

eurohealth

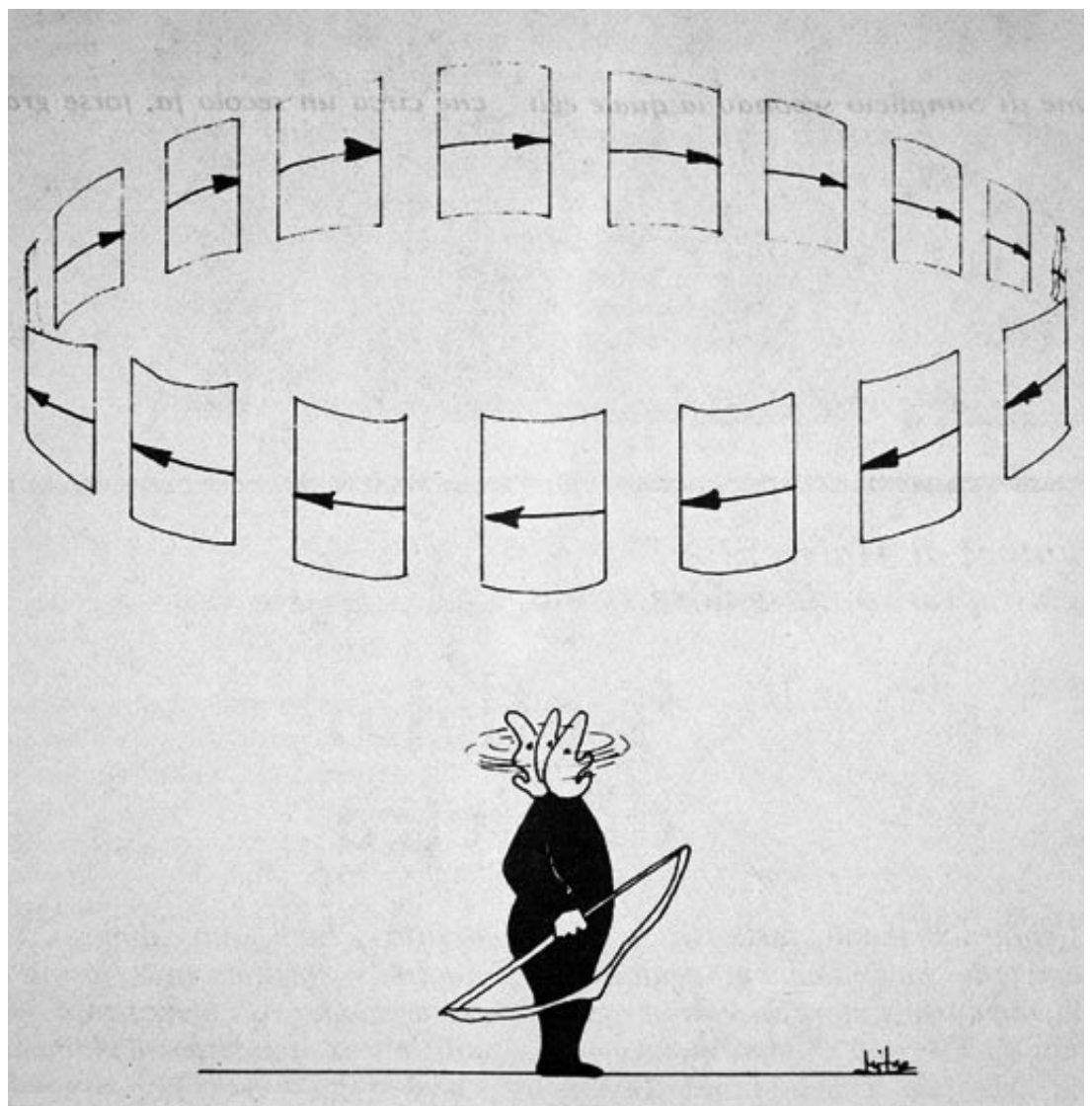
Analysing Health Targets in Europe

The European Parliament and public health

Measuring the appropriateness of health care

Cost sharing in health care

Health policy in the UK



preface

On behalf of the editorial team I am very pleased to welcome Mike Sedgley as the new editor of *eurohealth*. He arrives at an exciting time of change for the European Union. Many important developments in European politics have and will continue to take place over the coming year, with a new Commission and Parliament, the bringing together of health and consumer policy issues into a single Directorate General within the Commission, and, importantly, the publication of proposals early next year for a future EU health policy. It has been a pleasure to work with Mike on his first issue of *eurohealth* and I look forward to working with him on many issues to come.

Paul Belcher
Senior Editorial Adviser

It is an exciting time for *eurohealth*, as a forum for debate between policy makers and academics, to have a new generation of decision-makers in Europe's institutions, and I hope that many of them, over the coming months, will be contributing to discussion about the place of the Union in the health policy field. We are making a good start in this issue, in which Caroline Jackson, the new Chair of the European Parliament committee responsible for public health, outlines her views of the role of the European Union and the Parliamentary Committee in this field.

The new Directorate General for Health and Consumer Protection to some extent reflects the nature of the EU's primary role in public health and also the connection between these two policy areas. It remains to be seen, however, whether important areas of health policy are eclipsed by food safety issues. There are worrying signs that the public perception of the new DG is as one primarily concerned with this important but narrow aspect of health.

There are further challenges ahead for health policy-makers in Europe, as member-state populations age and technologies advance. *eurohealth* will continue to have an important part to play in the exchange of ideas and opinions about the future of Europe's public health and health care systems into the next century. This issue contains several articles discussing many of these problems and providing some options for action.

I hope readers will be able to continue to rely on *eurohealth* as a source of the very best discussion, debate and information about all that is happening in European health.

Mike Sedgley

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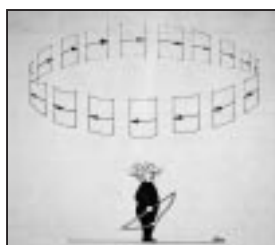
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Following the European Parliamentary elections of last summer, Caroline Jackson has been nominated as the new Chair of the European Parliament Committee on the Environment, Public Health and Consumer Policy. Dr Jackson here elaborates on the role of the Union in the public health field and on the role of the Committee in the development of health-related policies and initiatives. She also comments on the major successes and failures of EU health programmes and on how the EU role in health policy fields is likely to and ought to develop in confronting challenges common to all Member States.



Caroline Jackson MEP

While the EU has long been active in contributing to health protection in a variety of ways, public health as such is a relatively new policy area for the EU. It was not until 1993, with the Treaty on European Union, that the health dimension was finally given full formal recognition in the European context, with the introduction among other things of a specific legal base for EU action. The Amsterdam Treaty, which came into force on 1 May 1999, develops the health dimension still further.

Community action, according to the Treaty, should be aimed at improving public health, preventing illness and disease, and obviating sources of danger to human health. It should cover research into the major health scourges, as well as health information and education activities. Specific reference is also made in the Treaty to quality and safety standards for organs and substances of human origin, blood and blood derivatives; measures in the veterinary and phy-

“Giving health the priority it deserves”

The role of the European Parliament and its Committee on the Environment, Public Health and Consumer Policy in health issues

tosanitary fields which have as their direct objective the protection of public health, and incentive measures designed to protect and improve human health. The emphasis throughout is on complementing the policies of the Member States and encouraging cooperation. Clearly, the EU is particularly well placed to do this, helping Member States to act more effectively together than would be possible separately in certain areas – in other words, providing what has become known as ‘Community added value’. But it is not in a position, and nor should it be – as the Amsterdam Treaty makes clear – to intervene in the running or funding of our respective national health services or their programmes and policies. There are however numerous areas where the EU can and should make a major contribution and where it, and the European Parliament in particular, has an important role to play.

European decision-making in the health area is based on the co-decision procedure. This implies the full and equal participation of Parliament in the decision-making process. It represents one of Parliament's most powerful tools. It means that while the European

Commission is responsible for putting forward proposals for actions, the actual decision-making power is shared equally between the Council on the one hand and the European Parliament on the other.

The detailed scrutiny of any proposals coming from the Commission relating to public health is the job of the European Parliament's Committee on Environment, Public Health and Consumer Policy, of which I am Chairman. This means that we deal with a wide range of issues. Towards the end of the last legislature, for example, we had been looking at matters as diverse as orphan drugs, exposure to electromagnetic fields and BSE. Our new responsibilities mean that in future we will most certainly be giving still more attention to areas such as food safety, animal foodstuff and veterinary health issues, as well as the more conventional health questions.

Once the committee has adopted its report on the Commission proposal, it goes to Parliament's plenary for further discussion and final adoption as Parliament's formal position on the question. When the co-decision procedure applies, as it now does in the vast majority of cases, if

Parliament is not satisfied with the way in which Council goes on to deal with the question, it can insist on conciliation. In the rare event that no compromise is possible, Parliament could if necessary reject the entire proposal.

It is rare for matters to reach that point – but it provides a valuable and so far extremely effective stimulus for all sides to find a solution. It was at the beginning of 1996 that the first health legislation was adopted by the Council of Ministers and the EP after a successful conciliation process. As a result, the EU now has a long-term action plan (1996-2000) on health promotion, information, education and training. Since then a number of other measures and programmes, including plans to combat cancer and AIDS, as well as programmes to combat rare and pollution-related diseases, have been successfully adopted under this procedure. In these and many other cases, the fact that Parliament enjoys the power of co-decision has meant that it has been able to influence the direction and budget of these programmes and to bring additional pressure to bear in order to achieve important concessions in the interests of citizens. The environment, public health and consumer policy committee will closely scrutinise any subsequent proposals coming from the Commission, as well as any assessment of what has been achieved to date, with a view to ensuring that the Community really is providing added value to the actions of the Member States.

While participation in the formal decision-making process is one of our most powerful activities, the committee has other means at its disposal which allow it to intervene in issues falling under its responsibility and to ensure that appropriate action is taken. For example, it can draw up reports and resolutions on its own initiative in order to highlight issues of particular concern and to stimulate new actions. It can also organise public hearings with a view to gathering knowledge and expertise on specific issues or on the direction of health policy in general. It can contribute to the information and awareness-raising actions that are so

central to the EU's activities on health, for example by encouraging and assisting with publicising certain initiatives. Last year's report on osteoporosis in the EC – "Action for Prevention" is just one example of this. Finally, it has significant power to intervene directly in the drawing up of the EU budget for the areas it covers, in order to ensure that resources are directed where they are needed most.

Given that public health is a relatively new policy area for the EU, much has already been achieved, but there is always scope for improvement. This is true not only with regard to specific programmes or actions but also, and especially, with regard to the extent to which public health concerns are being integrated into other policy areas. The health dimension cannot be viewed in isolation. It must be integrated at an early stage into all policy areas and initiatives – not least at EU level – and this is something which I feel sure my committee will be giving particular attention to during the coming legislature.

"The health dimension cannot be viewed in isolation. It must be integrated at an early stage into all policy areas and initiatives – not least at EU level."

The Commission's Communication on the development of public health policy in the EU provides a good starting point for re-defining the future shape of this crucial policy. It identifies the importance of better information; a rapid response to health threats, health promotion and the development of disease prevention. All excellent aims. But they are meaningless if they are not backed up by concrete action. In particular the Commission will need to come forward with specific, realistic proposals based on clearly defined targets, timescales, methods and strategies. There must also be a solid framework for dialogue between all

concerned – patients, consumers, the medical profession, industry, and government. Cooperation and openness is crucial if we are to manage the fast pace of change. This was the conclusion of the Parliament's report on the Communication at the end of the last legislature and I am confident that the new committee and Parliament will adopt a similar stance.

In the public health field, perhaps more than in many other areas, there is no place for complacency. Hardly a day goes by without some new concern being raised about the safety of the food we eat or the air we breathe. BSE, the dioxin crisis, uncertainty over the development and use of GMOs – these are just some of the most recent issues which have brought home to us all the nature and extent of the new challenges which exist and which must be met at national, European and international level if the health and safety of the consumer and the citizen are to be guaranteed. Consumers need clear, unambiguous, factual information to assist them in the choices they make – not only with regard to the food they eat, but also with regard to the lifestyles they choose to adopt. And most importantly of all, they need to be able to trust the products they buy and the information they receive about them. It is part of our task to help to bring this about and, by entering and shaping the debate, to cool any hysteria, and bring forward the facts.

The European Parliament's role, in this and all areas, is first and foremost to reflect and defend the interests and concerns of the citizens, whom we as MEPs have been elected to represent. Our aim, and especially that of the committee on the environment, public health and consumer policy, is to ensure that the health, rights, and expectations of those citizens – the patients and the consumers of the EU – are given the priority they deserve. As Chairman of that committee, I intend to do my best to ensure that this is indeed the case and that the EU makes a genuine contribution to ensuring the highest possible standards of health protection for all our citizens as we enter the new millennium.

Health targets, care and policy in the EU: Setting the agenda

Matthias Wismar, Reinhard Busse and Friedrich Wilhelm Schwartz

To achieve better health outcomes with scarce resources is a health policy leitmotif for policy makers, administrators and scientists across all Member States of the European Union. Nevertheless, health care policies in most countries remain dominated by economic considerations and cost-containment policies.

The World Health Organization's 'Health For All' (HFA) policy agenda aims to prioritise health through an increasing number of health target programmes – formulated and (partly) implemented at national, regional and local levels.¹ Although they address a wide range of intervention areas from health promotion via environment to education, health care is often only a minor area or is even neglected.

Is there a potential to include health care in health target programmes to counter-balance the economic orientation of health policies? This issue has rarely been addressed in a systematic way. Equally, the challenges of implementing and evaluating health targets for health care management have rarely been discussed. Quite to the contrary, there is little European comparison, information exchange and cooperation in this area even though the Commission of the European Communities has called for such measures in its communication "on the development of public health policy in the European Community,"² which was endorsed by the European Parliament.³

In the light of the growing support for health target programmes we need to address a simple question: is there evidence of a need for health targets within health services? Do they produce benefits in terms of redirecting health policies, improving medical outcomes, improving resource allocation and expanding citizen participation?

Empirical evidence of the effectiveness of ambitious health target programmes has

been sobering. An evaluation of the US campaign 'Healthy People 2000' was not encouraging. Out of the 319 strictly quantifiable targets set in 1990 only eight per cent were achieved by 1996. For 40 per cent there was at least a noticeable movement in the right direction. For eight per cent of the targets no change could be reported and 18 per cent developed in the wrong direction. For the remaining 26 per cent no data were available. The health service related targets like clinical preventive services, immunisation and infectious diseases, maternal and infant health scored even worse.⁴

Similarly, the analysis of the impact of the HFA strategy in the Netherlands comes to the conclusion that "the health targets for the year 2000 are too ambitious: not one target will be fully achieved, 10 targets will be achieved partially and in five cases some of the target levels had already been achieved before the start of the HFA campaign; 11 targets will not be achieved and no conclusion could be reached about the 17 other targets".⁵

The British "Health of the Nation" campaign which started in 1992 was assessed by two reports published in 1998. They conclude that the campaign, although welcomed by local authorities, healthcare institutions and health professionals had little impact in terms of readjusting priorities on the national, regional or local level.⁶

Despite fundamental criticism, the research teams from the Netherlands and the UK especially have concluded from their research that the health target programmes need a new start, rather than to be abolished all together.

To assess the scope, feasibility, impact and political options of health targets with a special focus on health policy and health care was the purpose of an international

workshop that took place in April 1999 in Celle, near Hannover, Germany. Under the auspices of the German Council presidency, the workshop aimed at agenda setting for a Europe-wide discussion on health target programmes. Four major themes were discussed:

- defining health targets;
- health targets and health policy;
- implementing health targets in health care;
- evaluation and outcomes of health targets.

Invited to discuss these issues were policy makers, administrators and scientists active in this field. The participants' backgrounds were either national or regional and comprised Finland, Germany, Northrhine-Westphalia (Germany), Spain, Portugal, Hungary, the UK, Cracow (Poland), Italy and The Netherlands. To complement this focus the European Public Health Alliance (EPHA) participated to introduce the citizens and patient perspective. Additionally there were representatives from the German Federal Ministry of Health, the European Commission, WHO Regional Office for Europe and from the industry.

The international workshop was organised by Medical School Hannover. We gratefully acknowledge the sponsorship by MSD

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“Empirical evidence of the effectiveness of ambitious health target programmes has been sobering.”

Preliminary Notice

Follow-up Conference on Health Targets, Autumn 2000

The Debate on health targets is rapidly receiving more attention both in terms of regulating healthcare and improving quality and outcomes. This year's workshop in Celle (as reported in this issue of *eurohealth*) and the international conference *Targets for Health - Shifting the Debate* in Paris, September 1999, sponsored by the European Public Health Association (EuPHA), the European Health Management Association (EHMA) and Merck, Sharp & Dohme have contributed to this development.

Different programme profiles and initiatives have been identified and discussed by a broad audience. To move forward it is necessary to understand the outcomes of health target programmes. Three outcome parameters have been suggested that may provide ground for further discussion:

- discursive outcome: segmented and segregated health services may profit from health targets because they re-focus healthcare on health related issues;
- political efficiency: conflict management in health politics may profit from health targets, since actors will more easily agree on measures in relation to established common objectives;
- improving health outcomes: implemented health targets may improve population health, efficiency and quality.

Scientific evidence and the international comparison of experience with existing programmes are limited. To bridge this gap will be the purpose of the upcoming conference.

eurohealth will provide details when they become available.

Defining health targets

“The target setting approach is seen as a step by step approach with increasing specificity: principles and values, goals, objectives, qualitative targets, quantitative targets, indicators for monitoring progress.”



Loes van Herten

The discussion in the first session of the workshop ‘Health targets, health care and health policy in the European Union’ focused on the definition of health targets, the process of health target setting and the scope and focus of health targets. As could be expected at the beginning of a workshop that was intended as a brainstorming exercise many questions were raised. During the session, even more questions arose and some of them were answered.

What is a health target?

What is a health target and what are targets in relation to goals and objectives? In attempting to clarify these matters, two references were made to the literature. The World Health Organization formulates a target as ‘an intermediate result towards the achievement of goals and objectives; it is more specific, has a time horizon and is frequently, though not always, quantified’. In the same chapter, WHO states ‘A goal refers to the long-range aims of society and is usually expressed in rather general terms. In international literature and in many national policy documents it is frequently used interchangeably with the term objective, although according to United Nations usage, an objective is rather more specific than a goal and it is an aim which can be partly achieved during the planning period’.¹

The other reference was to the report ‘Health policies on target?’.² In this report a health target is defined as ‘an explicit endpoint of public health or health care, expressed in terms of population health and its determinants, to be pursued within a given time with systematic monitoring of progress towards achievement’. Here also, the target setting approach is seen as a step by step approach with increasing specificity: principles and values > goals > objec-

tives > qualitative targets > quantitative targets > indicators for monitoring progress. The participants agreed with those definitions, although some saw difficulties in translating these terms into their own language. As one of them remarked: “We know the term ‘goal’ only in football”. In addition, remarks were made about the conditions related to targets such as realism, achievability within a given time frame, and so on. The targets should also preferably be defined in quantified measures, so that conclusions can be drawn about their attainability.

Which level and what kind of health targets?

The discussion then moved on to the level of target setting. Two types of levels were distinguished. The first one is based on geographical parameters, i.e. the European, national, regional and local levels. The second one is related to the aggregation level, i.e. the macro, meso and micro levels. The participants agreed that both types of levels could be used in combination.

During the discussion, four types of targets were mentioned. Distinctions were made between health outcome targets, intermediate targets, input targets and process targets. In addition, three types of target use were mentioned. Health targets were considered to be a source of inspiration and motivation, but they were also seen as technical tools for making policy decisions with an optimal balance between effect (health gain) and the allocation of the available resources. Furthermore, health targets were seen as a management tool for guiding the complicated team work that characterises present-day health policy and health care. These various opinions are of course complementary and compatible.

Why health targets?

During the discussion, the question ‘Why health targets?’ was raised. Most participants agreed that health targets could be used to rationalise health policy. Since society is becoming increasingly complex, the decision-making process is also becoming

“health targets can only help to make health policy transparent ... they will not reduce costs.”

more complex. Furthermore, at a time when most countries are revising their health policy due to the ageing of the population and the increasing prevalence of chronic diseases, together with the increase in technical possibilities and limited financial resources, health targets can also help to establish the 'big picture'. However, as one of the participants pointed out, health targets can only help to make health policy transparent and they will not reduce costs. Another argument mentioned in favour of using health targets was that they can also underline the shared commitment between the partners involved in the health target process.

Who should set health targets?

Another point in the discussion was related to the process of health target setting. Questions asked were: Who initiates the process? Who should be involved in the target setting process? Who is responsible? etc. In reply to the question 'Who is the target group?' the participants preferred the term 'citizen' to the word 'population'. They considered the word 'population' to be too abstract. The population cannot get involved in a health target process; citizens can. Other terms for referring to the target group, such as 'patients' or 'consumers', were rejected.

However, should citizens be involved in the target setting process? Some of the participants said that citizens expect leadership and that they therefore prefer a top-down approach. Others argued that you need commitment and consensus when setting health targets, and they therefore advocated a bottom-up approach. Some saw difficulties in the involvement of citizens, especially when citizens in large areas are asked to give their opinion. However, the example of the health facilitators in Sweden made it clear that it is not impossible to involve the public. Other difficulties were seen in the power of interest groups and patient organisations, because setting targets and priorities also means giving less priority to other areas.

So what is the answer, bottom-up or top-down? The participants came to the conclusion that this depends on the focus and the level of the health targets. A combination of bottom-up and top-down was considered necessary when defining a complete framework of health targets. All agreed that the crux lies in democracy and empowerment and that there should be some kind of involvement. This involvement in the health target process can come from citi-

zens, researchers, politicians, councils, institutions, other sectors, the media, etc. However, the answer to the question of who should be involved also depends on the question 'Where is the focus of health targets?'

Where is the focus of health targets?

The diversity in health targets can be explained by differences in interests, differences in priorities, differences in target groups, and so on. Until now, most health targets have focused on intervention areas like health promotion, while health care received less attention. The targets will also differ according to the levels chosen. Is a health target set at the national level or at the local level? Furthermore, does it focus on the macro or the micro level? Depending on the focus chosen, different expertise will be needed to start the process of health target setting. All participants agreed that the health target process is an ongoing one requiring an interdisciplinary approach. It is also a process that requires commitment and consensus. Such an approach will therefore take time. It is also more than an academic exercise. The setting of health targets stands or falls with political will. Nor does the process stop with the formulation of the targets. The definition of targets is not the end; it is only the beginning.

In addition, during the course of the discussions, more and more questions arose about the implementation and evaluation of health targets. However, these subjects were discussed in sessions three and four of the workshop.

Conclusion

During the first session of the workshop, a lot of questions were raised and some answers were given. All participants agreed that it would be impossible to define an ideal target. However, although most of the questions had more than one answer, the first session – like the others – was very helpful in establishing a common language about health targets.

"the crux lies in democracy and empowerment ... there should be some kind of involvement."

"The setting of health targets stands or falls with political will. Nor does the process stop with the formulation of the targets. The definition of targets is not the end; it is only the beginning."

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Health targets: policies, polity and politics



Matthias Wismar

The political dimension of setting and implementing health targets is a much neglected issue, both in terms of analytical understanding and strategic options for policy planning. No doubt the political process shapes health target programmes. A change in process will produce different targets and different implementation strategies. This in turn will determine the focus and success of a given programme. Therefore, it is crucial to understand the political dimension of health target programmes and what shapes the policy process.

There is a large body of political experience with health target programmes. This is unsurprising since The World Health Organization's Health For All campaign was initiated more than 20 years ago. The first lesson we can learn from this experience is that political will is a necessary but not sufficient prerequisite. Three other factors are highly relevant:

- _ proactive management of policy context relation – the policy factor;
- _ the impact of institutional settings – the polity factor;
- _ vertical and horizontal consensus building – the politics factor.

Proactive management of policy context relations

How do health target programmes relate to their context? Are health target programmes in conflict with their contexts or are they complementing or even supporting other policies, and existing social values and ethics?

It is assumed that health target programmes enjoy perfect context relations in regard to dominant social values and ethics. All health target programmes are strong in supporting equity in terms of access, health outcomes and choices. Many of them focus on sub-populations with special health risks. Although this is in line with the principle orientation of most health services across the European Union and the accession states, these values are in conflict with market ethics that exist at the same time. Market mechanisms – different in degree – have been introduced or reinforced in many countries since the early 80s. Examples are the internal market in the British NHS, the enforced competition among sickness funds in Germany, the

move towards selective contracting in the Netherlands, the growing relevance of user charges in many countries. Although markets promise to raise efficiency they are in principle indifferent if not contradictory to equity.

The relation of health target programmes with national or regional health service policies or other social sector policies is also complicated. Although health target programmes in general are welcomed or even initiated by health service departments on the national level or competent authorities on the regional level, they do not necessarily succeed in integrating different departments or sub-departments. Other social sector policies seem to be too far detached from health policies in terms of organisational structure, policy arenas and policy objectives. Even within health service departments a split between the strategic and management units can be observed, which constitutes a barrier that is difficult to overcome.

Health service policies are highly relevant for economic and industrial policy. Although throughout the 1980s major concerns related to the share of health care expenditure of GDP and the tax or contribution level, today there is a growing awareness that health services are a source of employment and an important market for high value-added 'sunrise' industries, such as the pharmaceutical, medical devices and telematics industries. It was therefore surprising that neither the negative nor the positive potential economic consequences of health target programmes were addressed.

A general conclusion that could be drawn is that health target programmes have rather complex, if not contradictory, relations to their context. But this is true for almost all health care policies. Health target initiatives should take this into account from the very beginning in order to specify the context relation of a programme in a proactive way. This would stimulate support for a policy and dampen conflicts that would otherwise hinder the programme.

The impact of institutional settings

Do institutions matter? This simple question is a key issue in political science and policy research. It addresses key factors that co-determine policies and politics. In

“a market driven health service will face even more difficulties in developing the relevant institutions and organisation in order to achieve a coherent and feasible policy.”

regard to health care institutions it became clear that the political process and the management of health targets requires the implementation of new institutions that are in principle complementary to existing health care institutions. A good example of this is the state health conference in Northrhine-Westphalia, which meets regularly and serves as a means of consensus building and policy setting. Since health target programmes often focus on the interface between health services and other policy sectors it is almost inevitable to introduce new institutional settings. Even if health targets are set in a very narrow fashion, for example indication specific targets, new institutions for coordinating and monitoring are required.

General institutional factors such as a health service model or regional/national polity do have an impact too. In a national health service the department of health provides a focal point that facilitates planning processes. Many social insurance based health services do not have such a focal point. Power, control, accountability and sources of information are dispersed over various institutions. In this respect a market driven health service will face even more difficulties in developing the relevant institutions and organisation in order to achieve a coherent and feasible policy. On the other hand, as soon as it comes to put policies into practice, social insurance schemes do have an advantage because the relations between purchasers and providers are often organised by a legally enforceable contractual arrangement. Contracts that specify prices, quality and volume may serve as a vehicle to make target achievement obligatory for providers. Contracts within a national health service are in this respect of limited use because purchasers and providers belong to the same institutional body. These contracts are not enforceable by court action or sanctions.

Besides the health service model, more general constitutional factors do play a role too – namely centralism, federalism, regional autonomy and the process of devolution. Health target initiatives at the regional level will find a greater political and administrative support than those at a national level, because the competent authorities will relate more easily to the people involved at the grassroots level.

Therefore it is essential that in countries with centralised political and administrative structures the necessary competencies be delegated to the regional level. Institutions

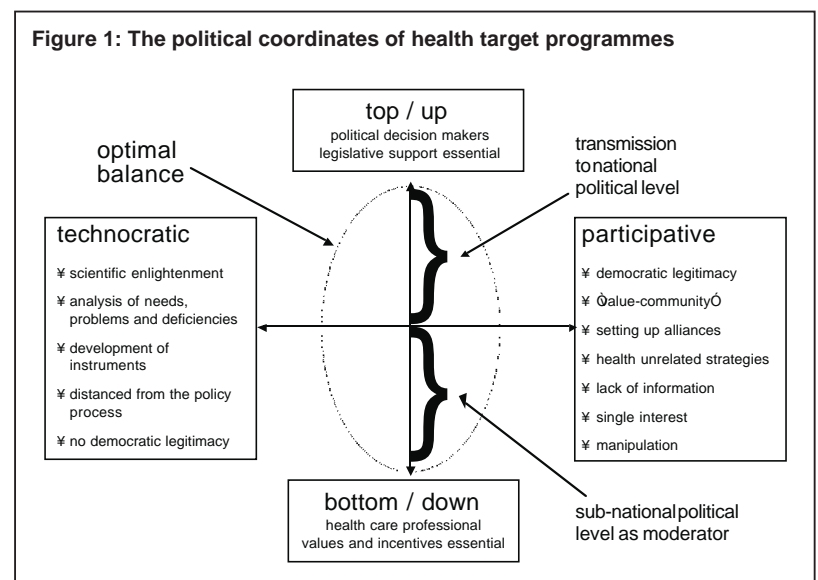
“Other social sector policies seem to be too far detached from health policies ... even within health service departments a split between the strategic and management units can be observed, which constitutes a barrier that is difficult to overcome.”

do play a role, but political will can contribute to adjust them to the needs of a health target programme.

Vertical and horizontal consensus building

To distinguish and analyse the various political strategies and conflicts in the process of defining and implementing health target programmes we have designed a model (see figure 1), which is based on the assumption that feasible programmes rely on a social and political compromise. This compromise is established between four poles.

The poles of the horizontal axis, which represents the process of defining target programmes, have been termed ‘technocratic’ and ‘participative’. The vertical axis signifies the relation between the policy makers and those who are responsible for implementing, executing and running a programme in a given health care setting. In terms of implementing a programme it is possible to distinguish between a top/down and a bottom/up strategy. While the first is carried out on behalf of the policy makers (top) the latter is at least initiated by those working in the health care settings or by the patients. The relation between the two



Modified from Wismar, Busse, Schwartz, 1998.

“Any health target initiative has to be supported both on the regional level and national level – an important role is played by competent political or administrative bodies at the regional level.”

poles on the vertical axis is crucial in regard to the success of implementing a health target programme. It is necessary to build a political alliance or consensus for a given health target programme.

Any health target initiative has to be supported both on regional and national levels – an important role is played by competent political or administrative bodies at the regional level. However, any regional programme that does not have the support of the national government will have a narrow room for manoeuvre. Therefore one necessary task of a regional political or administrative body is to ensure the transmission between the regional and the national level. At the same time, these bodies have an important role to play in regard to providing a platform for the initiative, either as a moderator or by leadership.

An optimal balance in terms of managing the tension between the poles is to arrange a compromise and build a political alliance as indicated with the dotted oval.

An important issue that emerged during the discussion was the ‘health target para-

dox’. Health target programmes do not necessarily serve the achievement of a health objective. In some instances, they are rather employed to introduce a strategy debate, to support consensus building or to process conflicts between different actors in the health policy arena that could not otherwise be solved. This follows the well-known saying ‘the way is the destination’. This approach is in stark contrast with the original purpose of health targets to contribute to the improvement of public health. From the perspective of ‘outcome-orientation’ and in the light of evidence based health policy making the ‘destination is the destination’.

The ‘health target paradox’ does play a role in most regional health target initiatives that were introduced in the absence of a coherent or sufficient national health strategy. It could be argued that the debate serves to provide grounds for the introduction of health targets in the future. But it remains unclear whether policy-makers will embark on a health policy concept that was once unsuccessful in achieving its own goals.

Implementing health targets in health care



David J Hunter

Putting policy into practice and translating objectives into action represents a particular challenge for health care reformers. Implementation is a difficult and undervalued area for governments and one that is often neglected and not well understood. Governments may prefer to shape policy, leaving others responsible for its subsequent implementation. But implementation often takes time, especially if complex changes in organisational and/or professional culture and behaviour are sought. Not surprisingly in view of the short-termism which is a feature of most modern governments, policy-makers invariably lose interest in implementation whatever their intentions at the outset.

Evidence based medicine

In health care systems across Europe, as elsewhere, there is increasing attention being given to evidence based medicine (EBM) and on the acquisition of evidence testifying to the effectiveness or otherwise

of clinical interventions. The aim is to ensure that scarce finite resources in health care are allocated only to those procedures and interventions displaying evidence of either clinical or cost effectiveness. So far, most of the effort and resources have been devoted to acquiring the evidence rather than on using or accessing the evidence that already exists to inform policy and practice. But when it comes to acting on the evidence, there continues to be something of a vacuum.

Evidence-based implementation has yet to receive serious attention, although the issue is now recognised as one in need of better understanding and attention and is firmly on the policy agenda in many countries. Although many countries are developing R&D strategies, for the most part the emphasis is on research rather than on development. There is a sound case for putting development first since in many cases the knowledge base is sufficiently robust to recommend a change in policy or

practice, or both. The problem has been securing change in the face of powerful professional resistance or other obstacles.

While EBM is becoming increasingly accepted in primary and secondary care, effective support for healthy public policy, and for establishing what works and does not work in this complex area, is needed. This demands institutional capacity building in public health where the infrastructure in terms of skills and resources needs strengthening. There is a risk that focusing on EBM directs attention towards acute care at the expense of preventive care or wider public health interventions. There is a case for evidence-based health policy.

The importance of prevention and the role of targets

There is an important role for the health care sector in promotion and prevention but the attitudes and understanding of health professionals need to be changed if they are to appreciate and realise their full potential. Incentives need to be identified to achieve change in organisational and professional behaviour in order to meet targets. Financial incentives may, paradoxically, be too successful, resulting in distortions or manipulation of the data in order to meet the target regardless of whether or not it is appropriate. The waiting-list target in the British National Health Service is a good example. 'Creative accounting' is not uncommon in order to be sure that targets are met. Incentives of a managerial and administrative nature also need to be identified. What is required is that resource flows should be linked to policy streams. If integrated care means anything at all, it is to achieve such linkage across the care spectrum in a seamless fashion.

In the UK, an evaluation of the health strategy that existed from 1992 to 1997, *The Health of the Nation*, reported that, by and large, it had been an implementation failure because there was an absence of sustained political commitment to it.¹ Nor was there an appropriate performance management system in place to ensure progress. Views were mixed both on the subject of the value of targeting and on the quality of the targets themselves. Some viewed targets as the centrepiece of the strategy, while others saw them as representing a distraction from the main agenda and as focusing too narrowly on medical issues rather than on the key determinants of people's health, which might include housing, employment and so on. The targets were seen to be directed at health care services rather than

"Putting policy into practice and translating objectives into action represents a particular challenge for health care reformers. Implementation is a difficult and undervalued area for governments and one that is often neglected and not well understood."

at other agencies and their contribution to improved health. As a consequence, the commitment of these other agencies to the health strategy was considerably weaker than it might otherwise have been.

If there was some strength seen in having national targets as a vehicle to encourage organisational coalescence, there was a general criticism at the failure to encourage local target setting. National targets on their own, regardless of their appropriateness, were not seen to be sufficient to effect change at local level unless those at that level 'owned' them and believed in them.

The actual targets themselves and their technical and scientific basis were also the subject of considerable criticism. Many did not consider them to be sufficiently challenging and maintained that they would have been achieved anyway without the NHS or other agencies having to do anything at all. As a result, the value of the targets set was not seen to amount to much. This, in turn, led to suspicion concerning the government's intentions and a feeling that perhaps its commitment to the health strategy left something to be desired.

Target-setting and related managerial devices are seen as central to government efforts to modernise public services. Yet this is increasingly viewed as a rather old-fashioned agenda as we are now in the postmodern age where the certainties of

Health Policy: Paradoxes and Puzzles

Health	Health care
Health services	Disease, sickness services
Joined up government	Departmentalitis
Whole systems approach	Vertical, fragmented, compartmentalised
Loose-tight (means-ends)	Tight-loose (means-ends)
Hierarchies	Markets

rational, linear policy-making are being questioned, since they have demonstrably failed to reflect the realities of achieving policy change. Postmodernism places a greater stress on chaos theory and complexity and accepts the inevitability of paradox, ambiguity and messiness. Rather than seek to eradicate such dysfunctional elements, there is an acceptance of them with efforts directed towards managing them more effectively.

Health policy is riddled with paradoxes and puzzles. Some of the more common ones are listed in the table below. These are not necessarily all to be found in all countries but it is likely that at least some will be found everywhere at some point in time. Foremost is the persistent tension between

“There is an important role for the health care sector in promotion and prevention but the attitudes and understanding of health professionals need to be changed if they are to appreciate and realise their full potential.”

health and health care. They need not be one and the same thing. Yet governments and the public invariably see them as indivisible. European health care systems are all good examples of what might be termed the ‘medical capture’ of health policy and health where the professional interests of those seeking to provide cure are the principal drivers of policy in those countries. In fact, it is not so much health care services that are provided, but sickness or ill-health services. Efforts to improve health in the broader sense have always been marginalised both in terms of the attention of policy makers and in terms of the resources invested. So health care systems continue to focus on disease or ‘dis-ease’.

A holistic approach to health care

Recently, there has been an attempt to move away from this fragmented model of health and emphasise the ‘whole’ person and the integrated nature of need for care ranging from prevention, through primary, to secondary and possibly tertiary care. Notions of ‘joined up’ policy and of finding connected solutions to tackle complex problems which are themselves interconnected are now finding favour with reformist governments anxious to overcome the narrow ‘departmentalism’ which

has tended to prevail. For example, the ‘whole systems’ approach being pursued in the UK by the modernising Labour government is an attempt to overcome the traditional compartmentalised nature of government.

From being concerned primarily with means, there is a trend among governments to place a greater emphasis on ends. In part this reflects the ‘cult of managerialism’ which has swept through governments in recent years, much of it borrowed from the private sector. A key component of this style of management - often referred to as ‘new public management’ - is the stress given to outcomes and to the setting of targets.² Under this approach, the theory is that governments should be tight about ends - that is, objectives and goals - but loose about how they are achieved, therefore allowing maximum freedom and space to local managers and professionals to find their own solutions to complex problems.

In this way governments steer more and row less. But in practice what happens is the precise opposite of this. Because governments often find it difficult to define with clarity and precision the outcomes of their actions in health care, or to be able to be sure that they are working within a reasonable timescale, it is far easier to specify means and to become tight about these while being loose about ends. A truly centralising government may of course attempt to be tight about both means and ends.³

Finally, many of the left-of-centre reforming governments in Europe are experimenting with the idea of finding a third way between hierarchies and command and control systems of government on the one hand, and highly devolved market systems on the other. The notion of the ‘third way’ is linked to the ‘loose-tight’ distinction. Just as it is not proving easy to maintain an appropriate ‘loose-tight’ separation, so finding a ‘third way’ between hierarchies and markets may prove equally illusive.

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Evaluation and outcomes of health targets

“If Russia in 1990 had passed a target to keep life expectancy constant until the year 2000, it would have been accused of passing a target that would be reached anyway. If this target had resulted in halving the actual decline, it would have been a success even though most evaluation strategies would label it a failure.”



Reinhard Busse

The technocratic approach to evaluation

To some, the issue of evaluating health targets is straightforward: since health targets are specific, quantifiable and measurable objectives to improve health, they provide a natural instrument for evaluation and adjustment. According to this view – which is the technocratic one in the framework provided earlier (see Matthias Wismar) – qualitative targets also have a concrete deadline and are in their most explicit form quantified. Evaluation of all targets should be based on the collection of necessary data, an appropriate timeframe and the margins of successes and failures. The equation used in measuring progress in target achievement is as follows:

$$\frac{\text{Current status} - \text{baseline}}{\text{Year X target} - \text{baseline}} \times 100 = \text{percentage of target achieved}$$

This is the approach used for evaluation in the USA and the Netherlands. But what do the results obtained mean? Two important questions have to be addressed in this context. First, what should we evaluate and, second, what are the desired outcomes of health targets. Concerning the first question, at least three foci are possible: the success – however measured – of whole health target programmes; the impact of individual targets on the achievement of the desired outcomes; or whether the epidemiological data set in the targets has been

achieved. We usually concentrate on the latter, that is, when the target is to lower the mortality or the incidence of a given problem by 10 per cent within 10 years, we evaluate whether the mortality or the incidence is actually 10 per cent lower 10 years later. However, does this really tell us much about the success of the target, let alone the programme in which this target is embedded?

Two common reproaches are worth mentioning in this context. If a target is not achieved it is easily dismissed as too ambitious, as in the Netherlands; if a target is achieved it is sometimes dismissed as one that would have been reached anyway, as in the coronary heart disease death rate target in the UK. These statements deserve a closer examination. The first statement requires a thorough knowledge of potential effect sizes – ‘efficacy’ – of various intervention strategies – and possible combinations of interventions. The second assumes that longitudinal trends remain constant over time. This is not the case, however, since external factors exercise large influences as well.

Take the example of life expectancy in Central and Eastern Europe. If Russia in 1990 had passed a target to keep life expectancy constant until the year 2000, it would have been accused of passing a target that would be reached anyway. If this target had resulted in halving the actual decline, it would have been a success even though most evaluation strategies would label it a failure.

The same holds true the other way around. If a target – judged by ‘experts’ to be neither over ambitious nor trivial – has been

“political or economic outcomes may be just as important as the health outcomes themselves.”

reached successfully, attributing this to the strategy itself is rather difficult. It is usually not possible to differentiate the contribution of the different elements to the measured outcome and we will probably never be able to control for all factors attributing to good or ill health. This leads to the second question: What are the desired outcomes of health targets?

Outcomes of health targets

In the technocratic-epidemiological view, the fundamental purpose of health targets is to improve the public's health. While health outcomes are the most important outcomes of health targets, at least two other categories of health target outcomes have to be mentioned: First, the intermediate and process outcomes and second, other outcomes. Paying attention to other categories of outcomes can in part be a response to the difficulty of reliably measuring health outcomes alone, which are often extremely small and slow – be they defined in terms of length of life or mortality, or in terms of quality of life, or both. Intermediate and process outcomes – that is, improved and/or equitable access to services or a reduction in risk factor profiles, therefore have their own relevance. They often change faster and are easier to detect. For example, to evaluate the success of an anti-smoking strategy to achieve the target of lowering lung cancer incidence, we would not rely on lung cancer trends alone but would also count numbers of smokers and ex-smokers.

“Indicators for measuring outcomes will depend on the kind of outcomes under evaluation and should be chosen in a pragmatic way.”

The ‘other’ outcomes are easily overlooked, especially if health targets are viewed from a purely epidemiological point of view. However, political or economic outcomes may be just as important as the health outcomes themselves. To create a climate for health improvement, to stimulate the creation of alliances for achieving better health or to facilitate economic growth should be viewed as reasonable goals for health target programmes. If these are explicit – or more often implicit – goals, then they must be taken into account when the targets are evaluated. But how do we measure a climate for health improvement quantitative-

ly? Health targets may be quantifiable and measurable – their appropriate evaluation, however, requires qualitative methods as well as quantitative methods.

The art of health target evaluation

Evaluation is a necessary component of health target setting. It should reflect both the multiple purposes of the evaluation and the multiple outcomes of health targets. Evaluation is a continuous process that starts even before the target setting is finalised. Evaluation should be in the minds of the persons setting targets and designing strategies to achieve targets. Necessary pre-conditions include a vision of the future, epidemiological knowledge, insight into intervention efficacy, as well as an articulation of what outcomes are desired other than health outcomes. Correct indicators should be chosen to measure progress towards each target. Indicators for monitoring progress are inherent in the process of achieving a target.

Indicators for measuring outcomes will depend on the kind of outcomes under evaluation and should be chosen in a pragmatic way. Measuring progress is assumed to be inherent in the target setting, which also facilitates rational adjustment. For those responsible for managing the implementation, the range of success in achieving the set targets should be a major impetus. To be able to do this continuously in order to provide feedback is another reason why evaluation should comprise all processes contributing to the achievement of a target and not only concentrate on final health outcomes.

The best evaluation, however, is useless if it is not followed up. For this purpose, health target achievement may be translated into financial consequences for those responsible. Health target achievement will also form the basis for a realistic re-definition of health targets and their desired outcomes. In this respect, evaluation of health target programmes is not the end of the programmes but the beginning of new ones. These may likewise be on the national level, or on regional or local levels, or even on the European level.

Setting targets for health: the WHO European experience

It is already twenty years since the decision was taken to set targets for health in Europe. Following the adoption by the World Health Assembly of a global strategy and targets for Health For All (HFA) in 1981, it was clear that the more economically developed countries in the European Region needed their own targets because many of the broad global targets had already been reached. These targets were to highlight a limited number of important areas for development, give practical examples of the meaning of the HFA strategy, making it more easily understandable to authorities, special interest groups and the public. By defining and monitoring relevant indicators it was hoped that the targets would act as a mirror in which countries could see the trends in health in the region, the possibilities for health gains and the consequences of failing to act.

Developing targets for Europe

The development of the European targets was a major undertaking, with more than 250 experts from across Europe working together and going through more than twenty drafts over a period of about three years.¹ When in 1984 the 38 targets were unanimously approved by the Regional Committee,² Europe had for the first time a common health policy – a considerable achievement, particularly in view of the fact that at that time there was no political cooperation across the region.

The sceptic might question the value of the target setting process in an organisation which, unlike the European Union, wields no financial or legal incentives to ensure that such joint decisions are actually carried out. Despite the fact that for many it represented a quite new way of working and others still felt rather uncomfortable with the notion of planning for health in pluralistic systems,³ considerable evidence indicates the seriousness with which most countries faced this challenge.

On a European level, the Regional Committee reaffirmed this approach in 1991 when the 38 targets were revised⁴ and again in 1998 when a new set of 21 targets were approved.⁵ Progress towards the achievement of the targets has been moni-

tored and evaluated on a regular basis using a wide range of indicators. One of the valuable results of this process has been the establishment of the HFA database, now available on the internet. A number of countries include reports on their progress towards the European targets in their regular public health reports or in reports to parliament.

On a country level, well over half the member states have formulated their own targets for health on national and/or regional and city levels. In 1989, just before the fall of the Berlin wall, top decision makers from 19 of the then 32 WHO member states in Europe that had formulated national HFA policy documents met to discuss their progress and experiences. They agreed that on the whole, most had tried to set too many targets. They felt that the 38 European targets should act as a check list, from which each country depending on its own national situation, could select a smaller number of strategic targets.⁶

“Europe had for the first time a common health policy – a considerable achievement, particularly in view of the fact that at that time there was no political cooperation across the region.”

Of the 51 countries which now make up the WHO European Region, again more than half have already formulated HFA type policies, most of which include targets for health. These range from policy documents which focus on only four or five target areas, usually related to the reduction of the major diseases, to those that, contrary to the advice from the 1989 meeting, adopt the full range of the European targets. A number of countries such as Bulgaria, Finland and the Netherlands, which embarked on this process in the early 1980s, are already going through third or fourth revisions of their national policies and targets.



Anna Ritsatakis

“The targets must appear feasible but also politically challenging, and be relevant to both the experts and the public”

Developing targets through actions

Over the years, partly in response to their sometimes disappointing progress towards intended health outcomes, a number of countries have set targets related to actions which must be taken to achieve the desired outcomes. In these cases, outcome or primary targets (for example reducing deaths from specific diseases) are linked to intermediate targets, related to risk factors, which must be achieved in order to reach the primary targets, (for example, targets related to changes in the prevalence of health conditions or symptoms, exposure to hazards, and changes in behaviour); and to input/output targets defining the necessary input of resources and output of services; or to process targets dealing with specific actions to be taken, such as legal measures or standard setting.⁷ In Catalonia for example, this method has led to the setting of more than 200 targets, most of which relate to inputs/outputs and process.

Even in countries that have persevered in this approach for many years and despite changing governments, the process of formulating and implementing targets for health has not been without problems. Politicians may be reluctant to embrace targets that cannot be fulfilled within their short span in power. Other problems relate to the level at which targets are to be set so that they are scientifically credible, but still go beyond the extension of existing trends. The targets must appear feasible but also politically challenging, and be relevant to both the experts and the public. A project has recently been initiated by the WHO European Centre for Health Policy (ECHP) to clarify some of these challenges and to provide a forum for policy makers to exchange their experiences.

Implementing targets

Formulating and monitoring targets for health is only part of the story however. What will make the difference are the measures taken to implement the targets. A recent study of the process of HFA policy development indicates that on the whole, countries are still not taking action to get to the root causes, particularly of inequities in health.⁷ Although the need for partnerships across all sectors of the economy is widely recognised as essential to achieving many of the health targets set, such change is not easy to achieve. The results of the study show that in most cases, the health sector is still working largely with familiar partners, and in familiar ways. There are very few examples where tackling the determinants of health such as poverty, unemployment or poor housing are seen to be among the main ways of achieving health targets. Among the exceptions are the recent measures initiated in the United Kingdom where England, Northern Ireland, Scotland and Wales provide interesting examples of trying to link health and development in order to achieve health targets.

With only two exceptions, all the EU countries have now formulated targets for health at national or local levels. The development of a public health policy for the European Union,⁸ and the provisions of article 152 of the recently ratified Amsterdam Treaty, offer exciting possibilities for also setting targets for health in areas where EU level policy is particularly influential. Fortunately there is now a wealth of experience in the Region and modern means of communication are making this easier to share. The ECHP intends to make much of the information available on the internet by the end of the year.

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Defining appropriate health care

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James P Kahan

Contemporary developed nations are confronted with the problem of managing their health care systems to assure that patients receive high quality health care. We define high quality health care as the consistent and reliable delivery of cost effective care, whose benefits outweigh its risks, which is faithful to the values of the society where the care takes place, is feasible given the resources available to the society, and is as responsive as possible to the individual needs and values of the care recipients.

A signal of possible low quality health care is the observation of different utilisation rates for a medical or surgical procedure in different geographical areas, where there is no reason to believe that the populations in those areas differ in their need for that procedure.¹ In such situations, there is the suspicion that either one area is over-using the procedure, another area is under-using the procedure, or both. Worse, a single area may be over-using and under-using simultaneously.^{2,3}

To assess the quality of health care, different analytic techniques are required to determine the cost effectiveness, benefit/harm ratio, adherence to values, implementability and responsiveness of care.⁴ To address the benefit/harm component of quality of care, a team of researchers at RAND and UCLA developed what has come to be termed the RAND Appropriateness Method (RAM) to determine ‘appropriate’ care.^{5,6} A procedure was used appropriately if its application—to a particular patient—provided the expectation of more benefit than harm. Benefits and harms were defined in terms of the patient's physical, functional, and subjective well being; costs were explicitly not included at this stage

of the determination of quality.

The RAM was rapidly disseminated from North America to Europe, and by the mid-1990s, there was a core of investigators throughout Europe using the method. This core formed the basis of a BIOMED concerted action to promulgate and further develop the RAM. In this paper, we briefly describe the RAM and then summarise the efforts of the concerted action. The following two articles in this issue (Fitch and Lázaro; Vader and Burnand) explore the development, dissemination and policy uses of the method.

Description of the RAM

The following presents an overview of the different steps involved in studies using the RAM. When a topic has been selected, the first step of a study using the RAM is to perform a detailed literature review to synthesise the latest available scientific evidence on the procedure to be rated. At the same time, a list of indications is produced in the form of a matrix, which categorises patients who might present for the procedure in question in terms of their symptoms, past medical history, and the results of relevant diagnostic tests.

The literature review and the list of indications are sent to the members of an expert panel. These panel members individually rate the appropriateness of using the procedures for each indication on a nine point scale, ranging from extremely inappropriate (one) to extremely appropriate (nine) for the patient described in the indication. The panel members assess the benefit/risk ratio for the ‘typical patient with specific characteristics receiving care delivered by the typical surgeon in the typical hospital.’



Mirjam van het Loo

“A signal of possible low quality health care is the observation of different utilisation rates for a medical or surgical procedure in different geographical areas”

After this first round of ratings, the panel members meet for one or two days under the leadership of a moderator. During this meeting, the panellists discuss their previous ratings, focusing on areas of disagreement, and are given the opportunity to modify the original list of indications and/or definitions. After discussing each chapter of the list of indications, they re-rate each indication individually. The two-round process is focused on *detecting* consensus among the panel members. No attempt is made to force the panel to consensus. In examining the potential use of the procedure for these indications, the method can determine situations when the procedure is inappropriate (that is, the risks outweigh the benefits) or necessary (that is, the procedure is the only possible means of providing substantial benefit for the patient).

The Concerted Action

The BIOMED II concerted action to promulgate and further develop the RAM consisted of eleven research organisations in seven different countries:

- RAND Europe, Leiden, NL (Coordinator)
- European Health Policy Forum, Leuven, BE
- Institute of Social and Preventive Medicine, Lausanne, CH
- Institute of Social and Preventive Medicine, Zürich, CH
- Galdakao Hospital, Galdakao, ES
- Carlos III Health Institute, Madrid, ES
- Valme University Hospital, Sevilla, ES
- University Hospital, Clermont-Ferrand, FR
- Mario Negri Institute, Milano, IT
- Institute for Health Care Policy and Management, Erasmus University, Rotterdam, NL
- Swedish Council on Technology Assessment in Health Care, Stockholm, SE

The concerted action began in the autumn of 1996 and culminated in March 1999 with a meeting of the

European Health Policy Forum to disseminate its findings to the health, scientific and policy communities. The three categories of activity of the concerted action were: (1) making the access to the method easier, (2) improving and expanding the method, and (3) examining the feasibility of multinational panels.

Access

We considered three aspects of access to the method. First, we consolidated the experience of the group to write a 'how to do it' manual for people considering using the RAM. This manual – Fitch et al., which is in preparation⁷ – will be available by request to the members of the group

“The number of indications to be rated was reduced by focusing on those indications that are actually seen in clinical practice and that are subject to some debate.”

within a few months of this writing. It takes the reader step by step from conceptualisation through analysis of the RAM.

Second, we explored the possibility of providing standardised software for the method. We discovered, however, that progress in the world of computers had outstripped our knowledge. Several of our research groups independently developed their own software, and all of the programmes worked admirably. Thus, instead of one standard package, there are a number of packages available.

Third, we developed new methods to make available the results of RAM studies. Two websites are being established where physicians or researchers can view the results of RAM panels for specific patients; other programmes for graphical presentation of panel results, and work is underway to more easily translate panel results into guidelines implementable at the local level.

Improvement

The RAM has been criticised for a number of reasons, some fair and some unfair. Among the former are that the burden of effort on panel-

lists is too great, that the linkages between the scientific evidence and panel ratings are vague, and that the method has difficulty when considering multiple possible treatments for a single condition (for example, surgery, angioplasty, or medical management for coronary artery disease). Each of these problems and others were addressed by the concerted action. The number of indications to be rated was reduced by focusing on those indications that are actually seen in clinical practice and that are subject to some debate. Indications that never occur in practice, or indications that are unequivocally either appropriate or inappropriate, were excluded from the rat-

ings. In a study on coronary artery disease, a 66 per cent reduction in indications was accomplished. In this same study, panellists were asked not only to rate the appropriateness of the indication, but the extent to which their rating was based on their understanding of the scientific evidence, using a four point scale ranging from sound scientific evidence to the rater's own experience and belief. In two panels conducted under the auspices of the concerted action, multiple treatment options were explored, using different ways of comparing treatments. In addition to these advances in the method, refinements of the statistical analyses of panel results were explored. Reports of all of these efforts are being prepared for journal publication.

Multinational panels

A major investment of the effort of the concerted action went into the conduct of three multinational panels. Before this effort, all previous RAM studies had been confined to one country; comparisons across nations were only possible if two or more countries studied the same procedure, and even then the variations in definitions, indications, and

time made the comparisons problematic. By conducting panels composed of experts from different nations, it could be determined whether agreement could be reached on the definitions of indications to be rated, and the extent of consensus across countries could be assessed. If this is possible, then there are potential economies of scale to be gained by having single multinational panels instead of multiple national panels.

The first multinational panel was of upper and lower gastrointestinal endoscopy, and was conducted in November 1998 in Lausanne. Experts from nine countries participated. The panel not only rated

consensus.

The third multinational panel was for treatment of benign prostatic hyperplasia, and was conducted in March 1999 in Amsterdam. Again, experts from five countries participated. The panellists compared surgery, two pharmaceutical interventions, and watchful waiting for over 1100 indications. This multinational panel replicated a Dutch panel conducted in June 1998; interest here was in whether or not the two panels yielded the same ratings.

Although the final results of the three multinational panels await further analyses, the process and early outcomes indicate that multinational panels are an efficient way of

tion into local guidelines that take into account the resources and values of the patient and caregiver communities. Building on the network that created and nurtured the concerted action, the research groups are together considering ways of addressing these issues.

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“appropriateness ratings are not guidelines in and of themselves. Further work needs to be done in developing ways to make the RAM more amenable to translation into local guidelines that take into account the resources and values of the patient and caregiver communities.”

indications for the procedure, but also explored the consequences of relative costs on their estimates of appropriateness. This study has been extended over time; the panel is on call to reconsider indications should there be scientific or clinical developments that could affect the appropriateness of endoscopy.

The second multinational panel was for treatment of coronary artery disease, and was conducted in December 1998 in Madrid. Experts from five countries participated. In each of these five countries, a previous RAM study of the appropriateness of treatment for coronary artery disease had been conducted, between two and seven years previously. To the extent possible (11 out of 15), panellists who had served on their own national study were recruited. In this study, particular attention was paid to whether a set of definitions of indications acceptable to all panellists could be developed, and whether the panellists' ratings of the evidence base for their judgements affected the degree of

obtaining appropriateness ratings. The panels were all able to agree upon definitions, reported satisfaction with the panel process and reported confidence that the ratings accurately reflected the state of the art with regard to the procedures examined.

Need for further research

The work of the concerted action led, as is inevitable, to the need for further research. Participants note that the method is time-bound in the sense that the panel ratings are fixed by when they are obtained. It is not efficient to conduct repeated panels every year, yet progress in clinical medicine must be tracked. Research is needed on how to make the RAM an ongoing process; as indicated, the Lausanne multinational panel is beginning work in this direction. Also, we have long recognised that the appropriateness ratings are not guidelines in and of themselves. Further work needs to be done in developing ways to make the RAM more amenable to transla-



Kathryn Fitch

Using appropriateness criteria to improve health care

“only around 15 per cent of medical decisions are based on scientific evidence about their outcomes”



Pablo Lázaro

The basic mission of health services is to improve the health of both the individual and society. As is well known, however, health services in recent decades have been faced with enormous challenges, making it ever more costly to fulfill this mission. These include the introduction of increasingly complex services, the rapid innovation and diffusion of medical technologies and procedures, and pressures on the demand for services from both patients and health professionals. These phenomena are part of the reason health spending has grown so quickly in the industrialised nations over recent decades. In 1965 European Union countries spent on average 4.3 per cent of their gross domestic product on health care, a proportion that rose to 6.3 per cent in 1975, 7.0 per cent in 1985 and 7.7 per cent in 1995.¹ Clearly, this proportion cannot continue to grow indefinitely.

What is driving this growth in health care expenditures? Studies have shown that it is mostly due to increases in the “volume and

intensity of services.”² To curtail the volume of services without negative effects on the health status of the population, we need to find ways to assure that our health expenditures are used for effective services – that is, those that have demonstrated value. Yet it has been estimated that only around 15 per cent of medical decisions are based on scientific evidence about their outcomes.³ If this proportion is even approximately correct, it is not surprising that such wide variations have consistently been shown to exist in the rates of use of medical procedures – differences that cannot be explained by patient characteristics. For example, a graph of carotid endarterectomy rates plotted as a function of the number of surgeons in three areas of the United States (Figure 1) shows that the site with the highest number of surgeons performed more than three times the number of surgical interventions as the site with the lowest number.⁴ Does this mean that the area with more surgeons is performing procedures that are inappropriate, or that the one with a lower number is not completely meeting the needs of the population? Based on these statistics alone, we cannot know. It may even be that both overuse and under-use are occurring simultaneously in any or all of the areas.

The RAND appropriateness method

In an attempt to answer these kinds of questions, researchers from RAND and the University of California in Los Angeles developed in the mid 1980s what has come to be called the ‘RAND appropriateness method’. The concept of appropriateness, in the RAND method, refers to the relative weight of the benefits and harms of a medical intervention. An appropriate procedure is one in which the expected benefits outweigh the expected risks by a sufficient margin that the procedure is worth doing. The rationale behind the method is that randomised clinical trials – the ‘gold standard’ for evidence-based medicine – often either are not available or cannot provide evidence at a level of detail sufficient to

Figure 1: Number of carotid endarterectomies by number of surgeons in three US sites



Source: Leape LL, et al. 1989.⁴

apply to the wide range of patients seen in everyday clinical practice. Although robust scientific evidence about the benefits of many procedures is lacking, physicians must nonetheless make decisions every day about when to apply them. Consequently, it was believed a method was needed that would combine the best available scientific evidence with the collective judgment of experts to yield a statement regarding the appropriateness of performing a procedure at the level of patient-specific symptoms, medical history and test results.

The basic steps in the RAND method are described in the accompanying article by Kahan and van het Loo in this issue. The final product of the two-round 'modified Delphi' process is a list of highly specific clinical scenarios or 'indications', each of which is classified as 'appropriate', 'uncertain' or 'inappropriate' for the procedure in question based on the median panel rating and the level of agreement among panelists. This set of indications – which may number from hundreds to thousands – with the corresponding appropriateness ratings constitutes what are called the 'appropriateness criteria'.

Using appropriateness criteria to measure performance

Appropriateness criteria have most often been used as a tool to measure performance retrospectively. This is done by reviewing the medical charts of a representative sample of patients who have undergone the procedure. A specially developed 'abstraction form' is used to collect sufficient data on each patient to permit assignment of an appropriateness rating in accordance with the list of indications. The proportion of patients who have received procedures done for 'appropriate', 'uncertain' and 'inappropriate' reasons can then be calculated. Procedures done for inappropriate reasons are considered *overuse* of the procedure. Early studies in the United States showed that a substantial number of procedures were judged to be inappropriate: 17 per cent of coronary angiographies, 32 per cent of carotid endarterectomies, 17 per cent of

upper GI endoscopies,⁵ and 16 per cent of hysterectomies.⁶

Of particular interest in these U.S. studies was the finding that the volume of procedures was generally not related with levels of appropriateness. That is, areas where relatively few procedures were performed did not necessarily have lower rates of inappropriate use than those where intensity of use was higher. For example, the proportion of inappropriate use of coronary angiography was approximately the same in three U.S. areas (ranging from 15 to 18 per cent), even though the rate of utilisation of the procedure in one area was more than double that of the other two.⁵ In one area of the United Kingdom – a country where physicians perform only about one-seventh the number of cardiac procedures as in the United States – 21 per cent of coronary angiographies were found to be performed for inappropriate reasons, in accordance with the criteria developed by a U.K. panel.⁷ These figures suggest that just reducing the number of proce-

dures performed will not necessarily reduce the rate of inappropriate use.

“In one area of the United Kingdom ... 21 per cent of coronary angiographies were found to be performed for inappropriate reasons”

dures performed will not necessarily reduce the rate of inappropriate use.

The RAND method can also be applied to measure the possible *underuse* of procedures. Some panels carry out a third round of ratings to determine which of the appropriate indications are also necessary. Necessity is a more stringent criterion than appropriateness and refers to procedures which must be offered to a patient fitting a particular clinical description. Necessity can be more difficult to measure than appropriateness, however, because it involves identifying a group of patients who might have benefited from the procedure, but did not receive it. For example, to measure the underuse of coronary revascularisation, data could be collected from the medical charts of patients who received coronary angiography to determine what pro-

Using appropriateness criteria as clinical decision aids

Appropriateness criteria can also be used prospectively, as the basis for developing different types of aids to clinical decision making. These might be in the form of guidelines or flowcharts, which summarise the criteria in a more 'user-friendly' way than the tables of indications with their appropriateness classifications. Such summary formats can be time consuming to develop, however, and may run the risk of losing the specificity provided by the complete indications list. The tables themselves can also be disseminated in different ways – through publication in a medical journal, distribution of a special report by the relevant medical society, for example – so that physicians can consult the recommendation of the expert panel when confronted with a particular

patient. The challenge is to make the criteria available to physicians in an easy-to-use format, while also devising a system to ensure that the appropriateness classifications are updated as new scientific evidence becomes available.

One possible solution being tested by the Swiss members of the concerted action group is to make the criteria available through a web-based page on the Internet. This has the advantage of allowing physicians to view the criteria in whatever way they prefer: in some cases they may only want to see the appropriateness classification, while in others they may be interested to see the complete panel ratings for a particular indication. Using an Internet-based system, it would also be possible to provide hyperlinks to the relevant publications supporting a particular appropriateness classification, and to

quickly modify criteria that have become outdated.

Gaining physician acceptance

Enlisting the support of the relevant medical societies early on is an important step in obtaining physician acceptance of the appropriateness criteria. Specialist societies are usually asked to provide nominations of panel members and may sponsor dissemination of the final ratings. Physicians need to be assured that the criteria are not dogmatic rules to be followed reflexively, but rather carefully considered recommendations that will usually apply to a patient fitting the clinical indication, in the absence of other unusual circumstances. If they do not agree with the recommendation for a particular case, they may be asked to justify why it constitutes an exception. Providing feedback to physicians on their own performance as measured by the appropriateness criteria can be a helpful way of motivating them to consider the appropriateness criteria when making clinical decisions.

Conclusions

Wide variations exist in clinical practice, and a substantial proportion of health interventions are thought to be performed for inappropriate reasons. Bureaucratic, administrative or economic solutions to rising costs may limit the quantity of health care provided, but will not necessarily improve the appropriateness and quality of care. The selective elimination of inappropriate care would free resources to deliver effective care to those who need it. One way to do this is by developing high quality, flexible appropriateness criteria, which can be used both to measure past performance and to guide clinical decision making.

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John-Paul Vader



Bernard Burnand

Prospective assessment of the appropriateness of health care

“retrospective evaluation of care that has been provided is of little use to the patient who has received inappropriate care”

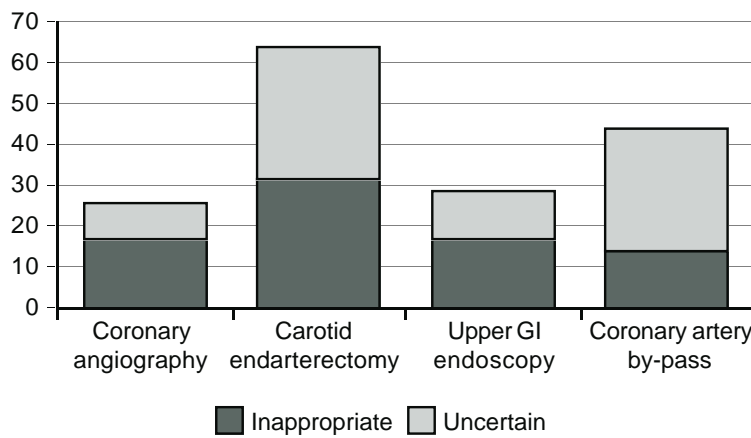
Within the framework of the challenges of improving quality of care, in general, and using the RAND appropriateness method in particular, this article will point out some of the limits and pitfalls of retrospective evaluation of care and argue that improvement of care requires prospective decision support. Given the complexity of the RAND appropriateness method – which is an explicit evidence and expert based method to develop specific clinical scenarios for the appropriate use of medical procedures – this article will describe the development of a computer-assisted, world wide web-based tool which incorporates data from recent expert panels on

appropriate use of low-back surgery and gastrointestinal endoscopy. It concludes with a call for collaboration for the testing and improvement of these instruments.

Background

Quality and cost of care are dependent on the provision of appropriate care. How to provide quality care within available budgets is a growing concern of all actors in the healthcare drama, whether providers, patients, payers or politicians. This concern is motivated by observed variations in clinical practice, by increasing financial pressure, in some cases by newly introduced legal constraints and most impor-

Figure 1: Examples of proportion of procedures examined that are inappropriate or uncertain.^{1,2}



tantly by the significant levels of inappropriate care that have been observed in widely divergent health-care systems throughout the world. For many, clinical practice guidelines are put forth as a response to this concern.

Although great effort has been and is being invested in the development of clinical practice guidelines, they still present a number of unanswered questions, in particular about the validity and implementation of such guidelines and the degree to which patients should participate in their development and use. This article will examine a new approach of implementation of medical practice guidelines for the appropriateness of care, developed using the RAND method.

From evaluation to improvement

Figure 1 is an example of an evaluation of the appropriateness of care that shows a substantial proportion of care being provided that is inappropriate or the appropriateness of which is open to question – a common occurrence in such evaluations.

Although the figures in the illustration reflect the situation some 15 years ago, with few exceptions, the proportion of care that is inappropriate generally exceeds 15 per cent of care examined. Also, however – and again with few exceptions – such studies have been carried out retrospectively, using a review of medical records. There are several problems with such an approach. First of all, it

has been shown that the medical record is not always precise enough to evaluate the appropriateness of what was done.³ Secondly, if the evaluator is aware of the outcome of care, s/he may be biased in his/her assessment of the appropriateness of care, a positive outcome for an individual patient being more often associated with appropriate care.⁴ Because numerous elements, besides the appropriateness and quality of care provided, affect patient outcome, such a reasoning can be fallacious. Thirdly, retrospective evaluation of care that has been provided is of little use to the patient who has received inappropriate care and probably also to the physician who provided it. Therefore, a key approach to going from evaluation of the appropriateness of care to the improvement of the appropriateness of care is to allow physician and

patient to access criteria for the appropriateness of care, prospectively, during the decision making process about care that is to be provided or received.

This is particularly so regarding the guidelines for the appropriateness of care that are developed according to the RAND method, because of the clinical detail contained in such guidelines. This clinical detail is at once a reason for their attractiveness for practicing physicians and an obstacle to their actual use in a prospective fashion by them. The output from RAND expert panels that have examined the appropriateness of different procedures generally presents itself as hundreds and at times thousands of different clinical scenarios.

Table 1 shows a small sample of the 600 sum scenarios that were evaluated recently by the European Panel on the Appropriateness of Gastrointestinal Endoscopy (EPAGE) – which was part of the EU concerted action described in the article by Kahan and van het Loo in this issue of Eurohealth (see that article also for a description of the method).⁵ In each cell of this Table the numbers above the one to nine appropriateness scale indicate the votes of the 14 experts of the EPAGE panel. Below the one to nine appropriateness scale the median vote is indicated, followed by the absolute deviation around the median and the degree of agreement between panelists (A = agreement, D = disagreement).

Table 1: Example of the scenario matrix, votes and results of European Panel on the Appropriateness of Gastrointestinal Endoscopy (EPAGE), in certain indications involving atypical chest pain

No known coronary artery disease	No GERD treatment	GERD treatment without response	GERD treatment with positive response
1. No cardiac work-up done	8 2 1 2 1 1 2 3 4 5 6 7 8 9 (1.0 1.36 A)	7 2 3 1 1 1 2 3 4 5 6 7 8 9 (2.0 1.14 A)	4 6 1 1 2 1 2 3 4 5 6 7 8 9 (2.0 1.36 A)
2. Cardiac work-up normal	2 3 1 3 3 2 1 2 3 4 5 6 7 8 9 (5.0 2.36 D)	2 5 3 4 1 2 3 4 5 6 7 8 9 (8.0 1.07 A)	3 2 3 1 3 2 1 2 3 4 5 6 7 8 9 (3.0 2.36 D)

Appropriateness scale:
1 = extremely inappropriate, 5 = uncertain, 9 = extremely appropriate.

“This clinical detail [of RAND guidelines] is at once a reason for their attractiveness for practicing physicians and an obstacle to their actual use in a prospective fashion by them”

It can readily be understood that a practicing physician will find it quite impracticable to wade through pages and pages, with hundreds and hundreds of such tables, in order to find a clinical scenario that corresponds to the patient, seeking assistance in deciding whether it would be appropriate to request or perform a gastroscopy to elucidate the nature of the patient's symptoms.

Towards a WWW-based approach

Given the pitfalls and drawbacks of retrospective evaluation of the appropriateness of care, the authors have been actively involved in the development of web-based technology to make the appropriateness criteria available for physicians, and indeed patients. The work is being done in collaboration with the Laboratory for Theoretical Computing at the Federal Institute of Technology in Lausanne.

One version exists already, integrating criteria from an expert panel convened in Switzerland in 1995 to examine the appropriateness of indications for low-back surgery.^{6,7} By responding to six questions, the physician is immediately pointed to the results of the experts' evaluation of the appropriateness of performing low-back surgery for patients with similar characteristics.

For example, the web site will show the results that one would obtain for a particular individual with a particular presentation: for example, a patient with sub-acute sciatica (lasting for less than six weeks), with major muscular weakness and a herniated disk on radiological imaging, who has already been treated with one non-operative treatment regimen, and is severely disabled. The results will indicate that for such a patient, low-back surgery would be considered appropriate, with votes of the experts ranging from five to nine on a nine point scale, concen-

trated at points seven and eight. The web page therefore shows in a simple and accessible format the assessments of physicians of the appropriateness of surgery for a category of patient. Elsewhere on the same web page, access is provided to summaries of articles from the medical literature concerning the efficacy, outcomes and complications of low-back surgery.

As with all guidelines, the conclusions concerning the appropriateness of an intervention using the results from an expert panel are intended to be a recommendation – rather than a hard and fast rule – to assist patient and physician to determine the appropriate strategy of care given the particular circumstances. It would be wrong and in some cases even harmful to base the decision to operate or not to operate solely on the basis of such a recommendation. It is felt however that if such information could be made available to physician and patient, via the world wide web, for example, it would provide valuable assistance in the decision that both need to make to determine appropriate care and optimise the desired outcome.

In addition to the pilot version described here for low-back surgery, a similar version is being prepared to incorporate criteria from the recent European Panel on the Appropriateness of Gastrointestinal Endoscopy. These instruments are still in the developmental stage and will require testing, as to their acceptability for physician and patient, their feasibility of use and their validity in terms of providing more appropriate care and optimising patient outcome.

Conclusion

We conclude by repeating that quality and cost of care depend on appropriateness of care. Given that, and given the rather complex nature of the guidelines on appropriate care stemming from the RAND

approach, innovative ways must be found to assist those on the front line in identifying and providing appropriate care. Such approaches will allow us to move from evaluation to improvement of the appropriateness of care. The world wide web offers great potential in this respect, but, as with the introduction of any new technology in medicine, its use still needs to be tested. Those interested in such testing are invited to contact the authors.

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Perspectives on cost sharing



Ray Robinson

The uncertain demand and often high cost of health care has meant that out-of-pocket payments represent only a small proportion of total health care expenditures in most OECD countries. Instead, risk-pooling insurance arrangements have been developed in order to cushion individuals from the financial consequences of ill health. These arrangements take a number of forms. In some countries, such as the United States, there is a flourishing private insurance market. In most European countries, on the other hand, heavy reliance is placed upon publicly financed schemes, either involving social insurance contributions or general tax payments. In public schemes, contributions are related to ability to pay rather than personal or group risk status. In all insurance schemes, however, individuals are not faced with the full financial costs of the services that they receive at the time of consumption, i.e. there are zero, or only nominal, user charges. Rather there is a *third party payer*, either public or private, that picks up most of the bill.

Although there are good reasons for a third party payer system – both in terms of equity and efficiency – the absence of user charges is periodically criticised on the grounds that it encourages excessive demand and thereby contributes towards escalating health care costs. This is generally referred to as the problem of *moral hazard*. By introducing a greater element of user charging, it is argued, individuals will be made more aware of the costs of health care services and will have an incentive to forgo those services that are not really necessary. Another, more recent, argument is that current attitudes towards public expenditure mean that governments will no longer be able to rely on the growth in public spending to meet the growing demands for health care as they have done in the past. According to this view, user charges also represent a promising source of extra revenue.

The pros and cons of these arguments are examined in the articles by Dawson, Towse and Anell and Svensson in this issue. Anell and Svensson explain how, contrary to the experience of most Northern European

countries, user charges have been applied increasingly in Sweden during the 1990s in order to deter excessive use of health services. Set against this approach, neither Dawson nor Towse chooses to make a case for the extension of charges on the grounds that they would combat moral hazard and reduce unnecessary utilisation. As Dawson argues, if unnecessary over-utilisation is the problem it is probably more to do with the supply-side – that is, moral hazard on the part of doctors who recommend excessive treatments to individuals with insurance – and would be more effectively countered through direct attempts to change their practice style, e.g. through financial incentives, guidelines and protocols.

On the second argument, that cost sharing is a potential means of raising revenue, Towse is more open-minded. He points out that cost sharing is used more vigorously in Central and Eastern Europe where the scope for raising extra revenue through taxation is limited. Even in Western Europe, political opposition to increases in public spending in the future might, as he points out, lead to a choice between cost sharing and cost containment. If, however, greater reliance is placed upon cost sharing for this purpose it has to be conceded that increases in health spending would be met by the sick. It would also be necessary to devise elaborate and possibly costly systems of exemptions to preserve equity objectives.

Looked at overall, it seems that the *economic* case for an extension of cost sharing either for reducing unnecessary demands or raising extra revenues is weak. In the first case, it is a blunt instrument that is unlikely to increase efficiency and will tend to have undesirable equity consequences. In the second case, even if additional expenditure on health care is justified on efficiency grounds, it is not clear why an earmarked tax related to health service use – which could be labelled a ‘tax on the sick’ – is preferable to a more broadly-based earmarked tax. But at a time when most European governments are keen to control rising public expenditures it may be that the *political* case for extensions of cost sharing will continue to be pressed, especially in established areas such as pharmaceutical reimbursement. If this happens, Anell and Svensson raise an interesting future possibility whereby a distinction is made between services of proven cost-effectiveness – for which only nominal charges would apply – and full cost charging for other services which do not meet this criterion.

“if unnecessary over-utilisation is the problem it is probably more to do with the supply-side – that is, moral hazard on the part of doctors”

User charges in health care: the Swedish case



Anders Anell



*Marianne
Svensson*

Contrary to the situation in many other countries in northern Europe, patients in Sweden pay a flat-rate fee per practitioner or hospital visit, and they are required to pay 100% of their prescriptions up to a specified limit. Swedish health-care decision-makers defend the charges as necessary to contain excessive care seeking, not least at hospital outpatient departments and for prescription drugs.

During the 1990s, several important changes have been made and new roles for user charges have been developed. In particular, following government decisions to increase charges for prescriptions and dentist services, user charges have gradually increased in importance from an overall financing perspective. As a result of a government decision to allow more local choice in charges for health services and nursing home care, changes have been introduced at the county council and municipality levels as well.

Charges for health services, nursing homes and prescription drugs

A standard payment for a visit to a general practitioner is approximately SEK 100. A specialist consultation at a hospital or clinic will cost between SEK 200 and 250, though the SEK 100 already paid will be deducted if the patient was referred from primary care. Children under the age of 20 years have had free access to dental care, however, and have recently been granted free health services in most of the county councils.

The responsibility for nursing home care was transferred from the 26 county councils to the 289 municipalities in 1992, as part of the so-called ÄDEL-reform. Following this transfer, new systems of user charges were established at the municipality level. Primarily, the changes were intended to create neutral charges paid by residents of old-peoples homes and nursing homes, and special housing and recipients of home help services, respectively. As a result of these new policies, charges for nursing home care vary considerably among the municipalities and depend heavily on individual income. The only limitations are that user charges must not exceed

the costs of care, and that the elderly are guaranteed a subsistence income level (SEK 3,380 in 1997) after charges have been paid.

Following a rapid increase in expenditures for medicines, user charges for prescriptions were changed in 1997. Under the old system, patients paid a flat-rate fee for each prescription and a second fee for each additional item on the prescription (SEK 170 + SEK 30 in 1996). Several patient groups, e.g. diabetics and asthma patients, were provided medicines free of charge. For other patients, the maximum payment during a 12 month period was SEK 1,800 (1996). Since June 1998, patients have been required to pay 100% of the first SEK 900 of their prescriptions, 50% of the cost between SEK 900 and 1,700, 25% of the cost between SEK 1,700 and 3,300, and 10% of the cost between SEK 3,300 and 4,300. Thereafter, prescriptions are free, which limits the maximum payment for an individual during a 12 month period to SEK 1,800. In principle, this new scheme applies to all patients.

High-cost protection

That public health services should be entirely free at the point of service for equity considerations has not gained support from Swedish health care decision-makers. Physicians, for example, have complained about the recent suspension of charges for services used by children under 20, since this decision has increased demand and hence required the reallocation of resources to the detriment of other patients.

The Swedish model has instead focused on protecting the sick from high costs associated with health services and prescription drugs through the high-cost protection scheme (högekostnadsskydd). Currently, two such schemes are in place, one for health services and one for drugs. These schemes guarantee that no individual pays more than SEK 900 for health services and no more than SEK 1,800 for prescription drugs during a 12 month period. Many elderly and chronically ill reach those limits quickly, however, and thus receive care free of user charges for the rest of the 12 month period.

The high-cost protection has no role, however, in preventing user charges from reducing initial demand for services relatively more for people with low income. The high-cost protection only causes healthy individuals to subsidise the not-so-healthy, but no redistribution occurs between different income groups. With low flat rate charges this is a small problem, but increased charges have the potential to greatly affect the distribution of services across income groups. Given the magnitude of the changes, and the potential impact from an equity point of view, surprisingly little research has been conducted in the area of equity.

User charges and equity

Surveys conducted by the Stockholm county council in 1993, 1995 and 1996 show that between 20 and 25% of the population refrained from seeking care at least once in a given 12 month period for financial reasons.¹ This is consistent with the argument that cost sharing is needed to contain unnecessary care seeking. The same studies also show that the unemployed, students, immigrants and single individuals, i.e. individuals that usually have low incomes, refrained from seeking care for financial reasons to a higher extent than high-income earners, which raises questions about overall equity.

There is not much research on the impact of the new prescription charges. According to a survey commissioned by the National Board of Health and Welfare (NBHW), about 8% of all households who had a prescription in 1997 refrained from collecting the drug at the pharmacy at least once for financial reasons.² The study could not with certainty point to any differences caused by socioeconomic factors. Further, little is known about the effects of the user charges that prevailed before 1997.

According to the NBHW the demand for services in elderly care has declined in connection with the higher user charges.³ Moreover, the difference in user charges across municipalities has also led to proposals to implement a nationally regulated system. The present system is deemed so complicated that even the municipalities have problems understanding the total effect on individuals.

A new role for user charges?

The usual theoretical rationale for user charges starts with the concept of moral hazard, i.e. the risk that economic agents maximise their own utilities in a situation

in which they do not bear the full consequences of their actions. In simplified form, the argument goes like this: patients who pay nothing for services will demand large quantities of services that offer only marginal benefits, to the detriment of taxpayers. User charges then are a steering mechanism that can enforce, at least to some degree, responsible behaviour among patients in the seeking of care.

“... user charges should be used selectively, rather than as a tool for rationing among basic needs across the board..”

The rationale behind user charges rests on several assumptions regarding the demand for health services, however.⁴ One such important assumption is that patients are able to make decisions about demand for care that are in their best interests. This assumption has been challenged. Studies have for example shown that cost sharing reduces demand for effective services just as much as it reduces demand for services of little medical value.⁵ This suggests that user charges should be used selectively, rather than as a tool for rationing among basic needs across the board.

One possibility for the future that takes this into account would be to charge nominal fees for services that are cost-effective or important by some social criteria, but introduce lower subsidies or full cost charges for services that do not meet such basic requirements. With such a more selective use of charges it would also be possible to link the need for priority setting from a social point of view with the rising demand for individual patient participation in medical decision-making. It remains to be seen if such a policy can be accepted by Swedish decision-makers, and the general public.

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Could charging patients fill the cash gap in Europe's health care systems?



Adrian Towse

One solution often proposed to relieve the financial strain on Europe's various health care systems is to ask patients to pay more 'out of pocket' towards the cost of their health care treatment. Not surprisingly this is a controversial issue because of concern that it will lead to patients not seeking or not receiving the treatment they need because they cannot afford the direct cash contribution. However, raising money from patients may serve two quite different purposes.

First, it may make patients take some responsibility for their health care. This is the 'moral hazard' problem associated with all forms of insurance. If health care is free at the point of use then people have less incentive to take care of themselves than if they had to pay out of pocket for the consequences. Once a patient, they have an incentive to over consume health care, i.e. as long as treatment yields some benefit they will demand it irrespective of whether the cost of providing it exceeds the benefit. There are a number of issues related to this argument, which are considered in the article by Dawson. Two are relevant here:

(1) Most decisions on the use of health care resources are made by doctors not patients, hence incentives to be responsible – that is, to use resources cost effectively – should be aimed at doctors not patients.¹

(2) Asking patients to pay directly for care requires them to put a monetary value on the care they will receive. Yet any such valuations will be constrained by how much

disposable income they have. Hence those on low incomes will be less likely to seek treatment for a given condition than those on higher incomes, with a consequent impact on their health.²

Second, charging patients will raise money for the health care system. Cost sharing payments provide an additional source of finance for health care services over and above that of social insurance premiums and taxation.

Charges as a source of revenue

This article discusses the second consequence of patient charging – namely, the case for using out of pocket contributions from patients to increase the resources available to Europe's tax and social insurance funded health care systems. We need to note that these two objectives of charging are not mutually compatible. This is because to the extent that charging patients reduces the utilisation of services it will not raise revenue. Extra revenue will only be raised if patients continue to use the services and to pay the direct contribution. Of course, both roles for cost sharing can be regarded as of benefit to those in charge of balancing the books of the publicly financed system. Both deterrence to utilisation and bringing extra cash into the system reduce pressure to put more tax or social insurance revenues into the health care budget. Yet the policy implications are quite different.

If the objective is to raise revenue then patient initiated care – such as the initial decision to visit the doctor with a symptom or health worry – should not be targetted, because the impact on utilisation will be much higher than where a doctor has initiated the treatment – for example by referring a patient for hospital in-patient treatment. Low income exemptions are also essential, not only on equity grounds but because no additional income will be raised from those who cannot afford to pay.

Charging to reduce demand

Europe currently has a patchwork of cost sharing arrangements which have been summarised for the World Health Organisation by Kutzin and Kincses.³ They conclude that, broadly, in Western Europe the main purpose of cost sharing has been to reduce utilisation, whereas in Central and Eastern Europe, it has been to raise revenue. Central and East European

“charging patients reduces the utilisation of services [and] it will not raise revenue. Extra revenue will only be raised if patients continue to use the services and to pay the direct contribution”

countries have not been able to raise the tax revenues to sustain their health care systems and hence have used direct charges to help fill the gap. The implication is that once the fiscal base is improved or a comprehensive social insurance scheme established, the role for patient charges will diminish. However, the evidence from Western Europe does not suggest that such a straightforward progression will necessarily occur:

- six out of the 15 EU member states have some patient payment for first contact with the system – usually a visit to a primary care doctor;
- nine member states have cost sharing for in patient stays;
- all have cost sharing for pharmaceuticals.

Patient charges are low as a proportion of total cost in comparison with Central and East European countries and there are usually extensive income or disease related exemptions. If the objective is to reduce utilisation it would make most sense to make patients contribute towards the first contact with the system, which is patient initiated. Yet this is the area of least cost sharing, suggesting that revenue raising is, perhaps, the more important consideration.

Pharmaceutical use is the area of greatest cost sharing. Although this has an element of patient initiation in that patients can choose whether or not to present a prescription at the pharmacy, “the objectives of such policies are rarely stated explicitly, their main purpose appears to be to shift much of the cost of drugs to the users.”³ This has certainly been the case in Italy, which has seen some of the biggest increases in cost sharing for pharmaceuticals over the last few years – although there have been important consequences for utilisation.⁴ In the UK, which has one of the lowest levels of patient charging, the flat rate prescription charge exceeds the cost of most pharmaceuticals that are dispensed to NHS patients and is therefore a user tax for the 50 per cent of the population that is not exempt.⁵

Problems to be overcome

Could – and should – cost sharing in the ‘mature’ health care systems of the European Union be increased and used explicitly to raise more money for the provision of health care services? Would it be efficient to do this? The question of efficiency is important and there are three hurdles to jump.

First, if we assume that achieving health gain is the main objective of providing health care, then at the macro level the question to ask is whether expenditure is currently too low, so denying efficient – that is, cost effective – treatment to some patients.⁶

Second, if so would the revenue raised from cost sharing be used to provide these services? Evans et al argue that the extra cash is more likely to go in higher prices and incomes for providers and could even reduce the pressure to improve the cost effectiveness of health care delivery.⁷

Third, if extra resources would deliver cost effective care, is patient charging the right source? Charging users meets the benefit criterion,⁸ but it is not clear that patients have much choice over their consumption of health care. Moreover there are important equity concerns. Given that health is linked to income, charging patients will be a relatively regressive way of raising money unless there are substantial income related exemptions.

We must be realistic in assessing the three hurdles. There are many examples of people failing to get cost effective treatment in most European Union countries. Debates about rationing health care are occurring in a number of member states. Whilst the efficiency of health care systems can and is being improved – notably through the use of contracts and health technology assessment – it is unrealistic to argue that no more resources should be put in until optimal efficiency has been achieved. Improving performance is a dynamic process not a one-off leap.

Where extra revenue comes from however is ultimately a political issue. If politicians do not believe the public will support increases in taxes or social insurance premiums to fund health care then the question is whether extra revenue from patients will be put to good use such that there is a net gain in welfare. The trade off in some EU member states may be cost containment versus cost sharing. In this context patient charging, structured to minimise the effects on the health of those on low incomes and in poor health – as discussed in Rubin et al⁹ – may have a useful though ultimately limited role to play. This is because, however well designed the scheme, it is hard not to share the conclusions of Kutzin and Kincses:³ “As a means of mobilising revenue for the health services, direct charges to patients are not likely to generate substantial amounts without causing adverse

“it is not clear that patients have much choice over their consumption of health care.”

consequences in terms of equity.”

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Why charge patients?

if there are better ways to contain costs, encourage efficiency and reach for equity



Diane Dawson

There has only been one economic efficiency argument for charging patients a proportion of the cost of their health care and that is ‘moral hazard’. The problem is that where the costs of health care are covered by private or social insurance, incentives for the inefficient use of resources will operate at four levels:

- (1) individuals will take less care of themselves and take greater risks than they would if they had to bear the full costs of any adverse effects (illness or accident);
- (2) once an adverse event occurs, the patient will demand more medical care if all costs are paid by a third party than they would demand if they had to pay all or

some of the costs directly;

- (3) clinicians who know patients are insured will provide more, or more expensive, treatment than if the patient is paying and especially if they expect the patient would find payment very difficult;
- (4) firms producing medical equipment and pharmaceuticals have incentives to innovate in areas covered by insurance as introduction of a new product likely to be covered by insurance will have a much larger market than if patients must pay directly.¹

Moral hazard is a problem because it contributes to the escalation of costs of the insured activity – in this case, health care. The traditional solution has been to impose deductibles or co-payments high enough to deter demands for excessive consumption by patients (levels one and two above). There is some hope that knowledge of a financial burden on the patient will deter clinicians from ‘excessive’ treatment (level three) but no one has suggested cost sharing is likely to have any impact on level four moral hazard: the incentives to pro-

“It only takes brief consideration of how charging patients ... is likely to affect behaviour ... to realise that the policy is unlikely to be very effective in deterring excessive use and is likely to result in defeating other important objectives of social health insurance and care.”

duce new products irrespective of their cost effectiveness.

It only takes brief consideration of how charging patients part of the cost of their treatment is likely to affect behaviour at each of the four levels listed above to realise that the policy is unlikely to be very effective in deterring excessive use and is likely to result in defeating other important objectives of social health insurance and care.

The effect of charges on lifestyle

With respect to level one moral hazard, there is virtually no evidence that individuals adopt less risky life styles because they anticipate having to pay a proportion of their health care costs should they become ill or suffer an accident. We do not have research evidence on whether people are less likely to smoke if their insurance requires co-payment than if their insurance covers all costs. In theory work could be done on the extent to which the prospect of having to pay part of the costs of treatment would discourage individuals from playing football or going mountain climbing. At present however, there is no evidence that cost sharing would reduce level one moral hazard.

Charges and demand for medical treatment

Most cost sharing relates to level two and attempts to deter patients – individuals already ill – from demanding excessive services. The theory is that, like any other consumer purchase, paying for a medical treatment or drug competes with other uses of the patient's income. If at the margin paying, say, an electricity bill is more important to the patient than obtaining the medical service, the patient will choose not to consume the medical service. In this case the charge has been effective in holding down consumption of health care. In practice it is difficult to separately identify the effectiveness of co-payments in discouraging the patient from using services (level two moral hazard) as opposed to discouraging clinicians from recommending services or prescribing drugs when they know the patient will have difficulty paying (level three). The research evidence therefore combines the two in measures of the extent of reduction in medical care consumption in the presence of cost sharing.

The research evidence here is unambiguous. Cost sharing does reduce consumption of health care. Most of the evidence relates to pharmaceuticals but some applies to

other medical services.^{2,3,4} However, charges are a blunt instrument. They are as likely to reduce clinically 'appropriate' or 'necessary' care as they are to reduce 'excessive' or 'unnecessary' care. It is important to remember that it is the clinician, not the patient who ordinarily decides what medical services the patient requires and prescribes what s/he considers appropriate for the patient's condition. The patient can only decline to act on the clinician's advice by refusing to pay the charge. Most countries have adopted systems of social insurance for health care in order to ensure that necessary health care is available to the entire population. To impose a system of co-payment that undermines achievement of that objective diminishes the efficiency of the system and can only be justified if there is no other set of feasible policies to reduce the extent to which resources are wasted on inappropriate or unnecessary care. Fortunately, there are alternatives to charging.

Clinicians and patient charges

As it is the clinician who ultimately decides what care to offer, most policies for reducing inappropriate treatment focus on the clinician. These policies include capitation payments for primary care, prospective payment for hospitalisation, prescribing budgets, utilisation review, treatment protocols and treatment guidelines. All the above are mechanisms to force clinicians to use their specialist knowledge to distinguish between necessary and marginal use of scarce health care resources. The patient is rarely in a position to know whether a large dose of a drug would be wasteful and a smaller dose adequate to produce the desired therapeutic outcome. Why use an instrument (co-payment) that requires the person with the least relevant information to make an important decision? The development of treatment guidelines and protocols reflects the fact that there is often disagreement between specialist clinicians over what is appropriate or inappropriate care. Why expect that by confronting a patient with the requirement to pay part of the cost of treatment, the patient will be able to single out the 'inappropriate' treatments suggested by his/her doctor and hence, by not paying for them, reduce consumption? If the objective is to reduce the use of unnecessary health care services, any, or preferably all of the policies directed at clinicians are to be preferred to charging patients.

The most frequent form of cost sharing in

“charges are a blunt instrument. They are as likely to reduce clinically ‘appropriate’ or ‘necessary’ care as they are to reduce ‘excessive’ or ‘unnecessary’ care.”

Europe relates to pharmaceuticals (see Towse article) and according to the argument above, it is the least effective way of reducing excessive or inappropriate consumption. It is the clinician, not the patient, who is in the best position to discriminate between necessary or excessive consumption of drugs. The second most common type of cost sharing is for in-patient days. What kinds of excessive consumption are these charges intended to discourage? The patient has no influence over length of stay – clinicians determine this. The patient has no influence over the tests administered or whether s/he receives intensive rather than ordinary nursing care. The only costs of an in-patient stay over which the patient may have some control are ‘hotel’ costs – choice of a single room or presence of a television set or a choice of menu. In order to reduce ‘excessive’ consumption of hotel services, it might be useful to have some charges that may influence a patient’s choice of these services while in hospital.

So far the argument of this article has focused on efficiency: the efficiency problem is to reduce excessive or unnecessary consumption of health care services. The evidence is that policies directed at clinicians can do this more effectively than charges on patients. It so happens that in this case the most efficient policy is also the most equitable! This rare event in economics arises from the fact that we would not expect the treatments avoided or curtailed through an instrument such as a treatment protocol to have an income bias whereas we know the impact of charges on curtailing consumption is highly income sensitive. It is sometimes argued that as long as exemptions are given for the very poor there is no equity problem in using charges, but this is untrue. The evidence available suggests that even with exemptions, reduced consumption is income related.⁴

Towards an efficient patient tax?

It is very difficult to see how anyone can make a case for co-payments for medical

services. If they do reduce consumption, they indiscriminately reduce necessary care and the reduction is greater in the lower income groups. If pushed, most supporters of cost sharing ultimately see it as a way of raising revenue rather than a means of reducing moral hazard. We can still ask if this revenue raising role for charges makes sense on efficiency grounds. All taxes other than poll taxes have efficiency costs. Might raising revenue through charging patients have lower efficiency costs than raising revenue through some other form of taxation?

What would be the characteristics of an efficient tax on patients? It must have no substitution effects – that is, there must be no action an individual can take that would reduce his/her tax liability. Therefore the basis for taxation could not be that a person reveals him/herself to be ill by presenting for treatment. The tax could be avoided, as the evidence suggests, by not seeking treatment. The tax would have to be levied on some characteristic of the individual that he or she could not control but that would predict that individual would become ill. Advocates of taxing patients on ‘efficiency’ grounds may have found a future role for genetic screening in the tax system!

An efficient tax on patients is clearly impracticable and choosing to tax the sick more heavily than the well represents a rather odd principle of taxation on equity grounds. It flies in the face of the principles of national health insurance that have led European countries to pool the costs of illness across the entire population. The efficiency costs of existing systems of co-payment and patient charges could be estimated as the additional costs of treatment through late diagnoses and failure to purchase prescribed medication. The efficiency costs would also include lost output through illness that would have been reduced if charging had not discouraged treatment. These are the efficiency costs to be compared with the efficiency costs of raising the same amount of revenue through income taxes or indirect taxes.

It is sometimes argued that a tax assigned to health care is more acceptable to people than a tax that goes into general government coffers – and therefore an assigned tax should have lower efficiency costs. If this is true, it is an argument for earmarking some tax that lacks the incentives for inefficient behaviour and inequity of existing systems of co-payment. The need to raise revenue in a relatively efficient manner is not an argument for charging patients.

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Reform of the NHS under New Labour



Julian Le Grand

As most readers of *eurohealth* will be aware, in the early 1990s the British National Health Service underwent a massive organisational change. The old state bureaucracy, where health care was provided by a command-and-control system and resources were allocated by managerial or professional fiat, was replaced by an internal or 'quasi' market. This split the purchaser from the provider, encouraged the providers – now called trusts – to compete with one another for contracts from purchasers, and set up two kinds of purchaser: the Health Authority that purchased services for a particular city or district and the General Practice (GP) Fundholder, a primary care practice that was given a budget for purchasing secondary care on behalf of the patients registered with the practice.

The internal market was highly controversial, and the Labour Government elected in 1997 was pledged to abolish it. In line with this pledge, in December of that year it published a White Paper (Department of Health 1997) that proposed a further re-organisation of the system, proposals that are currently in the process of implementation. But these have fuelled further controversy. Do they really constitute a change from the internal market? Alternatively, are they simply a return to the old command-and-control system? Or are they neither of these, but rather something quite different: a genuine Third Way?

New Labour Reforms

The principal changes are these. The purchaser/provider split remains. But the relationship between purchaser and provider is to be cooperative, and not competitive or adversarial. Purchasers are relabelled as commissioners, contracts as service agreements. More generally, throughout the service, competition is to be replaced by collaboration. Health Improvement Programmes (HimPs), local health and

health services strategies, have to be agreed with all relevant parties, including local governments as well as commissioners and trusts. However, an element of competition remains: as a last resort, commissioners can resort to other providers if they are unable to reach a satisfactory service agreement with their current provider.

The principal commissioners under the new system are Primary Care Groups (PCGs), led by GPs. PCGs include up to 50 GPs and cover populations of varying sizes (from around 30,000 to around 250,000). PCGs hold budgets; they will be able to retain surpluses, which can be spent on services or facilities of benefit to patients. All GPs are required to join PCGs. PCGs can operate simply in an advisory capacity to the health authority (Level 1), before graduating to the control of their own budgets and to merging their commissioning and primary care provider roles in new Primary Care Trusts (Level 4). The current secondary care trusts remain; they are also to retain surpluses.

GP Fundholders have been absorbed into PCGs. Health Authorities are losing their purchasing role, except for certain highly specialised services. But they are generally the lead for HimPs; they are also the body to whom PCGs are accountable for their spending of public funds. A new performance 'framework', with performance indicators emphasising effectiveness and outcomes, is being put in place. There are two new national bodies being set up: one – National Institute for Clinical Effectiveness or NICE – to set quality standards; the other – the Commission for Health Improvement or CHI – to enforce them.

A Third Way?

The first striking point about these proposals is that, despite the rhetoric to the contrary, key elements of the internal market have been retained. There is still a purchaser/provider split. The new GP-led commissioning organisations hold budgets, and in that respect are similar to GP Fundholders. Trusts and PCGs are both to be allowed to retain their surpluses. And purchasers will be able to switch to other providers if they are dissatisfied with their existing ones: so competition – or at least contestability (the

“A review of the evidence concerning the internal market's effectiveness ... concluded that the purchaser/ provider split had worked. It also found that GPs with budgets tended to be the most effective purchasers.”

“The atmosphere has changed ... there is an openness and cooperative spirit around the Service which is really rather different from the commercial suspiciousness which used to characterise some of the relationships in the market.”

potential in extremis for competition) – will remain.

Overall, these continuities are a good thing. A review of the evidence concerning the internal market's effectiveness (Le Grand, Mays and Mulligan 1998) concluded that the purchaser/provider split had worked. It also found that GPs with budgets tended to be the most effective purchasers. Under the internal market, health authorities and trusts could not retain any surpluses they might generate – which severely limited their incentives. And it would be impossible to retain the purchaser/provider split without some possibility of competition.

But there are differences from the internal market as well. These have both positive and negative aspects. On the positive side, the atmosphere has changed, at least for the moment; there is an openness and cooperative spirit around the Service which is really rather different from the commercial suspiciousness which used to characterise some of the relationships in the market. It remains to be seen whether this new spirit will survive when real conflicts of interest begin to emerge. There is also a danger that too great a cosiness between purchaser and provider, or between providers themselves, may not always operate in the public interest; after all, it was the fear that the NHS was being run too much in the interests of the providers, especially the acute hospitals, that led to the purchaser/provider split in the first place.

New organisational costs

Then there are the PCGs. These are much bigger than most fundholders; and again this has positive and negative aspects. Each purchaser now has quite a large risk pool, and given that, unlike most fundholders, they are purchasing the full range of secondary care services, this is probably sensible. On the other hand, the larger they are the more difficult they are to organise. 'Free-riding' may become more of a problem, and there may be other incentive issues that need resolving (see Hausman and Le Grand, 1999, for a more detailed discussion of this question). The experience of fundholding suggests that the smaller

groups did better, largely because they had less need to invest in inter-practice organisational development.

There is also another concern relating to the size of PCGs. The bigger the commissioning authority, the greater the danger that their purchasing constitutes too large a portion of local trusts' income, thereby restricting their ability to shift business elsewhere, if necessary. This problem was particularly acute for the old health authorities, which often found their attempts to alter significantly their pattern of purchasing stymied by the threat of collapse (either genuine or synthetic) from the trusts losing business.

Finally there is the role of the centre. The new institutions NICE and CHI have an important job to do in ensuring that quality is improved and that there is consistency across the country. However, they will have to operate with a light touch so as not to stifle innovation and legitimate diversity. Also they must demonstrate their independence, both from government and from the various interest groups within and outside the Service. In many ways running these will be the most challenging task for the new NHS.

Conclusion

The NHS is now well into the new world of the Labour reforms. Important elements of the internal market remain including the most successful ones such as the purchaser/provider split and GP-led purchasing and commissioning. However, in other respects there have been significant changes, some of them with echoes of a return to command-and-control, but by no means all. So the reforms do not really constitute either full continuity or a return to the past; and in that sense they do represent a Third Way. It is too early to say whether the new way will actually work better than either of the old ways; but so far, with one or two exceptions (such as the large size of some PCGs), the signs are quite encouraging.

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The new Health Development Agency for England

What will it do?

The British Government's recently published public health strategy (White Paper) for England,¹ has



Donald Reid

proposed the creation of a new organisation, called the Health Development Agency (HDA), to promote public health in England. Will the people of England be any healthier as a result?

We know what it won't be doing – sending a free tooth brush to every child in the land, inscribed “best wishes from the Minister for Health” – as happened once in another EU country just before a general election. Its stated role, according to the White Paper, is:

“to ensure that organisations and individual practitioners base their work on the highest standards (in order to) raise the quality of the public health function”.

Its functions will include:

- Maintaining an up-to-date evidence base for public health
- Commissioning research and evaluation to strengthen the evidence base
- Advising the Government on the setting of standards for public health and health promotion practice, and on their implementation by national and local organisations
- Providing advice on targeting health promotion most effectively on the worst off, and narrowing the gap in standards of health between rich and poor
- Disseminating effectiveness and good practice to those working in this field
- Advising the Government on the capacity and capability of the public health

workforce to deliver national strategies, and on their education and training needs

Although many of these aims are new, the HDA will not be an entirely new organisation since it will take over the staff and much of the budget of the existing Health Education Authority (HEA). The HEA has long been respected nationally and internationally for its extensive knowledge base on health promotion, but its main function has been to carry out Government funded programmes on lifestyle issues (e.g. HIV/Aids, smoking, coronary heart disease, etc). Some of these will continue to be carried out by the HDA, which will be launched in January 2000 with a likely annual budget around £30 million and between 150 and 200 staff, mainly based in London.

Brave new idea or quick fix gimmick?

Most UK commentators have welcomed the HDA, as part of the government's strategy to improve health overall, and to narrow the gap between the health of rich and poor in particular. Although the HEA is respected for its existing research base, in the past it has lacked the necessary authority to be truly influential, and has been generally known as the lead agent for the implementation of Government lifestyle programmes rather than as a national centre for research and evaluation.

The creation of an organisation which will focus on developing a research base and standards for the implementation of national programmes, will therefore be very welcome. It will undoubtedly contribute significantly to improvements in the standard of the public health function in the National Health Service (NHS) in the long run, as the Government intends.

However, there remains concern over a number of unresolved issues. For example, the requirement for the new Agency to conduct health promotion programmes does not fit well with its primary function – to compile and disseminate research findings and advise on standards – since it is difficult to see how a monitoring organisation can objectively assess the value of its own programmes. It seems inevitable that

“Success in reducing health inequalities will obviously depend on the Government’s willingness to create a more equal society – which requires increased benefits for the poor, healthier housing, reduced unemployment and better health services in deprived areas”

the programme delivery function will eventually be transferred elsewhere - perhaps to the Government Department of Health, as in Wales, Canada and Australia.

Other possible controversies concern the scope of its functions in relation to public health. Public Health Departments within the National Health Service (NHS) have a wide range of functions, which include advising on the most cost effective arrangements for clinical services, preventing communicable disease, promoting lifestyle programmes locally, and working with municipal Councils and others to improve health in the locality (e.g. by providing healthier housing). Currently, all NHS public health departments are led by medically qualified Directors of Public Health (DPHs). It seems unlikely that the HDA will be asked to pronounce on the more clinical aspects of the work of DPHs, nor on the prevention of communicable disease - but this clearly needs to be clarified.

The issue of standards may also lead to dissent, especially as the HDA could be perceived as some kind of national regulatory agency for public health. Health promotion officers within NHS public health departments, who are chiefly responsible for local implementation of national lifestyle programmes, have traditionally looked to the HEA for resources and advice on effective methods. However, they do not expect the HEA to play a significant role in drawing up quality standards, and may therefore not take kindly to the new Agency’s involvement. DPHs may be even more resistant to attempts to set standards across all of the broad functions of public health departments – especially if the HDA’s first Chief Executive is not a former DPH.

But by far the most testing question concerns the limits to the HDA’s remit in the field of “broader public health”. The new Labour Government is rightly focusing on the root causes of ill health - such as poverty, unemployment etc, rather than the lifestyle focused campaigns of its predecessor (though these will continue to a reduced extent). Particular emphasis is

being given to the need to reduce England’s unenviable record of health inequality – where men aged 25 to 39 in the most deprived social class are five times more likely to die each year than men in the wealthiest class.

Success in reducing health inequalities will obviously depend on the Government’s willingness to create a more equal society – which requires increased benefits for the poor, healthier housing, reduced unemployment and better health services in deprived areas, etc. Some would argue that “to redistribute health, you must first redistribute wealth” – which implies the need for higher taxes on the better off. It is difficult to believe that the Government will allow the HDA to commission research into areas as sensitive as the link between income inequality and health.

And even if politically unpalatable findings do emerge from its research, it is unlikely that the HDA will be allowed to speak freely about their implications. There is no sign that it will become an independent force, making public pronouncements on the effectiveness of broad Government policies on health inequalities.

Conclusion

The British Government’s initiative in setting up a central agency to provide a coordinated, evidence-led base for public health in England is greatly to be welcomed. It is likely to result in more cost effective programmes in the future, which will contribute to significant long term advances in the public’s health. However, it is doubtful whether the new organisation should also be responsible for the delivery of the very programmes that it has been set up to evaluate – the two functions are basically incompatible.

And it will be essential to clarify the limits to its remit as soon as possible – the present vagueness of definition can only lead to confusion. Finally, welcome though the HDA is in its present form, it would be even more valuable if it became an independent watchdog for public health – able to speak directly to the public provided it could produce sound evidence for its judgements. This, unfortunately, is most unlikely to happen.

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“even if politically unpalatable findings do emerge from its research, it is unlikely that the HDA will be allowed to speak freely about their implications”

PRODI'S COMMISSION

Mr. Romano Prodi, the future European Commission President, announced the names and portfolios of the 19 proposed Commissioners on 9 July 1999 (see Box 1). The European Parliament has now also approved Mr. Prodi's nominations.

During a speech to the European Parliament on 21 July 1999, Prodi promised a "revolution in the way the Commission works". Prodi stated, "The organisational structure of the Commission has not been substantially altered in 40 years", reflecting that "the world has moved on and the Commission has not kept pace." To resolve the collective loss of confidence amongst European citizens, Prodi claimed that he will make the European Union more relevant for the European public, by addressing issues such as jobs, growth and the challenge of sustainable development, which balances wealth creation, social justice and the quality of life. Prodi stated that transparency, accountability and efficiency will be the watchwords at every stage of this process.

In line with this, important changes have occurred within public health, as

the Public Health Directorate (formerly DG V/F) has been removed from the Social Affairs DG and fused with Consumer Protection to form a new DG called Health and Consumer Policy. In a speech to the European Council on the 3rd of June, Prodi stated that the objective of such mergers is to remove overlaps and duplications and, so far as is possible, to group together one or two DG policy areas that fall under the responsibility of a single Commissioner.

The 19 prospective Commissioners appeared before the European Parliament in special hearings during the week of 30 August–7 September, after having provided written answers to questionnaires that they received from the European Parliament. The answers to written and oral responses present a comprehensive overview of

the prospective Commissioners' thinking regarding their future areas of responsibility, and their personal views on key priorities and policies.

Profiles of all the prospective Commissioners can be found at Internet address: http://europa.eu.int/comm/newcomm/index_en.htm

The European Parliament's questionnaires and the answers from each prospective Commissioner can be found at: http://europa.eu.int/comm/newcomm/hearings/index_en.htm

Mr David Byrne has been appointed Commissioner of the Directorate on Health and Consumer Policy. Mrs. Anna Diamantopoulou, the new Commissioner for Employment and Social Affairs will have health interests in her portfolio, which includes social exclusion and poverty, and occupational health and safety. The following provides brief overviews of the new Commissioners' curriculum vitae, as well as some of the comments that they made during the parliamentary inquiries.

Mr David Byrne (Ireland)

Since 1970 Mr Byrne has served as a Barrister in Ireland, where his practice was exclusively in civil law, with a significant emphasis on commercial law. This involved a requirement to be familiar with community law. He served as the Irish member to the International Court of Arbitration in Paris between 1990–1997. Since his student days Mr. Byrne has been very active in issues relating to access to justice and he has also been involved in legal education. From June 1997 until his resignation in July 1999 he served as Attorney General in Ireland.

Mr. Byrne supports the merging of the public health and consumer responsibilities within a single directorate general, as it will bring greater coherence to these two policy areas. On food safety he has said that food legislation must be simplified and shortcomings remedied; specific rules must be tightened up, and controls

BOX 1

THE PRODI COMMISSION

The new organisation of the European Commission

President	Romano Prodi (Italy)
Vice President for Administrative Reform	Neil Kinnock (UK)
Vice-President for relations with the European Parliament, and for Transportation and Energy	Loyola de Palacio (Spain)
Commissioner for Competition	Mario Monti (Italy)
Commissioner for Agriculture and Fisheries	Franz Fischler (Austria)
Commissioner for Enterprise and Information Society	Erkki Liikanen (Finland)
Commissioner for Internal Market	Frits Bolkenstein (Netherlands)
Commissioner for Research	Philippe Busquin (Belgium)
Commissioner for Economic and Monetary Affairs	Pedro Solbes Mira (Spain)
Commissioner for Development and Humanitarian Aid	Paul Nielson (Denmark)
Commissioner for Enlargement	G nter Verheugen (Germany)
Commissioner for External Relations	Chris Patten (UK)
Commissioner for Trade	Pascal Lamy (France)
Commissioner for Health and Consumer Protection	David Byrne (Ireland)
Commissioner for Regional Policy	Michel Barnier (France)
Commissioner for Education and Culture	Viviane Reding (Luxembourg)
Commissioner for Budget	Michaele Schreyer (Germany)
Commissioner for Environment	Margot Wallstrom (Sweden)
Commissioner for Justice and Home Affairs	Antonio Vitorino (Portugal)
Commissioner for Employment and Social Affairs	Anna Diamantopoulou (Greece)

toughened. While stressing the importance of food safety and health, Mr. Byrne stated during his Parliamentary hearing that he was uneasy that the debate on Community health was being overly dominated by the food crisis. He has stressed that he will focus on ensuring transparency, and on working together with Parliament in order to restore public confidence, which has been shaken by the recent food crisis.

On public health Mr. Byrne has stated that it is important to be proactive, and that a fundamental review of Community public health policy is underway with the aim of presenting a comprehensive framework in this area for the future. He intends to present ideas on how best to exploit the new Treaty opportunities provided for by Article 152 in the Treaty of Amsterdam in the field of public health. He also stressed that there is a need for much better information on how public health systems work, in order to generate knowledge and to make comparisons as to best practices.

Some of the areas that he intends to focus on in the future are: the increase of environment-related diseases such as allergies and asthma affecting children and young people; the decline in rates of vaccination amongst children; and the adverse effects of genetic modification. He also intends to focus on health problems of the elderly and disabled people, and he will investigate ways of responding preventively to mental health problems.

Mrs. Diamantopoulou (Greece)

Mrs. Diamantopoulou trained as a Civil Engineer and did her Postgraduate studies in Regional Development. She has worked as a Civil Engineer, as a Lecturer at the Institutes of Higher Technological Education, and as Managing Director of a regional development company. Mrs. Diamantopoulou also has extensive experience in politics. Most recently, (1996–1999) she served as an elected politician in the European Council of Ministers, where she was a Deputy Minister for Development. She has also been a Member of Parliament for Kozani, Secretary General for Industry, President of

the Hellenic Organisation of Small and Medium-Sized Enterprises and Handicrafts (EOMMEX), member of the Central Committee of PASOK, Secretary General for Youth, Secretary General for Adult Education, and Prefect of Kastoria.

Mrs. Diamantopoulou has stressed the importance of social policy as a key factor in improving productivity and economic performance, and that it should not therefore be regarded as burdensome. She has said that some of the major elements of the European social model, such as pensions and work-related social protection, are in urgent need of reform, if they are to remain financially sustainable. Member States must cooperate at the European level to make sure that the European social model remains central to the European way of life, and a key factor in ensuring an effective integration of applicant countries into the Union.

In the area of health and safety at work, she will be guided by the four priorities that were laid out in the mid-term report on the "Community Programme Concerning Safety, Hygiene and Health at Work (1996–2000)." These are, a stronger emphasis upon proper implementation and practical application of legislation; preparing for enlargement, and ensuring that applicant countries comply with the social policy aspects of the *acquis communautaire*; to strengthen understanding of the link between improving the working environment and employability; and to focus on the potential risks generated by new technologies, new materials and new forms of organisation in the world of work.

Other Commissioner designates whose portfolios also include a wide range of issues that relate to public health are:

Franz Fischler (Austria),
Commissioner for Agriculture and Fisheries

Erkki Liikanen (Finland),
Commissioner for Enterprise and Information Society

Margot Wallstrom (Sweden),
Commissioner for Environment

Pascal Lamy (France), Commissioner for Trade

New European Parliament

Following the entry into force of the Amsterdam Treaty on 1 May, the European Parliament will have considerably more powers to shape legislation.

About 80% of all Community legislation must now pass through Parliament before it becomes law. Nevertheless, under half the electorate voted during the elections that were held on June 10-13 1999. In the Netherlands only one third of the electorate voted, while in the UK less than a quarter cast a ballot.

The election results herald significant changes for the Parliament, with more than half of the members being new to it, as well as being younger and including significantly more women. In addition, for the first time since direct elections were held 20 years ago, the Socialists have lost control of the chamber to the centre-right European People's Party. Socialist bloc losses came in particular from Germany and the UK.

The elections saw defeat for Clive Needle MEP (UK), who was the Labour spokesman for health in the European Parliament. Ken Collin MEP (UK), the rapporteur on the Public Health framework communication, and Christian Cabrol MEP (UK), two staunch health supporters, did not stand for re-election.

However, the new chairperson of the Committee on Environment, Public Health and Consumer Protection, Caroline Jackson MEP (UK) has committed herself to raising the profile of public health. New members of this Committee include former UK junior health Minister John Bowis MEP (UK), and Torben Lund MEP (Denmark), former Danish Health Minister.

A full list of the MEPs on the Environment, Health and Consumer Protection Committee can be found on Internet address: <http://www.europarl.eu.int>

HEALTH COUNCIL MEETING

The Health Council met on the 8th of June 1999.

Future Community Action in the Field of Public Health

The dioxin food scandal in Belgium and health and humanitarian aid aspects of recent events in Kosovo left little time for an in depth discussion of the future framework for public health policy. Nevertheless the Council did exchange views on future Community action in the field of Public Health. Ministers agreed to focus on three important areas.

First, they suggested developing a comprehensive system for collecting, analysing and distributing information on public health.

Second, they stressed the importance of reacting quickly to health threats by means of a Community surveillance system, including early warnings and rapid reactions.

Resolution on Antibiotic Resistance

Ministers adopted a Resolution that underlined their commitment to devising an overall strategy to guard against the development of resistance to antibiotics. The Resolution was a response to an Opinion handed down by the Scientific Steering Committee on 28 May.

The Resolution calls on member states to cooperate to monitor the supply and use of antibiotics, boost research and promote health-orientated animal production systems to reduce the need for antibiotics in feed. It also calls for more surveil-

lance and control of communicable diseases resulting from antibiotic resistance.

Finally, they agreed on the need to prevent diseases both through broad health promotion activities and specific actions targeting specific areas. Ministers also indicated a need for a better structuring of the health programmes by integrating all programmes under a single umbrella programme.

It was also considered necessary that the future health programme would adopt a more horizontal approach covering health aspects in other fields of Community policies, such as internal market, environment and social affairs. Ministers invited the European Commission to draw up a new legislative proposal promoting public health "as a matter of urgency".

The Scientific Steering Committee's "Opinion on Anti-microbial Resistance" is available at the following Internet address:

The Scientific Steering Committee's "Opinion on Anti-microbial Resistance" is available at the following Internet address: http://europa.eu.int/comm/dg24/health/sc/ssc/outcome_en.html

For information on an international scientific conference on anti-microbial resistance that was organised by the Commission on 20 July please see: <http://europa.eu.int/comm/dg24>

Informal meeting with the Health Ministers of CEECs and Cyprus

As part of a pre-accession strategy, agreed to at the Luxembourg Summit on 12–13 December 1997, the Health Council met Health Ministers from the CEECs (Central and Eastern European Countries) and Cyprus for the second time in an informal meeting.

The Council's objectives were threefold: to exchange views; to discuss

with applicant countries their present health laws and practices; and to identify potential areas of cooperation. The Council adopted a Resolution to review present working methods with the applicant countries and called on the Commission to draft a proposal that could be integrated into the future Health Framework Programme.

Commission sets out Millennium Round Priorities

The Commission published a Communication on 8th July that set out its proposals for the agenda of the Millennium Round of global trade talks to be launched this November in Seattle.

The Commission proposes a strategy that includes ensuring that the WTO continues to address issues of concern to the public at large, such as environment, health and social concerns. Other aspects of the strategy address more specific trade issues.

The Communication also stresses the importance of working with civil society, and of explaining to the public the benefits of the multilateral trading system. Furthermore, it suggests further steps that could be taken to improve WTO transparency.

On the issue of consumer health, the Report states that members may resort to restrictive measures in order to ensure the level of protection that they have established. Nevertheless, it emphasises that these measures should be taken on the basis of the 'precautionary principle', rather than on the 'zero risk approach'. This means that products that have been identified as posing a potential threat to people, animals or plants should be assessed on a case by case basis, and according to the scientific evidence available. The definition of the precautionary principle is not, however, entirely clear, and arriving at a common interpretation of the principle may prove to be a sensitive issue during the Round.

During his hearing at the European Parliament, Pascal Lamy, the new Commissioner of Trade, stated that in the US authorisation to the trade of a product is granted as long as that product has not been proven to pose a risk. Europeans, on the other hand, believe that a product should be banned if it is thought to pose a risk.

COMMISSION ADOPTS A COMMUNICATION ON MODERNISING SOCIAL PROTECTION

The European Commission adopted a Communication in June on a European Union-wide strategy for modernising social protection, in the face of common challenges such as the changing world of work, new family structures and the demographic changes of the forthcoming decades.

They must do so while balancing the clearly expressed wishes of citizens for continued high levels of protection against the requirement that public services should be economical and efficient. The Communication is a contribution on the part of the Commission to an ongoing process, which has been underway since the beginning of the 1990s, to establish social protection as an integral part of the European Social Model. The

Communication states that it is now time to deepen the existing cooperation on the European level in order to assist Member States in formulating a common political vision of Social Protection in the European Union, including the objective of high quality and sustainable health protection.

The Communication asserts that everyone should be in a position to benefit from systems to promote

health care, to treat illness, and to provide care and rehabilitation for those who need it. While the health of the Community population is better than ever before, demand on the health systems is increasing and will continue to do so with an ageing population. Constant innovation in medical technology can bring great benefits but also increased costs. The Commission thus invites the Council to endorse formally the following objectives as the basis of future deliberations:

- contribute to improve the efficiency and effectiveness of health systems so that they achieve their objectives within available resources. To this end, ensure that medical knowledge and technology is used in the most effective way possible and strengthen cooperation between Member States on evaluation of policies and techniques
- ensure access for all to high quality health services and reduce health inequalities
- strengthen support for long-term care of frail elderly people by, inter alia, providing appropriate care facilities and reviewing social protection cover of care and carers.
- focus on illness prevention and health protection as the best way to tackle health problems, reduce costs and promote healthier lifestyles.

The strategy that the Communication outlines aims at deepening the cooperation through exchange of experience, policy discussion and monitoring, in order to identify best practice and to give the process a higher public and political profile. To this end, Member States will be invited to designate senior officials to act as focal points for exchange and information gathering activities. The Commission will regularly organise meetings of these officials to analyse and evaluate the progress made.

The new communication is available on Internet at the following address: http://europa.eu.int/comm/dg05/soc-prot/social/index_en.htm

Dioxin Scandal

On the second of June EU veterinary officials ordered the Belgian authorities to destroy all chicken, eggs and derived products coming from farms that used feed that could have been contaminated with the carcinogen dioxin.

The restrictions were later extended to cover products from pork and bovine farms that may also have used contaminated feed. Animal fat, which is likely to have been tainted with motor oil, was supplied to animal food companies in late January and fed to birds on a quarter of Belgium's 1,500 poultry units. Suspect poultry was also traced and destroyed in the Netherlands, Germany, France and Portugal. The ban applies to all products coming from potentially infected farms, which were produced between 15th January and the first of June 1999. The EU stopped short of imposing a total sales ban after the authorities insisted that they could trace the contaminated feed back to specific farms. Farm Minister Karel Pinxten and Health Minister Marcel Colla resigned over the scandal on the first of June. The Commission has launched legal proceedings against the Belgian government over its handling of the dioxin crisis. Although farmers first noticed health problems with poultry in January, it was not until 26th April that the authorities had proof of high dioxin levels, and notified other member states. The Commission was not told until 27th May. Belgium also failed to comply fully with an order to remove and destroy foodstuffs.

Europe's latest food crisis follows the scare over BSE and the controversy

over tranquillisers in Belgian pork and hormones in beef, and it has shaken consumer confidence even further. Former Consumer Affairs Commissioner Emma Bonino stated that doses of dioxin that were found in Belgian chicken "gave rise to concern", although acute near-term effects were unlikely. There is, however, a chance of long-term effects, since dioxin is a category one carcinogen.

In attempts to restore consumer confidence, Farm ministers agreed to draft a new directive to amend the existing one to provide a method to prohibit the use of certain raw materials in animal feed that have harmful health or environmental effects and require labelling for animal waste. The new directive would also include proposals to facilitate the traceability of raw materials. Community legislation on the harmonisation and co-ordination of inspections will also be revised. Agricultural ministers are setting up a scientific committee to look at how the risk of animal feed contaminated with dioxin can be reduced. The World Health Organisation and the Food and Agricultural Organisation are in the process of reviewing guidelines for dioxin exposure in foods, which should in turn provide the EU with tools to implement stricter monitoring of such contaminants.

NEWS IN BRIEF

IT WILL soon be possible to detect more quickly and with greater precision animals suffering from BSE. Three rapid post-mortem BSE tests, which were developed by different groups of independent scientists in Ireland, Switzerland and France as part of a comparative Community evaluation programme, have shown remarkable effectiveness in distinguishing animals clinically affected with BSE from healthy animals. Since the tests were obtained from animals showing clinical signs of BSE, however, it remains to be seen if these tests are equally effective in the case of animals that, although affected with BSE, show no clinical signs of it. This new development has not led to any changes to current Community BSE legislation. The Scientific Steering Committee will publish the results of its evaluations of the tests as rapidly as possible.

The statement of the Scientific Steering Committee on the tests will be available under the following Internet address: http://europa.eu.int/comm/dg24/health/afb/index_en.html

THE GERMAN Presidency put forward the idea of setting up an agency within the Commission to handle all future approvals for genetically modified organisms (GMOs). Peter Jorgensen, former spokesman for the former Environment Commissioner Ritt Bjerregaard, called this plan to update the 1990 directive (90/220) on GMOs unacceptable, and accused the German Presidency of deliberately stalling efforts to revise legislation on approval procedures for all new crops and seeds containing GMOs. EU Environment Ministers agreed on a common position on the revamped Directive on releasing GMOs into the environment. The Ministers agreed that GMOs must pass a risk assessment before they are first marketed, and they insisted on regular, written procedures involving consultations with scientific committees in all circumstances as well as on the obligation to con-

sult with an ethics committee. Ministers also agreed on basing any new decision on the precautionary principle, and on ensuring the traceability and labelling of GMOs or products containing them. The maximum period for authorisations to place a product on the market should not exceed ten years. The Environment Minister also agreed to a three-year moratorium on approving new biotechnology varieties. The common position will go for a second reading to the newly elected European Parliament.

DAVID BOWE, the Parliament's former rapporteur on proposals to revise the EU's procedure for approving GMOs, has expressed his support for the adoption of the case by case precautionary principle. This follows recent evidence that the US government and the US Food and Drug Administration (FDA), which is responsible for food safety, ignored its own scientists' advice on the potential risks of GMOs. Documents obtained by the Iowa-based lobby group Alliance for Bio-Integrity reveal that a senior advisor on plant toxins warned that "genetically modified plants could contain unexpectedly high concentrations of plant toxins".

IN RESPONSE to growing public concern about production processes and their risks to the environment and human health, Romano Prodi has raised the possibility of establishing an independent European food-safety agency along lines of the American Food and Drug Administration (FDA). More information on this will be given when it becomes available.

MEANWHILE, despite the negative attention being received by the GM industry, European researchers have successfully managed to incorporate the production of beta-carotene into rice. This achievement represents a major breakthrough in the quest to

prevent severe vitamin A deficiencies in countries that rely on rice as a staple food. So far, researchers have not applied for a permit to release the rice outside of controlled test sites. Passing all European safety regulations may take at least five years; before this time, the rice cannot be planted in developing countries.

THE EUROPEAN Commission intervened against a quota arrangement to control expenditure on pharmaceuticals in Denmark. This agreement, which was concluded between the Danish Ministry for Health and the Danish Association of Pharmaceutical Producers (Lif), aimed to control public expenditure on price subsidies for pharmaceuticals by freezing prices for prescription drugs and placing a cap on total public expenditure on price subsidies. Furthermore, if Lif-members exceeded the quota that they were allocated on a monthly basis, they had to eliminate their surplus by means of price reductions during the following three months' period. In the Commission's view the quota arrangement violates Article 81 of the EC Treaty because it has anti-competitive effects and because less restrictive means to reduce public expenditure are available. Following the Commission's intervention the parties agreed on a quota scheme that does not force Lif-members to reduce prices below a calculated European average price for each individual product.

A NEW study, commissioned by Eurostat, has established a set of non-monetary indicators on social exclusion and poverty. While non-monetary indicators should not be regarded as an alternative to monetary indicators, the identification and analysis of these indicators may enhance understanding of this complex phenomenon.

The study is available under Internet address: <http://en/comm/eurostat/research/supcom.95/result/result02.pdf>