local health care services. Outreach services to make ex-patriots aware of their rights and responsibilities may well be merited.

Elsewhere in this issue, Walter Ricciardi and Stefania Boccia look at the implications of rapid advances in genetic technologies for public health, while a new occasional series of articles looking at what may be gleaned from experience in the United States kicks off with reflections on Kaiser Permanente and the use of performance related payment mechanisms.

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Published by LSE Health and the European Observatory on Health Systems and Policies, with the financial support of Merck & Co and the European Observatory on Health Systems and Policies.

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

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

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

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

Printing: Optichrome Ltd

ISSN 1356-1030

LSE Health

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Tackling assessment of the performance of health services

Walter Holland

Summary: The development of health care services in the UK in the past 150 years is described with reference to assessment of the service. Possible measures of performance such as acceptability, process and outcome are discussed with their advantages and disadvantages. Greater clarity in the development of objectives for services are advocated.

Key words: Performance measures, Acceptability, Process, Outcome, Avoidable mortality.

Life was simpler in the past. Doctors were judged by their manners and bedside behaviour, their willingness to dispense medicines, sign an off-work note and help in certifying that their patients needed better housing. Hospitals were judged by their cleanliness, their willingness to treat, the ability to provide employment, and the comfort of the chairs in the outpatient department.

Before 1948 and the introduction of the NHS, about half the UK hospitals were supported by charity, the rest were either 'Poor Law' or Local Authority Municipal Hospitals with a very small number of private institutions. Doctors were paid by the patient, the National Insurance Fund, or a sick fund associated with work. Many of the services they provided were given as an act of charity. This environment meant that most health (medical) services were considered as charitable and most patients were grateful for what they received.

Hospitals and doctors were judged by "word of mouth" or reputation. The most successful practitioners were those with a "smooth line" and good communication skills – some surgeons were shunned as being "killers", but no one really questioned the treatment they received. Florence Nightingale was considered a

revolutionary in reporting the deplorable conditions in Army hospitals in the Crimean War in the 19th Century, and she was one of the first to advocate the need to measure the performance of health services and their employees. However, real concern about health service performance only surfaced in the UK with the introduction of the NHS in 1948.

The founders of the NHS believed that its introduction would lead to less demand, following an initial surge due to an accumulation of untreated illness. But initial assumptions about future demand were grossly incorrect. Although it was recognised that the demand for and costs of care were rising, the open-ended system of funding and allocating resources meant that the problem was not confronted. Doctors were only concerned with providing what they considered was the best treatment for individual patients, secure in the belief that with advances in medical knowledge and methods of treatment things could only get better. The public assumed that their needs would be met – and the necessary resources found. In the early years of the NHS patients continued to be deferential and grateful for any treatment they received. As a result of the Second World War they accepted rationing and were willing to accept long waiting times before receiving treatment.

These conditions could not last. With the state responsible for funding all health services from tax revenues it became

obvious that some measures would need to be introduced to control expenditure. The pressures on health services were increasing because of the ageing of the population and the increasing availability of effective remedies. In addition, the inequalities in the provision of services in different geographic areas became noticeable. Between 1938 and 1966 no new hospital was built (except the Harvard Hospital on Salisbury Plain, built by the US Army to accommodate its personnel during the war.) With the renewal of hospital building it was rapidly noticeable that most, if not all, new building was in the southern half of England. As health resources were distributed on a historical basis, and before the introduction of the NHS health services were more prolific in the south than north, it was not surprising that this difference existed and had become worse.

These were the main reasons why in 1974, with the reorganisation of the NHS, Health Authorities were enjoined to develop methods of monitoring and assessment of the activities of the NHS. In recent years, with the growth of a 'consumer society', and the perception that many of the component parts of the NHS were not performing adequately, if not poorly, indexes of performance began to be developed. Furthermore with a greater emphasis on 'business practice' it was considered that incentives to 'perform better' both by individuals and institutions should be introduced.

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Monitoring and assessment frameworks

Donabedian,¹⁻³ from Ann Arbor, Michigan, is undoubtedly the progenitor of a framework by which the delivery of health services can be assessed and monitored. He identified three components – structure (or organisation), process and outcome. Doll⁴ recognised three major components for any evaluation – economic efficiency, social acceptability and medical efficacy. Each of these components, on their own, only give a partial view of how successful a service is in providing for the needs of the population it is supposed to serve.

Using Donabedian's classification is not easy. The structure of health services in the UK has one universal characteristic, individuals, except in emergencies, access the health service via a primary care provider who may, or may not, facilitate referral to secondary care (hospital) or secondary (specialist) diagnosis. Entry to the tertiary or rehabilitative services may be either from primary care or secondary care, i.e. there is a hierarchy of provision. This form of organisation is partly determined by historical reasons. In the 19th century secondary (hospital) care was largely provided by charitable institutions. When the latter started out-patient departments they were clearly in direct competition with general practitioners who depended on fees from patients. To avoid this conflict between medical practitioners a concordat was agreed that care/diagnosis in a secondary institution could only be provided after referral from primary care.

This hierarchical pattern is not often present in other countries, for example, the USA or Germany, where individuals may approach a specialist direct, depending on whether they consider they need immediate specialist help or feel that they have 'local' symptoms, for example, cardiac, and therefore immediately wish for the help of a cardiologist. There are no good studies to determine whether the first or second delivers a better form of care. Most observers consider that the hierarchical, general practitioner (GP) type of care is better. The GP, as gatekeeper, may be both a better judge of medical needs and may prevent the overuse of expensive diagnostic or treatment services, which in themselves, may be dangerous.⁵

The actual configuration of health services, whether hospital or general practice, are largely determined by political views, and rarely, if ever, evaluated. Thus the ethos of continuity of care by a general practitioner for a defined population group in the UK

is now being challenged with the development of 'walk-in surgeries' in supermarkets or railway stations. There is, as yet, no evidence of the advantages of one structure compared to another.

Formal methods of assessment

The assessment of performance by process measures is amenable to more formal methods of assessment:

Acceptability

Measurement of satisfaction with any particular service may be made by the use of questionnaires to assess satisfaction. Many examples of these, both short and long, have been used in the UK and USA for many years. It is important, if they are used in a hospital, to look at specific issues, for example, catering, cleanliness, attitude and behaviour of staff.⁶ GPs are now also being encouraged to measure satisfaction in their service provision. One measure of satisfaction, not often used routinely, is the collection of data on complaints, both those upheld as well as those rejected. Referral to an ombudsman (independent arbiter), legal procedures and convictions can also be used to highlight problems.

The limitation of using all of these forms of assessment is that they are restricted only to service users, and will not capture the views of the general population. These need to be sought by use of population questionnaires, for example, the General Household Survey.

Process

The commonest measure used to assess performance is by evaluation of the processes used in care. Thus it is considered important that certain investigations are done when a patient consults – and the measure of performance is whether these have been carried out. For example, it is considered that blood pressure is measured at regular intervals in adults by a GP in order to detect whether the level is normal or high. Measures of clinical activity are measured and rewarded by the 'Quality and Outcomes Framework' which has been introduced for the payment of general practitioners.

All the measures used are evidence-based. But it must be remembered that almost all interventions cause some harm, "even when effective treatments are applied to a series of patients in clinical practice some will be harmed (although more will benefit)."⁷ The authors of the latter have recently published a critical article which

summarises the problems in using process measures to assess performance. Their article emphasises that clinical care is not a mechanical process but needs to be tailored to individual patient needs, for example, age.

Thus, although measures of process are easy to collect – and there is usually consensus about what diagnostic or treatment procedures should be used for a given diagnosis, they may easily miss important factors which influence outcome. Also, of course, use of process measurements may imply that as long as the appropriate processes are used care must be adequate – but this completely neglects the appropriate requirements of action to react to the findings. Most measures of quality of care are, in practice, based on process measures – these are easy to measure. But it is increasingly becoming recognised that these process measures are not adequate for the assessment of performance.

Outcome

To monitor the effectiveness of a service, it must have a defined objective against which to measure the outcome of care. Of course, health services are meant to improve the current and future health of the population. But, the difficulty is that health services are complex and many environmental, social and other factors influence the outcome of all health care interventions.

The easiest, and routinely available, measure is mortality, before and after, or over time. But overall mortality is not very informative. However, mortality rates from specific conditions by age and/or sex have been, and are, used as indicators of particular services.

Rates for maternal, perinatal and neonatal mortality are accepted as indicators of the outcome of maternal services and have been used for many years. Confidential enquiries of the care and processes used in cases of maternal death have been used in the UK, under the auspices of the Royal College of Obstetricians, since the 1930s. They have had a major impact on maternity care, whereas at the start there were several thousand deaths there are now less than one hundred in any one year. The success has largely been due to the investigation of each death by a respected obstetrician with sympathetic, careful feedback to the clinicians responsible for the care of the mother who had died.

Table: Illustrative examples of potential outcome indicators for selected services

Service focus	Objectives	Indicator
Learning difficulties	Prevention: to prevent cases of Down's syndrome babies in mothers aged 38 or more years by referral to a specialist centre	Number and proportion of referrals and terminations carried out following amniocentesis in women over 38 years
	Good Practice: to encourage those with learning difficulties to reside outside of large institutions and live independently	Number of children by medical diagnosis/disability who live at home, in foster homes, hostels etc. Number of adults who are employed
Young people with disabilities	Prevention: to reduce the number of head injuries	Number and rate of deaths and discharges of head injuries for those aged 15–16, by sex
	Prevention: to reduce cases of paraplegia	Number and rates of death and discharges for cases of paraplegia in those aged 15–34, by sex
Older people	Prevention: to reduce loss of function	Number and rates for total hip replacement
		Number and rates of cataract removed

This method can also be applied to other causes of death. Rutstein et al,^{8,9} Charlton et al,¹⁰ Holland and Breeze,⁶ Holland et al,¹¹ and Nolte and McKee¹² have drawn up sets of conditions where mortality is avoidable. These conditions may illuminate certain curative services and identify defects. The method may also be used to assess the performance of surgical services: in the UK there are routine analyses, under the auspices of the Royal College of Surgeons, of operative deaths.

Holland et al¹¹ Nolte and McKee¹² and Jozan et al,¹³ have used the measure of 'avoidable deaths' to monitor the quality of services based on routinely collected statistics in a variety of European countries, both at one point and over a period of time. Age standardised mortality ratios (SMR) were calculated for age ranges in which medical care was most likely to be effective. A high SMR for any of these indicators is intended to serve as a warning for potential shortcomings in the health care services and a starting point for initiating detailed enquiry at a local level to determine the reason behind the apparent excess mortality. For example, hypertension death rates in those aged 5–64 are affected by primary care and hospital services; case detection and anti-hypertensive medication affect mortality. Deaths from abdominal hernia and appendicitis are affected by both primary care and

hospital services; again case-detection and surgery prior to complication influence mortality.

While careful examination of mortality from specific causes can provide information on the outcome and effectiveness of health services, mortality is not always an appropriate indicator. Deaths from 'avoidable causes' are rare, so deficiencies in services can often not be identified. Moreover mortality may not be an adequate indicator for the performance of a health care service, for example, for the elderly, where most of the focus is not on preventing death but on relieving pain and improving the quality of life.

The real difficulty in identifying outcome indicators is the lack of clarity as to the objectives of a particular service. The objective for maternity care is easy: to prevent maternal death and ensure the birth of a healthy baby, and can be measured easily. The objective of some acute services, for example, surgical services for acute appendicitis and for hernias are similarly easy to define and measure, but for many others services, for example, psychiatric or for the elderly, the objectives are much harder to define – particularly in such a way that routine data collection for assessment of performance can be done.

Thus the challenge for those responsible

for health care delivery is to define precise, measurable objectives and to develop methods of data collection to assess performance. Some illustrative examples of possible outcome indicators for some services are outlined in the Table.

It must be emphasised that these are only possible illustrative examples but nonetheless they demonstrate the need for the development of imaginative thinking.

Conclusion

It should be evident from this discussion that there is no easy method to measure health service performance. The major obstacles are the availability and accuracy of information, the lack of clear definition of objectives for many of the complex services that need to be provided and, of course, the willingness of those delivering the services to be subject to scrutiny. With the increasing availability of computerised records at least the availability of data has been tackled. But the problems of accuracy and identification of objectives are still present.

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Assessment of genomics as a priority for public health

Walter Ricciardi and Stefania Boccia

Summary: Advances in genetic technology are increasing the availability of genetic tests for common complex diseases and the evaluation of drug responses. Ensuring the appropriate use of these tests is an important challenge for health policy makers at this time. This requires that systematic, evidence-based technology assessments and economic evaluations are used to guide their incorporation into clinical practice and prevention. The next decade will provide the opportunity to establish infrastructures and educate health providers to enable genome-based technologies to be translated into evidence-based guidelines and policies.

Keywords: Genomics, Public health, Health technology assessment

The past decade has been an important time for human genetics, and many have asserted that the wealth of knowledge offered by the human genome portends a time of rapid change in medicine. Genome-based medicine includes amongst its scope the use of genetic tests to diagnose, predict and determine susceptibility to a disease, as well as the evaluation of drug response through genetic tests (pharmacogenomics). More than four years after the completion of the Human Genome Project however, researchers continue to express both excitement and scepticism concerning the opportunities for a near-term derived application in either preventive or curative fields.

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One of the most significant promises is that the unravelling of the genetic origins of common diseases will lead to individualised medicine, in which prevention and treatment strategies are personalised on the basis of the results of predictive genetic tests. According to some enthusiastic claims, the integration of genome-based knowledge into health care has the potential to change primary, secondary and tertiary prevention.¹ The possibility to provide early detection for those individuals more susceptible to complex diseases because of their genetic make-up, might in fact, theoretically result in individualised primary (for example, chemoprevention or prophylactic surgery interventions) and secondary prevention (for example, assiduous monitoring) programmes. Actually some emerging tests support this promise: mutations in *BRCA1* and *BRCA2* genes can be used to identify women with a higher lifetime risk of breast and ovarian cancer, thus eligible

to prophylactic surgery or assiduous breast magnetic resonance imaging screening; similarly, genotyping of *HER-2* expressions identifies women with metastatic breast cancer eligible for trastuzumab drug treatment.

Nonetheless, due to the progressive release of results from large population-based studies and meta-analyses in genetic epidemiology, this great optimism has been counterbalanced by the realisation that most gene variants associated with common complex diseases have only modest effects (relative risk of 1.5) that increase only in the presence of well known environmental risk factors. The example of *BRCA* genes, in fact, represents a rare mutation accounting only for a small minority of breast cancer cases, while most genetic contributors to breast cancer risk have only a small effect. With many genes each contributing a small effect to disease aetiology, the question of their clinical

utility in disease prevention management is no doubt pertinent, and an emphasis on genetic contributors to disease might also result in the neglect of environmental risk factors.

Additionally, among the sceptics concern has been raised over the ethical, legal and social implications of genomic medicine, such as the protection of privacy and autonomy, stigmatisation, discrimination and the psychological burden of genetic testing.² As the possibilities for investigating many gene variants (genome profiling) in the same individual become a reality, these concerns will probably require a different approach from that applied to predictive genetic testing for monogenic diseases due to the low predictive value of multiple genetic testing.

From this premise, it is evident that the extent of the contribution of genomics to population health over the next fifty years remains uncertain. Undoubtedly, increased understanding will lead to measurable improvements in human health, but the time scale and extent of final impact remain unknown. At least in the preventive field, according to a more realistic forecast, genomics will help facilitate the integration of traditional community-based activities with individually targeted preventive strategies.³ So, the pressing challenge of genome-related technologies at the moment is to devise an efficient strategy to distinguish between innovative and clinically useful advances and false leads. Last but not least, the pace of this transformation will be limited not only by the pace of discovery and the proofs of effectiveness, but also by the need to educate practicing physicians and health-care professionals more generally in order to ensure the appropriate use of genome-based knowledge.

Public health genomics

The integration of genomics into public health research, practice and policy will be one of the most important challenges for health care systems in the future. Thus far health care systems and industries are not prepared for this conceptual change and all stakeholders are struggling to transfer emerging knowledge into clinical and technological applications. Public Health Genomics (PHG) is an emerging multidisciplinary scientific approach which aims to integrate genome-based knowledge in a responsible and effective way into public health. According to the statement of an expert group that discussed public health

genomics concepts in Bellagio, Italy, in 2005, it can be defined as: 'the responsible and effective translation of genome-based knowledge and technologies for the benefit of population health'. The working group in Bellagio soon after established an international forum to address public health genomics challenges, known as the Genome Based International Network (GRAPH *Int*). This includes participants from the National Office of Public Health Genomics in the US Centres for Disease Control (CDC), as well European partners.

In Europe, being aware of the future possible benefits of genomics for population health, in 2005 the European Commission made a call in the work plan 2005 of the public health programme for a networking exercise, aiming to identify 'public health issues linked to current national practices in applying genetic testing and on that basis contribute to developing best practice in applying genetic testing'. The Institute of Public Health North Rhine-Westphalia (Iögd) in Bielefeld, Germany, as lead partner, together with the PHG Foundation in Cambridge, UK, and the German Centre for Public Health Genomics (DZPHG) at the University of Applied Sciences in Bielefeld, Germany, applied to develop a 'Public Health Genomics European Network' (PHGEN) and subsequently received funding.⁴ PHGEN was officially established in February 2006 and involves experts as collaborating partners from the fields of public health and epidemiology, human genetics and molecular biology, social sciences, ethics, medicine, economics, political sciences and law. It is envisaged that PHGEN, together with its spin-offs, will serve the European Commission as an 'early detection unit' for horizon scanning, fact finding, and monitoring of the integration of genome-based knowledge and technologies into public health.

The proper evaluation of genome technologies

The development of efficient research strategies to investigate health outcomes associated with genetic testing is a crucial factor in ensuring appropriate test use. According to the 'evidence-based medicine' concept, every medical intervention should be recommended if: high-quality evidence shows that it results in improving health outcomes; it delivers a net benefit; and is cost-effective. Subsequently, evidence-based guidelines should

be developed for using genetic information to profile disease risk or guide a pharmacological treatment. At this point it is clear that the proper evaluation of genome-based technologies within the Health Technology Assessment (HTA) framework is one of the most important challenges for health service researchers and health policy makers to consider at this time.

Genetic tests for more than 1,300 diseases and conditions are currently available in clinical practice, while many more are being developed in research settings. Moreover, a number of companies in the US and UK offer genomic profiles consisting of chips for the concurrent detection of multiple gene variants associated with an increased risk to a particular condition, such as the Oxidative Stress Profile and Obesity Susceptibility Profile. The same can be said for pharmacogenomic tests, whose clinical implementation seems to be driven in some instances more by intensive pharmaceutical company campaigns rather than by evidence on clinical utility and cost-effectiveness.

Clearly, there is a strong need to distinguish useful genetic tests from those that are useless or even potentially dangerous. One approach is the ACCE framework developed by Haddow and Palomaki in 2004,⁵ and subsequently updated by the PHG Foundation and Eurogentest. That model takes its name from the four components of a genetic test evaluated: analytic validity (A), clinical validity (C), clinical utility (C) and ethical, legal and social issues (E). Unfortunately, this approach is unfeasible in some instances because of the lack of data on which such evaluations, especially those concerning clinical utility, depend. In fact, as described in the methodology of the US Preventive Task Force,⁶ definitive evidence of effectiveness requires randomised clinical trials that evaluate all relevant outcomes of testing, as well as the effects of any associated intervention. While these types of study design are often unfeasible or unethical for many genetic conditions, nonetheless some HTA reports on genetic tests have now been released from both AETMIS (Agence d'Évaluation des Technologies et des Modes d'Intervention et Santé) in Quebec, Canada, and EGAPP (Evaluation of Genomic Applications in Practice and Prevention) inside the CDC.

Additionally, genomic technologies will influence not only health outcomes but also the delivery and costs of health care.

In this era of increasing concern about health care costs, it will be impossible to consider the implications of genomic medicines without also considering their economic implications.⁷ The use of genetic information to guide interventions should be justified only if data demonstrate improved outcomes, reduced costs, or preferably both. Thus the need for a strong evidence base of efficacy, effectiveness and cost-effectiveness will be an essential element if resources are not to be wasted, particularly where health services are publicly funded. Although some cost-effectiveness evaluations have been published in the last few years on genetic and pharmacogenetic tests, there remains an urgent need from health service researchers for a rigorous and systematic evaluation of genome technologies. This requires new collaborations between public health providers, geneticists, economists and policy-makers.

The policy response and education of health care providers

At this point it should be clear that it is difficult to predict to what extent these advances will lead to effective and affordable clinical and public health interventions. Policy should therefore ensure that expertise is harnessed in all pertinent fields, first beginning with public health professionals, to prepare the ground and enable society and citizens to be equipped and respond responsibly. To make this happen, the provision of education and training for health providers in the public health genomics field and related disciplines is needed. Some research indicates that health care providers are poorly prepared to integrate genetics into practice,⁸ while other surveys suggest that 90% of US public health schools teach health policy but only 15% genomics.* In order to achieve this goal, there needs to be additional development in infrastructures for training courses in genetics, health care and health economics, targeted as appropriate at health care providers, geneticists and economists.

In conclusion, an unfortunate feature of the genomic revolution has been a tendency to hype up the scope and timing of the integration of genome technologies into health care.⁹ This situation, together with its commercial potential, has manifested itself in the widespread use of

genetic testing for susceptibility to complex disorders, or for drug responses, with little evidence of efficacy, effectiveness and cost-effectiveness.¹⁰ Since a shared methodology for the proper evaluation of genomic tests does not as yet exist, health service research should work hard to identify universal criteria against which to evaluate genetic tests. This should also take into account the acceptability and the potential for harm of the testing process itself. So, public health professionals and policy-makers in the next decade would do well to clarify the conditions under which the genomic revolution, already underway in medicine, will result in public health benefits.

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Migration patterns of Polish doctors within the EU

Joanna Leśniowska

The accession of Poland to the European Union (EU) has brought with it many challenges as well as benefits. These challenges inevitably include the migration of health care professionals. The principle of the free movement of labour implies that health professionals, as a part of the European workforce, can move across borders and work in other Member States. Free movement of health care personnel within the EU is permitted by European Council Directive 2005/36/EEC, subject to the mutual recognition of professional qualifications. Under this legislation doctors, dentists and nurses are entitled to full registration in any EU Member State. As the living standards in most of the old EU countries continue to exceed those seen in Poland, the economic incentive to move is often high.

Verification certificates

Despite these economic pressures, there remains little information on the migration patterns of doctors. The principal source of information is the Polish Chamber of Physicians and Dentists which issues professional verification certificates, allowing Polish doctors to apply for jobs in other EU countries. Data from this organisation indicates that between January 2004 and April 2007 more than 6,000 doctors received such certificates. Most were issued to doctors specialising in anaesthesiology and intensive care (17.54%), plastic surgery (14.97%) and chest surgery (13.18%).

As the Polish Chamber of Physicians and Dentists collects data only within the context of issuing documents for potential migration, this does not provide a picture of how many of these individuals actually leave the country. The number of certifi-

cates should be perceived only as an indicator of the interest of medical personnel in taking up work abroad. A better sense of the scale of migration can be obtained from the competent authorities in other EU countries responsible for the registration of the medical workforce.

Migration patterns

As Figure 1 indicates, between January 2004 and March 2007 2,961 doctors were newly registered to practice in the EU-15 countries.* This represented a dramatic increase on registration rates in the pre accession period. Most of these migrant doctors were specialists in the fields of anaesthesiology (327), internal medicine (213) and general surgery (129).

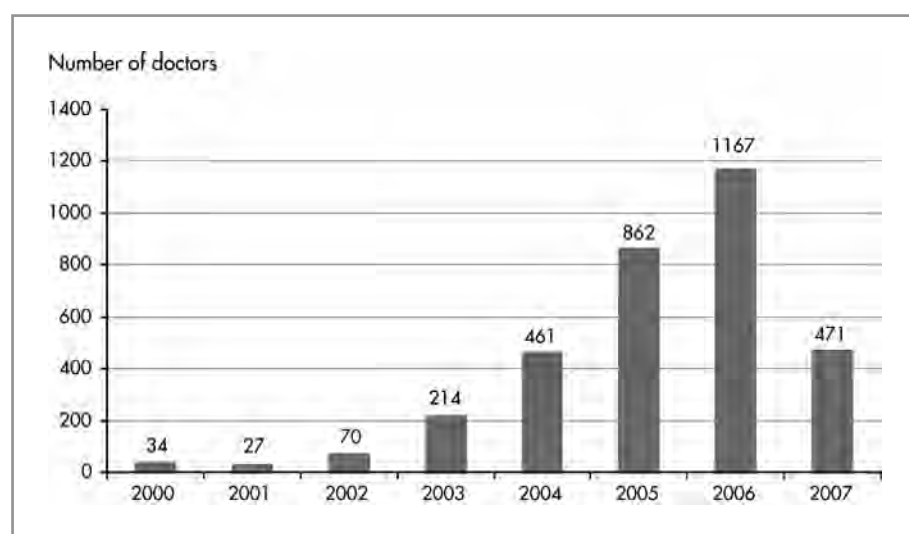
By far the most popular destination was Great Britain (England, Scotland and Wales), which registered 1,633 doctors post accession, compared with just fifty-three between 2000 and 2003 (Figure 2).

Substantial levels of migration were also seen in Sweden, Germany (where migration had been longstanding), Ireland, Denmark and the Netherlands.

Conclusions

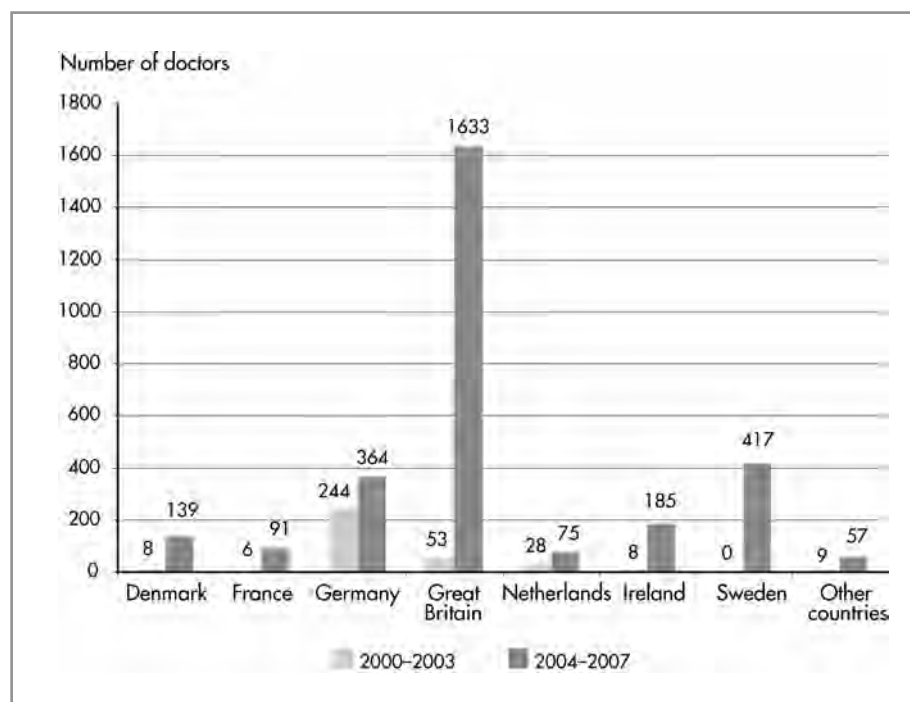
Clearly, the accession of Poland to the EU has had a considerable impact on the escalation of the migration process for doctors. This is most notable in Great Britain where prior to accession there were just 335 Polish doctors registered compared with 1,968 by 2007. Although it is also the case that a much lower number of doctors migrate compared to those who obtain the necessary professional validation certificates (6,007 versus 2,961), it must be stressed that the number of migrant doctors shown here is conservative. There are gaps in registration data from several EU-15 countries which if plugged would increase the number of migrant doctors. Other doctors have also migrated to the principal European Economic Area coun-

Figure 1. New Polish doctor registrations in the EU-15 2000–2007



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* No data were available from Austria and Greece; only partial data available from Germany (1 regional medical office 'Landesärztekammer' out of 17 existing), Ireland (registration of specialists not compulsory), Italy (26 of 69 regional medical offices 'Ordine Provinciale dei Medici Chirurghi e degli Odontoiatri'), Sweden (data from 2004–2007 only), Spain (8 of 40 regional medical offices 'Colegio Oficial de Medicos').

Figure 2. Total Polish doctor registration by selected host country

Note: Data on registrations in Sweden from 2000–2003 unavailable

tries (Iceland and Norway), the data for which were not included in this analysis.

One consequence of this growing rate of outward migration has been to make access to doctors in some medical fields more difficult. Between 2003 and 2006 the

number of doctors employed in Poland decreased by more than 10,000, with most of this decrease (9,577) occurring in 2005.¹ In 2006, the Minister of Health commissioned a survey across the local administrative areas (voivodships) to obtain

information on workforce deficits in medical care centres. The survey recorded the number of vacancies on 30 May 2006. The ensuing data indicated that there were 4,113 unfilled posts. The greatest number of vacancies were for anaesthesiologists (398) and internists (312).² These deficits in personnel may just be a foretaste of problems to come; migration rates continue to increase, with 1,167 doctors obtaining the necessary certification to pursue professional opportunities elsewhere in the EU in 2006, compared with 862 in 2005 and 461 in 2004.

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Restructuring municipalities and municipal health services in Finland

Lauri Vuorenkoski

Public responsibilities for health care services have been decentralised more in Finland than in any other country.¹ In Finland, 415 municipalities, with a median of about 5,000 inhabitants, hold legislative responsibility for organising and funding health services for their residents. In

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addition to health services, municipalities are also responsible for organising social services and primary education. Municipalities have a significant degree of freedom to plan and organise these services as they see fit and state-level steering is quite weak. Municipal services are funded mainly by municipal income tax, state subsidies and user fees.

The municipal health care system provides the largest share of health care services in Finland (for example about 70% of outpatient physician visits, about 60% of outpa-

tient dentists visits and about 95% of inpatient care periods). In addition to the municipal system, health care services are also delivered by occupational health care and private health care providers; these are partly reimbursed by the statutory National Health Insurance.

National legislation stipulates that every municipality must have a health centre that organises primary health services. Municipalities can either have their own health centre or they can jointly host a health centre with neighbouring municipalities

(that is, a health centre maintained by a municipal federation). There are altogether 237 health centres in Finland, from which fifty-eight are joint health centre federations (2007, excluding the autonomous Åland islands). Legislation also divides the country into twenty hospital districts that are responsible for the organisation of municipal secondary health care services. Each municipality must be a member of one of the hospital districts. Hospital districts are financed and managed by the member municipalities. The catchment population of hospital districts varies from 65,000 to 1.4 million inhabitants.

Decentralisation has provided a good chance to ensure the accountability of health services to the local citizens. However, population movement from rural municipalities to cities, ageing of the population especially in rural areas (increasing demand of health services and a decreasing pool of health professionals), increasing problems in balancing public-sector finances and the increasing demands of new technology for resources and skills have made small municipalities more and more vulnerable when solely responsible for the organisation of health services.

“it is considered ... that the number of municipalities could be much lower and regional cooperation stronger”

In recent years concerns have grown that the problems with decentralisation of this magnitude outweigh the advantages. One of the most discussed future developments of the Finnish public sector health care system has been the creation of a more solid structural and financial basis for municipal services by creating larger units to take responsibility for the organisation of health services. Although the number of municipalities has already decreased in recent years (from 452 to 415 in 2000–2008), it is considered in the state administration that the number of municipalities could be much lower and regional cooperation stronger.

Numerous regional development projects have been conducted to both increase regional cooperation in primary health care provision and to integrate primary and secondary care services. One important example of such regional reform

is the administrative experiment in the Kainuu region (North-East Finland) which started in 2005.² The region covers nine municipalities and a total of 85,000 inhabitants. The experiment created a new regional self-regulating mid-level administrative body with its own regional council. The council is elected for a four-year term at the same time as the general municipal elections. The new administrative body has no right to levy taxes but it gets funding from member municipalities. It is responsible for organising several welfare services that were previously organised by the municipalities: upper secondary schools and vocational health services, primary and secondary health services, and a large part of social services.

The two most recent reforms of this type have been carried out in the Itä-Savo and Päijät-Häme regions in 2007.³ Itä-Savo has a population base of 60,000 and Päijät-Häme 210,000. In both regions, the municipalities formed a new municipal federation to organise primary and secondary care and some social services. However, some municipalities in both regions still organise primary health care services on their own instead of giving organisational responsibility to the new municipal federation. The new organisations replaced hospital districts that organised only secondary medical services. Like hospital districts, the new municipal federations are governed and funded by member municipalities.

National project to restructure municipalities and municipal services

In May 2005, the government launched *The Project to Restructure Municipalities and Services*.³ The goal of the project was to create a sound structural and financial basis for the services that municipalities are currently responsible for, so that the required standard of quality, effectiveness, availability, efficiency, and technological advancement are secured.

In the first phase, the project made three alternative proposals for reforming municipal services. The first alternative was to merge current municipalities so that each municipality would have a population base of at least 20,000 inhabitants. The second alternative was to integrate organisational responsibility of primary and secondary health care as well as certain social welfare services into new regional organisations with a population size of between 100,000 to 200,000 inhabitants (current municipalities would still be

responsible for funding services). The third alternative was to introduce a new mid-level administration of twenty regions which would have organisational and funding responsibility to arrange most of the services (somewhat similar to the Landsting in Sweden). These regions would have their own representative elected councils and the power to levy tax and receive state subsidies.

“mergers of municipalities can be a difficult process for local politicians, municipal employees and residents. However, the general view is that this is the right direction”

In January 2007, the Eduskunta (Finnish parliament) approved an act defining how to continue the process. The act states that organisational responsibility for primary health care and those social services closely related to health services should reside with organisations covering at least 20,000 inhabitants (currently only 23% of health centres have a population base of 20,000 or more). This would not necessarily require mergers of municipalities smaller than 20,000 inhabitants, but rather the forming of, for example, municipal federations where funding liability resides with individual municipalities. According to the act, the state will financially support mergers of municipalities. Additionally, the responsibility for the organisation and funding of forensic psychiatry examinations and examinations related to sexual abuse of children will be transferred to the state no later than 2009.

In autumn 2007, all the municipalities made detailed plans for the state administration on how these stated goals are to be achieved. However, the state administration was satisfied only with a minority of these plans. The majority of the municipalities were required to further specify their plans or have been summoned for negotiations with the state administration. Plans reveal that municipalities intend to form about seventy co-operational regions involving about three hundred municipalities. About half of these would work as joint-municipal federations. Another proposed model is that one municipality have the administrative responsibility of organising services and others have a

contract with that municipality related to the organisation of services for their residents (currently about twenty municipalities have arranged services according to this model). One identified problem with these proposals would be that social and health services could be dispersed to different regional organisations, which could hamper the seamless provision of services. Decisions on municipal mergers have already been made so that the number of municipalities will be reduced by sixty-two by January 2009. Additionally, in January 2008 there are another twelve ongoing merger processes involving twenty-nine municipalities.

The government will produce a report to the Eduskunta on the project's progress in 2009. Municipalities are obliged to make final decisions on how they will implement the law prior to this date. The target for this process to be completed is 2012.

Conclusions

Municipal health services in Finland are undergoing major changes, with organisational responsibility for primary health services being transferred to larger organisations. However, it is difficult to estimate what the outcome of this process will be. The principle of municipal autonomy has a strong tradition in Finland. Municipalities value rather highly their independence to arrange basic services, so the reform will not be very easy. In particular, mergers of municipalities can be a difficult process for local politicians, municipal employees and residents. However, the general view is that this is the right direction in which to develop the organisation of health services in Finland.

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Observatory Venice Summer School

Hospital reengineering: New roles, tasks and structures

The European Observatory on Health Systems and Policies will hold its annual Summer School in collaboration with the Veneto Region of Italy from 3 to 8 August, 2008 on the island of San Servolo in Venice.

The theme of the summer school will focus on "Hospital reengineering: new roles, tasks and structures". It will address how hospitals interact with the rest of the health and care systems and with the communities around them. The focus will be on the policy rather than management dimensions of boundaries to the outside world. The implications of relationships with other actors (including patient and consumer groups) will be addressed as well as the repercussions for the division of labour and internal organisation. It will help to understand and show how to support seamless links between services; and how to identify, plan for and manage hospitals' place in health systems.

The summer school's target groups are (i) senior to mid-level policy-makers and (ii) a limited number of junior professionals who are making careers in policy and management at a regional, national or European level. The intention is to raise key issues, share participants' insights, develop a greater understanding of how evidence and context interact and build networks. The emphasis will be on participative approaches, complemented by some formal teaching (in English).

All participants should be in institutions with decision-making powers, whether government or non-governmental (for example, ministries, national health institutes, federal committees), relevant provider or payer associations (such as national insurance boards, hospitals or hospital federations, management boards, physicians' chambers) or community stakeholder or consumer groups. Applications are welcome from all countries across the European Region.

The deadline for applications is 30 April 2008, earlier applications are encouraged. A selection process will follow and a limited number of bursaries will be available. The Summer School is accredited by the European Accreditation Council for Continuing Medical Education.

The programme will be tailored to the mix of participants and the course will be led by leading international experts and decision makers.

More information is available at www.observatorysummerschool.org

For specific questions regarding the Summer School please email summerschool2008@obs.euro.who.int

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Health care services for tourists in the Veneto Region

Simona Bellometti and Luigi Bertinato

Summary: The combination of the area's natural beauty, multi-purpose businesses and quality service makes tourism one of the Veneto Region's main resources. Analysis demonstrates a proportionately high level of tourist inflows and highlights two phenomena: (a) the impact of mass tourism on the health system; (b) the rising levels of tourist and patient mobility in Europe. Realising the potential and underlying risks in the relationship between tourism and health, the Veneto Regional government has set about planning and organising specific health care services for tourists, integrating them with those already available to the resident population. The question of protecting and satisfying the health care needs of tourists is of increasing importance to many areas of Europe experiencing significantly high levels of tourist inflows.

Key words: tourism, cross-border health care, patient safety, patient mobility, Italy

The recent expansion of the Schengen Area to twenty-four Member States of the EU runs alongside the increasing movement of citizens across the EU for work, tourism and study. Moreover, a rising number of pensioners from northern Europe are spending the winter season and extended periods of the summer in southern Europe and the Mediterranean. Accessing health care in any European country should, theoretically, be a straightforward process, but it often creates problems, both for patients and the health care systems involved. The experience of certain European areas with heavy tourist inflows, such as the Veneto Region in Italy, illustrate clearly the extent of this tourism phenomenon, implying the need for action at different levels (regional, national and European), involving specific legal, organisational and regulatory approaches.

Historical background

The Veneto Region has always enjoyed an important strategic geographical location at the crossroads of Europe (see

Figures 1 and 2). It has a population of 4.8 million, which increases dramatically twice a year during the peak summer and winter seasons. Travelling has played an important role for the Venetians. In the past, the rule of the 'Serenissima' Republic was dominated by seafaring and trading in the Mediterranean Sea as well as along the Silk Road as far as China. Throughout history, therefore, Veneto has always placed great importance on protecting the health and well-being of travellers.¹ The Venetians are renowned for having fought vehemently against the importation of communicable diseases from far away countries, as the history of its *lazarettos* (hospitals set up for the treatment and quarantine of people with infectious diseases) and thorough quarantining procedures have demonstrated.

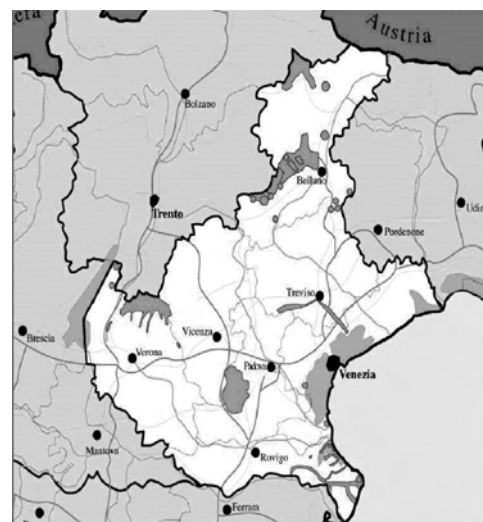
The impact of tourism on the Region

In more recent times, Veneto has become famous as a major tourist destination, thanks to three main attractions: Venice itself, as a city of art and culture, along with Verona, Treviso, Padua and

Figure 1: Italy and the Veneto Region



Figure 2: The Veneto Region



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Table 1: National and international tourist flows to the Veneto Region, 2006

Nationality	Arrivals	Percentage	Total overnight stays	Percentage	Average days of stay
Italian	5,259,736	39%	25,093,862	42%	4.77
Other	8,179,099	61%	34,266,727	58%	4.18
Total	13,438,835	100%	59,360,589	100%	4.40

Source: Veneto Regional Statistics Office data based on ISTAT 2006

Vicenza; the beaches of the Adriatic Sea and the lake region (Lake Garda); and the Dolomite mountains.² Economically, tourism has become one of Veneto's main resources. In 2006, spending by foreign visitors to Veneto amounted to €3,845 million – 15.9% of total spending by foreign visitors in Italy, second only to Lazio.³ It now ranks first among Italian regions in terms of tourist flows (see Table 1).

More detailed examination of international tourist flows to the region in 2006 indicates that tourists mainly from Germany (1,888,235), USA (818,262), Austria (642,886), the UK (592,926), France (521,043), Spain (387,330), Japan (280,601) and Australia (118,053) made up the majority of total overnight stays, which in total amounted to over 59 million nights.

Consequently, Veneto makes for a very interesting case study of patient mobility and health tourism in Europe. The significant flow of tourists brings a series of health care challenges for regional health care services to contend with. In some cases this is done through the organisation of specific services to respond to the high demands arising from seasonal tourist flows and long-term foreign residents (approximately 3,500 mainly German elderly residents living in the Lake Garda area, near Verona).⁴ Visitors to the region can also, in the case of a medical emergency, turn to a wide range of health services provided by Local Health Authorities (LHAs), in close collaboration with the Department of Health and Social Services and the Department of Tourism of the Veneto Region.

Responding to the challenges

This heavy flow of tourists brings with it a series of health care issues. Since 2003, a special 'task force' has been operating in the region with the aim of broadening knowledge on this tourist phenomenon and patient mobility, as well as improving

the ability to cope with underlying administrative and organisational problems.

The taskforce collects data on the scale of patient mobility between the Veneto Region and other Italian regions or EU Member States. It analyses the impact of cross-border health demands and related health issues at the regional level. Moreover, it aims to map and classify the needs and concerns of EU citizens who require medical assistance when abroad by gathering information on: the patient-system interface; different aspects of health system re-organisation; health service demands; patient orientation; access to and quality of care; patient rights and obligations and financial arrangements.

The long-term objective is to establish a detailed framework of the ongoing pattern of EU citizens receiving care from health care providers in the Veneto Region, with a special focus on: (i) tourist flows; (ii) patients requesting authorisation to access the health care system in another European country (using the E112 form); and (iii) long-term residents (such as the retired) from other Member States who live in Veneto for the greater part of the year.

An emphasis on patient safety

The significant tourist flows distributed among the various types of tourist destinations in Veneto (cities of culture, coastline resorts, lakes, mountains and spas) have compelled the regional health care system to plan and organise specific health care services for tourists, while at the same time integrating them with those already available services provided for the resident population.

The Local Health Authorities, responsible for the provision of health and social services to the resident population, and the Veneto Region government have for a long time been aware of the enormous potential underlying the relationship between tourism and health, not only in as far as it

is the driving force of the economy, but also in terms of the potential risks it unearths as a result of the impact of the tourist population on the resident population and the local environment.

The increasing demand for health care from tourists is a challenge that LHAs strive to meet year after year.⁵ The seasonal peak coincides with the main summer season, which is more pronounced in coastal areas. Seasonality is thus an important factor in the organisation of health care services which need to be flexible in their response to the needs of tourists.⁶ The main reasons for foreign citizens accessing health services in the region include the sudden alteration in health (70.6% of cases); 9.5% requiring pharmaceuticals; 2.8% for medical treatment or surgery and 1.1% receiving dialysis.

Seaside tourism is marked by large and seasonal concentrations of individuals which affect facilities and services set up to respond to this demand.⁷ Each year preparations for the summer season commence in March (a similar practice takes place in the autumn in the run up to the ski season) with the selection of specific health staff able to communicate in various European languages. A number of specific measures are then undertaken.

The 'Eastern Veneto' area (the coastal area along the Adriatic Sea) has extended and adapted already-existing schemes and initiated a series of new services aimed at coping with the impact of the influx of summer tourists, while health care services and technical know how have also been enhanced at the main hospital in Jesolo responsible for covering the marina. Twenty-four hour first-aid points have been installed in the seaside resorts of Caorle and Bibione, where additional dialysis services, not normally available to the public in this area, are also provided.

Four clinics that are fully operational during the months of May through to September have also been set up in Eastern Veneto, together with eight clinics during the period from June to August, totalling 113 opening hours per day, with twenty-two doctors and six interpreters. For some reason, clinics provided near to the beach are not readily accessed by foreign tourists; this is why one of the three tourist clinics in Jesolo has been set up inside the main hospital next to the emergency department. This arrangement allows patients to be registered, while making

them aware of the inappropriate use of emergency services.

Within the city of Venice, in the Veneziana area, additional health care and ambulatory services are also put in place over the summer period to guarantee emergency aid to tourists on the island. This is supported by a central unit that coordinates emergency services and organises helicopter rescue services in the region. A special clinic for tourists is provided between mid-June and mid-September, opening from 08:00 to 20:00 daily. The clinic, employing nine doctors and an administrator, always has one doctor available (two in July and August).

In the Lake Garda area, services have been optimised through the opening of eight specific tourist clinics, including dialysis services. Foreign tourists requiring medical attention can turn to special 'tourist medicine' services, as well as hospital emergency services, and the aforementioned first-aid points, the latter being available only from May to September.¹ There are also nine outpatient clinics, six of which are located in Lake Garda itself, and three in the surrounding mountainous areas, guaranteeing a total of thirty hours per day availability to the public.

Safe Holidays Project

During the summer season, with the aim of ensuring a prompt response to medical emergencies, 'Progetto Vacanze Sicure' (Safe Holidays Project) has been implemented along the entire Veneto coastline, incorporating a number of different initiatives: the distribution of semiautomatic defibrillators financed by the regional health service; seven medically-equipped vehicles; three medically-equipped motor-cycles and sixteen ambulances (including two water ambulances).

An additional helicopter rescue service tailored specifically to tourists has been put into operation, representing a further development within the complex system of tried-and-tested emergency services available in the Veneto Region. The helicopter health care rescue service ensures that there is coverage throughout the Veneto region via four helicopter stations. Based at the Venice Lido it covers the entire 120 km stretch of Adriatic coastline and is equipped with sea rescue facilities. In the space of ten to fifteen minutes the rescue team, made up of a doctor, nurse and air pilot, are able to reach the individual in danger at the location where the emergency has occurred.

Veneto, being the number one Italian region in terms of tourist flows, thus continues to be very much concerned with safeguarding its tourist industry and sets out to combine a high quality of tourist attractions with an equally high level of health care services for those European citizens with chronic health problems, for example, those in need of dialysis treatment, who can pre-book health services before departure.⁸ Within this contextual framework, the Veneto Region seeks to take advantage of all opportunities made available to adapt its health services to handle the enormous impact of mass tourism from Central and Northern Europe. By doing so the region aims to increase its appeal and attraction to both foreign and national tourists and thereby compete effectively with other major European tourist destinations. Health services face important challenges from the sudden demands on health services due to mass tourism. Better marketing and more effective communication tactics are called for, as more often than not, tourists are almost oblivious towards or else poorly informed about services provided by the public sector in their destination country.

Conclusions

Patient mobility and the provision of cross-border health care services are themes which are increasingly high on the majority of European policy agendas. The challenges facing the Veneto Region's health system are similar to those being faced in other parts of the EU affected by mass tourism. The need to develop strategies to guarantee health protection and satisfy the health needs of tourists add further weight to the case for solutions to provide access to quality health services for acute and chronic care to individuals not already covered as part of the European Health Insurance Card (EHIC) system.⁹ Special reimbursement systems have been set up involving two major German health insurance companies, to cater for German visitors with non-acute health problems that, for instance, require cardiac or muscular rehabilitation services, or dialysis treatment.

Special training courses for health professionals have been organised to facilitate communication with non-Italian patients, making use of appropriate supporting information materials. Cross-border initiatives with the Austrian Länder of Carinthia, the north-eastern border region of Friuli Venezia-Giulia and Slovenia have also contributed towards setting bench-

marking strategies for tourist health services, at the same time reconciling services provided by universal versus insurance-based health systems. This experience of organising health services for tourists at regional level can help identify future solutions that Member States may implement to respond to the phenomenon of patient mobility in an increasingly mobilised Europe.

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The health care needs of UK pensioners living in Spain: an agenda for research

Helena Legido-Quigley and Daniel La Parra

Summary: There is a growing interest in learning how older migrants adapt to their new country of residence, in understanding their motivations for migration and the factors that influence international retirement migration patterns. However, there has been little research into the health and health care needs of international migrants retiring to other countries. This paper presents findings on health status and utilisation of health services with a particular focus on UK pensioners retiring to Spain. Future research should focus on the health needs of pensioners and their perspectives as to whether and how these health needs are met.

Keywords: Older migrants, Inequalities in access, Social security, Spain, UK

A key contextual factor which helps to explain international retirement migration patterns is the changing regulatory framework of the European Union (EU). This phenomenon is embedded in EU legislation and social policy considerations, including Articles 48 and 49 of the Treaty of Rome on the freedom of movement, the Single European Act which removes barriers to property rights across Member States, Article 8 of the Treaty of the EU which confers limited electoral rights and the Social Charter which envisages the potential to harmonise pension and welfare systems across the EU.¹ In addition, in the mid 1970s the then European Economic Community recognised that freedom of movement should not be restricted to the healthy. In 1971, Council Regulation (EC) No. 1408/71 on the application of social security schemes provided avenues for statutory

cover of treatment received outside the state of residence or affiliation. This included EU pensioners deciding to retire to another Member State through the E121 scheme (See Box 1).

Some EU citizens have seen these mechanisms as an opportunity to move to another Member State and they are likely to have been a factor in the growing numbers of northern Europeans retiring to southern Europe. Although this is a phenomenon that has existed for many years (for example, Irish people returning to Ireland after spending their working lives in England) the numbers involved, and the destinations being chosen, have changed greatly. There are now many people from northern Europe retiring to southern Europe, in particular to Spain, France, Portugal, Italy, Greece and Bulgaria, as well as to candidate countries such as Croatia.²

The phenomenon of international retirement migration in Europe

Systematic academic interest in the study of European international retirement migration only emerged in the mid-1990s, mostly in the field of migration studies and social gerontology. The main focus of social gerontology is on the

Box 1: Background to the E121 scheme

The process described here refers to the administrative steps a pensioner has to go through when he or she decides to move to another Member State.

The individual applies for an E121 form in their home country so that their social rights are transferred from the social security system of the home country to the 'receiving country'. Together with this transfer of rights, a lump sum of money, agreed upon in the Social Commission on Migrant Workers, is also transferred to the central government of the receiving country to cover costs for health care. The information is passed to the region or locality where the pensioner is planning to settle. The long-term resident receives a national health insurance card in the new country and is thus integrated into the system. No distinctions are made between older newcomers and any other member of the social security system.

These communication routes and information flows involve no direct contact between the local health care provider in the new country and the state-level public authorities of the home country. Thus, in the event of the death of a long-term resident, the home country might not be informed and will therefore continue to transfer money.

Through the E121 scheme long-term residents obtain the right to health care in the new or 'receiving country' and at the same time renounce their right to health care at home. However, Directive 1408/71 also requires that the receiving country provide the pensioner with an E112 (form for planned treatment abroad), regardless of whether the treatment is already available in the 'receiving country'.

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reconstruction of older people's lives by connecting individual biographies to the history of society and the study of social change. Through the analysis of different cohorts of older migrants and the identification of positive attributes of retirement in later life, it has helped to challenge previous misconceptions on retiring migrants by providing a more solid empirical base.¹

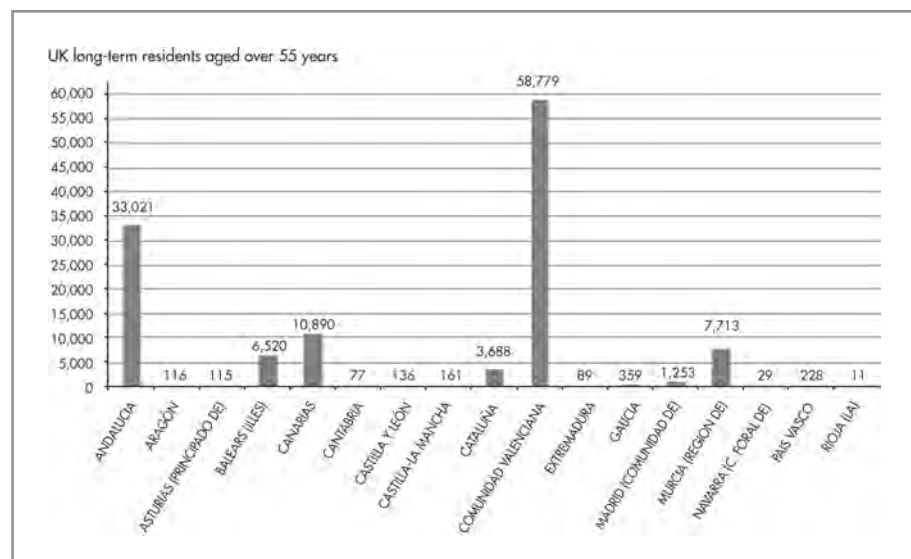
A growing literature has focused on determining the number of retirees migrating in Europe, choice of location and reasons for migrating. Key socio-economic and personal characteristics of migrants, including life-stage, cultural, attitudinal, recreational and environmental factors and personal influences have been analysed. Locations of study have included coastal Croatia, Spain (Majorca, Costa Blanca, Costa del Sol), Italy (Tuscany) and Malta.

“in 2006, more than 300,000 UK citizens retired to other Member States”

This research has illustrated how there has been an increase in the number of older Europeans migrating in retirement. This needs to be understood in the context of a rise in older people's income and assets, as well as major transformations in their preferences and opportunities.¹ Moreover, increasing life expectancy, along with the increasing availability of new medicines and medical technologies, has meant that a growing number of older people are living healthier and longer lives. At the same time older people in most northern European countries are no longer expected to take care of their grandchildren or children and are to a greater extent more concerned with enjoying their lives.

The rise in consumption and mass communication combined with the move in society towards individualism has also influenced older individuals' motivation to move abroad. As Lipovetsky notes, we live in a society with unprecedented social temporality marked by the primacy of the here-and-now.³ This individualism and social temporality also applies to older people. Thus, pensioners retiring abroad can increasingly access the internet, affordable telephone calls and own language cable television. With the advent

Figure 1: UK long-term residents aged over 55 years in Spain by Autonomous Community



Source: Instituto Nacional de Estadística 2006.¹⁰

of low-cost airlines there are also greater opportunities for travelling between home and host country for both migrants and their relatives.

Some of the evidence on patterns of European retirement migration identifies a series of key factors encouraging older people to retire abroad. Božić looking at ex-patriots in Croatia identified the most important factors for migration as climate, geopolitical location, level of property prices and familiarity with the region.⁴ One study of 266 retirees to Tuscany⁵ and another looking specifically at UK pensioners retiring to Spain reported similar factors including favourable natural resources and landscape, respect for children and older people, friendly atmosphere, security and the slow pace of life.⁶

In addition, older people preferred Spain over the UK because of perceived advantages to health, a good climate, the opportunity to be active, the possibility of spending more time outdoors and the wider availability of recreational clubs and associations. This study also emphasised the lower costs of living in Spain as an advantage over the UK in terms of value-for-money.⁶

Another study reported that UK pensioners form well-defined territorial and social units, benefiting from the strong value of their currency and previous presence in Spain as tourists or residents. However, a lack of proficiency in Spanish has prevented them from developing closer links with the local community.⁷ Other studies also suggested that these EU

pensioners tend to be isolated with few, if any, close relationships with the local population.^{4,7,8}

The scale of the phenomenon

There has been a significant growth in the number of UK citizens retiring abroad. Aggregate data from the Department of Work and Pensions indicated that, in 2006, more than 300,000 UK citizens retired to other Member States. This data is based on the number of pensions transferred. A breakdown of countries of destination indicates that UK citizens have a primary affinity with Ireland (103,667) followed by Spain (76,357) and then to France, Italy and Germany each of which receives more than 30,000 migrants.⁹

The information available on the UK population in Spain is somewhat limited. The Instituto Nacional de Estadística (INE) estimates that there are currently 314,098 UK citizens living in the country.¹⁰ That would make UK citizens the fourth largest foreign community in Spain, following Moroccans, Romanians and Ecuadorians. It is estimated that 53% are over the age of fifty. However, the true figures are likely to be higher because of the underreporting of pensioners who stay more than three months per year in two (or three) countries. These pensioners may travel back and forth without regularising their situation each time they move.

The INE estimates, through the figures provided by the municipalities (the padrón), that the total number of UK men aged over sixty-five and UK women over sixty was 87,359 in January 2007. This is

possibly the most reliable source of data on foreign pensioners since migrants who wish to access health and social services need to register with local municipalities. However, this register is not used to define the administrative residential situation of UK pensioners, since municipalities are not responsible for processing residence permits. In fact, only 56% of the UK population registered with the *padróns* hold a residence permit. Figure 1 shows UK citizens resident in Spain by Autonomous Community (AC) and age in January 2006. The ACs with the most UK residents over fifty-five were Valencia with 58,779, Andalucía (33,021), Canarias (10,809) and Baleares (6,520).

Health, health care arrangements and experiences of EU pensioners retiring to Spain

Looking at some studies on the health care arrangements of pensioners retiring to another Member State, one study, based on interviews with key informants and a survey amongst Germans aged fifty-five plus living in Majorca in 1999, identified several problems impacting on their health.¹¹ These included housing and dwelling locations that were perceived not to be compatible with the requirements of older people; the lack of harmonisation of the health and social care systems between Germany and Spain which complicated applying for access to the health care system, and the scarcity of welfare institutions for those who had become frail. Another study using in-depth interviews and focus groups obtained similar results after studying the retired population in Cambrils and Calvia (Spain).¹²

The migration of older Swiss people to the Costa Blanca (Spain) in the period from 1999 to 2001 has also been analysed.¹³ Using a mix of methods, it suggested that the majority of pensioners did not wish to return to Switzerland under any circumstances, not even in the event of the death of their partner. While this information is not directly related to the health and health care needs of Swiss retirees in Spain, it points to a potential great future demand for health care services for this population.

In contrast, Norwegian migrants were found to have very different views.¹⁴ Based on interviews with eighteen people aged 60–75 years, the main concerns voiced were the loss of social rights previously enjoyed in Norway and problems related to the process of repatriation. There was a perceived lack of nursing homes in Spain

having staff familiar with the Norwegian language. These Norwegian pensioners tended to prefer to move back to Norway to spend their ‘last days’ and be buried near their families.

UK migrant retirees

As indicated above, there is little research relating specifically to the health care needs of migrants retiring abroad. We now discuss the situation in respect of UK migrants, drawing on data both from the ‘*Europe for Patients*’ project¹⁵ which explored the health care arrangements of long-term residents, including pensioners in Spain through stakeholder analysis, and from research carried out by La Parra and Mateo.¹⁶ The latter looked at the general health of UK older citizens living on the Costa Blanca and their access to and utilisation of health care services (see Box 2).

“the lack of long-term care and home care in Mediterranean countries is a concern”

All the foreigners registered in the *padrón* in Spain, have the right to access the National Health System. The Spanish Law on Foreign Nationals (LE 4/2000) guarantees this right to all EU and non-EU migrants regardless of whether they are undocumented or legal migrants. Once a migrant has registered in a municipality, he/she can apply for a health card. The total number of health cards issued in Spain for UK Citizens is difficult to estimate, as each AC manages their health care service independently.

As of March 2007, in the Valencian AC alone the total number of UK citizens holding a health card was 64,820, representing 52% of the total UK population registered in the *padrón*.^{17,18} These figures suggest that some citizens have no public arrangements to cover their needs and must be using private health care in Spain or/and the National Health Service in the UK. This has been confirmed in another study which stated that 67% of UK pensioners were covered exclusively by the Spanish National Health System or the UK National Health Service, 17% by both public health care providers and private medical insurance, 12% relied exclusively on private health-care, and 3% claimed not to be covered by public or private care.¹⁶

Box 2 Health status of UK pensioners retiring abroad

- UK nationals resident on the Costa score higher than Spaniards and UK-based citizens on some indicators, with fewer mobility problems and a more positive perception of their state of health.
- It is suggested that some residents who become dependent choose to return to their home countries to seek professional help and support services.
- Other indicators suggest that all age groups are more vulnerable to mental health problems than the UK home population.
- Cigarette smoking and alcohol consumption are higher among the UK ex-pats living on the Costa Blanca; consumption of both rises when they move to Spain.
- The number of visits to a general practitioner by UK ex-pats was approximately the same as for their Spanish neighbours. Although, admissions to hospital are higher than for the Spanish, rates for UK ex-pats are comparable to those seen in the UK. This normal level of health service use results from access to multiple providers: the Valencia Region Health Service, the UK National Health Service, and the private sector
- UK residents on the Costa Blanca make relatively high use of private health care compared to the Spanish and UK populations. The reasons that encourage them to turn to the private sector are likely to be language difficulties in the public sector as well as the usual advantages, such as short waiting times, faster follow-up, fewer clinic visits and less paperwork.¹⁹
- The most commonly cited problems involved in using the Valencia Region Health Service were perceived to be communication (use of the Spanish language) and the administrative processes (information, places, rights, procedures, waiting times). However, their overall perception was quite positive.

Source: 16

Among those who benefited from public health care services, 73% made use of the Valencian Region Health Service and the remainder the UK National Health Service.

Foreign residents in Spain who do not have a Spanish Health Card are primarily those who spend half of the year in their ‘home country’. In these cases, patients are only registered in one of the two health care systems. Formally they should apply for a new E121 every time they go back and forth, but this option creates a huge bureaucratic burden as it must be repeated at least twice a year.

Some long-term residents are also concerned that by applying for the E121 they will lose some social welfare benefits, due to the difference in benefits provided by each Member State. For example, pensioners in the UK have supplementary social benefits such as a winter heating allowance, disability allowances and care allowances. Another concern is the lack of long-term care and home care in Mediterranean countries where these services have traditionally been provided by the family.

Furthermore, the processes involved in transferring registration are perceived as bureaucratic and inflexible. Long-term residents who have been through the process of transferring their rights using the E121 are reluctant to engage in what is seen as a lengthy and painful process to reverse their registration. They are often afraid of losing the option of returning to their home country. Thus there are large numbers of long-term residents who opt not to regularise their situation, so forming part of the 'floating population'.¹⁵ There is no clear provision for these groups, which becomes particularly problematic for patients with chronic diseases.

"hospitals are beginning to include language skills as a criterion when hiring staff"

It is suggested that this 'floating population' of long-term residents in fact have their health care needs met primarily by means of the European Health Insurance Card (EHIC)* while in the 'receiving country'. However, this scheme is designed for use in emergency situations only and does not ensure continuity of care. Furthermore, the recording of treatment provided under the EHIC scheme is often poor, creating gaps in an individual's medical records.

It is also suggested that some pensioners do not hold the Spanish Health Card because of a lack of information or difficulties with administrative procedures.

Stakeholders report that patients are often not well informed on how the system in the country works, partly due to the segregation of expatriate communities, language barriers and patients' ignorance of the problems as long as they have no real need.

Language barriers are reported by key-informants, when the patient and the provider do not speak the same language. In countries with different linguistic and cultural traditions to the home country, these factors can constitute a barrier to newcomers. Lack of a common language could lead to considerable problems in communication between patients and doctors. However, hospitals are becoming aware of the need to assist non-Spanish speakers and are beginning to include language skills as a criterion when hiring new staff.¹⁵

Conclusion

Analysis to date suggests that there is a great need for research on health needs and utilisation of health services; to explore UK pensioners' perceptions of the need for health care and their health care seeking behaviour; and to assess UK pensioners' perspectives of the responsiveness of health care services in Spain. Health care needs in this population are determined by their demographic situation (as the health profile of migrants differs somewhat from that of the general home and receiving country populations); their cultural background (language acting as a determinant of their health care seeking behaviour); and their administrative situation in a context of higher human mobility ('fixed laws, fluid lives').²⁰ In addition, it is also important to consider how local and regional authorities are planning health care services and what financial compensation mechanisms are agreed between Member States. An understanding of these issues would be beneficial for all the actors involved in planning health services and assuring their financial sustainability, and for those who wish to retire or have already retired in another Member State.

However, these effects are complex to study and some contradictions can be expected. Health status can act as a factor when taking the decision to move abroad,

as well as influencing how long a migrant stays in the host country. UK citizens are entitled to use the Spanish health system, but cultural barriers might prevent them from doing so. They might instead prefer to use private health care services or the UK NHS. The relative use of health services by unit is low (UK pensioners have relatively good health and prefer private and home care services), but the absolute use of health services by this growing and concentrated population could have an important effect on the dynamics of the health service. If government and policy makers promote immigration through the urbanisation process, they should also plan services that take into account the health status and health care needs of these newcomers.

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Choice, competition and the political left

Zachary Cooper and Julian Le Grand

Summary: Choice and competition can no longer be viewed as an exclusive tool of the political right. Beyond creating incentives to drive up quality and increase efficiency in the English NHS, choice and competition stand to promote equity. While many left-leaning critics are quick to point out ways in which choice and competition could induce inequity, few critics objectively compare the equity implications of choice and competition to the no-choice system which preceded it. This article lays out the basic arguments for how choice and competition stand to improve equity. If the political left is serious about reducing inequities in public services, the time is right for them to open their eyes to the potential for choice and competition.

Keywords: Equity, NHS, Choice, Competition, Collectivism, England

Since 1955, when Milton Friedman published *The Role of Government in Education*,¹ the political right has had a virtual monopoly on choice and competition in public services. Traditional thinking on the right posited that greater user choice of providers tied to a reimbursement system where money followed users' choices would promote both allocative and technical efficiency. The political left not only disputed the right's efficiency claims, but went one step further and argued that any increase in user choice would come at the expense of equity.

This left/right battle over choice and competition continued until quite recently, when left leaning policy-makers began to come around to the notion that choice and competition in public services might not be such a disaster. Not only did the political left begin to argue that choice and competition could incentivise efficiency, they began to draw attention to the fact that injecting choice and competition into public services could improve the care that is delivered to traditionally under served users.

We argue that this emphasis on the potential positive impact of choice and competition on equity is quite justifiable. In what follows, we draw on theory, past experience and empirical evidence to articulate a case for the equity benefits of choice and competition.

A new rhetoric...

From 2002 onwards, Tony Blair's Labour Party embarked on an ambitious reform agenda to modernise the English National Health Service (NHS). At the core of the former Prime Minister's health service reforms was a belief that greater user choice and provider competition would create a more personalised NHS with better quality and less inequity than traditionally collectivist public health systems.

Speaking in 2003, Tony Blair said:

“People should not forget the current system is a two-tier system when those who can afford it go private...choice mechanisms enhance equity by exerting pressure on low-quality or incompetent providers. Competitive pressures and

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incentives drive up quality, efficiency and responsiveness in the public sector. Choice leads to higher standards.

“The overriding principle is clear. We should give poorer patients...the same range of choice the rich have always enjoyed. In a heterogeneous society where there is enormous variation in needs and preferences, public services must be equipped to respond.”²

Echoing the former Prime Minister’s sentiments, former Health Minister John Reid said:

“These choices will be there for everybody ...not just for a few who know their way around the system. Not just for those who know someone ‘in the loop’ – but for everybody with every referral. That’s why our approach to increasing choice and increasing equity go hand in hand. We can only improve equity by equalising as far as possible the information and the capacity to choose.”³

What sets John Reid and Tony Blair’s comments apart from the choice and competition rhetoric of old is their focus on the potential of choice and competition to promote equity. Their rhetoric was clear and consistent: the political right need not have a monopoly on choice; choice is not exclusively related to efficiency; and greater choice could mean better services for all users, including, and perhaps in particular, users in the lower socioeconomic groups.

A new rationale...

But why? Choice and competition stand to promote equity largely in two ways: first, by blunting the advantage the middle and upper classes have long had in creating additional choices and negotiating better care in systems without formal choice mechanisms; and second, by sharpening incentives for providers to become responsive to all users, possibly in particular, users from the lower socioeconomic groups.

The old political left has long assumed, *a priori*, that collectivist public services like the NHS are inherently equitable. Standard ‘collectivist’ thinking is that when there is no choice for users, the government can equalise the standard of care across the country and every user can have access to the same quality services. This collectivist ideal sounds ok in theory, but fails (rather dramatically) in practice.

In particular, the faulty assumption in the

old left’s thinking was taking for granted that there was no choice for users in systems without formalised choice mechanisms. There is. Even in public service systems without formalised choice mechanisms, choice still exists for users who are (1) able to negotiate with their general practitioners and other medical providers for more choices using their louder voices; (2) able to move to areas with better local services; and (3) when all else fails, opt out of public services and enter the private sector.

“Giving a choice of providers to all service users would take away the advantage that the middle and upper classes have long had accessing privileged care”

Using voice, moving to areas with better local services, and paying for care in the private sector all favour the middle and upper classes. The wealthy and the more educated tend to be more articulate, more confident and more comfortable speaking to doctors and as a result, are more persuasive negotiating for more care. Home prices tend to be closely correlated to the quality of local public services, so those users who move to areas with better services tend to be users with greater incomes. Finally, middle and upper class citizens tend to have the ability to pay for private sector care and live in areas where there is greater availability of private sector services.

Giving a choice of providers to all users, irrespective of their socioeconomic status, would take away the advantage that the middle and upper classes have long had accessing privileged care. Now, less advantaged users can have access to the same fleet of providers the wealthy have become accustomed to.

Greater choice of provider, tied to a reimbursement scheme where money follows user choice can also make providers more sensitive to user preferences. Without choice, if users were not happy with their services, their only option for improving their care would be to negotiate with providers and voice their preferences or turn to a formal complaint mechanism. The only incentive for providers to listen

to patients was appeasing unhappy users (and quieting their complaining) or heeding to their greater sense of professional responsibility. When money follows users’ choices and users have the option of exiting their current service, providers have a financial incentive to be responsive to their patients. In a health service with choice of provider and a reimbursement scheme where money follows patients’ choices, if providers do not listen to their patients, then patients can choose to seek care elsewhere and providers will see their income start to fall.

The old left has two primary criticisms of choice on equity grounds. First, they argue that the well off are better equipped to make choices and will take the best options for themselves, leaving what they do not choose for everyone else. Second, the old left argues that choice is going to lead to cream-skimming: if providers are paid per episode of care they deliver, then they are likely to select patients who are the cheapest to treat. Wealthier patients are usually healthier, so the old left argues that this type of scheme will embed incentives for providers to avoid treating poor patients.

The first equity criticism of choice is summarised by Roy Hattersley, who wrote:

“[C]hoice is an obsession of the suburban middle classes. But when some families choose, the rest accept what is left. And the rest are always the disadvantaged and dispossessed.”⁴

To be sure, the wealthy and educated may be better equipped to interpret information, but that is not to say that those who are less well equipped to make choices cannot be assisted in getting the most from a public service scheme with choice. In an effort to help patients choose, provider quality information needs to be made as accessible as possible and there must be staff assigned to help users choose and determine which providers and options are best for them.

This is precisely what was done in the London Patient Choice Pilots, where patients were assisted in choosing by Patient Care Advisers (usually specially trained nurses). The Patient Care Advisers were very well liked and nearly every piece of evidence from the London Patient Choice Pilot suggests that there was no difference in outcomes or likelihood to choose between social classes or age groups.⁵

In addition, implicit within this old-left critique of choice are assumptions that (1) referral patterns will dramatically change after choice is introduced and (2) that patients need to choose in order to get the benefits of choice. However, rather than creating a mass exodus away from current providers, user choice will not dramatically impact current referral patterns; it is most likely to induce change at the margins with a small percentage of patients opting to receive care elsewhere.

Traditional micro-economic theory posits that an 'exit' of five to ten per cent of users will send sharp signals to providers to raise their performance. In effect, users who choose to remain with their local services benefit from the minority who choose to leave. Looking at school choice in the US, Caroline Hoxby examined the outcomes of students who did not exercise choice and who remained in their original school.⁶ Hoxby found that students in schools with greater competition (where more students chose to exit) did better than students in schools where fewer students exercised their ability to exit. Essentially, Hoxby's results suggest that greater choice and competition in public services creates a tide that lifts all boats: users who do not exercise choice are positively impacted by users who do and everyone's public services improve together.

The fear that increased choice of provider and provider competition will lead to providers cream-skimming and selecting healthier, wealthier users is perhaps the strongest strike against choice and competition. However, cream-skimming is not inevitable. For starters, there is nothing to say that providers should be afforded the opportunity to select their patients in advance. Policy-makers could organise public services in such a way that providers had no choice of who they see.

Beyond that, a more appealing option to thwart cream-skimming might be by making provider reimbursements inversely proportional to service users' socio-economic status. Providers could be reimbursed more for seeing less wealthy patients and reimbursed less for seeing wealthier patients. Not only would this mute any incentives for providers to cream-skim, it would create incentives for providers to become more responsive to less advantaged service users. The more policy-makers weight reimbursements in favour of the less-well off, the more likely providers are to compete with one another

to see patients who are often marginalised in the health system. This would prompt a dramatic shift from the doctor-patient dynamic we would ordinarily expect in a traditional collectivist health system.

“Choice creates strong incentives for providers to become responsive to all users, not just those with the loudest voices”

Some closing thoughts...

The question before us is not whether a particular reform is equitable or inequitable *in toto*; rather, the question we need to address is whether a particular reform stands to be more or less equitable than the structures that precede it. Critics of choice and competition have been ravenous in their desire to point out every conceivable way in which choice of provider and provider competition could induce inequity. While this is certainly a valid academic exercise, it is not policy relevant. Instead of pointing out every detectable flaw (of which there are many in any reform, whether collectivist or market-based), health policy commentators would be better off examining the equity implications of choice-based reforms in comparison to the collectivist structure it replaced.

When viewed in the context of traditional collectivist public services, it is clear that there is a strong argument to be made that increased choice and competition have the potential to promote equity. Greater user choice, tied to a reimbursement scheme

where money follows user choice ameliorates many of the ways middle and upper class citizens have historically been able to garner more privileged care. Moreover, they create strong incentives for providers to become responsive to all users, not just those with the loudest voices.

If the traditional left is serious about addressing equity, it is time that they shake off their intuitive dislike of market-based reforms and take a hard look at whether choice and competition has the potential to improve the care delivered to traditionally underserved users. We think it does.

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New Health Systems in Transition (HiT) profile

The latest addition to the Health Systems in Transition series has just been published and is available online.

It focuses on Denmark, a small country with 5.4 million inhabitants. Danish health care is dominated by the public sector, financed by local and state taxes and administered by the regions. In recent years the focus of health care reform has been on patient choice, waiting times, quality assurance and coordination of care.

The publication of the HiT is very timely because a major structural reform in 2007 changed the political and administrative landscape dramatically. Reforms in the way health care is financed also took place.

Available at <http://www.euro.who.int/Document/E91190.pdf>



Pay-for-Performance in the US: What lessons for Europe?

Marin Gemmill

Summary: Pay-for-performance (P4P), a model of provider reimbursement linked to quality achievement or improvements, has been gaining traction in the United States. This paper examines the rationale behind P4P programmes and discusses some recent examples of pay-for-performance initiatives within the private insurance, Medicare, and Medicaid programmes in the US. While the evidence on P4P is still relatively scant, we are able to derive some preliminary conclusions on the design and effectiveness of P4P activities from the existing evidence. These considerations are then discussed in light of European health policy, and we provide some insight for European policy makers on the adoption of P4P programmes.

Keywords: pay-for-performance, provider reimbursement, quality

During the past decade health care insurers in the United States have been integrating a model of provider reimbursement called pay-for-performance (P4P) into the traditional reimbursement system, where the models have been fee-for-service, capitation or budgets, case-related reimbursement (for example, diagnosis-related groups – DRGs), and salaries. Under pay-for-performance, providers are given financial incentives to encourage and reinforce pre-established targets for health care delivery.¹ The overall intent is to improve the quality of health care provision and enhance patient outcomes.

In Europe pay-for-performance within health care is still a relatively new concept, with the UK being one of the first European countries to implement a system of this kind. Given its novelty in Europe, it is important to discuss whether the outcomes of P4P in the US have been as expected and their relevant implications for European health policy.

Introduction to health insurance and delivery in the US

Health insurance coverage in the US is fragmented between public and private

payers. The main public organisations are Medicare, Medicaid, and other public insurers like the Veterans Administration and TRICARE. Medicare is mainly available to certain disabled people and individuals aged sixty-five and above. Physician reimbursement is based on a fee schedule that is adjusted according to factors such as the type of service provided, where the service is performed, and geographical location. Hospitals are reimbursed according to the DRG methodology, which is a system that classifies hospital cases into groups with similar expected hospital resource use.

Medicaid covers certain low-income individuals, and the programme is overseen by the Federal government and administered by the states. While Medicaid programmes have considerable leeway in determining methods of provider reimbursement, most states reimburse physicians via fee-for-service (adjusted by the specific service performed) or capitation. Hospital reimbursement methodologies include per diem rates, cost-based payments, DRG payments, and capitation.

Private insurance coverage encompasses group and non-group coverage and managed care and fee-for-service programmes. Even within these categories, physician and inpatient reimbursement methodologies may vary considerably. Physician reimbursement is generally fee-

for-service or capitation, while inpatient reimbursement may be per diem, capitation, or case rates (including DRGs).

The rationale behind P4P

One disadvantage of the traditional reimbursement models is the lack of emphasis on quality. For instance, there may be overuse of medical treatment under fee-for-service, while there may be underuse under capitation or salaries. The US Institute of Medicine (IOM) highlighted the importance of provider reimbursement in a 2001 report, *Crossing the Quality Chasm*.² The IOM argued that the quality of US health care was well below established benchmarks based on the best available evidence, and that payment mechanisms were an important contributor to the poor quality of care. Other researchers have indicated that adherence to evidence-based practices is variable across regions and providers,³ implying that US insurers and providers have considerable scope to implement quality improvements. In response, health plans and purchasers have put a considerable amount of effort into profiling providers and publicly reporting information on the quality of different providers, but evidence indicates that consumers fail to use this information when making health care decisions.³

The nature of health care delivery,

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whereby a physician acts as an agent for the patient and a third-party payer covers the majority of costs, implies that consumer choice alone may be insufficient for bringing about quality improvements. Pay-for-performance provides financial incentives to improve quality even when consumers are unresponsive to quality information. This reimbursement model is also expected to encourage ongoing quality improvements, for instance, through the installation of health information technology and more health care staff. Importantly, P4P may not reduce health care costs, but it is meant to ensure better value for money.

P4P methodologies

There are multiple ways in which models can be designed. The main features centre around the aspects of quality that are targeted, the allocation of the rewards, and whether rewards are based on quality improvements or target achievement. The targeted aspects of quality may be structure, process, outcome, or a combination of all three.³ Structure encompasses the resources needed to deliver care (for example, labour, facilities, and materials), process covers the completion of specific tasks or suggested procedures, and outcome includes the effect of treatment, mainly the patient's experience and health status. Each aspect has its own advantages and disadvantages, but essentially the choice of which aspects to target influences the level of quality improvements, equity, and the amount of risk that providers experience.

Third-party payers can also choose whether to allocate rewards to individual providers or groups of providers. The difficulty in allocating rewards to individual providers is that some providers may have small patient groups leading to skewed outcomes, while incentives to improve quality may be muted in provider groups. The intuition is that within provider groups, some providers may 'free-ride' on the efforts of other providers. However, by rewarding provider groups, P4P programmes may create an incentive for coordinated care, for instance, through the creation of multi-disciplinary provider groups. Another important aspect of P4P is whether providers are rewarded for good performance or for improving quality. The former method rewards providers that are already high-quality but gives little incentive to low-quality providers to improve.

The uptake of P4P in the US

Pay-for-performance systems have diffused relatively rapidly throughout US health care insurers within the past decade, albeit on a small scale. Within private insurance markets more than half of health maintenance organisations (HMOs) have instituted P4P programmes, coverage that represents more than 80% of HMO enrollees in the US.⁴ Pay-for-performance is also growing in importance within the public insurance arena. By July 2006 more than half of the state Medicaid programmes had implemented pay-for-performance schedules, and it is estimated that by 2011, almost 85% of states will operate Medicaid P4P programmes.⁵ Medicare is also embracing P4P, although more detail on Medicare initiatives is given later in the article.

Despite the widespread use of P4P, these programmes typically make up a small proportion of provider reimbursement. Rosenthal and colleagues previously indicated that most payers only put 5% or less of provider compensation at risk of profit or loss from the P4P system.³

Examples of P4P in the US

While there are hundreds of different P4P activities running, it is useful to discuss the main initiatives on the part of public and private payers. Medicare began running a P4P demonstration project jointly with Premier, Inc. (a nationwide organisation for non-profit hospitals) in 2003.³ The programme rewarded hospitals according to performance in five critical treatment areas for older people: acute myocardial infarction, heart failure, pneumonia, coronary artery bypass graft (CABG) surgery, and hip and knee replacement. The quality determinations were based on process and outcome measures. All hospitals were scored and ranked by treatment area. Hospitals in the top 10% of performers for each condition received a bonus of 2% of their Medicare payments. Hospitals in the next decile received a 1% bonus. The demonstration has ended, and Premier, Inc. and Medicare are currently discussing whether to extend the experiment. In 2007 Medicare also launched the Physician Quality Reporting Initiative, providing a 1.5% (of total allowed charges for eligible services) bonus for participating providers that successfully report the designated set of seventy-four quality indicators.

Pay-for-performance programmes within Medicaid are generally state-specific.

However, nine Medicaid programmes have joined with other groups to improve pay-for-performance activities.⁵ A specific example is the Oregon Health Care Quality Corporation, a group of organisations (the state government, health plans, medical groups, insurers, purchasers, providers, and consumers) that are working together to incorporate standardised performance measures into P4P programmes.⁵ Interestingly, many Medicaid agencies are encouraging participation rather than performance in their P4P programmes; the intent is to incentivise providers to adopt technologies such as electronic health records and electronic prescribing.⁵

In California, a group of health plans and physician groups developed the California Pay for Performance programme,⁶ which entails a set of quality performance measures, public report cards and financial incentives. The programme is now the largest of its kind in the US. Performance is measured on three main domains: clinical events (preventative measures and chronic care management), patient experience, and information technology investment.⁶ The California programme does not define the level of financial reward; instead this decision is left up to the individual participating health plans.

Another P4P programme backed by large employers is Bridges to Excellence (BTE), which aims to incentivise physicians in a number of target markets across the US to improve health care quality.³ BTE has four distinct initiatives: the Diabetes Care Link, the Cardiac Care Link, the Spine Care Link, and the Physician Office Link. Participants are awarded points for achieving quality measures within each of these links, and points are translated into financial awards that are specific to each link.

Evidence from the literature

Empirical evidence on P4P programmes is still relatively scant, but based on one review of the literature it is possible to draw preliminary conclusions regarding the outcomes and design of P4P programmes.⁷ This review indicated that most studies found partial or positive effects of P4P financial incentives on quality measures, whether the activity was at the individual physician or physician group level.

In addition, the design of incentives is important. A few studies have determined that documentation, as opposed to actual

use of preventative services, improved under P4P.⁷ While documentation is important, quality improvements also need to come from better use of services. The design of incentives may also have influenced risk selection in that providers may have avoided sicker patients where this was possible. Given that P4P programmes can target individual providers or provider groups, the authors of the review also indicated that the effect of P4P at the provider group-level is small, whereas the effect seems less muted for rewards at the individual physician level. Thus, it appears that some providers may 'free-ride' on the efforts of other providers within the group.

As discussed earlier, there is debate over whether providers should be rewarded for meeting benchmarks or for improving performance. Interestingly, providers with the lowest baseline performance may improve the most even if they receive the smallest amount of performance pay, implying that a P4P programme should consider incentives for both improvement and target achievement. The size of the reward may also influence whether P4P has any effect on the achievement of target indicators.⁷ Some studies that have found no relationship between the P4P programme and quality may have obtained this result because of small bonuses.

The review of P4P programmes found only one article that examined their cost-effectiveness. This study considered incentives to improve access to nursing homes and patient outcomes within the nursing home.⁸ This indicated that the P4P programme saved an estimated \$3,000 per stay. However, not only is that study over fifteen years old, but the savings that the study found may not have accrued to the third-party payer. Thus, there is insufficient evidence available to draw any conclusions on the cost-effectiveness of P4P programmes.

Pay-for-performance in Europe

The P4P model has already made its way into Europe with the implementation of the large-scale Quality and Outcomes Framework (QOF) for primary care in the UK. Under QOF general practitioners are rewarded for chronic disease management, practice organisation, patient experience, and extra services (for example, child health and maternity services)⁹ Overall, Europe lags behind the US in implementation of P4P programmes, and thus a number of comments can be offered to

European policy makers considering P4P.

One important but unanswered question is whether P4P is cost effective. While literature on this topic is lacking, it seems prudent for European policy makers to determine if a P4P programme provides value for money in a pilot setting before implementing it on a large scale. Related to the costs of the programme, the reward structure that a third-party payer imposes is important. If rewards are insufficient, providers may not change their behaviour. While there are few guidelines available on the size of rewards, some suggest that 5% of the physician's capitation income is necessary for behavioural change.⁷ In addition, policy makers must decide whether the reward is for meeting a benchmark, improving the influence of quality on outcomes, or both. The choice of the reward is related to whether the aim is to improve the performance of the lowest-quality providers, to maintain the performance of the highest-quality providers, or to achieve a combination of both.

Risk selection is also important to consider. If it is more difficult for providers to improve performance with certain types of patients (for example, sicker patients), then providers have an incentive to select healthier patients if this is possible. Since many European health care systems explicitly aim for equity, disincentives for risk selection should be built into any European P4P activities. England has addressed the possibility of risk selection by allowing providers to exempt reports on patients whose targets were more difficult to meet.¹⁰

There is also the question of whether providers shift their focus to targets under the P4P system and pay insufficient attention to medical issues that are not part of the system. This may lead to a focus on the disease rather than on the patient.¹⁰ The question for policy makers is whether this influences the overall quality of care provided. There is also a consideration of whether it is possible to design a P4P system that encompasses more quality measures or whether this type of system would create too much of an administrative burden.

Overall, the success of a P4P programme appears to depend crucially on the programme design, as this influences the achievement of quality improvements. Importantly, there may be a trade-off between cost and quality, although more

research on cost-effectiveness is needed to make any definitive statements regarding a trade-off. The variety of P4P measures that can be adopted also implies that European policy makers need to clearly define the aims of any P4P programme and adopt specific P4P measures to meet these aims.

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Kaiser Permanente revisited – Can European health care systems learn?

Martin Strandberg-Larsen, Michaela L Schiøtz, Anne Frølich

Summary: European health care systems are facing the challenge of macroeconomic constraints and a rise in patients with chronic conditions demanding a continuum of services. The US managed care organisation, Kaiser Permanente, has been highlighted as a successful model of integrated, cost effective care. This claim has been disputed, but the evidence base to guide European policymakers and health system planners is limited. This article presents an overview of the organisational structure and developments within Kaiser Permanente to inform this debate. Research initiatives that are still needed to critically investigate the usefulness of the Kaiser Permanente model for Europe are discussed.

Keywords: Integrated health care delivery, Self Care, Disease Management, Chronic Conditions, USA

In recent years the US managed care organisation Kaiser Permanente (KP) has started to influence mindsets and policy development within many European health care systems. Delegations from twenty-six countries, including thirteen from Europe have visited the organisation.¹ The reason for this interest is that KP has been highlighted as a successful model of integrated cost effective care.²⁻⁴ In their influential article in the British Medical Journal (BMJ), Feachem *et al.* compared the costs and performance of the English NHS with those of KP in California. They concluded that KP provided much better value, largely by using only one third of the acute bed days used in the NHS. This was explained by better integration throughout the system, efficient management of hospital use, the benefits

of competition and greater investment in information technology.²

Taken at face value, the benefits of the KP model are substantial. However, the claim was subsequently disputed and several serious criticisms were levelled at the methods used.^{5,6} Seventy-five letters were sent to the BMJ.⁷ Forty-six tried to dismantle the authors' analysis, while twenty-seven letters supported the paper, but many added that the superiority of KP could be explained by the extra resources at its disposal.⁷ To investigate further Ham *et al.* carried out a more detailed study of the KP model.³ Their findings were again in favour of KP, with much lower hospital admission rates and overall length of stay than the NHS. Existing studies therefore indicate that there are important lessons to be learned from the KP model; the evidence base, however, is not conclusive.

To inform ongoing policy debate and facilitate competent learning processes, this

paper presents an overview of the organisational structure of Kaiser Permanente Northern California (KPNC), recent developments within the system, and highlights points of interest for European health care systems. Finally, we briefly discuss the necessity for research initiatives that critically investigate the usefulness and transferability of the KP model to Europe. This is done in recognition of the need for high level policy making to be based on evidence instead of convincing rhetoric and supposition.

The Kaiser Permanente health care model

KP is an integrated managed care organisation founded in 1945 by the industrialist Henry J Kaiser and the physician Sidney R Garfield. It operates in the USA where health care is largely provided by a mix of private insurance companies, as well as through government programmes

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* Medicaid is the United States health care programme for individuals and families with low incomes and resources.

** Medicare is a health insurance programme administered by the United States government, covering people who are either aged 65 and over, or who meet other special criteria.

including Medicaid* and Medicare**. Thus KP operates in a competitive market across eight regional areas and is the largest not-for-profit managed care organisation in the United States, with 8.2 million members.⁸

Structure of KPNC

There has been a particular focus in debate on the KPNC, the largest of the eight regional entities.

This is a consortium of three separate but interdependent groups: the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals are integrated with independent physician group practices called Permanente Medical Groups. The health plan is the insurance component of the organisation, while the hospitals and medical groups provide all clinical services.⁷ To the public these hospitals and general practitioner type facilities are seen as one organisation, commonly referred to as Kaiser.

Integrated patient pathways

Within KPNC a range of health services are provided, including hospital admissions, ambulatory, preventive, sub-acute, accident and emergency care, as well as optometry, rehabilitation and home health care. Coverage provided by KPNC depends on an individual's chosen health plan, ranging from low coverage health plans with relatively high co-payments to plans providing extensive coverage but minimal co-payments.^{2,9} Some European health care systems cover dental services and both long term psychiatric or nursing care to a greater extent than KPNC.

“there is a strong emphasis on primary care and preventive services, including screening programmes”

A typical patient in need of primary care will in the KPNC be treated and cared for solely within an out-patient medical centre. The medical centre will have a range of primary care facilities available, including paediatricians, internal medicine physicians, geriatricians, other specialists, nurse practitioners, nurses, health educators, administrative personnel, a pharmacy and an emergency department. Physicians also have access to in-house

Table 1. Financial structure of Kaiser Permanente

Source of finance	Member dues (71%) Medicare (22.3%) Co-payments, deductibles, fees and other (6.7%)
Financial intermediary	Kaiser Foundation Health Plan between purchaser and provider
Service provision	Not-for-profit Kaiser Foundation Hospital For-profit Permanente Medical Groups
Low income and unemployed	3.5% of Kaiser members are from California's Medicaid programme Medi-Cal Kaiser provides care to uninsured people who account for 5% of admissions to the community hospitals Medicare members can choose to obtain health care from KP
Payment of physicians	Physicians are paid a salary, including 5%–10% in financial incentives
Payment of hospitals	Contracting with the Kaiser Foundation Health Plan

Sources: Feachem RG, Sekhri NK, White KL²; Kaiser Permanente¹¹

laboratory facilities and other advanced medical equipment.

Patients can be admitted to hospital where necessary. Subsequent care and some rehabilitation will be administered outside the hospital at a skilled nursing facility (SNIF). KPNC enters into contracts with these independent SNIFs. Integrated patient pathways are facilitated by a team based approach and by multi speciality medical centres. Information exchange across providers is made possible by the operational electronic health record 'KP Health-Connect'. This also allows for multiple patient panel management and two-way patient contact.⁸ Furthermore, KP Health Connect has been an important driver in quality improvement by creating competition between providers inside KPNC through the benchmarking of performance outcomes.

Financial resources

The financial structure of KPNC sets the framework for the integrated delivery of care. The health plan and hospitals operate under state and federal not-for-profit tax status, while the medical groups operate as for-profit partnerships or professional corporations in their respective regions.¹⁰

In 2004 member dues accounted for 71% of KP revenues, with Medicare making up

a further 22.3% and co-payment, deductibles, fees and other revenues 6.7%.¹¹ These are paid to the Kaiser Foundation Health Plan which contracts with the for-profit Permanente Medical Groups and the Kaiser Foundation Hospitals that run medical centres in California, Oregon and Hawaii and outpatient facilities throughout KP regions. Table 1 provides an overview of the financial structure of Kaiser Permanente, NC.

Focus on primary care and disease management

Due to its history of being a support facility for an industrial production line, the KP system focused on keeping workers healthy and treating the early signs of ill health. Its prepaid, fixed budget design aroused fierce opposition from county, state, and national medical societies. Consequently, Kaiser doctors were barred from existing facilities, thus KP had to build its own hospitals, this becoming a self-contained delivery system with its own full-time doctors, nurses, and other staff.

KP has continued to recruit clinicians who value prevention, provide a whole systems approach to health care and embrace team-based treatment.⁴ This is reflected within the organisation by a strong emphasis on primary care and preventive services,

Box 1: Research to assess the transferability of the Kaiser Permanente approach

Cross country comparisons are important as a driver for change but highly complex to undertake. An initiative is now underway to disseminate the results of empirical work comparing the Danish health care system with that of Kaiser Permanente Northern California.

The initiative has been established by an international research network involving both Danish and US researchers. The network is assessing the general transferability of the KP model and focuses in particular on chronic care management, self management support programmes and care coordination strategies. Findings will be broadly disseminated to policy makers and health system planners.

The research initiative is funded by the Rockwool Foundation.

including screening programmes for a range of diseases. The electronic health record in KP supports this preventive approach, making it possible to reach out to patients due for follow-up examinations. These, for instance, might include individuals having difficulty in managing their conditions, as well as those overdue for a mammogram, cholesterol check or Pap smear. This outreach work is undertaken by Medical Assistants that contact KP members using the telephone or secure messaging (confidential email).

During recent decades KP has also implemented Disease Management (DM) programmes for coronary artery disease, heart failure, diabetes and asthma. DM programmes include clinical guidelines, patient self-management education, disease registries, proactive outreach, reminders, multidisciplinary care teams and performance feedback to providers. The components are integrated in a comprehensive effort to help clinicians plan and deliver care to help patients play an active and informed role in caring for themselves.¹² To strengthen quality and the ongoing development and implementation of evidence based clinical guidelines, KP established the Care Management Institute (CMI) in 1998.

Another initiative to ensure high quality cost-effective care is risk stratification of patients with chronic conditions, along three levels according to the severity of their disease. The philosophy behind these DM programmes is that they will result in

both higher quality and lower cost treatment of chronic conditions.

This idea that DM programmes can reduce health care costs by improving quality has been called into question. An investigation in KPNC revealed that actual cost savings were elusive but that the programme might have sizable potential savings, since costs might increase at a greater rate without the use of DM programmes. The continuous use of this approach to the treatment of chronic conditions thus requires that organisational structures have the political will and capital to invest in DM programmes even though it might take many years for the benefits of these programmes to be realised.¹²

“increased investment alone will not provide health services that are most beneficial to the overall health of the European population”

Conclusion

One key message from the ongoing debate over KP is that policymakers, health system planners and medical practitioners are increasingly realising that increased investment alone will not provide health services that are most beneficial to the overall health of the European population. Fundamental changes in the way that services are organised and managed will also be necessary, as will be a shift in the balance of priorities between primary and specialised hospital care.

To direct policy efforts and assist health system planners in the potential reorganisation of European health systems, we need to strengthen the evidence base through detailed research comparing KP and similar organisations with the broad spectrum of European health care systems. Such research may enlighten us as to whether the KP approach is efficient compared to existing European practices. One example of such comparative work is presented in Box 1. Data sources and techniques for such comparative studies must be refined; more in depth analysis of the potential to transfer selected programmes and system elements to different European settings must be encouraged.

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Mythbusters

Myth: The risks of immunising children often outweigh the benefits

A significant number of parents are preoccupied with vaccine side-effects.¹ Hundreds of anti-vaccine web sites link vaccines for once-common childhood diseases to sudden infant death syndrome, Crohn's disease, autism, diabetes, and other diseases. Many claim the risks of vaccines are far greater than the benefits of being immunised.^{2,3}

Growing doubts about the benefits of vaccines are even seen among health care providers. For example, one study in Quebec found more than 40% of nurses do not fully agree with the opinion that vaccines are safe, effective, or altogether useful for children.⁴ And 40% of nurses also believed that practices such as homeopathy and healthy eating were effective alternatives to vaccination.⁴

However, research shows vaccination has saved more lives in Canada in the last fifty years than any other intervention,⁵ and vaccination ranks as one of the most effective and cost-effective public health achievements. In fact, when you consider the number of lives immunisations save each year, it actually costs more not to invest in vaccination programmes.^{6,7}

A calculated risk

While no vaccine is risk-free, these interventions have been dubbed "the safest tools of modern medicine."⁷ The large majority of vaccine side-effects are minor and temporary, such as a sore arm

or mild fever.^{6,8} Although more serious side-effects – such as severe allergic reactions – can occur, these are rare, occurring less than once in every one million vaccine doses in Canada.⁶ On the other hand, the risks of letting children get a disease like measles or diphtheria are far greater than any vaccine side-effect.^{6,8}

Take diphtheria for example – while the vaccine can cause minor and temporary redness and swelling at the injection site or fever, the disease may lead to heart and neurological complications, not to mention a 5–10% death rate.⁶ In the case of mumps, the occasional side-effects of the vaccine are a fever and mild skin rash. However, one in 200 children who get mumps will develop a brain disorder.⁶ Other children who get mumps may become deaf.⁶ Mumps in adolescent or adult males can cause painful swelling of the testicles and may lead to infertility.⁶

MMR and autism: no link

One vaccine that has come in for serious criticism is the measles, mumps, rubella (MMR) vaccine, which critics claim is the cause of a range of developmental problems in children, including autism. However, the argument made in one or two reports that the link exists has been highly refuted in numerous scientific studies and in major systematic reviews.^{9–11} A recently updated Cochrane review

Comparison of effects of diseases and common side-effects of vaccines⁶

Disease	Effects of disease	Side-effects of vaccine
Tetanus (lockjaw)	One in 10 dies	One in five has discomfort or swelling; one in 20 has fever
Pertussis (whooping cough)	One in 100 children less than six months dies from pneumonia or a fatal brain disorder	One in five has discomfort or swelling; one in 20 has fever
Haemophilus influenzae, type B disease	One in 20 dies from meningitis; 10–15% have permanent neurological dysfunction; 15–20% become deaf	One in 20 has discomfort and swelling; one in 50 has fever; no serious side-effects have been attributed to Hib vaccine
Measles (red measles)	One in 10 develops pneumonia or an ear infection; one in 1,000 develops brain inflammation and, of these, 10% die and 25% will have permanent brain damage; one in 25,000 develops a rare chronic brain infection	One in 20 has discomfort and fever with or without a rash; one in a million develops brain inflammation

Mythbusters are prepared by Knowledge Transfer and Exchange staff at the Canadian Health Services Research Foundation and published only after review by a researcher expert on the topic.

The full series is available at www.chsrf.ca/mythbusters/index_e.php. This paper was first published in 2006. © CHSRF, 2006.

found “no credible evidence” of an association between the MMR vaccine and autism.⁹ Similarly, a 2006 Montreal-based study that explored the relationship between recent trends in pervasive developmental disorders – a wide spectrum of social and communication disorders, including autism – and exposure to MMR vaccine ruled out any association.¹⁰ In fact, there is no sound evidence whatsoever that links immunisations with sudden infant death syndrome,¹² diabetes,¹³ or Crohn’s disease.⁹

One thing not in doubt is the MMR vaccine’s ability to prevent the diseases it is designed for – used in more than thirty countries, this vaccine has been given to populations en masse, successfully demonstrating its ability to virtually eliminate the target diseases.⁹

The key to preventing outbreaks

While vaccination coverage data vary by province and territory, the 2002 National Immunisation Survey shows, for example, that reported coverage of MMR in seven year-olds is just more than 75%¹⁴ – well below the national goal, which is closer to 95%.¹⁵ The same survey shows many children are under immunised; the rate of children receiving their booster of MMR vaccine falls nearly twenty percentage points below the national target.¹⁴

As recent history tells us, the possible outcomes of low vaccination rates are alarming.^{16,17} In Great Britain in 1974, an epidemic of more than 100,000 cases – including thirty-six deaths – of pertussis (whooping cough) followed a dramatic drop in vaccine use for this disease.¹⁷ Following the outbreaks, vaccination rates rose once again, which, in turn, saw disease rates fall.¹⁷ Similarly, a recent US study found that for states with lax vaccination laws, there is a 90% higher incidence of whooping cough.¹⁸

To keep measles and other once-common childhood diseases from spreading, a high percentage of the population – in the realm of 95% for measles, for example – must be immunised. When vaccination rates are close to this percentage, ‘herd

immunity’ is said to exist, where the majority (and vaccinated) portion of the population protects the rest of the population.^{19,20} If this critical mass is not achieved, outbreaks can occur.²⁰

Conclusion

No medical intervention is ever one hundred percent effective or comes without any risks. In the final analysis, vaccines for childhood diseases that were once common in Canada appear to be particularly well-evaluated interventions where the benefits clearly outweigh the risks.

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Evidence-based health care



Bandolier

Mobile phones and cancer

Many of us use mobile telephones to a greater or lesser extent. Because mobile phones emit radio frequencies that can penetrate several centimetres into the human brain, it has been hypothesised that their use could possibly lead to tumours of the head and neck

This possibility has led to a number of 'scare' stories in the popular press. Typically, debunking the scare involves trying to prove a negative, never an easy thing at the best of times. About the only way to prove a negative is to have very large amounts of data, but also demonstrating the lack of any sort of dose-response as well as no biological plausibility. A large Danish study goes most of the way to doing that for mobile phones and cancer.¹

Study

In the period 1982 to 1995 over 700,000 Danish citizens subscribed to a mobile telephone service. After eliminating those in which individual users could not be identified because they were corporate subscriptions, had incorrect addresses, were from Greenland or the Faroe islands, had a history of previous cancer, or were under eighteen years, the final cohort consisted of 420,000 identified subscribers.

Because Denmark has a system of personal identification numbers, cohort members could be linked to files of a cancer registry that is virtually complete, using a nationwide system of cancer

classification. Follow up began from the first day of subscription, and ended on date of diagnosis of any cancer, death, emigration, or end of 2002.

Numbers of cancers found were compared with the number expected in the general Danish population, for men and women, and in five-year age groups. Mobile phone subscribers were omitted from this comparison group.

Results

Most (85%) of the 420,000 subscribers were men. The median time of mobile telephone subscription was 8.0 years. Mobile subscribers had 14,250 cases of diagnosed cancer, against an expected number of 15,000, giving an overall standardised incidence ratio of 0.95 (95% confidence interval of 0.93 to 0.97).

For men and women analysed separately there was no difference from expected in all brain and nervous system cancers, or cancers of the salivary glands or eye. For men and women analysed together, there was no increased risk of any type of intracranial cancer, with a hint of a decreased risk for parietal lobe tumours. There was no increase in brain and nervous system tumours and leukaemias

according to time from first subscription (Table 1).

There was no increased risk of any other type of cancer for men, with hints of decreased risk for lung, bladder, buccal, oesophageal and liver cancers, as well as other cancers and unspecified cancers. For women the numbers of individual cancers were small, and none had any large increase or decrease in incidence over expected.

Comment

What is good about this study is that it was large, of long duration, covered a whole population, and was performed in Denmark. Denmark has an almost unique ability to successfully link different databases through the use of personal identification numbers.

The results all but eliminate the concept that the use of mobile phones can cause cancer. And not just cancer, because the study allows detailed diagnosis of particular cancer types, including acoustic neuromas and cancers of temporal and parietal lobes which would be the parts of the brain closest to a mobile phone antenna, and hence most at risk.

The paper has a wonderful discussion, which not only puts these results into the context of others, but tells us that the authors could find no studies indicating any biological plausibility for a link between mobile phones and cancer. This comes as close to proving a negative as we are ever likely to get, but even more data will come out in future from continuation and extension of the study.

If you Google mobile phones and cancer, you will find links to over nine million sites. Some are good, some are up to date, but many are not. They should all reflect on the data from Denmark.

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Table 1: Brain and nervous system cancers and leukaemias by years of mobile phone subscription compared with non-subscribers in Denmark

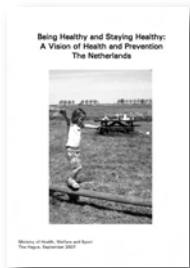
Years of subscription	Person years	Standardised incidence rate (95%CI)	
		Brain and nervous system	Leukaemia
<1	420,000	0.9 (0.7 to 1.2)	1.1 (0.8 to 1.5)
1-4	1,656,000	1.0 (0.9 to 1.2)	1.1 (0.9 to 1.2)
5-9	1,327,000	1.0 (0.8 to 1.1)	0.9 (0.8 to 1.1)
≥10	170,000	0.7 (0.4 to 0.95)	1.1 (0.7 to 1.5)

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

This paper was first published in 2007. © Bandolier, 2007

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Being Healthy and Staying Healthy: A Vision of Health and Prevention



Dutch Ministry of Health, Welfare and Sport, 2007

The Netherlands, The Hague.

44 pages

Freely available online at:

http://www.minvws.nl/images/fo-being-healthy-_tcm20-156779.pdf

This document, detailing the vision of the Dutch Ministry of Health, Welfare and Sport and its partners, begins with an analysis of the present health status of the Netherlands and its implications (sections 2 and 3). It raises concerns that the Netherlands is less healthy than many other European countries and that health inequalities within the country persist.

The Ministry's vision for the future is then presented in the context of two key themes: the relationship between the individual and his/her environment and the links between preventive health care and other forms of health care (sections 4 and 5).

The report argues that since in modern society people are constantly tempted to make unhealthy lifestyle decisions, it is the role of the government to make the healthy

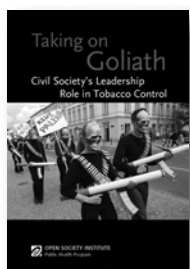
option easy wherever possible. This implies tailoring initiatives to the relevant target groups. Furthermore, the report advocates preventive action undertaken in the curative care sector by identifying and addressing risk factors. In order to create an appropriate funding structure and achieve continuity, the report argues it will ultimately be necessary to fund preventive health care practitioners through private and/or state health insurance schemes.

Section 6 identifies a number of ways in which the governmental setting must be improved and modernised. Making the case for moving "from public health policy to a healthy public policy", the report envisions municipalities serving as hubs of cooperation, being central to the implementation of the policy.

Contents: Introduction; health in the Netherlands; stakes, responsibilities and forms of prevention; the association between setting and behaviour; the association between preventive and curative care; the administrative setting; integration, cooperation and modernisation; conclusion.

Taking on Goliath. Civil Society's Leadership Role in Tobacco Control

Jeff Hoover



New York: Open Society Institute, 2007

60 pages

ISBN: 978-1-891385-72-8

Freely available online at:

http://www.soros.org/initiatives/health/articles_publications/publications/goliath_20070530/a_complete_report.pdf

Before briefly outlining statistics on smoking and lung cancer prevalence and international policy developments in tobacco control, this report turns to its main topic, the need for more extensive tobacco control in central and eastern Europe and central Asia. It argues that many legislative regulations and national tobacco control programmes, especially in the less developed countries farther east, are not effectively enforced and still have serious loopholes that prevent them from meeting WHO standards.

In many countries, civil society groups have been leading the way in devising, implementing, and demanding the enforcement of tobacco control policies and regulations.

The case studies in the report document the advocacy efforts of non governmental organisations in four countries all at

different stages in tobacco control: Kazakhstan, Moldova, Romania, and Ukraine. The report suggests that taken together, the case studies offer important lessons for future tobacco control efforts in the region, but also anywhere in the world.

Among the notable lessons are the following: civil society is crucial to successful tobacco control efforts; effective tobacco control efforts require comprehensive, multi-pronged approaches and strategies; economic research is an important, yet often neglected, component of effective advocacy; the media can be a powerful tool for and ally of tobacco control advocates; tobacco control regulations and affordable 'quit smoking' services are equally important in reducing tobacco use; expanded regional learning and cooperation offer clear benefits to local tobacco control efforts.

Contents: preface; summary; introduction; case studies: Kazakhstan, Moldova, Romania, Ukraine; lessons learned; notes

Slovenian EU Presidency 2008 News and information from the Slovenian Presidency of the European Union

<http://www.eu2008.si/en>

Health Information and Quality Authority (HIQA)

<http://www.hiqa.ie>

The Health Information and Quality Authority (HIQA), an independent body reporting to the Minister for Health, was formally established in Ireland in May 2007. It is responsible for setting standards in health and social care, monitoring health care quality, inspecting social care services, commissioning health technology assessments (including economic evaluations) and providing health information to all stakeholders. As part of its activities it is implementing a programme of quality assurance reviews for hospitals, primary care, general practice and the provision of ambulance services. This includes development of a standards framework for each of these sectors, incorporating all aspects of quality and service. The website provides detailed information about HIQA functions, newsletters, annual reports, inspection reports and health care standards.

European Environment and Health Information System (ENHIS)

<http://www.enhis.org>

This English language website hosts comparable data and information on priority environment and health issues as reflected by international policy frameworks on environment and health. Its content includes: a core set of indicators; a series of fact sheets presenting indicator-based assessments; country information for the fifty-three Member States of the WHO European Region; an overview of policies on core issues at both national and international levels; methodological guidance on the core set of indicators; and guidance on and examples of health impact assessments.

Institute of Alcohol Studies (IAS)

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

The UK based non-governmental organisation IAS aims to serve the public interest on public policy issues linked to alcohol by advocating for the use of scientific evidence in policy-making to reduce alcohol-related harm. The English language web site provides access to many resources including: a series of factsheets which cover a broad range of topics related to alcohol; papers responding to UK government initiatives; occasional papers; reports from European alcohol projects; a 'data map' of publicly available data on alcohol in the UK; *Alcohol Alert*, a quarterly magazine; a *Guide to Resources on the Night-time Economy* which provides an overview of academic and policy literature on the topic; and links to other alcohol related web sites.

International Union for Health Promotion and Education (IUHPE)

<http://www.iuhpe.org>

Established more than fifty years ago and based in Paris, the International Union for Health Promotion and Education (IUHPE) is the only global organisation entirely devoted to advancing public health through health promotion and health education. Members range from government bodies to universities and institutes, non-governmental organisations and individuals across all continents. In addition to annual reports and official responses to EU consultation papers, the website provides full text access to the organisation's journal, *Promotion and Education*, links to two other official academic journals of the IUHPE and details of a series of video conversations with individuals working in public health. Information on the organisation's scientific activities, conferences and links to other resources are also provided. The website is available in English, French and Spanish.

World Bank Human Development Network: Health, Nutrition and Population (HNP)

<http://go.worldbank.org/RQU0H5VGJ0>

The Health, Nutrition and Population (HNP) section of the World Bank's web site covers low and middle income countries, including those in eastern Europe and central Asia. It provides information on the HNP strategy; links to relevant data sources, including the database HNPstats and its research programme; a searchable database of discussion papers; downloadable toolkits and guidelines; details of all HNP funded projects and programmes; a list of related links; and details of relevant news and events. Most of the resources are in English and are freely available to download.

EUROPEAN MONITOR

Slovenian Presidency health priorities focus on cancer

Slovenian Health Minister Kukovic set out the priorities of the Presidency in the areas of public health in the European Parliament. The issue that raised the most interest and questions from MEPs was the initiative on cancer and a conference that took place on 7 and 8 February in Brdo. Minister Kukovic said they also planned formal and informal Council meetings to push forward the still awaited legislative proposal on cross-border health care. Slovenia also renewed its commitment to efforts in the fields of mental health, alcohol and obesity.

Joint commitments were mutually developed within the framework of the eighteen-month programme of the German-Portuguese-Slovenian Presidency. They are based on the promotion of health by encouraging a healthy lifestyle, particularly healthy nutrition and physical activity, prevention and control of communicable diseases such as HIV/AIDS and flu pandemics, innovations in health care and the accessibility of health care services.

The Presidency will also support a conference on 10–11 March on cross-sectoral policies in the field of nutrition and physical activity.

More information at
http://www.eu2008.si/en/Policy_Areas/Employment_Social_Policy_Health_and_Consumer_Affairs/Health.html

High Level Conference on Mental Health

Former Health and Consumer Protection Commissioner Markos Kyprianou outlined his intention to organise a high level conference on mental health. This will be a follow-up to the consultation on the Commission's Green Paper on Mental Health of 2005. This High Level event will take place

on the 13 June 2008 in Brussels, in the presence of the President of the European Commission, Dr José Manuel Baroso. It is expected to establish a cross-sectoral European Pact for Mental Health. The Conference will focus on four key action fields: suicide prevention; mental health in youth and education; mental health in workplace environments; and older people.

More information at
http://ec.europa.eu/health/ph_determinants/life_style/mental/mental_health_en.htm

Brussels presses for progress on lead markets for eHealth

The European Commission has called for quick action and strengthened national cooperation on lead market opportunities for eHealth in order to increase economic benefits and improve the quality of health services. E-health, along with a number of other products, will benefit from the 'Lead Markets Initiative for Europe' (LMI). Proposed by the Commission, this will foster the emergence of these markets by notably improving legislation, encouraging public procurement and developing interoperable standards. European enterprises would profit from fair and better chances of entering new fast-growing worldwide markets with a competitive advantage as lead producers. LMI would also rapidly bring visible advantage for Europe's consumers in key areas for their welfare.

"The prospective return on investment of eHealth is relatively high when compared to the costs inherent in the health sector," argued a Commission report on the development of the eHealth Market in Europe, published in late December 2007.

The report, drafted by a Commission eHealth task force, comprising representatives of several Directorate Generals, outlines a number of policy

recommendations for areas of intervention up to 2010. The recommendations, directed at industry, Member States and other eHealth stakeholders, focus on four main obstacles to the development of the eHealth lead market.

One aim is to reduce market fragmentation and the lack of interoperability through pilot actions, benchmarking, standardisation and certification. Another is to improve legal certainty and consumer acceptance by possibly adopting a legal initiative for eHealth and telemedicine, as well as an initiative to enforce personal data protection legislation, disseminating best practice and guidelines. Other key issues are to optimise funding opportunities through strengthened national and community research and development cooperation on eHealth; and to improve procurement by facilitating the expression of public demand through more innovation-friendly procurement activities and networking public procurers.

Just days before the publication of the report, the Commission adopted a new strategy on investing public money in high-risk technological research. The initiative seeks to clarify possible conflicts on this type of investment with EU state aid rules and procurement regulations and envisages flexibility for the Member States to cooperate with suppliers across borders in risk-benefit sharing.

The report Accelerating the Development of the eHealth Market in Europe is available at
http://ec.europa.eu/information_society/activities/health/docs/lmi-report-final-2007dec.pdf

Guidance on obtaining 11-year marketing protection

New guidance has been issued by the European Commission on the elements required to support a significant clinical benefit of a new therapeutic

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

indication in order to obtain an eleven year marketing protection. Under Regulation (EC) 726/2004 (Article 14(ii)) and Directive 2001/83/EC (Article 10(i)), authorised medicinal products are granted a ten year period of marketing protection during which generic medicinal products cannot be placed on the market. This period can be extended to eleven years if the marketing authorisation (MA) holder obtains an authorisation for one or more new therapeutic indications that bring a significant clinical benefit in comparison with existing therapies. The authorisation of the new indication should take place within eight years from the date of the first authorisation. The aim of the European Commission's guidance is to outline the level of evidence required to demonstrate a significant clinical benefit.

To request an extension of the period of marketing protection, a MA holder is required to prepare a report to enable the relevant competent authority to assess if a new indication is of significant clinical benefit. This report should include justification of the proposed new indication compared to the therapeutic indications already authorised for the medicinal product in question, details of existing therapies relating to the proposed new indication and justification as to why the new indication is of significant clinical benefit compared to the existing therapies. The Commission's publication provides guidance on each of these elements.

The guidance states that a new therapeutic indication may refer to either diagnosis, prevention or treatment of a disease and could include a new target disease, different stages or severity of a disease, an extended target population or a change from treatment to prevention or diagnosis of a disease. The justification of the new indication by the MA holder should be supported by appropriate scientific information.

When providing details of the existing therapies, the MA holder should consider other satisfactory methods of diagnosis, prevention or treatment of the disease in question. This should include other authorised medicinal products and non-pharmacological approaches such as surgical interventions or radiological techniques. The MA holder should refer to scientific and medical literature to describe the value of such methods.

To establish that a new indication has a significant clinical benefit in comparison with existing therapies, the MA holder should provide scientific data and documentation, supported by results of comparative clinical studies. The new indication should provide a clinically relevant advantage or a major contribution to patient care. This can be demonstrated by greater efficacy, improved safety profile or more favourable pharmacokinetic properties.

A copy of the guidance can be obtained at http://ec.europa.eu/enterprise/pharmaceuticals/eudralex/vol-2/c/guideline_14-11-2007.pdf

European Commission investigates the pharmaceutical sector

On 16 January 2008 the European Commission launched a sector inquiry into competition in the pharmaceuticals sector (under Article 17 of Regulation 1/2003), and is conducting inspections at the premises of a number of innovative and generic pharmaceutical companies.

Sector inquiries are investigations that the European Commission may decide to carry out into sectors of the economy, when a sector does not seem to be working as well as it should. The Commission uses the information obtained in the inquiry to better understand the market from the point of view of competition policy, as analysed in its report on the sector. Should there be grounds for doing so, the Commission may – at a later stage – assess whether it needs to open specific investigations to ensure the respect of Community rules on restrictive agreements and abuse of dominant market position (Articles 81 and 82 of the EC Treaty).

The use of surprise inspections as part of this inquiry is unprecedented and comes as a response to indications that competition in pharmaceutical markets in Europe may not be working well: fewer new pharmaceuticals are being brought to market and the entry of generic pharmaceuticals sometimes seems to be delayed. The inquiry will therefore look at the reasons for this.

In particular, it will examine whether agreements between pharmaceutical companies, such as settlements in patent disputes, may infringe the EC Treaty's prohibition on restrictive business practices (Article 81). It will also look into whether companies may have created

artificial barriers to entry, whether through the misuse of patent rights, vexatious litigation or other means, and whether such practices may infringe the EC Treaty's ban on abuses of dominant market positions (Article 82).

Vigorous competition in this sector is crucial for the public, as it ensures both access by patients to state-of-the-art medicines, and value for money for health spending by individuals, private health schemes and government health services in Europe. An interim report is planned for autumn 2008 and final results are expected in the spring of 2009. The inquiry's findings will allow the Commission, or national competition authorities, to focus any future action on the most serious competition concerns, and to identify remedies to resolve the specific competition problems in individual cases.

Competition Commissioner Neelie Kroes said that “individuals and governments want a strong pharmaceuticals sector that delivers better products and value for money. But if innovative products are not being produced, and cheaper generic alternatives to existing products are in some cases being delayed, then we need to find out why and, if necessary, take action.”

Unlike cartel cases, where the Commission carries out inspections when it has indications that specific companies have committed competition law infringements, these inspections are not aimed at investigating practices of companies where the Commission has already positive indications of wrongdoing. They are just the starting point of this general sector inquiry and aim to ensure that the Commission has immediate access to relevant information that will guide the next steps in the inquiry. The kind of information the Commission will be examining, such as the use of intellectual property rights, litigation and settlement agreements covering the EU, is by its nature information that companies tend to consider highly confidential. Such information may also be easily withheld, concealed or destroyed. This is why inspections have been considered appropriate.

Innovation in the pharmaceutical sector is driven by patents and other intellectual property rights, and the inquiry will be conducted taking into account these existing rights. The Commission's

action will therefore complement, not challenge, intellectual property law, as both systems share the objectives of fostering innovation, and increasing consumer welfare. The inquiry will also take due account of the specificities of the relevant regulatory frameworks. It will not in any way put into question the various health schemes in force in the Member States. The inquiry is limited to medicines for human consumption.

To carry out the inquiry, the Commission can use a wide range of investigative tools to gather information from companies and trade associations, including requests for information. During the inquiry, the Commission will maintain an open dialogue with all stakeholders, and will keep the sector informed about progress.

More information at
<http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/08/20&format=HTML&aged=0&language=EN&guiLanguage=en>

NEWS FROM THE ECJ

European Court of First Instance upholds Commission's Decision to approve Ireland's risk equalisation system for PHI

On 12 February 2008, the European Court of First Instance issued its judgement confirming the Commission's original decision approving Ireland's risk equalisation system (RES) for the private health insurance (PHI) sector, and dismissing the challenge to this decision by the private health insurer British United Provident Association Ltd (BUPA). In dismissing the BUPA action, the Court declared that "such a mechanism is a necessary and proportionate means of compensating the insurers required to cover, at the same price, all persons living in Ireland, independently of their state of health, age or sex".

In January 2003, the Irish authorities had formally notified the RES to the Commission, in accordance with the Community rules on state aid. In practice, operation of the RES would mean the transfer of funds from BUPA to the long established semi-state organisation VHI healthcare which has about 80% of the private health insurance market in Ireland. On 13 May 2003, the Commission decided not to raise objections to the establishment of the RES. It decided that the compensation provided

for by the RES constituted an amount intended as compensation for the obligations associated with a service in the general economic interest (SGEI), namely obligations aimed at ensuring that all persons living in Ireland would receive a minimum level of PHI services at the same price, independently of their state of health, age or sex (the PHI obligations).

This latest judgement is the result of a formal Application for Annulment against the Commission's decision in 2003 which was lodged with the Court of First Instance of the EU and heard in March 2006.

In reaching its judgement, as a preliminary point, the Court noted that Member States have wide discretion as to the definition of SGEIs, particularly in the field of health, which falls almost exclusively within their competence. In that context, the control which the Community institutions are authorised to exercise is limited to ascertaining whether there is a manifest error of assessment. However, where a Member State invokes the existence and the need for protection of an SGEI mission, certain minimum criteria must be satisfied, in particular, the presence of an act of a public authority entrusting the operators in question with an SGEI mission and the universal and compulsory nature of that mission.

The Court considers that in the present case those conditions are indeed satisfied. The Irish legislation, which defines the PHI obligations in detail, was an act of a public authority. Furthermore, the fact that the insurers are required to cover any person requesting insurance means that the PHI services are compulsory and universal.

The Commission was thus entitled, in this case, to consider that the imposition, in the public interest, of the PMI obligations on the PHI insurers relates to an SGEI mission.

Finally, the Court finds that BUPA has not shown that the Commission had erred in concluding that the compensation system provided for by the RES was necessary and proportionate by reference to the costs incurred in discharging the PMI obligations. The Court considers that there is no error in the finding that risk equalisation is necessary on a PHI market where insurers are required to cover any person

at the same price and independently of the individual risk in order to ensure the cross-subsidy of premiums between the generations and to permit every PHI insurer to bear only the burdens linked with the average market risk profile. In addition, the RES seeks only to compensate PMI insurers for the financial consequences arising from the PMI obligations, which prohibit them from setting premiums according to the risk insured and from rejecting the 'bad' risks.

Commenting on the decision, the Minister for Health and Children, Mary Harney, said "the government, my department and I have always seen risk equalisation as important and necessary in the provision of an equitable and competitive health insurance market in Ireland. We are pleased to have this upheld by the judgement of the European Court of First Instance. Risk equalisation enables the provision of a level playing field for all consumers and insurers and allows for the protection of the consumer by facilitating community rating and open enrolment. I am committed to protecting equality and encouraging competition in the health insurance market in this way".

VHI Healthcare, which has a notably older customer profile than its competitors, welcomed the decision. According to its Chief Executive, Vincent Sheridan, "the decision of the European Court to dismiss the BUPA action is very good news for consumers in Ireland since a negative judgement could have meant the end of community rating for health insurance in this country. Community rating has been the basis of health insurance in Ireland for the past fifty years. Indeed the decision will be welcomed right across Europe as evidenced by the involvement of the Dutch government in the case".

He continued that the "decision is bad news for those who wish to use community rating as a means of generating windfall profits by way of regulatory arbitrage. It also marks another failed attempt by BUPA to destroy Community Rating in Ireland." BUPA has declined to make any comment until it has studied the judgement further, but Oliver Tattan, Chief Executive of rival Irish private health insurance company, VIVAS Health, said that "while we are disappointed that the Commission has endorsed a system of subsidisation of the

most dominant player in the market and has deemed that this form of state aid is legal, it should be recognised that this case was just one of many legal investigations underway at a local and European level. The outcome of the other cases may not be known for a substantial period of time. Until all investigations are resolved the market will continue to suffer from a lack of investment and from limited competition." Tattan called for urgent reform in the health insurance system and, in particular, to look at ways in which to reduce VHI's dominant market share.

In coming to its decision the European Court of First Instance ordered BUPA to pay the EC and the VHI's legal costs in the action. VHI healthcare is due €33m from BUPA and €1m from its successor Quinn healthcare in risk equalisation payments. However, it will have to await the verdict of another Supreme Court challenge before it can hope to receive any payments

More information at <http://curia.europa.eu/en/actu/communiqués/cp08/aff/cp080008en.pdf>

Germany failed to fulfil obligations in respect of psychotherapists

In December 2007 the European Court of Justice (ECJ) declared that Germany failed to fulfil its obligations under Article 43 EC by applying 'established rights' in its Law on Psychotherapists. The Law provides that, from 1 January 1999, psychotherapists wishing to practise under the statutory sickness insurance scheme have been subject to a quota system structured on a regional basis. According to the law, psychotherapists who establish themselves in a particular region may practise under the statutory sickness insurance scheme only if the number of psychotherapists in that region does not exceed a number which corresponds to the needs of the region.

However, the German Law on Psychotherapists contains provisions under which psychotherapists already established in a region and who practise under the statutory sickness insurance scheme may continue to practise under that scheme, even in the case where the number of psychotherapists required in the region has been exceeded, if they fulfil certain conditions. Among these is that they took part, in the period from 25 June 1994 to 24 June 1997, in the psychotherapeutic out-patient treatment

of individuals insured under the compulsory sickness insurance scheme.

However, by refusing to grant the possibility of continuing to practice to psychotherapists who are already established in a region but who actually worked in the health care system of another Member State, in the Commission's view, Germany failed to fulfil its obligations under Article 43 EC. It had not treated previous activity carried out in another Member State worthy of the same protection as that given to professional activities carried out under the German compulsory sickness insurance schemes. Article 43 of the Treaty establishing the European Community declares that restrictions on the freedom of establishment of nationals of a Member State in the territory of another Member State shall be prohibited.

Further details can be accessed at: <http://curia.europa.eu/jurisp/cgi-bin/form.pl?lang=EN&Submit=Rechercher&docrequire=alldocs&numaff=C-456/05&datefs=&datefe=&nomusuel=&domaine=&mots=&resmax=100>

Garlic Preparations in capsule form deemed not to be medicinal products

On 15 November 2007, the European Court of Justice issued a judgement on case C-319/05, European Commission versus the Federal Republic of Germany, pursuant to which Germany had wrongly classified garlic preparations in capsule form as medicinal products, thereby imposing a restriction on the free movement of goods as prohibited by Article 28 of the EC Treaty.

In 2005, the German authorities had refused to allow the importation and marketing of 'garlic extract powder capsules', i.e. capsules containing pure dried garlic powder, as food supplements, on the grounds that they were not regarded as foodstuffs but medicinal products within the meaning of Directive 2001/83/EC on the Community Code relating to Medicinal Products for Human Use (the Medicinal Products Directive).

The European Commission, however, took the view that the garlic preparation in question was not a medicinal product. The Commission stated that the classification as a medicinal product imposed a burden on importers of the product in Germany which constituted an obstacle

to the free movement of goods contrary to Article 28 of the EC Treaty. Hence, the Commission brought an action against the Federal Republic of Germany before the ECJ for failure to fulfil its Treaty obligations concerning the free movement of goods.

In its ruling the ECJ determined that the garlic preparation in question could not be classified as a medicinal product as it did not fall within one of the two definitions of medicinal products, i.e. by presentation or by function. A medicinal product by presentation is a product "presented for treating or preventing disease" within the meaning of Medicinal Products Directive "when it is expressly indicated or recommended as such, possibly by means of labels, leaflets or oral representation". In this case, the ECJ held that no aspect of the packaging of the garlic preparation made the product resemble a medicinal product and the capsule form was not exclusive to medicinal products.

A product can be considered as a medicinal product by function taking into account "all the characteristics of the product, in particular its composition, its pharmacological properties to the extent to which they can be established in the present state of scientific knowledge, the manner in which it is used, the extent of its distribution, its familiarity to consumers and the risks which its use may entail". In this case, the ECJ stated that the garlic preparation did not contain any substances other than natural garlic and had no additional effects, either positive or negative, compared to those derived from the consumption of garlic in its natural state. Therefore, the effect of the garlic preparation was no more than the effect of a foodstuff containing garlic consumed in a reasonable quantity. In contrast, a medicinal product must have the 'function of treating or preventing disease'. Beneficial effects for health in general, such as those of garlic, are not sufficient.

The ECJ further held that Germany's classification of the garlic preparation created an obstacle to intra-Community trade since garlic products legally marketed as foodstuffs in other Member States could be marketed in Germany only after having been subjected to the authorisation procedure for the placing on the market of a medicinal product. According to the ECJ, this obstacle

could not be justified for reasons relating to the protection of health and life of humans in accordance with Article 30 EC.

As a result, the ECJ held that the Federal Republic of Germany had failed to fulfil its Treaty obligations concerning the free movement of goods under Article 28 EC and Article 30 EC. This judgment lays down very specific criteria with respect to the classification of borderline products containing botanicals. As a consequence, the former practice of some Member States to classify products containing specific botanicals automatically as medicinal products by function becomes obsolete. Pending procedures with respect to the classification of products containing garlic might mean that this ruling is introduced as a basis on which to reinforce the marketability of the product as a foodstuff.

COUNTRY NEWS

Tajikistan: severe cold and energy supply crisis threatens health

Tajikistan is facing a growing humanitarian crisis. United Nations agencies warn that the health of large parts of the population is already affected, as the country struggles with a cold and energy emergency. The central Asian republic, home to about seven million people, is currently experiencing its harshest winter for three decades. The average temperature is around -15°C , dropping to as low as -25°C at night. Roads between several districts are blocked by heavy snowfall, affecting supplies of food and other basic products.

The cold wave has also led to severe problems with the water supply system, as supply lines either break or freeze. The energy problems are seriously affecting the health sector: 50% of all health facilities in the four major districts of Tajikistan – Kulyab, Rasht valley, Kurgan-Tube and Sogd oblast – report severe power shortages and complete blackouts. According to a WHO assessment, all hospitals in the Kulyab district are without a water supply. Hospitals and health facilities in other districts are facing serious water shortages. Maternal morbidity and cold-related diseases are reported to be on the increase.

Together with the government, United Nations partners present in the country,

including WHO, are urgently assessing the immediate needs that must be met as soon as possible. WHO has already started making medical supplies available to the people who are most at risk. “The energy crisis puts thousands at risk. There is particular concern for the health of elderly people, children and pregnant women,” says Dr Marc Danzon, WHO Regional Director for Europe. “Every effort must be made to get medical and energy supplies to the country.” The United Nations is preparing a joint appeal for international assistance to address the most urgent needs.

More information at http://www.euro.who.int/emergencies/fieldwork/20080208_1

UK government seeks 10% cut in drug prices from industry

Discussions between UK health ministers and the pharmaceutical industry are ongoing as the Pharmaceutical Price Regulation Scheme (PPRS) is renegotiated. Representatives of the industry had previously agreed to an average 7% cut in the cost of pharmaceutical products in 2005 during the last renegotiation of the PPRS. The 2005 PPRS was originally planned to run for five years, but at the end of 2007 Health Minister Alan Johnson told the Parliamentary Health Select Committee that he had reopened the PPRS negotiations.

Mr Johnson emphasised the influence of the PPRS on the NHS budget as a whole. He said the negotiations on the PPRS were a “very big and important part of achieving these flexibilities and achieving these efficiencies.” *The Financial Times* (7 January 2008) reported that Mr Johnson had told the paper that he planned to generate “substantial savings” in the drugs budget during talks on the PPRS. The extent of these savings has not been made official yet, but it has been widely reported in the UK press that government officials have presented plans to industry to reduce the £11 billion annual medicines bill by at least 10%.

The Association of the British Pharmaceutical Industry (ABPI) and the Department of Health issued a joint press release on 8 January 2008, clarifying that negotiations on a potential new PPRS agreement have begun, but that neither party is commenting on any speculation on the content of the negotiations, although any new agreement will

be based upon the government's four principles made in response to the 2007 Office of Fair Trading (OFT) report: Value for Money, Reward for Innovation, Accelerated Uptake of New Medicines and Sustainability.

As well as the government's desire to cut the UK's drugs bill, there are additional pressures on the PPRS. One report published by the OFT in February 2007 recommended that the PPRS ‘should be reformed, to deliver better value for money from NHS drug spend and to focus business investment on drugs that have the greatest benefits for patients.’ In December 2007, the OFT published a further report recommending that medicines distribution in the UK be reformed, arguing that “any future widespread use of exclusive distribution arrangements might lead to longer-term competition concerns.” The OFT also concluded that there is a significant risk that the ‘direct to pharmacy’ arrangements will result in greater costs to the NHS. Furthermore, a High Court ruling involving Glaxo SmithKline in June 2007 held that the PPRS was not an informal agreement but a formal legal contract, prompting calls that this ruling warranted a review of the PPRS.

The negotiations over the PPRS are expected to continue until June 2008.

England: Payment by Results successfully implemented but needs to develop to achieve more for patients

Payment by Results (PbR), one of the English government's key national health service (NHS) modernisation reforms, has been embedded across the NHS and has helped hospitals to be more business-like according to the Audit Commission report published on 14 February, *The Right Result? Payment by Results 2003–07*. It should start to deliver the significant increases in productivity and efficiency across the NHS that the policy was designed to achieve.

The Payment by Results policy, which was introduced four years ago, is a system of paying hospitals nationally set prices for the number of patients and types of conditions they treat. It is designed to encourage hospitals to treat more patients, more efficiently without compromising the quality of care. Meanwhile, primary care trusts (PCTs) have been expected to find ways of reducing unnecessary hospital admissions by

commissioning new, more cost-effective services, for example from general practitioners.

The report concludes that Payment by Results has been embedded across the NHS. Most hospitals have improved their financial management and now have a better understanding of how much it costs them to treat patients. The fear that patient care would suffer because hospitals would be tempted to cut costs at the expense of quality has not materialised.

There are some indications that the NHS is providing care more efficiently. For example, there has been an increase in the number of patients treated as day cases and the length of time patients spend in hospital has fallen. Spurred on by Payment by Results incentives, PCTs have reduced the number of avoidable admissions to hospitals

The report sets out a number of priorities for future development of the policy and the implementation issues that need to be addressed at the national level if Payment by Results is to deliver further improvements. These include strengthening the quality of information available on how much each patient costs to treat so that it is more accurate, precise and timely.

*The report *The Right Result* is available at <http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=30321654-7A78-4be6-ADA3-C2FC1AD3B515&fromREPORTSANDDATA=NATIONAL-REPORT>*

Scotland: Free personal and nursing care needs to be better planned, managed and funded

An Audit Scotland report published on 1 February, *A Review of Free Personal and Nursing Care*, says demand for Free Personal and Nursing Care (FPNC) will grow with the projected increase in the older population in Scotland. Scottish ministers decided to introduce FPNC in early 2001 and set the Scottish Executive (now known as the Scottish Government) and councils a challenging timetable for developing and implementing the policy. The Executive and all councils met this deadline and had systems in place to deliver FPNC from July 2002. The policy was introduced at the same time as several other significant changes in health and social care, making

it difficult to isolate the impact of FPNC.

The Auditor General for Scotland, Robert W Black, said that “free personal and nursing care is an important policy for older people in Scotland. It is well documented that Scotland has a growing older population, and demand for free personal care will grow. There needs to be better planning and better funding of this policy. Because of the limited information at the time the Scottish Parliament did not receive sufficiently robust and comprehensive financial information and risk assessments. The Parliament should require this as a matter of course to enable it to properly scrutinise all major policy proposals.”

The report finds that continuing ambiguities in what constitutes free personal care mean the policy has been applied inconsistently across the country. For example, eight councils charge for food preparation, whereas others do not. Older people are often unclear about what they can receive under FPNC. Accounts Commission chairman Professor John Baillie said that “the Scottish Executive and Scotland’s councils were set a tight deadline for developing and implementing this policy. They were successful in doing so. However, there is variation across the country in how the policy has been implemented.”

“Councils and the Scottish Government should work together as a matter of urgency to clarify the current ambiguities and ensure FPNC is consistently applied across Scotland. Councils should also provide clear information to older people about what care they are entitled to under the policy.”

The total cost of FPNC in its first four years was an estimated £1.8 billion. Councils would have spent around £1.2 billion of this even if the policy had not been introduced, as older people were previously means-tested for free care. The report indicates that there is likely to be a growing shortfall in funding for FPNC. Working with the existing data Audit Scotland estimates this shortfall at £46 million or £63 million for 2005/06. However, there are continuing limitations in the available financial information about FPNC, and no long-term projections of the costs.

More information at <http://www.audit-scotland.gov.uk/media/article.php?id=68>

France: Church calls for embryos to be given clear legal status

France's Roman Catholic Church has called for embryos to be given a clear legal status following a court decision that let the parents of miscarried foetuses enter them with a name in the official civil registry. Previously in France, a miscarried foetus or stillborn child could only be registered if it was once viable, this being defined as more than twenty-two weeks of pregnancy or weighing more than five hundred grams. Any below that age have usually been treated as hospital waste and incinerated. Three couples whose miscarried foetuses fell below the age limit sued to register and bury them. The Cour de Cassation, France's highest appeals court, ruled on February 6 that the limits were not legally binding and a miscarried foetus could be entered into the civil registry if a couple wished to commemorate it that way.

The Catholic Church has always stated that an embryo is human life from the moment of conception and must be protected. Most legal systems protect the unborn after a fixed number of weeks of pregnancy but only grant full legal status to live-born babies. Groups opposed to abortion in many countries have therefore long argued for a legal status for embryos as the first step towards having courts rule that abortion is a form of murder.

Abortion rights supporters vigorously oppose any such status. Cardinal Andre Vingt-Trois, head of the French bishops' conference, said establishing this status would not undermine legal abortion in France because of the way the law allowing the termination of pregnancies was constructed. Speaking of the ruling, the Cardinal said that “this means that a foetus has a status. The Church's position is that we must act as if the embryo were a person,” he told the Rennes daily Ouest-France. “We protect endangered animals so we should protect people too.”

Abortion rights campaigner Marie-Francoise Colombani, columnist for the women's magazine *Elle*, said the court had opened a Pandora's box by trying to accommodate grieving parents. “Why don't we give legal status to what develops in a test tube during in vitro fertilisation?” she asked. “The law is supposed to be a safeguard, but it has produced sheer folly.” Defining

'personhood' for the unborn is a complex medical and ethical issue. Opinions differ widely on when an embryo or foetus feels pain or takes on traits that show it is developing into a full human being.

Ireland: Independent body to assess a fair community pharmacy dispensing fee

On 18 February 2008, the Minister for Health and Children, Mary Harney, announced a new Independent Body to begin work immediately to assess an interim, fair community pharmacy dispensing fee of at least €5 to be paid in respect of the General Medical Service, Drugs Payment and other community drug schemes. This three man body will be chaired by Seán Dorgan, former Head of the Industrial Development Agency Ireland. It will take submissions from all sides, carry out its own analysis and is expected to make its recommendations by the end of May on an appropriate dispensing fee that would represent a fair and reasonable price to be paid for the pharmaceutical service currently being provided by community pharmacists to the Health Service Executive (HSE). Its recommended fee level, subject to Government approval, will be backdated to 1 March 2008.

In announcing the body, the Minister said that "the government is firm in its view that the wholesale mark-up paid on the price of drugs should be reduced to a level that is fair to both taxpayers and wholesalers. The existing mark-up of almost 18% is neither reasonable nor sustainable and the HSE's plan to pay an 8% mark-up from 1 March, and 7% from 1 January 2009, is to go ahead."

The new body will make its recommendations having regard to (i) the overall public interest including the issues of patient safety and continuity of supply; (ii) the fee of €5 per item which has already been offered; (iii) the reasonable costs incurred by pharmacists in providing services under the schemes and the value of the professional service of dispensing; and (iv) the statutory obligation on the HSE to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.

Minister Harney acknowledged that the government had "listened to issues raised by the Irish Pharmaceutical

Union about retail pharmacies." These concerned the practice by wholesalers of passing on part of their mark-up to retail pharmacies by way of discounts, with larger discounts given to larger pharmacies. The Minister stated that "wholesaler discounting has been described by pharmacists as a method 'to prop up' the fees paid on medical card prescriptions. I believe dispensing fees should stand in their own right, without external, artificial props. We are concerned, in particular, to support pharmacies which have a high proportion of medical card patients and where a dispensing fee of €3.27 applies for most transactions. Many of these pharmacies are in rural or inner city areas and provide an important social and health service. With my support, the HSE has indicated it is prepared to offer a higher fee, of no less than €5 per item dispensed, to community pharmacists, on the basis of an interim contract which would be essentially the same as the existing contract."

Each pharmacist will have three options: to avail of the interim contract immediately; to accept the interim contract upon the report of the Independent Body; or to stay with the existing retail fee structure until the agreement of a substantive new contract. The development of a substantive new contract is now also underway; this will be determined under the auspices of an agreed facilitator and it too will be priced by the Independent Body.

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

Netherlands: Health Minister seeks European consensus on e-cigarettes

Health Minister, Ab Klink, wants EU countries to take a common stance on the e-cigarette's status. He plans to pressure the European Commission to take action.

The e-cigarette is a new device that takes the form of a tiny rod which is slightly longer than a normal cigarette. The mouthpiece of the device contains a replaceable cartridge filled with liquid. The main substances contained in the liquid are nicotine and propylene glycol. When air flows through the device, it is detected by a microprocessor. This microprocessor then activates an atomiser which injects tiny droplets of the liquid into the flowing air. This produces a vapour mist which is inhaled by the user. The addition of propylene

glycol to the liquid makes the mist better resemble normal cigarette smoke. The microprocessor also activates an orange light emitting diode at the tip to simulate real smoking. This not only simulates cigarette smoke but also the temperature of common cigarette's smoke (50–60°C). The units use a rechargeable battery as a power source. Energy produced by the battery is enough to heat the nicotine inside and produce smoke like usual cigarettes do. No harmful tars; only nicotine, in small concentrations.

In a letter submitted to the Dutch House of Representatives, Klink stated that consumers need to know that there are no safety issues regarding the e-cigarette. To this end, he suggested that the product be submitted to the Medicines Evaluation Board for assessment.

Until that happens, we must proceed on the assumption that the e-cigarette is a medicinal product, which means that advertising is no longer permitted. The Netherlands Health Care Inspectorate has issued a warning regarding the e-cigarette's potential health risks. Those who violate the advertising ban risk being fined up to €150,000 by the Inspectorate. At the moment, however, there are no plans to pull the e-cigarette from the shelves.

The e-cigarette is currently classified as a medicinal product in a number of European countries, including Austria and Belgium. Other countries, such as the UK, have not yet taken a stance on the product's status. In the USA, the Food and Drug Administration (FDA) has chosen to classify the e-cigarette as a medicinal product due to the health risks involved.

If the e-cigarette is indeed classified as a medicinal product, then the manufacturer must register the product with the Medicines Evaluation Board in order to be able to market it legally. The Board will assess the product's safety and will determine whether it should be available over the counter, sold exclusively at pharmacies and chemists, or available on prescription only.

Sweden: New plans for mentally ill offenders

As reported by the English language daily, *the Local*, the Swedish government has stated that it wants to discard the ban on prison sentences for those with serious psychological problems.

Currently, mentally ill offenders are sent to mental health facilities. Under the government's new plan, courts would have the option of prison sentences in certain cases, allowing for more flexibility in the sentencing process.

According to the proposed changes, courts would be required to consider a number of factors in deciding whether or not to sentence a mentally ill offender to prison. The factors include the severity of the crime, whether the suspect requires long-term hospitalisation, and whether the suspect was under the influence of drugs when the crime was committed.

Under the new guidelines, a prison sentence would be possible in the case of a very serious crime committed while the suspect was in a temporary state of psychosis. The government has submitted the suggestion to the Council on Legislation (Lagrådet) for examination and hopes to implement the changes by 1 July 2008.

Russian Federation: Health chief signs directive to accelerate the fight against TB

On 2 January 2008, Russian Chief Public Health Officer Gennady Onishchenko signed a directive to scale up efforts to fight tuberculosis (TB) in the country. As reported by the Russian news agency, Interfax, the incidence of TB has 'stabilised at a high level' during the past five years, according to a release from the government's Consumer Rights Protection service. The TB death rate also 'remains high,' the release said, noting that about 80% of deaths from infectious diseases result from TB.

Onishchenko, in his directive, has proposed that the heads of municipalities throughout the country organise mass TB screenings; take additional steps to examine children and young people; and organise regular medical examinations as part of prevention efforts. According to the directive, a significant part of the population currently goes two years or more without receiving a TB test. Screening among high-risk groups is inadequate and early detection of TB among children and teenagers is incomplete, Onishchenko said.

Only 9% of TB hospitals meet current hygiene standards, 60% need capital repairs, 21% lack either hot or cold running water, and 11% lack a sewage

system, the government release said. The release also noted that 42% of hospitals have inadequate medical equipment and that 20% have a shortage of TB drugs

More information at http://www.globalhealthreporting.org/article.asp?DR_ID=49568

Finland: New national framework for services for older people

The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities have together published a new national framework for high-quality services for older people. The framework is a recommendation intended for the local authorities as an instrument for the development and assessment of the services they provide for older people. Furthermore, the recommendation incorporates ethical principles for the services.

The new framework is further recognition that the population in Finland will be ageing rapidly in the next few decades. It would be difficult to curb expenditures without reforming the service structures and manner of service provision. In recent years, quality recommendations developed for various services have served as new instruments in guiding the development of welfare services at the national level. The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued the first National Framework for High-Quality Care and Services for Older People in 2001. In municipalities the framework has been considered a necessary and useful tool in the development of services for older people. It is however important to include assessment data as a part of the implementation of the recommendation.

The new framework outlines the most important strategic sub-areas to improve the quality and effectiveness of services for older people. Those are the promotion of wellbeing and health, development of the service structure, staffing, staff skills and management, as well as living and care environments. The recommendations cover the services used by older people on a regular basis, such as home care, support for informal care, long-term care in units of intensified service housing and in institutions and, more generally, measures to promote the wellbeing and health of

older people. They also set the national quantitative and qualitative targets for these services, on the basis of which the local authorities should define their own objectives taking into account the local needs.

The importance of actions to promote health and prevent illness is stressed.

Independent living of older people in their own homes will be supported and service needs assessed individually.

Advice and other preventive services will diversify the choice of services. Health, functional capacity and rehabilitation are supported in the context of all services.

The framework describes the criteria for staffing and gives recommendations for the minimum staffing levels in twenty-four-hour care. Other important elements are enhancing the personnel's wellbeing at work, development of gerontological skills and knowledge, and management skills. It also includes monitoring indicators for measuring how the targets have been achieved in the different sub-areas both according to municipality and nationally and emphasises the importance of partnerships between the public, private and third sector. The revised recommendations take into account national objectives of governmental policy on ageing, outcomes of the assessment of quality recommendations, the latest research findings, changes in the operating environment, and the ongoing restructuring of local government and services.

More information in English at <http://www.stm.fi/Resource.pbx/publishing/documents/14084/index.htm>

Ukraine: New measures to combat HIV/AIDS approved

The Ukrainian Ministry of Health Ministry has approved measures aimed at combating HIV/AIDS in 2008. The measures are part of President Yushchenko's instruction to draft and approve a national HIV/AIDS programme for 2009 to 2013. Yushchenko, previously in December 2007 had ordered ministers in the country's cabinet to develop measures for conducting large-scale HIV prevention programmes, as well as for providing access to HIV testing and treatment.

More information at <http://www.tpaa.net/news/regional/news/?id=3220>

News in Brief

EU study on deinstitutionalisation and community living published

A new report entitled 'Deinstitutionalisation and Community Living – Outcomes and Costs' was recently launched in Prague. It is the result of a project funded by the European Commission and implemented by a European consortium led by the Tizard Centre at the University of Kent and the Personal Social Services Research Unit at the London School of Economics. The aim of the project was to collect available information on the number of disabled people living in residential institutions in twenty-eight European countries, and to provide Member States with recommendations and strategies for replacing institutions with community-based services.

According to the report, in Europe, well over one million disabled people still live in some form of institutional care, which is often of an unacceptably poor quality and represents a serious breach of internationally accepted human rights standards. Community-based services, when properly established and managed, deliver better outcomes in terms of quality of life and ensure that disabled people can live as full citizens. They need not be more expensive than institutional care once proper account has been taken of the needs of residents and the quality of care.

The report can be accessed at http://www.kent.ac.uk/tizard/research/DECL_network/Project_reports.html

Commission to continue financing Community Tobacco Fund

The European Commission has proposed to extend the financing of the Community Tobacco Fund for a further two years. Since the reform of the Common Market Organisation for Tobacco in 2004, the Fund has financed information policies to improve public awareness of the harmful effects of tobacco consumption. In the current funding period, the Fund gave support to the 'HELP – for a life without tobacco' campaign (www.help-eu.com). The 2004 reform put in place a gradual phasing-out of tobacco subsidies between 2006 and 2010. In the transitional period

before the disappearance of tobacco subsidies, it also set aside for the Tobacco Fund 5% of the annual budget for direct payments to tobacco producers. However, this originally only was in place until the end of 2007. The Fund could be worth up to €16,897 million per year.

More information at http://ec.europa.eu/agriculture/markets/tobacco/index_en.htm

OECD: Health at a Glance 2007

Progress in the prevention and treatment of diseases has contributed to remarkable improvements in life expectancy and quality of life in OECD countries in recent decades. At the same time, spending on health care continues to climb, consuming an ever-increasing share of national income: health expenditure now accounts for 9% of GDP on average in OECD countries, up from just over 5% in 1970. This fourth edition of *Health at a Glance* provides updated comparable data and trends on different aspects of the performance of health systems in OECD countries. For the first time, it also includes a chapter on new comparable indicators of quality of care, showing variations across countries in measures such as survival rates after heart attack, stroke and cancer.

More information at <http://www.oecd.org/health/healthataglance>

World Health Day 2008: protecting health from climate change

The health impacts of climate change are already evident in different ways: more people are dying from excessive heat, changes are occurring in the incidence of vector-borne diseases, and the pattern of natural disasters is altering. On 7 April 2008, World Health Day will focus on the need to protect health from the adverse effects of climate change. Many of the steps needed to prevent climate change have positive health benefits. For example, the increased use of bicycles and public transport instead of personal cars in industrialised countries will reduce greenhouse gas emissions. It will

also improve air quality and lead to better respiratory health and fewer premature deaths. The increase in physical activity from cycling and walking will lead to less obesity and fewer obesity-related illness.

More information at <http://www.who.int/world-health-day/en/>

Call for expression of interest for a list of experts

A call for expressions of interest was launched by the European Commission on 9 February 2008 to draw up a list of experts to assist in activities related to the second programme of Community action in the field of health (2008–2013). Activities will include reviewing applications for Community financial support (for projects, conferences, operating grants, joint actions); reviewing technical and/or financial reports on completed or ongoing projects; and monitoring and evaluating activities under the programme.

Further information on how to apply is available at http://ec.europa.eu/health/ph_programme/ami/ami_036831_en.htm

Updated information on the Alcohol Forum

The EU's multi stakeholder body on alcohol has updated its section of the DG Health and Consumer Protection website. This includes reports of its latest meetings and working groups, plus the first meeting of Member State governments on the subject.

More at http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/alcohol_forum_en.htm

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

European
Observatory 
on Health Systems and Policies

LSE Health

ISSN 1356-1030