

eurohealth

Health and the Environment



The challenges of enlargement for public health

Improving the quality of healthcare

The developing role of nursing

The Commission's Health Strategy: view from the Committee of the Regions

preface

Public health policy in the EU is being shaped by several political and structural forces. At the political level, the increased emphasis on public health issues that has taken place in recent years is highlighting the centrality of health issues across the public policy spectrum. Quite apart from the overt requirement for public health to be recognised in policy design across directorates, the intrinsic presence of public health issues in various areas of policy requires in itself that there is a health focus in setting the policy agenda. This is perhaps nowhere more true than in environment policy where issues such as pollution are in essence public health issues.

Environment Commissioner Margot Wallström here sets out the importance of health concerns in environmental policy making and describes the initiatives and policies being pursued in order to address the serious environmental health concerns that face the European Union as a modern industrial society. Erwin Jackson of Greenpeace discusses climate change and its potential impact on human disease and agriculture. The emergence or return of infectious diseases through changing climatic conditions is a real issue for public health planners and managers. Mark McCarthy concludes this section with a look at central and east European countries a decade after the end of the Soviet era, which left massive environmental problems in a context of economic disruption and institutional breakdown.

The approaching enlargement to the east is itself another political question facing all of Europe's policy makers. Martin McKee and Laura MacLehose discuss the implications for communicable diseases and the ability of Community initiatives to deal with an increasingly important policy area in the face of an ever broadening single European market. Following his Health and Enlargement Report to the European Parliament, John Bowis MEP discusses the severe problems facing central and east European countries and the difficulties incurred by the continued delay in their full membership. Magdalene Rosenmöller notes that while a great deal of progress has been made in preparing for enlargement, there is a lot more that both the Commission and the candidate countries need to do.

The organisation and structure of healthcare delivery are also changing rapidly and are other sources of pressure on policy makers, managers and healthcare practitioners. Two important areas are examined here. Thanks are due to Professor David Banta for his editing of a series of articles on quality in healthcare. This section looks at quality management and the potential for improvement in the quality of healthcare across Europe. Three articles consider the changing, and expanding, role of the nursing profession within European healthcare systems.

Finally, we begin with a contribution from Roger Kaliff detailing the report of the Committee of the Regions on the Commission's new health strategy. This will be an ongoing subject of debate in future issues as the effectiveness of the strategy becomes clear and its various aspects are implemented, including the precise shape of the new Health Forum.

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The European Commission's proposed health strategy

A regional perspective

The mandate of the European Union is such that decisions made, or not made, have an impact on public health. It is therefore vital that the EU acts with the best interests of public health in mind when making decisions in a wide range of areas, for example agricultural policy, priorities in the social field or the utilisation of research funds.



Roger Kaliff

There are major variations in health status among the citizens of the Union, and this will become even clearer as enlargement progresses. This means that there will be major opportunities to significantly improve health in many countries and among large groups of the population, but this will not happen automatically.

The report of the Committee of the Regions on the Commission's proposed health strategy for the EU concludes that the focus of the EU's new health strategy must be on achieving improvements in health for all, with the overriding goal being to reduce inequalities in health. The report is based on broad consultation between the regions of Europe.

Good health is an issue of the highest priority for the citizens of Europe and an area in which they have high expectations, and this will of course continue to be so. If young people are asked what they believe to be the most important thing in life, then health usually comes at the top of the list.

How is health created?

Generally speaking, we can say that our health has improved enormously within the Union. In only a century, average life expectancy has increased from just over 50 to almost 80 years in many Member States. In other words, we can count on living almost half a lifetime longer than our forebears of a few generations ago. This trend has nothing to do with genetic changes. The reasons for this unparalleled change are to be found in background factors such as economic development and social policy.

Is average life expectancy so important? An increase in the average life span is not only a question of a few extra years at the end of our lives, it also has to do with more children surviving infectious diseases and fewer middle aged men dying from cardiovascular diseases. The trend means not only that we are living longer, but also that we feel better. Nor have the opportunities for a longer and better life been entirely exhausted. They are, however, largely dependent on the policies that can be pursued both jointly for, and individually in, the countries of the EU.

The importance of various areas of policy to public health

The Commission has proposed, in accordance with the Amsterdam Treaty, that public health aspects should be taken into account in connection with all of the EU's proposals and measures. The Committee of the Regions has welcomed this, as the EU is the joint body that has the competence and possibility to influence many of the factors that are of decisive importance to health. The EU must now begin to define the impacts that its policies have on the health of the people of Europe and formulate an effective policy that steers the Community's actions in various areas towards better public health.

The Committee of the Regions believes that the Commission should begin by analysing public health aspects in areas where supranational decisions are made, i.e. agricultural policy, the introduction of the common currency and enlargement of the Community eastwards.

Agriculture and agricultural subsidies are the largest area of work of the EU. A closer examination of the EU's agricultural policy reveals that the EU subsidises the cultivation of tobacco to the tune of 1 billion euros per year. This should be seen in light of the fact that smoking causes over 500,000 deaths in the EU each year, almost half of which occur within the age range 35 to 69. A change in the EU's agricultural

"A change in the EU's agricultural policy could lead to an important improvement in health and lend credibility to its health policy."

policy could lead to an important improvement in health and lend credibility to its health policy.

Inequalities in health

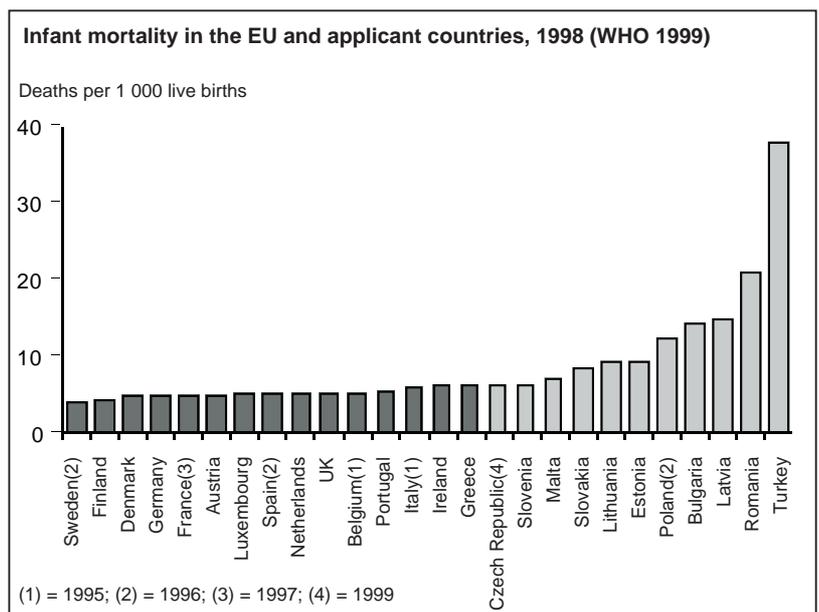
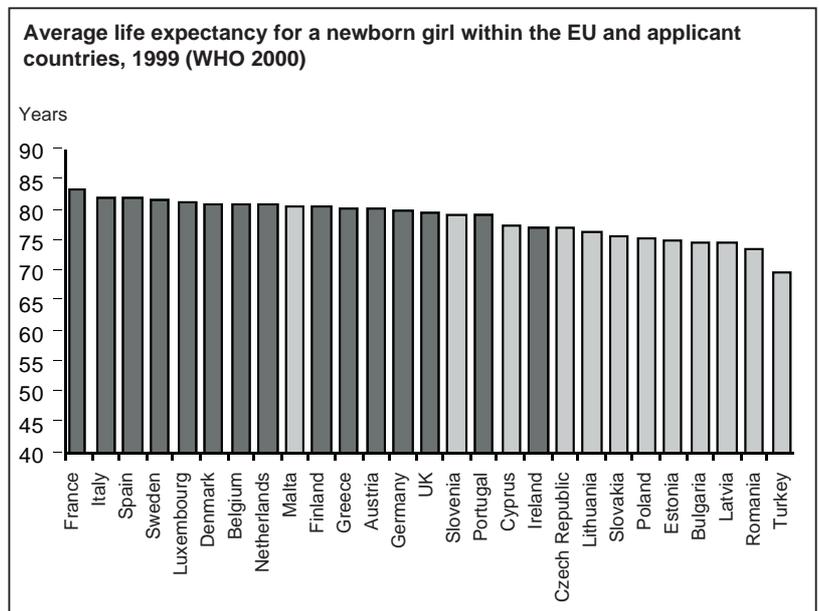
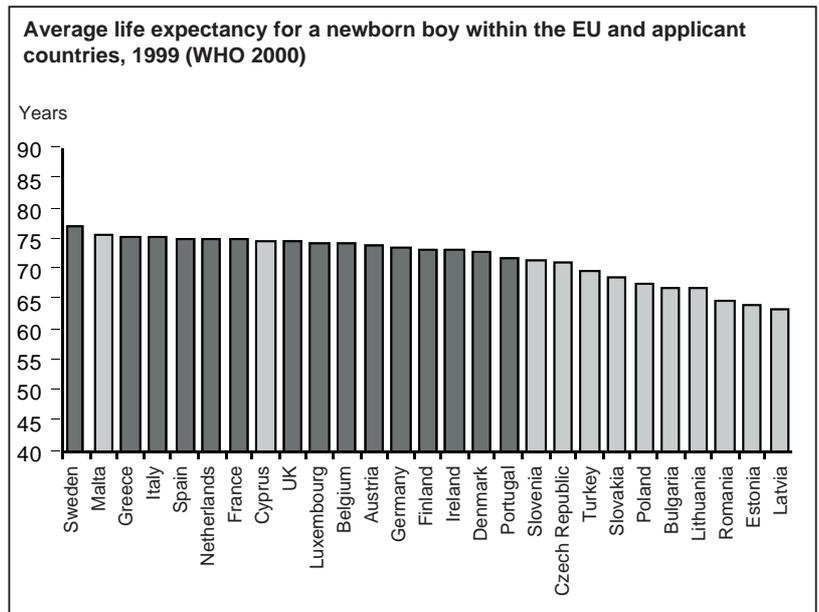
Creating the preconditions for good health for all of the people of Europe must become a matter of priority for the Community in the future.

There are major variations in health today, with a higher level of disease and mortality among less privileged groups and in less prosperous areas. However, this is a problem that also presents the Community with a great opportunity to improve the lives of many of its citizens. Some examples: the average life span for women is five years longer in France than in Ireland, while the average life span of men is five years longer in Sweden than in Portugal. Infant mortality is much higher in Greece than in Finland.

The enlargement of the Union involves even greater challenges. The state of health in many of the applicant countries is much poorer than in the present Member States (see Tables).

The Committee of the Regions feels, therefore, that the Commission should focus on these inequalities in health and draw up an overall target for the health strategy. This could, for example, state that: 'The overall target should be to reduce health risks and differences in health throughout the EU. The health status of different countries and different population groups should, in the long term, approach the level of the best in the Union'. The applicant countries should, of course, also be seen as part of the EU in this context. There is no reason not to regard them as 'target groups' for measures or programmes, although obviously in the form of offers or invitations until they become members.

The Treaty and the competence of the EU must of course be taken into account when following up this target and translating it into concrete measures. In the case of concrete measures aimed at achieving the target, the Committee of the Regions points out that the EU should assess what impacts the implementation of decisions taken on various issues will have for different groups of the population. Another example is that special attention should be paid to particular groups when the Public Health Programme is implemented. Smoking, for example, is especially prevalent in the lower socioeconomic groups and the measures taken should be based on the needs of these groups.



(1) = 1995; (2) = 1996; (3) = 1997; (4) = 1999

EU countries Applicant countries

“There is a risk that the health strategy will go up in smoke!”

The Public Health Programme

The Commission's proposed Public Health Programme is, like the rest of the health strategy, very ambitious. The Commission proposes that a comprehensive information system should be developed and aimed at the policy makers, health professionals and the general public. This is a proposal that is well in line with the rapid development of information technology and the opportunities it offers.

Surveying and following health trends in the different countries may provide great added value for public health policy within the Community, and consequently for the health of the people of Europe. Such comparisons will make it possible to detect health risks that may otherwise be difficult to identify. They can also help to tighten up health policy.

It can be tempting to give priority to measures in the field of health and medical care when discussing public health. The wording of the proposed strategy indicates the desire to forge such a link in some cases. However, the Committee of the Regions opposes any move to extend the competence of the Union to cover healthcare. The factors that are of primary importance in improving the level of health within the Union lie outside the field of healthcare.

Comparing waiting times and queues for operations and treatment and so on may be of interest to the public and is important when setting priorities or designing healthcare services. It is unlikely, however, to have any great impact on public health and can therefore be performed by those who have direct responsibility for healthcare systems. There is also a risk that the EU, by making such comparisons and by providing advice on clinical guidelines, quality and so on, will slip into a role in which it controls and governs healthcare policy. Such powers would clash with the principle of subsidiarity as a governing principle for the division of competence within the EU. Healthcare and the planning, operation and financing of healthcare systems must remain areas within the competence of each Member State.

The Committee of the Regions proposes, on the other hand, that continuous reports on *expected* health trends should be submitted in order to meet new threats to public health at an early stage. Forecasts, scenarios and so on can help to ensure that new health threats within the Community are dealt with quickly.

In addition, the Committee of the Regions

feels that a European study, ‘Investing in Health’, should be drawn up. This would be similar to the report from the World Bank. The aim would be to analyse the economic costs of ill health and the value of investments in health. Similar discussions have been held previously, but now that the proposal on a new health strategy has been presented, this would seem to be the right time to produce such a report.

The Committee fully supports the proposal that the EU should ‘respond rapidly to threats to health’. This must be seen as a very important part of the Commission's work that may play a major role in the future.

‘Addressing health determinants’ is another area of work taken up in the proposed Public Health Programme. The Committee of the Regions believes that this area must be given higher priority. In the present proposal, only six million of the 287 million euros for the six years of the programme are devoted to health risks relating to tobacco. This should be seen in the light of the fact that the EU is currently spending a thousand times more on the subsidisation of tobacco cultivation than on efforts to counteract the health risks stemming from tobacco — there is a risk that the health strategy will go up in smoke!

The role of the regions

The Committee of the Regions, naturally enough, highlights the importance of the regions in the field of public health. The fact is that the regions or their equivalent are responsible for public health and healthcare in many of the Member States, particularly in northern Europe. In many of these countries, such as those in Scandinavia, the regions have no legal influence within the EU. The regions must therefore be guaranteed the right to exert influence over the public health policy of the Community in a special statute.

Ethical discussion

An ethical discussion on the fundamental values that should apply in the field of health is required. We are currently witnessing a lot of new initiatives in the health field, many of which are based on ‘the four freedoms’. The healthcare systems of the Member States have been built up over many years and are based on the cultural traditions and ethical principles of the individual countries. Safeguarding these ethical principles, as well as cultural diversity, may generate great added value for the Community in the future.

“The Commission should begin by analysing public health aspects in areas where supranational decisions are made.”

The health challenges of enlargement



John Bowis MEP

“I look to the Commission to initiate more collaborative action with the World Health Organisation”

There is a large majority in the European Parliament and also in the Council and Commission who want the process of enlargement to succeed. We must, therefore, make it clear both to the applicant countries and to ourselves that the process of enlargement should not simply be an obstacle course or a set of exam questions.. It is a process whereby we work together to enable all of our European family of nations to join us in a

way that makes them and us feel comfortable with the Union.

We must remember, however, just where we have all been in the past sixty years. First our European family was separated by war and then by peace and by the new alliances after the war. The West took the capitalist road and the East took the road of socialism. That latter road led away from freedom, although some of the Eastern countries had barely experienced freedom under their ancien regimes. It led to many cases of repression. Yet it also provided a degree of stability. Then the iron curtain was ripped aside. Freedom dawned, but at a price. How often people in some former Soviet republics have said to me, “We like the freedom but we wish we still had the economic certainties of the communist years”. Others have relished the independence from the old Soviet dominance of Comecon and the Warsaw Pact and have moved steadily to a free market system, despite the odd political, economic or social bump on the way. What is certain is that, give or take Belarus and Turkmenistan, virtually all our Eastern family is on the move in a political and economic sense and it is our duty and our wish to help that process.

There is, of course, an *acquis* and there are genuine concerns – some serious – which we must tackle and surmount. But those who say, “Clear the hurdles or don’t come in”, knowing very well that some of the *acquis* hurdles are still not met by current

Member States, must be firmly told to put away their rule book and get out their guide book.

Our neighbours to the east have seen and felt the seismic changes of the end of communism. When Pandora opened her box all the ills of mankind were released and sometimes that is how it must have felt as opened borders meant a two-way traffic of bad habits. Bad habits move fast. Good practice moves more slowly. And many of these bad habits were linked to health: infectious diseases – some drug resistant and some we thought we had seen the last of; drug abuse and the horrors of AIDS and syphilis; and the negative impact of tobacco and alcohol.

But that, of course, happened before, not after, enlargement. You cannot erect some new curtain – a *cordon sanitaire* to protect west from east and east from west. Enlargement of the EU or no, it is in our mutual and collective interest that such problems are dealt with. It is my belief that enlargement can help that process.

In my Health & Enlargement Report, now adopted by the Parliament, I summarised the position as being that :

- Virtually all Applicant Countries have economic difficulties, with less money available for public spending.
- Virtually all have lowered the priority of health in their spending plans, so health has a smaller portion of a smaller cake.
- Some aspects of health provision were good and remain so, such as the number of doctors – even if too many of them are in hospitals and too few in the community.
- Some aspects were good and have deteriorated, such as the vaccination coverage of children.
- Some aspects were bad and are now improving, such as the abuse of psychiatry.

*“Bad habits move fast.
Good practice moves
more slowly.”*

- Some aspects hardly existed and are now rapidly growing, such as treating sexually transmitted diseases.
- Some aspects were poor and are getting worse, such as addiction.
- For most the challenge is to reform infrastructures, management and resource systems; to improve health education and promotion; to protect individual rights; to keep their professionals; and to afford drugs and health technology.

Affording adequate healthcare is a challenge for all of us. People are living longer, with a disproportionate amount of health and social care resources inevitably going to older people. Medical science moves on at an exciting but expensive pace, with new queues forming for new drugs and treatments and public demand for access to what is available. If you then consider that, while current EU Member States spend a weighted average of 8.75 per cent of GDP on health, with Germany at 10.5 per cent, mainland applicant countries spend an

“Not only are infectious and notifiable diseases on the increase and, but life expectancy has suffered.”

average of 5.8 per cent, with the lowest at 3.8 per cent and only Slovenia some way out in front at 9.4 per cent. These are percentages of very low GDPs and the size of the problem in cash terms is extremely stark. The awesome comparison in US dollars is \$1771 per EU citizen and only \$357 per applicant citizen.

It is then no wonder that not only are infectious and notifiable diseases on the increase and that protection campaigns such as vaccination and education have been cut back, but that life expectancy has suffered. EU life expectancy is 74.5 for men and 81.2 for women. Applicant equivalents are 67.4 and 75.8. And disability rates too show a 20 per cent difference in the years lived with a disability. If we bear in mind shorter life spans, that means disability not only lasts longer, it starts earlier.

So what does Europe expect from its applicant friends. In simple health acquis terms the answer is not a great deal, but that is to miss the wider health-related acquis and to miss the developing acquis that has come from recent EU Treaties and notably the

Treaty of Amsterdam.

Since the 1950s, we have had standards of Health & Safety at Work laid down in the Treaties of Rome and Paris. Then steadily over the years Europe added competencies and standards from Public Health to Health Promotion; with rules from tobacco to blood safety; rights from mobility for doctors, patients, services and capital to human rights; and laws such as those on mental health. Pharmaceutical companies are regulated and medicines for people and animals licensed. Then we have a range of activities in research, dissemination of good practice, education and training, and we are building a compendium of Directives and Regulations on matters wholly germane to health, such as emissions, pollution, radioactive and other dangerous substances, waste disposal, water and air and soil quality, food safety and novel foods, product liability; and a charter of fundamental rights of some sort is on the way.

It is a long list, but one that is often more honoured in the breach than in observance by Member States. There is a message there for EU governments on compliance and for the Commission on enforcement. More importantly there is a message that we need to use all the channels available to support progress within Accession Countries. That is why my Report stresses the need to encourage the PHARE Programme to do more in the health field. It is why we should bring the countries into partnership with us *now* in the Health Action, research and monitoring programmes and organisations of the Union. I also look to the European Investment Bank to play the bigger health role I know it is willing to play and I look to the Commission to initiate more collaborative action with the World Health Organisation.

At the same time we need to look at other issues than are directly and immediately the domain of the European Institutions. I think, for example, of the problems or potential problems of medicines provided at discounted prices to Eastern and Central Europe but which, after accession, might be sold back into the Western countries, at a healthy price, but one which could distort both markets.

We have time to tackle the *acquis* problems before accession, but not too much. Then we can tick the Health box on the application form and get on with the much more important and longer term task of working together to meet the health and care challenges of this twenty first century.

Enlarging the European Union: Implications for communicable disease control?



Martin McKee

For as long as international trade has existed there has been a tension between the free movement of goods and people and the control of epidemic disease. The planned enlargement of the European Union by 12 countries and 105 million¹ people brings this issue to the forefront once again.

In March 1998, accession negotiations were formally opened with six countries: the Cyprus, Czech Republic, Estonia, Hungary, Poland, and Slovenia. The process was widened in February 2000 to include six additional candidates: Bulgaria, Latvia, Lithuania, Malta, Romania and the Slovak Republic. Turkey is also a candidate country for accession to the EU although not yet in accession negotiations.

The first formal agreement recognising the problems created by trade and travel for communicable diseases was the adoption of the International Health Regulations by the 22nd World Health Assembly in 1969. By the 1960s and 1970s, many were optimistic that the burden of disease and premature death due to infectious diseases would soon be relegated to history. Fired by the successes of anti-microbial drugs and immunisation programmes, an American Surgeon General declared that infectious diseases had been conquered.² These hopes were soon dashed. Antibiotic resistance, the re-emergence of old threats, such as tuberculosis, and the appearance of new ones such as HIV and legionnaires disease, shattered the complacency.

In the past three decades these threats have returned with a vengeance. One reason is the vast increase in the scale and pace with which people and goods are moving across

international boundaries. The development of the European Union has contributed considerably to this increased mobility by removing obstacles such as tariffs and, at least within the Schengen countries, frontier checks.

The public health response

In contrast to this openness, the public health response has largely remained constrained within national boundaries. Surveillance and control systems within the EU continue to be the responsibility of Member States, with the international dimension based primarily on the 1969 International Health Regulations. It is, however, rapidly becoming apparent that the growth in international travel and trade has stretched these systems to the limit, as highly publicised food safety and other crises have highlighted the challenges to national surveillance systems arising from an increasing global environment. From the European Union perspective, these challenges emerge in three situations:

- outbreaks detected in one country which may affect people in other countries;
- outbreaks that can only be detected by pooling national surveillance data;
- outbreaks arising outside the EU that pose a potential public health threat to the EU.

The European Union has responded to these challenges, within the framework of what is permitted by the Treaties. In recognition of the health implications of increased trade, the European Union's competence in public health has steadily expanded. While some mention of health was present in the early treaties, going back as far as European Coal and Steel Community (ECSC) Treaty of 1951, its



Laura MacLehose

NOTE:

This paper draws on a report on the management of outbreaks of communicable disease affecting more than one EU Member State, undertaken by the authors and others on behalf of the European Commission (Brand H, Camaroni I, Gill N, Fulop N, MacLehose L, McKee M, Reintjes R, Schaefer O, Weinberg J. An evaluation of the arrangements for managing an epidemiological emergency involving more than one EU Member State. Bielefeld: L_GD, 2000) as well as on work being undertaken as part of a study of the implications of accession for health and healthcare, by the European Observatory on Health Care Systems.

RECENT EU SUPPORTED INITIATIVES IN COMMUNICABLE DISEASE SURVEILLANCE AND CONTROL

1. Training

- ✠ European Programme for Intervention Epidemiology Training (EPIET)

2. Surveillance and Related Research

- ✠ European Working Group on Legionella Infection (EWGLI)
- ✠ European Network on Salmonella and VTEC Infections (Enter-Net)
- ✠ European Influenza Surveillance Scheme (EISS)
- ✠ European Monitoring Group on Meningococci (EMGM)
- ✠ EuroTB
- ✠ European Anti-microbial Resistance Surveillance System (EARSS)
- ✠ EuroHIV
- ✠ RAPEX (Rapid Alert Information Exchange System incorporating Rapid Alert Food Safety System RASFF)
- ✠ European Network for Diagnostics of Imported Viral Diseases (ENIVD)

3. Information

- ✠ Eurosurveillance Weekly & Monthly
- ✠ Health Surveillance System for Communicable Diseases (HSSCD) Information IDA (Interchange of Data between Administrations)
- ✠ Inventory of resources for communicable diseases in Europe
- ✠ Inventory of resources for communicable diseases related to travel and tourism
- ✠ Inventory on arrangements dealing with zoonoses
- ✠ EUVAX scientific and technical evaluation of vaccination programmes in the EU
- ✠ Development of Minimal Data Set (standardisation of data across the EU)
- ✠ An evaluation of the arrangements for managing an epidemiological emergency involving more than one EU Member State (1999-2000)

should be adopted or whether the response should be based on a supranational centre.

In 1998, agreement was reached on a network approach, which was formalised in Decision 2119/98/EC on setting up a network for the epidemiological surveillance and control of communicable diseases in the EU.⁴ The new 2001 to 2006 European Commission proposal for adopting a programme of community action in the field of public health reinforces these concepts. One of its three objectives is to enhance the capability of the EU to respond rapidly to threats to health by strengthening surveillance, early warning and rapid reaction systems.⁵

These provisions form part of the accumulated body of existing EU law, the *Acquis Communautaire*, that each candidate country must incorporate in its entirety into national legislation as a condition for accession. Currently, the *Acquis* is estimated to run to 80,000 pages of documentation and is continually expanding.⁶

Networks and initiatives

The various decisions on communicable disease have their concrete manifestations in a number of disease specific networks linking national surveillance centres across the EU, as well as the beginnings of an early warning system. In addition, two surveillance journals, *Eurosurveillance* weekly and monthly, have been established. An EU wide training scheme on intervention epidemiology, EPIET, is also in place. The box shows some of the initiatives currently in place or planned.

Two advisory groups help guide such activities: the Charter Group (heads of national communicable disease surveillance institutions) and the Network Committee (two representatives from each EU Member State). An example of a network is EWGLI, the European Working Group on Legionella Infection. In this network, Member States exchange data on cases of travel-associated legionnaires disease. As the disease may only appear 10 to 14 days after exposure, by which time holiday makers from a contaminated hotel may have returned to their homes all over Europe, an international surveillance system is essential if clusters associated with a particular resort are to be identified. 'Enternet' is another EU network, in this case focusing on human salmonella infection and other gastrointestinal diseases.

The system of networks has facilitated the use of common case definitions and stan-

first substantive appearance was in the Single European Act of 1987, which enabled the development of the Europe Against Cancer and Europe Against AIDS programmes. However it was only in 1992, in Article 129 of the Maastricht Treaty, that a competence in the field of communicable disease, which could be considered to be one of the 'main health scourges' facing the population of Europe was introduced. This was reinforced in the Amsterdam Treaty of 1997, which came into force in 1999, which emphasised that 'a high level of health protection shall be ensured in the definition and implementation of all Community policies and activities'.

The provisions of the Treaties have enabled the development of a range of policies on communicable disease prevention and control. The 1996 Decision on AIDS prevention,³ for example, has extended the scope for coordinated European action. There has been a general agreement among Member States that closer coordination is necessary but the form that it should take has provoked considerable debate. In particular, there have been conflicting views on whether a 'network' approach

"Participation in European Union surveillance and prevention activities should not necessarily have to wait for formal accession."

standardised laboratory practices for many common diseases. It has been shown, for example, that EWGLI has detected many more outbreaks than was previously the case.⁷

Health challenges

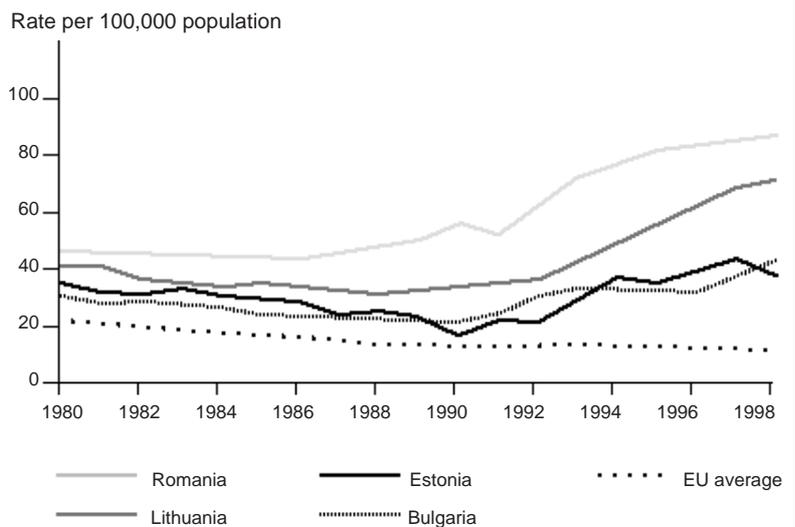
The health challenges facing the candidate countries vary considerably, with some, such as the Czech Republic and Poland, showing rapid gains in life expectancy while in others, such as Romania and Bulgaria, it is stagnating and, for some groups, continuing to deteriorate. Malta and Cyprus are, of course, exceptions, as they do not display the high levels of adult mortality seen throughout central and eastern Europe. In general, however, levels of communicable disease are higher than in existing Member States while investment, both physical and human, in the capacity to detect, investigate and manage them may be more limited. Earlier gains in communicable disease control, particularly with tuberculosis and syphilis, have been lost in some of countries. Rates of tuberculosis are significantly higher than in the European Union, rising to over six and seven times the European Union average in Lithuania and Romania in 1998 (see Figure).⁸

Participation

Against this background, preparation for participation in the EU surveillance initiatives will be extremely important. Some candidate countries already participate informally in the Enternet network and the EWGLI network has also expanded beyond the borders of the EU. There are, however, a number of challenges to be addressed. One is in the training in modern epidemiological methods, which has been given lower emphasis in some countries because of the dominant role of microbiologists in the response to communicable diseases. Microbiology laboratories will also need to be upgraded in some areas and in some cases, the use of common case definitions and laboratory procedures may need to be introduced. The speed with which disease can now spread means that there is also a need for enhanced communication systems, taking advantages of the growing role of the internet.

Participation in European Union surveillance and prevention activities should not necessarily have to wait for formal accession. The scale of the challenge is such that, if it is left until accession negotiations are completed, it will be many more years before common systems are in place. There

Figure TUBERCULOSIS INCIDENCE, ALL FORMS, IN THE EU AND SELECTED ACCESSION COUNTRIES



Source: WHO Health for All database

is a need to identify mechanisms to enable representatives of candidate countries to participate more widely in the existing European Union schemes as soon as possible. This would bring advantages to both candidate countries and the current EU Member States.

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“Surveillance and control systems within the EU continue to be the responsibility of Member States.”

Health and enlargement

Half way there

Nearly two years have passed since the Staff Working Paper on Health and Enlargement was published. The Commission has gone some way towards addressing the issues identified in this paper, but there is a need for greater effort and closer collaboration between the different health and enlargement related Commission services.



*Magdalene
Rosenmüller*

The health reforms in the candidate countries were undertaken in the very adverse context of the wider political and economic transition.¹ Despite considerable progress, the feeling is that health sector reforms have gone only 'half way'. Western countries have all realised that reform is a never ending story, and should be considered more as a continuous improvement effort. In the candidate countries, unfortunately, the effort seems to have come to a halt. Reforms are stagnating and policies are not being implemented as planned. In many cases the system seems to be a 'patchwork' and remains ill defined. New and old institutions have competing responsibilities, procedures are unclear and regulations are lacking.

The legacy of the communist system has been slow to disappear. The vertical, hierarchical and party-influenced command structure prevented people from developing their capabilities; many still have difficulties with decision analysis and risk taking. Political instability and the slow recovery of economic growth have further hampered reform efforts, while the early decentralisation has complicated national decision making. The challenges of implementing the reform have been underestimated, with politically sensitive issues such as excess capacity in human resources and hospital beds often not being tackled. The infrastructure is old and poorly maintained as resources are lacking and managerial capacity has not been sufficiently developed at the different levels. Healthcare professionals have poor working conditions, are badly paid and unmotivated; often they feel they are expected to make up for the inefficiencies of the system.

Health status indicators are starting to recover from the downturn of the early nineties, and life expectancy is now

approaching the EU average. Infant mortality has improved, too, except in Romania, where a worryingly high rate persists. In most countries healthcare is still very clinically orientated, while primary care and public health concepts are elaborated, but not really implemented. Expectations in relation to healthcare are rising, especially with increasing access to the Internet. At the same time the population remains poorly informed about the reforms, as public communication is weak.

Healthcare reforms have been supported by technical assistance from various sources, such as the Phare programme, especially Phare Consensus. Twinning programmes between candidate countries and Member States promote the transposition and implementation of the *acquis communautaire*, i.e. occupational health and safety and phyto-sanitary control. Phare supports the participation in Community public health programmes and the fifth framework programme. Substantial bilateral support has been, and still is, provided by Member States and others. A recently signed Memorandum of Understanding serves as a foundation for co-financing of programmes between the Commission and the International Financing Institutions. The cooperation with WHO-Europe activities – the HIT series,² liaison officers, and specific programmes – is likely to be enhanced on the basis of the recent exchange of letters between the Commission and WHO-Geneva.

Progress towards accession

Most candidate countries now meet the so-called Copenhagen criteria, as stated in the Agenda 2000: stable institutions guaranteeing democracy, respect for human rights, a functioning market economy and the capacity to absorb the *acquis communautaire*. The regular reports on progress towards accession review progress in the different areas of the *acquis communautaire*, the most recent one dating from November 2000.³ The legal transposition is underway, but most countries lack proper

“New and old institutions have competing responsibilities, procedures are unclear and regulations are lacking.”

implementation and enforcement structures. This is also true for health related areas such as health and safety at work, phyto-sanitary health and consumer protection.

Progress on the Tobacco directive has been mixed, with the Czech Republic, Estonia, Lithuania, Romania, Cyprus and Malta still lagging behind. In most countries the conditions for the mutual recognition of healthcare qualifications, allowing the free movement of professionals, have not yet been created. This is mainly due to the overlapping responsibilities of different professional organisations. Similarly, the network for epidemiological surveillance and control of communicable diseases has not yet been set up in most countries. Drug use is generally on the rise and even though candidate countries are increasingly collaborating with the European Centre for Drug Monitoring in Lisbon, nationally the fight against drugs is hindered by the lack of internal and interministerial coordination.

Corruption is still a significant problem. It is particularly prevalent in healthcare, and the Czech Republic, Romania and Slovakia receive special mention. Although not all the countries are mentioned by name, it is to be suspected that the problem is widespread, as reported in a study on Bulgaria and Hungary.⁴ The deficient health situation in prisons in some countries is pointed out, notably in Slovenia, Latvia and Lithuania. In Romania there is an overall "degradation of social, education and healthcare infrastructure".

Participation in Community programmes has increased. Interest is strongest in the AIDS, Cancer, Drugs and Health Promotion programme. The Czech Republic, Hungary, Romania and Slovenia are the most active participants. Even though there is still some hesitation on the part of the candidate countries, mainly for budgetary reasons, they are becoming more familiar with the bureaucratic hurdles, as a series of expert meetings were organised in the different programmes for this purpose. And yet, no country is formally taking part in the recently created health monitoring programme, which is quite relevant to accession. There is some doubt whether it is reasonable to begin the lengthy administrative procedure for the four more recent programmes as the new European public health programme is due to start soon. However, it is foreseen to involve the candidate countries very actively in the preparation and implementation of the new pro-

gramme and the European Health Forum.

Although the reports concentrate mainly on the *acquis* as such – and there are not many 'hard' *acquis* related to health – they stress that most countries are lagging behind in healthcare reform, especially with regard to economic sustainability. In Hungary, for example, "the weak financial structures (in the healthcare system) continue to place a heavy burden on public finances". Unfortunately, there is some inconsistency in the reports, which makes comparison difficult. The reporting of health related issues in the different countries could be improved through closer cooperation between DG Enlargement and DG Sanco.

The Staff Working Paper

In June 1999, the European Commission published the Staff Working Paper (SEC) on health and enlargement.⁵ The November 1999 Health Council under the Finnish Presidency reacted very positively to the SEC asking the Commission to follow up on the different options put forward.⁶ The European Parliament Bowis report from last summer again stressed the importance of health and enlargement.⁷

The Commission has started to tackle some of the issues identified in these reports, especially by fostering the participation of the candidate countries in the different public health programmes. But several of the issues have not been fully addressed, such as the idea of developing a specific action plan for each candidate country, including health status reports and information exchange on resource allocation and health system issues. A country approach, developing specific health and enlargement strategies in collaboration with the candidate countries, would be beneficial.

Another option envisaged in the working paper was to promote research into health and enlargement related issues. So far no related project line has been opened under the fifth framework programme. A great deal of effort has been put into raising general awareness of the European research programme in the candidate countries. All the same, better coordination between DG Sanco and DG Research would be a good thing.

A start has been made to allow candidate countries to participate in health activities at EU level. Officials from the candidate countries' health ministries now regularly take part in the meetings of the High Level Committee on Health. Candidate countries

"A country approach, developing specific health and enlargement strategies in collaboration with the candidate countries, would be beneficial."

“All Commission services related to health and enlargement should increase collaboration”

now participate as observers in public health programme committees, and have a say on programmes that directly concern them. Yet there are no experts from candidate countries in the all important scientific committees, which are generally open to non-EU scientists. A targeted search for suitable scientists would elicit candidatures and help strengthen the countries' scientific capacity in health and consumer protection.

The Commission has organised various expert rounds on different health related topics specially aimed at the candidate countries. The Commission's Public Health Policy Unit and Taiex (Technical Assistance Information Exchange Office), together with the Spanish and Catalan Health Ministries, organised a workshop on health and enlargement at IESE Business School in Barcelona in July 1999. This workshop offered officials from candidate countries a comprehensive overview of health related areas at European level. Enlargement has been on the programme of the yearly European Health Forum, Gastein and there is an increasing number of informal exchanges at all levels. But more guidance or support from the Commission would be helpful.

Although Commissioner Byrne, at the EP Public Hearing on health and enlargement in July 2000, again described the Staff Working Paper as an important initiative, he did not give details about how the 'options' it put forward have actually been followed up. The reorganisation of the Commission in 1999 strengthened the role of health at EU level, but the inevitable delay in the Commission's activity and the departure of the Director of the Public Health Directorate in summer 2000 go some way to explaining why health and enlargement did not get attention as promptly as it deserved. It is to be hoped that with the arrival of Fernand Sauer as the new Director in December 2000 and the timely launch of the New European Public Health Strategy, work on health and enlargement issues will be intensified. In the meantime Commissioner Byrne has started a series of visits to the candidate countries. Poland was first, in October, followed by Hungary and the Czech Republic in November and December 2000, to be continued this year. Public health is on the agenda, but evidently the *acquis* takes precedence over health system issues.

The creation of a 'coordination centre' for enlargement issues within the Public Health directorate would be helpful. Its

task would be: to act as an information point for all health and enlargement related questions that officials in the candidate countries might have; to liaise with DG Enlargement on priority fixing for twinning, Phare and Taiex activities; to support Member States in preparing for twinning or bilateral support; and to enhance guidance to the candidate countries in their participation in public health programmes, especially in view of the implementation of the new public health strategy. The once proposed EC health and enlargement internet portal – to be created as part of the proposed 'virtual health forum' – could foster information exchange, offering links to health related activities at Community level and to the national health pages of candidate countries. It could also provide answers to frequently asked questions and a discussion forum for exchanging experiences. Health should be given higher priority under the Phare programme, for example by using twinning for public health and health systems issues. A well defined general and country strategy would help to seriously address the problems identified in the EC document.

Conclusions

There is still a lot to be done in health and enlargement. To make activities consistent with the issues identified in the Staff Working Paper and others that have appeared since, all Commission services related to health and enlargement should increase collaboration and efforts.

On the other side, candidate countries, too, need to step up their efforts. They need to pay more attention to their health systems in their preparation for accession. Talented people in the public administration are trying to work miracles against heavy odds. Accession is very demanding, and people in the candidate countries have ever higher expectations. These countries need to create the conditions in which their public administrators can work effectively towards accession, giving them the resources in time and money to carry out health and enlargement related activities effectively.

The Swedish presidency has put enlargement very high on its agenda. A special conference on 'EU Enlargement, Research and Public Health: Health as a Lever for Economic Growth' is planned for June 2001. The Baltic countries, in particular, are hoping for a drive on health and enlargement issues, and we can only join them in this hope.

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Health and the environmental imperative



The link between environment and health is easy to recognise. In Europe alone, several thousand people die from air pollution each year. More children are suffering from asthma, many of our rivers and lakes are still not safe to swim in, and there is evidence that particulate matters such as dust and ground-level ozone affect the health of people and provoke premature deaths. We also face emerging issues such as endocrine disruptors, which may have serious impacts on people's health.

Margot Wallström

A study conducted in Austria, France and Switzerland concludes that air pollution caused six per cent of total mortality, or more than 40,000 attributable cases per year in these countries. About half of all mortality caused by air pollution was attributed to motorised traffic, accounting also for: more than 25,000 new cases of chronic bronchitis (adults); more than 290,000 episodes of bronchitis (children); more than 0.5 million asthma attacks; and more than 16 million persondays of restricted activities!

Environment, along with health, is among the top concerns of the citizens of the European Union. They expect action from the European Institutions regarding the environmental causes of health problems. Environment and health are policy areas that have special status at the European level. The Amsterdam Treaty requires that both environmental and health concerns be taken into account when decisions are made in other policy areas. Much progress has been made regarding single pollutants in air and water, but many problems clearly still remain, e.g. regarding chemicals and noise.

New initiative

I declared health one of my priority areas when I took office as Environment Commissioner in 1999. This is reflected in the new environmental action programme *Environment 2010: Our future, our choice*.¹ The programme, which outlines environmental policy for the next ten years, pre-

sents four key areas of action:

- Fighting climate change.
- Nature and biodiversity – protecting a unique resource.
- Health and environment.
- Ensuring the sustainable management of natural resources and wastes.

The overall environment-health objective is to achieve a quality of the environment where the levels of man-made contaminants do not give rise to significant impacts on, or risks to, human health. Special attention is paid to the handling of chemicals, pesticides, water, air pollution and noise.

The causes of environment-health problems are numerous and include transport, agricultural activities, industrial processes and domestic waste. Environmental policy alone will not solve all problems – action and initiatives must be taken on many different fronts. One of the key objectives for the new environmental action programme is consequently that environmental concerns must be better integrated into all other policy areas.

It is important to improve the understanding of how different pollutants are spread and how we can tackle their aggravated combined effects. In the programme, the Commission suggests that particular attention is paid to how we can improve our research efforts and that early warning systems are established. The programme also suggests a review of the approach in which

“We must take precautionary action where there are serious concerns but not yet a clear picture.”

“One of the key objectives for the new environmental action programme is that environmental concerns must be better integrated into all other policy areas.”

some existing standards have been established with the ‘average’ adult in mind without taking into account the need to protect particularly vulnerable groups in society such as children and elderly people.

Children – the ‘living’ indicators of our environmental state

As the first victims of any environmental disturbance, children are the first to show signs that something is seriously wrong with the environment. Even the foetus is threatened. Through the placenta the foetus takes in environmental toxins which enter its body and cardiovascular system in concentrated form. Toxins that pass through the placenta include lead, mercury, DDT and dioxins. Environmental toxins can cause miscarriages or impair foetal growth in different ways. In the worst case the child will sustain serious injury for life. After birth, children are also more vulnerable and sensitive. Many of the body’s main organs, such as the kidneys, the liver and the brain, undergo significant development during the first few years of life. In addition, children do not have the knowledge or know-how to avoid environmental risks. On the contrary: abandoned industrial sites and refuse dumps can be exciting playgrounds! Children are in several ways more exposed to environmental pollution than adults – they are crawling on the ground or on the floor, and they are – due to their size – subject to a more direct inhalation of fumes from cars. Furthermore, children eat proportionately more food, drink more fluids and breathe more air per pound of body weight than adults.

Newly born children are extremely vulnerable since their immune system is not fully developed and they are completely at the mercy of those around them. Nature has solved this problem by allowing the mother’s protective antibodies to be passed to the infant in the mother’s milk. It is also part of our natural instincts to protect and look after small children. However, because of our influence on the environment and environmental impacts on us and our health, breast milk has often been found to contain chemicals which are also passed on to the child. I have been told that as adults we have 300 to 500 ‘unnatural’ chemicals in our bodies!

Chemicals – we use them daily

Our society uses many thousands of chemicals in the manufacture of the wide variety of products that we have come to rely on. The environmental risks potentially

associated with the use of many of these substances were not always evident when they were first brought into use and it is important that our regulatory system is capable of assessing and managing these risks. The current system has proved to be incapable of dealing with the vast number of chemicals that need to be reviewed and we will give priority to overhauling our chemicals legislation in order to implement a system which can give the citizen the protection he/she deserves.

Cooperation with the WHO

It stands clear that health is the most powerful argument in environmental policy-making. The European Commission and WHO have together started to identify strategic areas for further cooperation in the field of environment and health. Discussions cover issues such as air and water quality, transport, noise, chemical safety, radiation protection (both ionising and non-ionising radiation, including electro-magnetic fields), climate change, environment and health indicators, as well as international issues, in particular the preparation of the Rio+10 Conference due to take place in 2002.

Joint research efforts will be strengthened in order to enhance the application of scientific knowledge in standard setting by both WHO and the EU. As I have mentioned, I think it is necessary to use the vulnerability of children as a starting point when setting standards of protection. Indicators and health impact assessments will be examined in relation to complex, cross-sector issues such as transport and children’s environment and health.

Need to be proactive

Health remains a key area for the future. We need to find out more about how various environment pollutants are influencing our health in order to shape policies so as to avoid further health problems. Therefore we must continue to invest resources in research and development. It is crucial to provide consumers – and parents of course – with basic information to allow them to make informed choices and to take individual responsibility for protecting themselves and their children from environmental health threats. In short, we need to be more proactive rather than reacting with hindsight to serious problems. We must take precautionary action where there are serious concerns but not yet a clear picture. This proactive approach is fundamental for my role as Environment Commissioner.

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The impacts of climate change on European population health



Erwin Jackson

“The most severe effects of climate change on human health are expected to occur in developing countries.”

Climate change threatens human health on a global scale. The current scale of human activity and the consequent impacts on the Earth’s life support systems – stable climate, high levels of biological diversity, adequate food and protection from UV radiation – are unprecedented in human history. Various international, regional and national assessments of the consequences for human population health have concluded that the impact of these global changes will be largely negative.¹

Assessing the impacts of climate change on the health of human populations is a difficult task. While environmental factors such as temperature and rainfall affect human health in many ways, socioeconomic factors also play a significant role. For example, the climatic conditions suitable for malaria transmission currently exist in parts of Europe. However, public health measures have all but eliminated the disease. In addition, many uncertainties exist in the projection of future climate change and many of the influences of climate and its interaction with other factors are poorly understood. Despite this ambiguity, a consensus has emerged of the types of health impacts that climate change will cause.

In general terms, the impacts of climate change can be broken into two groups – direct and indirect. Direct impacts involve the loss of life and sickness from the

projected increased frequency, severity and geographical extent of extreme climate events. Indirect effects include changes in food supply owing to the disruption of agriculture and fisheries, the spread of infectious diseases, and the climate-enforced mass migration of populations. These impacts will interact with each other. For example, the direct loss of life from flooding is often followed by the spread of infectious disease as social dislocation and favourable environments for disease carriers are created.

The populations most vulnerable to climate change will be those on the ‘edge’ – the poor, the poverty stricken, homeless, the aged, the chronically ill and drug dependent. These populations are more vulnerable to climate change because they lack the capacity and resources to respond effectively to the short and long term changes in weather and climate. As a result, the most severe effects of climate change on human health are expected to occur in developing countries. For example, the effects of climate change on cereal production have been estimated to place an additional 40–300 million people at risk of hunger in the developing world by 2060.

Direct effects of climate change on health in Europe

Extreme weather events can have significant health and economic consequences (see Table 1.) and climate scientists project significant changes in weather extremes across Europe over this century.² For example, a heat wave that would be expected to occur once every 310 years under the current climate in the UK is expected to occur once every five to six years by 2050. Under one scenario for Spain, the current one ‘hot’ summer in ten becomes four to five times more frequent by 2050. At the opposite end of the temperature extreme, ‘cold’ winters are projected to have almost entirely disappeared across large parts of Europe by 2080.

An increase in heat waves will cause increases in the number of deaths due to hot weather. Hot weather can also increase the health impact of certain air pollutants (for example, ground level ozone).

Table 1 Examples of the extreme weather event impacts in Europe^{2,3}

Extreme event	Health impact	Economic impact (US\$)
Heat waves UK (London) 1995 Greece (Athens) 1997	137 excess deaths (compared with the seasonal average) 2000 deaths	
Floods Central Europe (Germany, Poland, Czech Republic, Slovakia, Austria, Hungary, Romania and the Ukraine) 1997	Over 100 deaths, 200,000 homeless	~\$5 billion
Windstorms January — February 1990	159 deaths	\$8.6 billion
Mud slides Italy (Naples region) 1998	150 deaths	

“Climate change would be expected to exacerbate problems with malaria in eastern European countries.”

It is also expected that the number of deaths related to cold weather will decrease. For example, one study of the UK suggests a decrease in annual deaths from cold by around 20,000 by 2050. However, as social and behavioural changes play a major role in cold related deaths in countries with high rates of winter mortality, improvements in socio-economic conditions – e.g. reduced fuel poverty in the UK – will probably play a bigger role in reducing cold related deaths than will climate change.³

In addition to the direct loss of life and injury associated with extreme events, floods, storms and heat waves have other short term and long term health consequences. Floods for example, may increase the risk of communicable diseases such as leptospirosis, overload water purification and sewage systems, and cause the discharge of toxic chemicals as waste sites and industrial centres overflow. Mental health problems have also been associated with extreme weather. For example, in Poland 50 suicides were attributed to floods in 1997.

Indirect effects of climate change on health in Europe

Climate change is expected to affect the distribution and occurrence of a number of infectious diseases. The World Health Organisation has identified diseases carried by intermediate (‘vector’) organisms such as insects as being particularly vulnerable to climate change. Climatic factors such as temperature, humidity and rainfall have a strong influence on both the disease and the host organism. In the case of malaria, for example, rainfall affects the availability of breeding sites for mosquito vectors, and

temperature affects the reproduction and maturation rate of the disease.

A number of European vector-borne diseases are likely to be affected by climate change including Lyme disease and tick-borne encephalitis (TBE).^{3,4} Lyme disease is the most common vector borne disease in Europe and there is concern about its increased incidence, as well as that of TBE, in the northern part of the continent.

Climate directly and indirectly affects the disease carrying ticks, their environment and host animals (e.g. mice, deer and birds), the time between blood meals, and disease transmission. If host animals are available, climate change is expected to enable tick-borne diseases to expand into higher latitudes and altitudes. Milder winters could reduce host mortality and extend the time that the ticks are active. Swedish researchers conclude that the recent northern shift of one tick species is related to the decrease in winter days below -12°C .⁵ In southern Sweden, milder spring and autumn months also appear to have increased tick activity.

In addition to tick-borne diseases, climate change would be expected to exacerbate problems with malaria in eastern European countries where the public health infrastructure has broken down and poverty has increased. Changes in average climate or extremes could also facilitate the introduction of previously unidentified diseases into populations (such as hantavirus pulmonary syndrome in the USA).

Conclusions

Climate change is likely to affect the health of European populations in a multitude of ways. While significant uncertainties exist, it is the judgement of health experts that these impacts will be largely negative. Some impacts will be obvious and direct (mortality from flood and heat waves) while others will be indirect and harder to identify (the spread of infectious disease). It is also clear that populations in poorer eastern European countries will suffer more than richer northern and western European populations. Outside Europe significant impacts are expected across developing country populations.

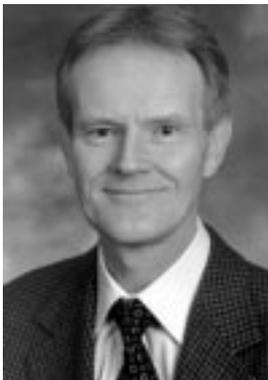
While policy measures are required to adapt to the climate change that is already occurring, unless the primary causes of climate change are addressed – the burning of fossil fuels – the rate and magnitude of impact will grow along with the acceleration of changes in the climate.

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Local environment and health practice in central and eastern Europe

A striking revelation to people in western European countries following the 'velvet revolutions' in countries of central and eastern Europe in 1989/90 was the state of the environment. Dramatically evident in the Ukraine in the aftermath of the Chernobyl nuclear power station explosion, many other countries also revealed pollution from heavy industry at levels only seen in western Europe many years ago.



Mark McCarthy

Rapid changes in economic conditions in the 1990s have led to many of the industrial sites closing, and investment in cleaner technologies has also reduced pollution. But there remains strong public and political concern for the environment, and its consequences for health. The European Union's 'acquis Communautaire' (criteria for accession) includes exacting standards in environmental Directives. National legislation is needed, but local management and control will be crucial for effective implementation.

The systems of the former governments did, in fact, often include decentralised environmental services with epidemiological expertise. But these services had little encouragement to investigate state-managed industries, and could be sidelined into monitoring rather than intervening. Much local action at present is led by new non-governmental organisations (NGOs), often supported by western aid agencies as alternatives to the public structures and sympathetic to western commercial investment.

Developments

The environment has received less attention from the health sector in recent years than economic and organisational reform of health services for two reasons. Environmental action is usually outside the control (especially economic) of the health sector; in addition, epidemiological evidence linking diseases with environmental exposure has been less strong than conventional 'risk factor' approaches. Especially when large populations are exposed at very low levels, the causal links are often open to debate. Considering how the tobacco industry has sought to deflect the compelling evidence of the effects of cigarettes, it is not surprising that the effects of other low level environmental exposures remain controversial.

WHO Europe

The World Health Organisation European Region has taken a steady and progressive approach, working from principles of scientific evidence towards action programmes. WHO has organised three international meetings for ministers of environment and ministers of health of its member states. (The WHO European region includes states of the former Soviet Union, and thus ranges from countries with a long environmental tradition, such as Norway to the new central Asian republics with pressing environmental problems, such as the Aral Sea region in Uzbekistan.)

Much of the science linking environment with health was set out in an authoritative report, *Concern for Europe's Tomorrow*, prepared for the second WHO Ministerial Conference held in Helsinki. The report considers traditional environmental concerns, such as drinking water purity, waste disposal and air quality. But the debate on environment has broadened for two reasons. The 'determinants' of pollution are seen to include more complex human systems such as transport and habitation; and environmental concerns for sustainable development have shown the need to work across sectors as well as within them.

Issues

The third Ministerial Conference held in London in June 1999 discussed two big issues – water quality, and transport, environment and health – as well as nine other themes including research, children and local implementation.

Water is of greatest concern in the east of the region, especially the Newly Independent States (NIS). More than 100 million people are without an adequate supply, either an absolute lack or using water that is polluted. Water borne infectious diseases such as hepatitis A and parasitic infections are common, even in major cities, and sporadic outbreaks of cholera have occurred. The solutions are partly technical, including better equipment and alternative methods of water capture and supply. They are also economic, for example in reducing industrial pollution. And they are social, including improving hygiene in rural areas.

“National legislation is needed, but local management and control will be crucial for effective implementation.”

“While industry has been the major polluting agency in the past, traffic is increasingly the major cause of urban air pollution.”

Transport, environment and health was the second main theme of the conference. This is the first time that WHO has formally recognised the importance of the whole transport sector to health. Indeed, it is important not only for its environmental damage – through air pollution and accidents – but also through behaviour (walking and cycling promote cardiovascular health) and social support functions.

Up until now, thinking on transport, environment and health have often been compartmentalised rather than integrated. Municipal environment departments measure air pollution but not the health consequences; epidemiologists measure health impacts without political action; traffic engineers build more roads to save lives from road accidents without understanding the other health impacts of their work. The Ministerial Conference agreed a declaration on transport, environment and health, a document less binding than a protocol, but giving national health ministries support and encouragement to develop policies for action and research in transport.

Transport is of particular relevance to the countries of central and eastern Europe. Gains in air quality from industrial change are being reversed by rising pollution from motor vehicles. The boom in cars during the 1990s is a result both of pent-up demand, and of active marketing by western companies that have invested heavily in car production for the east. In addition, with falling tax revenues, investment in public transport has been minimal. Central and Eastern European countries (CEECs) are rapidly developing private transport systems that imitate the western countries, and with their attendant damaging environmental and health effects.

Local practice

While international health work is often focused on Ministries of Health, ministers of health come and go, and the powers of central ministries vary. Sustained public health action also requires participation at local level, and local authorities are crucial for popular involvement and democratic decision making.

Some CEECs have long traditions of local public health departments. Hungary and Croatia both have well established services at county level, linked to academic schools of public health. Elsewhere, modern public health perspectives are less strong, and municipal health departments are concerned more with clinical care for disadvan-

tagged groups (such as maternal and child health) than with a population perspective.

Healthy Planet Forum

During the London Ministerial Conference, the UN Environment and Development Committee held an open meeting for NGOs – the Healthy Planet Forum. People attending the Healthy Planet Forum tended to know more about the environment than about health. But a special effort was made to invite professionals working in local health and environment departments in CEECs.

A workshop was organised during the Forum for 40 professionals from health and environment departments in 15 central and eastern European countries. It was funded by grants from the European Commission and the UK Department for International Development. The chance to exchange ideas was welcomed because domestic problems in the period of political and economic transition were frequently similar. The WHO declaration on transport, environment and health was seen as an important opportunity for collaboration.

As a contribution to discussion, a report on environment and health in London brought together quantitative information and presented the data in accessible visual form. The report showed that 60 per cent of Londoners are concerned with the health effects of poor air and many of the representatives from eastern European cities agreed that air quality was an important issue for them. While industry was the culprit in the past, traffic is increasingly the major cause of urban air pollution.

Conclusion

The CEECs had well established sanitary-epidemiological departments that collected valuable routine data on environment and hygiene. These departments offer an important information base for health needs assessment and monitoring. Through their influence on local political processes, the environment and health departments can together contribute significantly to local public health, and thus collectively to the nation's health. They can also provide a link at local level for improving clinical management in the reformed health services.

It is important that the contribution of local practice is recognised in national health planning, both in health services reforms and in health strategies. It is also important that assistance is given in capacity building through international exchange.

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Quality of healthcare in Europe:

An introduction

Concerns about the quality of healthcare are increasingly visible in health policy circles in Europe. While the overall benefits of healthcare seem relatively clear, there is considerable evidence that optimal care is not being given. This set of articles concerns quality of healthcare in Europe. They focus on approaches to improving the quality of care.



David Banta

No country can claim to have addressed quality concerns adequately, although some countries are certainly attempting to improve quality with more structured approaches to the problem, and there is some evidence of improving quality in these countries.

Definitions of quality of care

To discuss quality it is necessary to have a clear definition. 'Quality' implies a degree of excellence. However, there is no consensus on the actual definition of quality nor on those aspects of care that should be measured to determine quality. This is difficult to understand. The goal of the health system is to help the individual and the population to become more healthy. For example, the US Office of Technology Assessment in 1988 defined quality as "the degree to which the process of care increases the probability of outcomes desired by patients and reduces the probability of undesired outcomes, given the state of medical knowledge."¹ This definition is consistent with definitions put forward by the World Health Organisation and others, in emphasising health outcomes. However, others consider the focus on health outcomes alone inadequate. For example, Wilson and Goldschmidt insist that the definition has four elements:

1. technical quality (leading to improved health outcome)
2. cost of care
3. patient satisfaction
4. value trade-offs among the three dimensions.²

Others emphasise equity, access, or efficiency. For the purposes of this paper,

health outcome is considered the predominant factor in defining and measuring quality of care, and the goal of quality assurance or quality improvement activities is – and should be – primarily the improvement in health outcomes.

Evidence of problems in quality of care

Evidence of unsatisfactory care comes from many sources.³ Ideally, one would wish to evaluate quality on the basis of health outcomes and compare doctors, facilities, and even countries in order to identify and disseminate practices shown to be beneficial and cost-effective. However, mortality is not very susceptible to healthcare intervention. Studies of the use of mortality rates in measuring quality in Europe has not produced useful insights on quality. For example, Mackenbach et al found that eleven studies of mortality from 'amenable causes' (causes that could be addressed effectively by healthcare) showed relatively little difference between Western European countries.⁴ In fact, death rates from amenable causes were low and had declined rapidly. The picture was not so positive in Eastern European countries, but the main differences could be attributed to environmental and personal behavioural factors, not to differences in healthcare.

Therefore, tentative conclusions concerning quality of care must come from indirect evidence, such as evidence of use of ineffective health technology, broadly defined, and evidence of lack of use of effective technology. Twenty years of studies of variations of use in different regions and countries have shown dramatic differences that are difficult to explain.³ The problem of variations in use has led to studies of inappropriate care. Care considered to be inappropriate, that is, use of technology that has not been found to be beneficial in the defined circumstances, has been found to occur in as many as 30 per cent of cases. The rates of medical errors have been examined by the US Institute of Medicine, which concluded that a large number of preventable errors in healthcare occur in the United States.⁵

"Health outcome is the predominant factor in defining and measuring quality of care."

Approaches to improving quality of care

The papers that follow will give some insights into formal programmes for improving quality and their cost-effectiveness. The traditional method is to examine structure, process or outcomes of care in relation to accepted norms or standards of care, although the relation between the structure and process of care and the outcomes of care is often not clear. Evidence for the validity of many standards, which assume links between structure/process of care and health outcomes, is generally lacking, and hampers the evaluation of such quality activities as medical audits and hospital accreditation. Gulacsi and Banta examine this problem further in the last paper in the section.

A more recent development has followed from the introduction of ideas concerning quality from outside the health field. These approaches emphasise the providers' motivations to provide good care and seek to help them meet their goals in this area. Thus, such terms as 'continuous quality management' and 'quality improvement' seem to be supplanting the earlier terms such as quality assessment and quality assurance. This is well-illustrated by Isuf Kalo's paper, describing the approach of the World Health Organisation.

The evidence of widespread use of ineffective technology or overuse of beneficial technology has led to the establishment of agencies and programmes to assess health technology, broadly defined, in terms of health outcomes and costs. This subject is covered in more detail below.

Institutionalisation of quality of care

Europe shows a mix of voluntary internal and external mechanisms for improving quality of care. It has been stated that the definition of quality in Europe has often been physician-orientated, whereas the United States and Canada have followed a more patient-orientated definition emphasising health outcomes.⁶

As shown in the papers that follow, Europe has made progress in implementing quality improvement programmes during the last decade, although it must be said that this progress is disappointing in relation to the needs for quality improvement. Developments in quality improvement have been given a further impetus by the health policy paper published by the European Commission in 2000. The main approach by the European Commission

will be to try to improve information on quality and approaches to its improvement, including carrying out and implementing health technology assessments.⁷ Eastern Europe is behind Western Europe in such developments, but as the article by Gulacsi et al shows, rapid progress has been seen in some countries.

Quality improvement and HTA

The main goal of health technology assessment (HTA) is to improve health outcomes by assessing technology and implementing its results into policy and practice. Virtually every Member State of the European Union now has a formal agency or programme in HTA, and Eastern European countries are rapidly following suit. One of the main activities of HTA is to examine the efficacy (health benefits) from new and existing technology, broadly defined.

'Health technology' includes the drugs, devices, and medical and surgical procedures of healthcare and the supportive and organisational systems in which care is provided. Thus, a drug or machine is a technology, but so is a system of care. For that matter, quality improvement activities can be considered a health technology and also need assessment. Another aspect of HTA is examining the effectiveness of care. While efficacy refers to care in ideal or optimal conditions, effectiveness refers to the outcomes under ordinary conditions of healthcare practice. Efficacy is essentially always greater than effectiveness. One could say that one of the main tasks of quality improvement is to narrow the gap between efficacy and effectiveness.

HTA agencies generally have limited means to implement their findings. They must make alliances with other programmes that can use their results. While links between quality improvement and HTA are not great today, they are growing, and such a trend will no doubt continue. This is an area examined by Steen Henrik Sandø in his article on continuous quality development.

Conclusions

Quality of care in Europe can and should be improved. Quality management and improvement can lead to such improvements. However, quality improvement encompasses a wide variety of approaches, many of uncertain usefulness. There is a pressing need to evaluate such activities and use the information obtained to improve programmes in the future. This will undoubtedly be a thrust of European health policy initiatives for years to come.

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Development of quality of health systems in Europe



Isuf Kalo

“No comprehensive quality development systems function at the national level.”

Around the world interest is increasing in the improvement of quality in health systems. This is linked to the changes in the paradigms of health systems from biomedical to social accountability: citizens, patients, politicians, health authorities and professionals, payers, and other national or international partners in health are demanding the highest possible quality in terms of health improvement, responsiveness to people’s expectations and cost effectiveness.

In addition, due to globalisation and the IT revolution, countries are looking beyond their borders in their common quest for policy, tools and methods, and are sharing and learning from each other.

The WHO Regional Office for Europe model and experience in quality development

The Quality Assurance and Health Technology Assessment (HTA) programme established in 1980 pursued a continuous quality of care development approach, focusing on the improvement of quality of care by developing information tools and systems for measuring and comparing clinical outcomes. This approach was based on self assessment and self regulation of quality by healthcare providers who used comparison with peers, feedback, and the identification of the best demonstrated practice as motivation for benchmarking and continuous incentives to

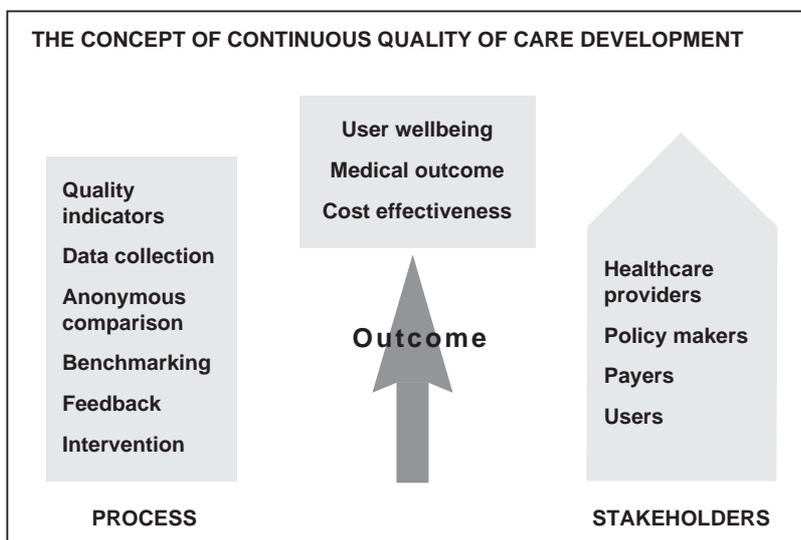
improve. Quality can be assessed through collection of data on the basis of internationally standardised outcome indicators accepted by providers in the field. By using electronic patient records, information can be transferred to servers or nodes via the internet and anonymised for comparison and identification of best practice. Dedicated servers within the Regional Office can host such data enabling cross-European comparison, feedback and benchmarking. In the St Vincent Diabetes Programme (Diabcare) and in perinatal care (the OBSQID project) it has been shown that this concept is feasible and works.

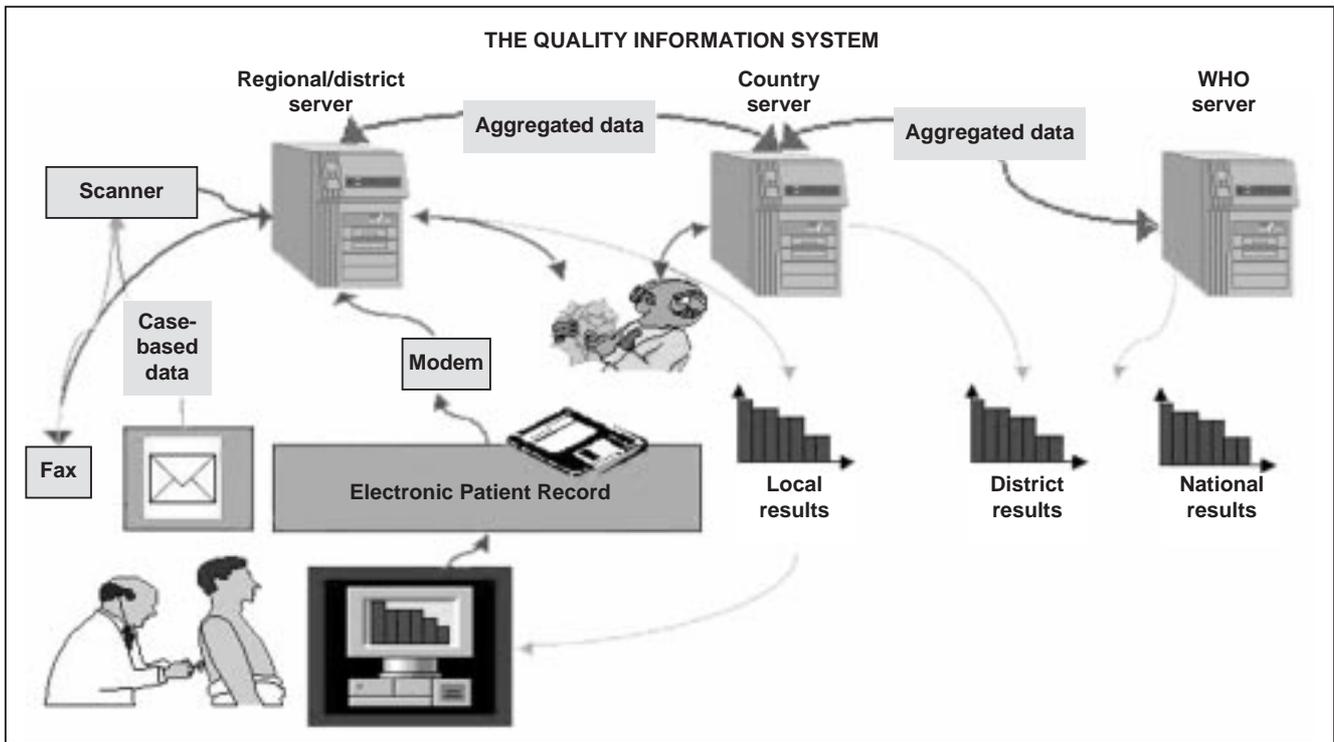
These projects have been widely disseminated to the countries for implementation. This approach has shown improvement in the outcomes of quality at individual or centre level but has been impossible to document at national level. It was expected, based on these models, that Regional Office member states would design national policies and programmes for the development of quality of care. However, only Belgium, Denmark, Sweden, and the United Kingdom have in fact done so, and these policies have only been partially implemented to date.

The recent situation of quality of health systems in Europe

Due to the lack of reliable evidence and adequate information systems to monitor quality, it is impossible to draw a comprehensive picture of the quality of health systems (QHS) in Europe and beyond. Most quality health systems operate as a set of distinct, unconnected entities rather than as one coherent system. Although quality initiatives have been launched in several countries, no comprehensive quality development systems function at the national level.

In addition to the Regional Office, the following European and international societies and organisations are dealing with quality programmes in Europe: The European Commission Directorate General for Research, Council of Europe, World Bank, European Forum of Medical Associations (EFMA), European Organisation for Quality (EOQ), International Society for Health Technology Assessment





“The main idea of the quality programme is to apply evidence based thinking at the level of everyday practice to all activities of a health system.”

(ISTAHC), International Society for Quality (ISQua), ExPeRT (European Union project on External Peer Review Techniques), European Forum for Quality Management (EFQM) European Quality Awards, and European Clearing House on Health Outcomes.

At the national level, several countries, including Belgium, Denmark, Norway, Sweden, and the United Kingdom have initiated national strategies for quality development. Most of them focus on development of quality of care. In other member states (Hungary, Poland, Romania and Slovenia), national quality and HTA structures have been set up which are acting as National Coordinating Centres for quality development. In the field of accreditation particularly, several programmes are operating at national level in Croatia, France, Germany, Ireland, Italy, the Netherlands, Slovenia, Spain and the United Kingdom.

National societies for quality in healthcare have been established in Austria, Belgium, Denmark, Germany, Greece, Hungary, Ireland, Italy, the Netherlands, Norway, Poland, Spain, Sweden, the United Kingdom and Yugoslavia. In some countries of central and eastern Europe and newly independent states (Bosnia & Herzegovina, Estonia, Kazakhstan, Kyrgyzstan, Russia and Uzbekistan) World Bank and USAID have initiated accreditation projects focused mainly on specific activities or subsystems such as primary healthcare or hospitals.

The new concept of quality development

In line with current reforms within the Regional Office and the new country strategy of ‘Matching services to new needs’, the former Quality of Care and Technologies programme has broadened its scope to become the Quality of Health Systems (QHS) programme. The quality concept is based on a system approach which aims to optimise interaction between all parts of the health system. The development of quality is based on management of stability or minimisation of variation (quality assurance) and progressing upwards in a spiral of continuous quality improvement. The main idea of the quality programme is to apply evidence based thinking at the level of everyday practice to all activities of a health system. In this context the QHS programme will advocate that:

Quality should be considered in all components of the health system

It should encompass not just the field of care provision but all activities pertaining to the promotion, restoration and maintenance of health. Also, it will focus on a country framework rather than on individuals, clinicians or health centres.

Health system quality should be approached in its complexity as an interface between quality at the ‘macro level’ and ‘quality/best practice level’

This means tackling different dimensions and components including:

- service organisations (standards,

- accreditation, documentation)
- finance (budget reports, payment systems and control mechanisms)
- technical performance (external quality assurance systems)
- clinical practice (internal self assessment, clinical audit, guidelines, indicators)
- clinical training (curriculum, licensing, certification, accreditation)
- citizen and patient satisfaction (well-being, rights, empowerment)
- safety and health protection (legislation, inspection, risk management)
- linked quality information systems (indicators, databases, standards, tools, evidence)

A broader scope should be applied to quality values

In addition to best outcomes, safety, equity, effectiveness, efficiency, appropriateness, access, user choice, acceptability and availability are now all being taken into account.

Countries should identify an appropriate mix of values and design quality programmes by making choices and trade-offs in accordance with their priorities and circumstances.

The involvement of all stakeholders

In addition to politicians, health administrators and professionals, payers, users, other interested local and international parties, particularly the EU, World Bank, industry and NGOs should be approached.

Links should be established with health technology assessment institutions and programmes

Health technology programmes are crucial for helping health systems to select and do the 'right things' and the quality development programme has to ensure adequate mechanisms to monitor and evaluate continuously to ensure that things are done correctly. Joint activities between the Regional Office and ISTAHC have been planned for setting up national comprehensive strategies for health technology assessment and quality development.

Challenges for development of quality in health systems

The development of quality is difficult and progresses slowly, requiring fundamental change in the health system. It must bring together, in a common strategy framework, four main players: healthcare providers, health authorities, consumers and payers, taking into account that each group has its

own vision and expectations of quality. Other challenges are related to the difficulty in measuring quality, generating valid information, and making policy decisions, given the inadequate, incomplete or ambiguous evidence available. In implementing quality programmes, an appropriate mix of incentives and sanctions, and an acceptable mix of quality components, should be requirements for the development of quality in accordance with country specifics. That is to say, quality has a limited meaning within a given culture, social structure, level of development and organisation.

Future strategies

The strategies for development of quality in health systems in Europe should aim at:

- Advocating and supporting the development of national strategies, policies and programmes on quality in the countries of Europe.
- Creating a framework for quality development policy based on best practice and 'model cases' in the countries, and enhancing research to ensure evidence for quality development.
- Developing coherence and cooperation with other quality initiatives and programmes in the European region, particularly with ISTAHC, accreditation agencies and European associations for quality.
- Developing quality information tools and systems and promoting incentives to encourage rewards for quality.

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HTA in Denmark:

The connection between health technology assessment and continuous quality development



Steen Henrik Sandø

The history of health technology assessment and the history of continuous quality development both go back many centuries, and although they derive from different origins they have many similarities. Where the health technology assessment could be defined as “What is the right thing to do?”, continuous quality development could be defined as “Do we do it in the right way?”. The nature of continuous quality development differs from health technology assessment. While health technology assessment systematically seeks new knowledge in order to evaluate a technology, continuous quality development systematically reviews data to ensure optimal use of new validated knowledge. Both however, require methodology based on sound scientific principles.

The purpose of health technology assessment is to inform technology related policy making in healthcare. Health technology assessment should be carried out by interdisciplinary groups. Health technology assessment can be described as an evaluation of:¹

- Technical properties, such as performance characteristics, conformity with specifications and standards and reliability.
- Safety as a judgement of the risk associated with the use of the technology.
- Efficacy and/or effectiveness. Efficacy refers to the health outcomes provided by the technology. Effectiveness refers to the benefit of using the technology for a specific problem under routine conditions.
- Economic attributes or impacts.
- Social, legal, and/or political impacts. Health technologies may raise social and ethical concerns.

Corresponding to health technology assessment, quality can be defined by²

Efficacy: the ability of care, at its best, to improve health.

Effectiveness: the degree to which attainable health improvements are realised.

Efficiency: the ability to obtain the greatest health improvement at the lowest cost.

Optimality: the most advantageous balancing of costs and benefits.

Acceptability: conformity to patient preferences regarding accessibility, the patient-practitioner relation, the amenities, the effects of care, and the cost of care.

Legitimacy: conformity to social preferences concerning all of the above.

Equity: fairness in the distribution of care and its effects on health.

Quality can be divided into the quality of:³

- Structure
- Process
- Outcome

Where structure is concerned with the buildings, equipment and the human resources, process is related to the process of care and the outcome is related to the health impact. In the Danish National strategy for Quality Development,⁴ quality is described as:

- a high degree of professional excellence;
- efficiency in the use of resources;
- minimal risk to the patient;
- patient satisfaction;
- the final health impact.

The process of quality development is described as:

Goal setting which means defining criteria and standards for quality

Quality assessment meaning defining indicators of quality, and collecting and analysing data, and giving feedback to care providers. Data collection and analysis mean both identifying the best results and thus the processes and structures conducive to them, and when the quality of care does not meet the criteria or standards set, finding reasons and solutions.

Quality improvement meaning developing and taking action.

“The use of meta analysis provides us with knowledge that could not have been obtained in any other way.”

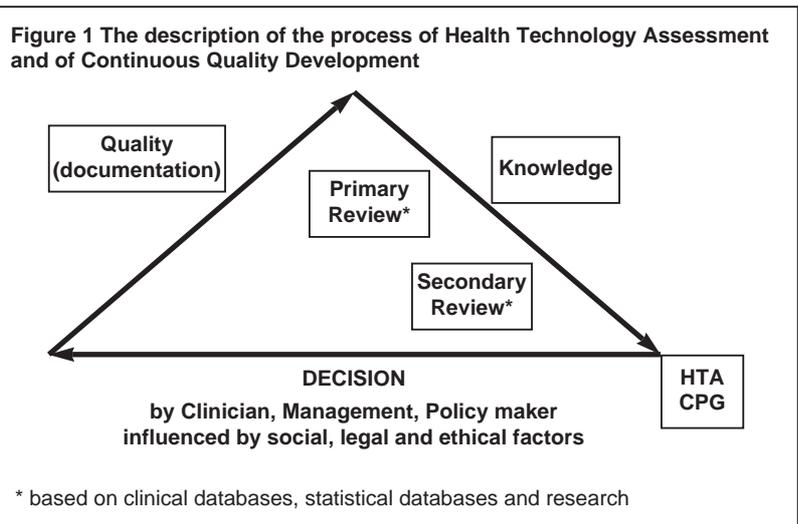
Follow up meaning monitoring and evaluating the impact of the action taken, continuously monitoring and assessing the quality of care, and identifying positive outcomes in order to update the quality criteria and standards.

As described above there is an overlap between health technology assessment (HTA) and continuous quality development both in methodology and definitions. Figure 1 shows a model of health technology assessment. A health technology assessment starts with the documentation, continues with the primary review of knowledge acquired by existing data sources such as research, clinical databases and healthcare statistical databases, leading to the proposal of Clinical Practice Guidelines (CPG), and ends with the decisions based on social, legal and ethical factors.

The process of continuous quality development contains the same elements, starting with the clinical practice guidelines and the results of the health technology assessment, criteria, standards and indicators are developed. This is followed by documentation in clinical databases followed by secondary review of the collected knowledge. This review should be followed by a revision of the Clinical Practice Guidelines. After this the circle is repeated. As a consequence, continuous quality development can be seen as continuous or repeated health technology assessment. Some basic requirements of continuous quality development should be observed:

- When clinical practice guidelines are developed evaluation of the guidelines must be included.
- For the acceptance of quality development staff participation and commitment is mandatory.
- Professional acceptance of the developed standards and indicators is necessary.

Even though there are many overlaps between the theory and the implementation of health technology assessment and continuous quality development, there are some basic differences. Health technology assessment has a long tradition for basing the knowledge acquisition on evidence based medicine in the form of meta analysis. There has lately been a discussion about the problems of selection bias and publication bias of this type of analysis. Continuous quality development is primarily collection data through the use of clinical databases. Over recent years several studies have reported on databases constructed for continuous quality develop-



ment that have been used in evaluation of technology^{5,6} It is however known that the collection of data from a daily clinical setting normally will cause problems with the validity of the data. Experiences have shown that through quality assurance and external evaluation of the data collection these problems can be solved. It is certain that the use of meta analysis provides us with knowledge that could not have been obtained in any other way, but the implementation of clinical documentation systems and the use of continuous quality development might lead us to a more scientific and solid solution based on practice data.

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From unconscious incompetence towards conscious competence: Quality improvement in healthcare in the CEECs



Laszlo Gulacsi



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Ales Bourek

“There is no evidence that we are better today at applying what we know than we were 30 years ago.”

East-West life expectancy gap: the possible role of quality improvement

Life expectancy at birth in EU countries for males as well as females is five to ten years longer than in most of the Central and East European Countries (the CEECs), and that between 1990 and 1995 the gap has widened instead diminished.¹ As Jozan et al point out, “In the first decade of the 20th Century, men and women in the Netherlands could expect to live about 10 to 15 years longer than Hungarian citizens.”²

Improving effectiveness of healthcare is among the main goals of quality improvement (QI), and might provide a positive contribution to the population’s health status. Some indirect evidence shows that the East-West life expectancy gap is, at least, partly due to the lack of effectiveness of medical care in the CEECs.³

A number of factors might have direct implications for health:

Increasing complexity of medicine:

This is an issue identified by Brook et al: “Although the likelihood that a person will benefit from medical care is better now than it was a third of a century ago, largely as a result of investment in basic science and clinical research, there is no evidence that we are better today at applying what we know than we were 30 years ago. Indeed, we may be worse because the complexity of medicine has increased so greatly.”⁴ Massive diffusion of healthcare technology has occurred in the CEECs since 1990, and the complexity of medicine increased rapidly within the last two to five years.

No systematic method to translate scientific evidence into clinical decision making and clinical practice:

Commonly used interventions in different areas are either definitely ineffective or

probably ineffective. Research findings indicate that a great deal of ineffective technology is in use, and/or effective technologies are frequently over used and/or under used.

Medical errors:

As Berwick points out: “Between three and four per cent of hospital patients are harmed by the care that is supposed to help them. ... We estimate that between 44,000 and 98,000 Americans die in hospitals each year as a result of errors in their care.”⁵ Although no information about medical errors is available in the CEECs, this argument may be relevant to the CEECs.

Inconspicuous incompetence: the socialist era

In the socialist era, the quality of healthcare in the CEECs was declared by the communist parties and the governments as the best in the world. Reerink saw the situation correctly when he wrote, “Formal quality assurance programmes were not possible under former socialist governments for ideological reasons.”⁶ Not only was it not allowed to criticise the quality of healthcare, but it was not possible to analyse and investigate it, as data that would have enabled such analyses were partly non-accessible and partly not usable for researchers.

Quality improvement in the CEECs 1990–2000

In 1993, the representatives of medical societies in the CEECs agreed upon the quality improvement targets of the World Health Organisation and signed the ‘Recommendations for National Medical Associations Regarding Quality of Care Development’ that were endorsed at The European Forum of Medical Associations and WHO.⁷

Quality improvement in the CEECs was initiated by the European Concerted Action Programmes on Quality Assurance in Hospitals, COMAC/HSR/QA and BIOMED/PECO, which were part of the Medical and Health Research Coordination Programme of the European Commission. These were multi-centre comparative studies on different QI strategies and their effect on improvement of care with respect to:

- (a) preoperative assessment in surgery;
- (b) prevention and treatment of bedsores;
- (c) keeping patients record;
- (d) prophylactic antibiotic use in surgery.

Altogether, 465 hospitals participated between 1992 and 1997 from 14 European countries, mainly Member States of the European Union. Hospitals from CEECs were involved: 37 from Hungary, 67 from Poland, 25 from Russia and two hospitals from the Slovak Republic.

Professionalisation

Societies on QI were established in Hungary (1992), in Poland (1994), in Yugoslavia (1995) and in Lithuania (1999).

Legislation

As required by the 'Act 154 of 1997 on Health Care', QI is increasingly present in the daily work of the Hungarian hospitals. The Lithuanian National Health Concept and Health Programme gives priority to healthcare quality and effectiveness. Issues related to quality and effectiveness is considered in existing regulations in Poland and Russia. In the Czech Republic the responsibility of the Medical Chamber is to look after the quality of medical care.

Institutionalisation

Institutionalisation of QI started in Poland where the National Centre for Quality Assessment in Healthcare (NCQA) was created in 1995. NCQA is developing evidence based practice guidelines and running a successful accreditation programme. In the Czech Republic, the National Board for Medical Standards evaluates the current state of the medical guidelines and converts them into standards of effective medical care. In Hungary the Ministry of Health and the National Health Insurance Fund have departments dedicated to QI. The Hungarian Healthcare Quality Award was launched recently. In Slovakia, in 1996 the Ministry of Health accepted the concept for development of a national policy for QI, and in 2000, the Centre for Quality and Accreditation in Healthcare was created. The State Healthcare Accreditation

"Quality improvement should be identified as an important tool of health policy and planning."

Service under the Ministry of Health in Lithuania has recently begun to operate.

Towards conscious competence

Based on the findings of the QI studies in the CEECs the following recommendations can be made:

(a) Quality improvement should be identified as an important tool of health policy and planning. According to the Hungarian experience, some form of QI activity has to be in place in order to allow for a particular problem, and the extent of the burden it creates needs to be identified. The example of studies on pressure ulcer (PU) showed that the real problem is considerably worse than expected. The prevalence of PU is 16 to 27 times higher than the published rate (3.7 to 5.7 per cent, as opposed to 0.18 to 0.21 per cent).

(b) A national QI policy should be formulated. Long term strategic goals have to be clear and known. This policy should clearly separate areas where QI should have an important role from areas within the healthcare system where other types of activity – such as management or finances – have priority.

(c) A good professional body on QI, supported by a strong QI research capability is necessary to achieving improvement.

(d) More comprehensive data collection is needed as a routine in healthcare settings. In the CEECs, 80 per cent of time and resources have been spent on collection of basic data of limited utility and quality checks on these data. Further QI activities will be very difficult to implement without more focussed and structured data of good quality. Data collection and processing have often been successful, but interpretation and presentation of findings have often been forgotten, contributing to a lack of intervention.

(e) Steps have to be taken in order to achieve the support of the healthcare professionals and their professional organisations. Quality of care cannot be improved without the active involvement of the professionals.

(f) All of these strategies point to the need for more education and training in the field of QI.

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The need for cost effective quality improvement interventions



David Banta



Laszlo Gulacsi

Need for evaluation of the effectiveness, cost and cost effectiveness of quality improvement programmes

The articles in this section have indicated that quality improvement (QI) is a very important tool. However, the same or similar goals might be achieved through the implementation of very different QI programmes. Structure, process and outcome orientated programmes can be used separately or in almost infinite combination. Numerous process and/or outcome indicators can be used and various educational, training, regulatory and control methods can be implemented. There are many ways to improve the effectiveness of QI, for example to improve cost effectiveness. Administrative, financing and regulatory tools can be used, licensing, accreditation, peer review, audit and guidelines are common tools. Healthcare settings have to implement effective and cost effective QI programmes to improve their capacity to provide cost effective services.

The role of QI

As already discussed in these papers, the main aim of QI activities is to improve the actual benefit of a given healthcare service where there is the possibility of achieving further benefit. This is a rather narrow, but very practical focus of QI, which is used in this paper.

QI is part of medical technology

According to the definition of the US Office of Health Technology Assessment (OTA, 1978) the "Medical Technology: The drugs, devices, and medical and surgical procedures used in medical care, and the organisational and supportive systems within which such care is provided." QI is just one more health technology competing for scarce healthcare resources. It is an organisational technology, well within a standard definition of technology, and it should be subject to rigorous assessment, in the manner now properly being demanded for all health technologies. QI is not free of

charge. It requires staff, clinicians' time, facilities, equipment, information and other resources. All these resources might be used in other ways, such as to treat patients, to undertake clinical research, or to engage in education or professional development. In the long run, the investment of healthcare resources in QI activities has to be justified by results.

Judging quality and cost

There is no general understanding and agreement on the meaning of quality and cost. The term 'quality' is used in many different ways. In fact, QI does not often focus on health outcomes. Most QI activities have dealt with the structure or process of care.

There is also a lack of clarity in definitions of cost. Is it direct, indirect, average, marginal, incremental or opportunity cost? Each of these has a very different meaning. Is it the cost of poor or good quality? Poor quality is expensive and a waste of resources while improvements in quality can reduce costs and might be considered as investment instead of expenses. Pure data on costs of quality are impossible to interpret and cost information without understanding of quality is meaningless.

Towards cost effective QI

To create cost effective QI interventions, four challenges have to be faced. Good information is needed on:

- effectiveness (both achieved and achievable) of healthcare interventions;
- effectiveness (both achieved and achievable) of QI interventions;
- cost;
- cost effectiveness of QI programmes.

First challenge – effectiveness of healthcare

It is clear that information about the effectiveness of present healthcare interventions is often lacking. The actual performance of the care processes can only be described in qualitative terms and virtually no quantita-

"Quality improvement can be seen as a mirror confronting healthcare providers with the results of their work."

tive data on actual effectiveness can be found.

Given limited resources and the difficulties in changing professional behaviour, QI activities should be focused on those areas of clinical practice where good evidence exists and change would be worthwhile. Measuring the size of the gap between efficacy and effectiveness is crucial. Efficacy shows the maximum benefit achievable by a given intervention under idealised conditions; effectiveness show the actual benefit achieved under actual conditions. Due to the different conditions, especially the patient sample (co-morbidity, severity of illness) and settings of care, efficacy as defined by randomised clinical trials can rarely be achieved. There are differences in the actual effectiveness due to the limited availability of resources (financial resources, knowledge, staff); differences in the health or sickness of patients, and differences in the appropriateness and effectiveness of the quality assurance tools. The achievable benefit of every given situation has to be defined carefully, by benchmarking in any given QI programme.

Policy makers and administrative and clinical decision makers at all levels need this information. The marginal utility of additional spending may be quite low. Large differences between efficacy and effectiveness can point the way to significant cost effective interventions to improve quality within a relatively short time frame.

Second challenge – effectiveness of QI interventions

Another challenge is to find information on the effectiveness of investment in QI strategies. As it was pointed out by Donabedian,¹ there is very little information available on the effectiveness of QI. Developing information indicates that a great deal of ineffective and/or non cost effective quality assurance activity is in use in healthcare.

The level of achievable benefit has to be defined, predicted and explicitly stated within all QI programmes. Achievable benefit, as a crucial cornerstone of every QI activity, has to be tailor made. Different aspects have to be taken into consideration, for example, the size, location and teaching status of the hospitals or other healthcare settings.

Although there is some evidence of the efficacy of various QI tools (for example, medical audit, peer review, accreditation status) there is little evidence of their effectiveness. According to the literature, for

instance, evidence is available to show that practice guideline setting and implementation is a good tool in changing physicians' behaviour and probably to improve health outcomes.²

Third challenge – economic costs

Studies conducted in industry show that the cost of quality is estimated to equal 20 per cent to 40 per cent of the total organisational costs.³ These costs are due to the waste incurred through poor quality and unnecessary work, rework waste and redesign waste. In healthcare, the cost of providing quality care, including the price of conformance and the price of non-conformance, was estimated by Berwick et al. to consume up to 50 per cent of all healthcare costs.⁴

Unfortunately, very few studies on the cost of quality are available and most of them are incomplete and suffer from various methodological weaknesses.⁵ Development of guidelines and other QI tools has largely ignored the issue of costs.⁶

Fourth challenge – cost effectiveness of QI programmes

According to the literature very little is known about the cost effectiveness of QI programmes, due to the lack of data on quality of care and its outcome and the cost implications of different alternatives. However, this probably means a lack of evidence rather than a lack of cost effectiveness of all QI interventions.

Accountability of QI

Further development of QI requires information about its results, costs (cost per unit of additional benefit has to be calculated – incremental cost) and cost effectiveness. New evidence needs to focus on the cost effectiveness of improvements in the 'real world' (how should it be done?). Increasingly, studies on the effectiveness of QI programmes have to include consideration of cost effectiveness.

Quality improvement can be seen as a mirror confronting healthcare providers with the results of their work. The time has come to hold up the same mirror to QI programmes, evaluating their effectiveness and probably most important, demonstrating their cost effectiveness. On the one hand, this is required by 'clients' of quality endeavours: providers, purchasers and patients; on the other hand, this has become an increasingly important factor for quality professionals trying to promote their work.

“Very little is known about the cost effectiveness of QI programmes.”

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Nursing in the WHO European Region in the 21st Century



Ainna Fawcett-Henesy

“Nurses and midwives are voting with their feet and leaving the professions in droves.”

In January 2001 the WHO Executive Board,¹ which comprises representatives of 32 of the 191 member states, had a lengthy discussion on nursing and midwifery globally. It was acknowledged that nursing and midwifery are in crisis worldwide and that there is an urgent need to tackle the root cause of the problem. Minister after Minister spoke passionately about the importance of the profession in helping Governments to tackle the health and sickness needs of the population of the respective countries. The unique role of the professions in addressing the issue of accessibility to the healthcare system, for the more vulnerable, was strongly emphasised by many. It was however acknowledged that words of encouragement, important though they are, are no longer enough in themselves. One of the member states called for an action plan that addresses the problems within the professions not least the issue of recruitment and retention. This in turn means tackling the issue of better pay and working conditions, greater acknowledgement of the autonomous role of the professions, capacity building and a recognised role in research as well as influence at the policy making level.

The Regional Directors from the WHO regional offices added their support to the debate in very positive terms. Consensus was reached that Nursing and Midwifery should be on the agenda at the World Health Assembly, the Ministerial meeting of the 191 countries in membership with WHO in May this year. A Resolution and an Action Plan is proposed for the meeting.

European Ministerial Conference on Nursing and Midwifery

In June 2000 the WHO European Regional Office for Europe demonstrated its own commitment to the professions by organising a Ministerial Conference² to discuss

and debate the concerns and aspirations of the professions. Ministers, or their representatives, attended from 48 European member states. Each delegation endorsed the Declaration³ which emanated from the event and which summed up what needs to happen if nursing and midwifery are, firstly, to continue to be professions to which people are attracted and wish to remain associated with; and secondly, if the profession is to continue to add value to the health of the population of each country. It was a successful event as demonstrated by the standing ovation when the then Minister of Health for Germany symbolically signed the Declaration on behalf of all Governments and the Regional Director of the WHO Regional Office for Europe signed it on behalf of WHO.

In many ways the debate at the Executive Board echoed that of the Munich Conference. Nurses and midwives are voting with their feet and leaving the professions in droves, in particular in Western Europe. Almost every country in Western Europe has a nursing and midwifery shortage.

Worse still those who may previously have chosen nursing and midwifery as their preferred career option are looking elsewhere. The outcome is huge staff shortages, inadequate cover for clinical areas which in turn means those who remain are having to work twice as hard and provide far lower standards of care than they would wish. This results in an unfulfilled and disillusioned workforce, as many of the surveys point out. This situation has also resulted in industrial disputes in many European countries the latest of which has been in Poland where during the Christmas period, disillusioned nurses occupied government buildings and brought traffic to a standstill in the capital, Warsaw.

The picture at face value looks gloomy. Yet despite all the negatives, the vast majority of nurses and midwives seem to be pushing back the frontiers and doing their utmost to manage the crisis and develop their roles in a changing healthcare world in the European region. The lead up to the WHO Ministerial Conference on Nursing and Midwifery in Munich in June 2000 provided a useful opportunity to do a stocktake on where nursing and midwifery is positioned at the beginning of the 21st century. Numerous conferences and summits over the previous decade, advocated a range of developments in education, practice, management and research. But perhaps the overriding recommendation at all these past events was that nurses and midwives should be acknowledged as *autonomous* and *distinct* but complimentary to other healthcare practitioners.

Indeed the first ever WHO European conference on Nursing and Midwifery held in Vienna in 1988⁴ included a Declaration with a long list of issues that needed to be addressed both within and outside the professions if nurses and midwives are to contribute in an effective way to meeting the health and related needs of the populations of the European region. Key was that nurses and midwives should be a resource to the public and that their practice should be based on the principles of primary healthcare as espoused at the Alma Ata Conference in 1978.⁵ Owing to their intimate knowledge of the needs and wants of patients and their families as well as the very personal nature of their work 24 hour a day and in every setting, it was believed that nurses and midwives should play a key role at all health policy making levels.

The analysis⁶ or 'stocktake' undertaken in the 51 member states of the WHO European region was illuminating. Some countries had really demonstrated that they had listened to the various debates on nursing and midwifery and had taken appropriate action. For example in the Scandinavian countries, the Netherlands, and the United Kingdom nurses and midwives are in receipt of a much more rounded education and on a continuing basis too. Many countries are now educating nurses on 3-4 year programmes, beyond 12 years secondary education, at university level in line with WHO policy. Nurses and midwives are also availing themselves of advanced education at Masters degree level. More nurses than ever before are studying for PhDs.

As part of the healthcare reform movement

many countries have amended their legislation, which has in turn allowed nurses and midwives to practice in more autonomous roles. Such new legislation and regulation, in some instances, requires nurses to base their practice on research evidence as in Austria as well as apply health promoting principles and practice in their work with patients and clients.

In line with increased decentralisation, nurses and midwives are now being employed in several countries as independent contractors, in particular in primary care. This arrangement may be on an individual basis or through agencies established by groups of nurses. Such independent contractual agreements are either with health insurance funds or with regional health authorities and some are even with family physician practices. This is not only happening in the western part of the region but also in countries of central and eastern Europe, such as in Poland⁶ and Croatia.

New Roles for Nurses and Midwives

Primary healthcare is the preferred approach⁷ for most countries as they reorganise their health systems. Hospitals across the region continue to be rationalised in size and numbers. In-patient stays are becoming shorter and shorter⁷ with often only the very sick being admitted to hospital and as a consequence necessitating very good follow up home care services. The role of the Family Physician is becoming much more commonplace across the region with him/her acting as gatekeeper to the hospital services. Substitution is also becoming the norm and many of the activities that were previously carried out in hospital are being carried out in the community. Nurses are beginning to assume roles previously perceived as the prerogative of the physician. In the same way nurses are transferring some of their responsibilities to other professionals and to healthcare assistants. Vast areas of care are also taking place in patients' own homes, clinics and on the premises of the family physician. There is also a gradual move to promote self-care and give more responsibility to families and carers.

Nurses are increasingly moving from the hospital to the community and health promotion and illness prevention are becoming an integral part of their role. There is some good evidence of nurses and midwives developing partnerships with the community, working alongside them, helping them to solve their own problems. Working with the voluntary sector is also on the increase,

"Nurses are beginning to assume roles previously perceived as the prerogative of the physician."

“Many countries are now educating nurses beyond secondary education, at university level. ... More nurses than ever before are studying for PhDs.”

an important new development as this sector increases its role in service provision. Nurses are also beginning to work more effectively in integrated teams of physicians and others.

In some countries nurses are taking a more crucial role in primary care, acting as front line workers and only referring to the family physician when the needs of patients and families can be met more adequately by his/her expertise.

In the *United Kingdom*, nurses, through the advent of the Primary Care Trusts, are managing the whole primary care service and are employing doctors, social workers and others to provide comprehensive care to individuals and families. Nurses in *Iceland*⁸ are undertaking the direct access Nurse Practitioner role and nurses in *Sweden* are assuming innovative leadership roles with the elderly population at regional level. Nurses are also establishing open access clinics for the more vulnerable, those with mental health problems, those who misuse drugs and those who are for whatever reason without a home. Nurses and midwives are also providing sensitive services for refugees, newly arrived immigrant groups such as for the Ethiopian community in *Israel* and for those who are reluctant or feel unable to use the regular health services on offer. Midwives in *Austria* have created unique personal midwifery services for the family preparing for the birth of a baby. With an increasing elderly population nurses are re-engineering old services as well as designing new services including

outreach services for the elderly. Nurses in *Belgium* have for example developed new services for the elderly mentally frail so that they can stay in their own homes for as long as possible, yet not be a burden to the family.

Nurses in *Ireland* have worked with the travelling community, a section of the population with the worst health problems, to agree together what are their needs and helped develop the most appropriate services to meet them.

Nurses and midwives in *Finland* have helped women and their families to access a whole wealth of information through the internet to make the experience of childbirth and afterwards an informed and a happy experience.

Conclusion

Nurses and midwives are making concerted efforts to develop their roles in line with the needs of the respective populations of their countries. They are also in many instances showing demonstrable improvements in the health gain agenda. Yet often such achievements are ignored and rarely is money forthcoming to ensure sustainability. Is it any wonder therefore that the profession feels disillusioned and undervalued? As was evident during the lead up to the Munich Conference and during the meeting itself, there is no lack of goodwill from the professions. What has been truly lacking is political will. Despite the warning signs over many years of an imminent crisis in nursing and midwifery recruitment and retention, little notice was taken. These problems will not go away overnight unless their root cause is tackled.

At the Munich Conference in June last year, the enthusiasm and commitment of those present to ensure that nurses and midwives maximised their efforts in the interests of meeting the health and related needs of the people of Europe, were electrifying. A whole set of achievable recommendations was set out in the Munich Declaration. These included tackling the obstacles to progress for example medical dominance, education, legislation, regulation, developing a research and evidence base for the profession and most importantly nurses and midwives having a place of influence at all policy making levels. Without doubt if each member state took each of these recommendations seriously the current crisis could be averted and a profession fit for its purpose could lead us safely through 21st Century

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Nursing and its developing role: A British case study

The UK Government published its National Health Service (NHS) Plan for England at the end of July 2000.¹ This plan is the blueprint for how the Government wants the NHS and social services to meet health and social care needs for the next ten years. The main theme underpinning the plan is that of ‘modernisation’ – requiring fundamental changes in attitude and culture.



Pippa Gough

“The power base within the health service is beginning to shift.”

It is a rare moment when there is a coming together of ideas and beliefs, as has happened with nursing and Government policy over recent years. Nursing’s credo is founded upon being patient centred and upon social justice. Essential to these ideas are equality of access, compassion and humanism, and the promotion of patient autonomy. Putting the person back into patient care has been at the heart of nursing innovation over the last 20 years. And now so much of nursing’s agenda – of what we think is important in the way care is delivered – suddenly resonates with the present Government’s modernisation programme.

Opportunities for nurses

The opportunities opening up for nursing and nurses are huge. The power base within the health service is beginning to shift. This is especially apparent with innovations such as the nurse-led telephone triage service in England known as NHS Direct. This is nursing at its creative best with nurses being free right from the start to develop a brand new service, unrestricted by the structures and structures of the past. The service not only enables nurses to become the new gatekeepers of the NHS. It is also pioneering a model of healthcare that is driven by what people want and how people live their lives today.

Further opportunities include:

- Nurses taking up posts in the planning and commissioning of healthcare.
- The introduction of consultant nurses.
- Investment in nursing leadership.
- The development of new and comprehensive intermediate care services.
- The creation of the ‘modern matron’ where senior clinical nurses are given more responsibility and authority to

organise and develop the environment of care.

- A focus on patient centred measures of quality.

All of these things recognise the enormous potential of nurses and nursing to develop modern patient centred care and patient centred services. And yet there are some enormous challenges that must be addressed, for instance:

- The nursing shortages. Despite a Government promise in the NHS Plan of 20,000 more nurses by 2004, there are currently 21,000 nursing vacancies in England alone.² We cannot underestimate the scale of recruitment and retention that lies ahead.
- The development of 5,000 new intermediate care beds. The predominant therapy in intermediate care is nursing. How do we create quickly the nursing workforce to design, manage and lead this vital component of care?
- The perennial issue of pay and reward. If you want nurses and nursing to change and modernise our health services then pay is a crucial factor. Many senior nurses are leaving the NHS citing low pay as a significant factor.

Changes in culture and attitude

The Government has identified changes in culture and attitude within the health service as the key factor for successful modernisation. Investment in nurses and nursing and achieving this change are two sides of the same coin. The Government’s concerns are that the NHS has been too professionally dominated for too long. This inhibits more patient centred care where the patient has a major say in decisions about the care he or she receives.

Moreover, there exists a pressing political imperative to stop the recent scandals and horror around professional neglect, incompetence and misconduct. There is now a growing loss of trust and confidence by the public in the health professions to provide safe and effective care. This isn’t confined just to doctors – nurses too are tainted. The

“We cannot under estimate the scale of recruitment and retention that lies ahead.”

Government has to be seen to improve standards of patient care generally and to overcome unacceptable variations in efficiency, access and outcomes of care from place to place. There is a determination both in the Government and among the public to see the professions brought to heel. There are moves in the NHS Plan to develop competence assessment linked to systems of clinical governance and to introduce revalidation for doctors and the review of re-registration for nurses. The changes to our systems of statutory regulation are all part of this.

Linked to all these issues is an urgent need to address shortfalls in the workforce. We are all being urged to break down professional boundaries, to work more flexibly, to be less tribal and to develop new roles. The emphasis here is on how the patient can be served best through new ways of working – not on shoring up old professional demarcations and engaging in endless turf wars.

The future of the professions

Implicit within modernising is the notion of change. ‘Traditional’ practices – ways of being, thinking and doing – must be re-examined. But there is a paradox here. For despite nursing and nurses finding themselves very much in sync with Government policy, and seeing nursing come of age in political minds, we are also being asked to discard much of what we have subscribed to in terms of professional identity. That is not to say that empowering patients and making them centre stage was not overdue but it is to recognise that part of this approach is to unpick the professions and the old style model of professionalism. So whilst celebrating the role that nurses and nursing have to play we must also look deep into our hearts to ask whether we are ready to deconstruct some of the beliefs, the mores, the attributes that are at the very core of the professional model to which nurses have for so long aspired.

Professor Celia Davies has argued that nurses in search of professional status have looked to the ‘old professions’ such as medicine and law for a lead and have ended up subscribing to a model of ‘old professionalism’.³ She argues that the this model is characterised by elitism, paternalism, authoritarianism, highly exclusive knowledge, control and detachment.

She goes on to argue that aspiring to this professional paradigm creates real tensions for nursing. Progressive nursing espouses a

whole different set of values. Best nursing practice is characterised not by paternalism but by partnership; not by authoritarianism but by collegiality and collaboration; not by a mastery of knowledge but by shared and borrowed knowledge and by reflective practice and lifelong learning; not by aloofness and detachment but by engagement; not by control but by empowerment – of self and others. Celia suggests this is the basis of a ‘new professional’ model; a new professional identity. Many of these attributes of the ‘new professions’ are at the heart of the Government’s modernisation agenda – issues of partnership, lifelong learning, flexibility, and collegiality.

The professions as we know them are a social construct that emerged from 18th and 19th century society. That society has now moved on. We are in a new era characterised by consumerism, citizenship and new democracies. We are now seeing new professions emerge. People will always need nursing and nursing care. Our biggest challenge in modernising is to ensure that they receive this in the most compassionate, humane, well informed and competent way. Our professional identity should be founded on this.

Leadership

The NHS Plan places significant emphasis on leadership as a major vehicle for change and developing new roles. The approach that is being espoused is of transformational leadership – where leaders work to enable others to change and cope with change. It is only through this type of leadership that the desired culture and attitudes will become reality. The position of the professions is, arguably, increasingly unsustainable. Our old professional frameworks are no longer a suitable vehicle to deliver the type of care that is expected and needed. But our first step is to transform ourselves.

There are therefore some tough questions to be addressed. If enabling people around us to cope with change is dependent upon transforming ourselves first, how far along the road of this personal journey are we? How far are any of us along the path of that emotional and intellectual change; of stepping out of old professional ways of being, thinking and doing; of changing our beliefs and ideas about who we are and how we do what we have always done; of letting go of old certainties and being courageous enough both professionally and personally to view the world through a different lens?

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The role of the Community Chief Nurse in the Swedish municipalities



Marianne
Lidbrink

The function of the Community Chief Nurse (CCN) was established in Sweden with the implementation of the so called Care of the Elderly Reform in January 1992. The aim of the reform was to give the municipalities more comprehensive responsibility for long term care, nursing, and services for the elderly and disabled. Through the reform, the municipalities have become financially liable for patients, who, when found to have completed their medical treatment, could not be discharged to their own homes owing to inadequate assistance or unsuitable housing. Hence, the municipalities became financially liable to pay for each day the patient remains in the hospital.

In 1995, the responsibility was broadened to apply to the mentally retarded and the long term mentally ill.

The aim of the Care of the Elderly Reform is to coordinate – into a common working organisation with a uniform direction – the social and medical expertise required to fulfil the responsibility of the municipalities as stipulated by the Social Services Act and the Health Services Act.

Hence, the municipalities were given medical responsibility, including the services of registered nurses, enrolled nurses as well as the services of physical therapists and occupational therapists.

The municipalities deliver care in so called assisted living environments, which include facilities such as nursing homes, group homes for patients with dementia and for retarded people, group homes for the long term mentally ill, and day activities. Furthermore, more than half of the municipalities in Sweden have also taken over the responsibility for home nursing, following agreements or contracts with their county councils.

Accordingly, the municipalities have, through the reforms, taken over a large part of the county council's responsibility for healthcare. The extent of the responsibility can, among other things, be illustrated with the aid of particulars concerning access to numbers of beds etc (see box).

The Community Chief Nurse has played and plays a key role in the implementation of the changes.

The Function of the Community Chief Nurse

According to the Health Services Act, §24, the municipalities, to meet their medical responsibilities, shall have a Community Chief Nurse who is responsible for the following:

1. that routines are in place to assure that a physician or other medical staff member is contacted when a patient's condition so requires,

Follow-up:

The physicians' work in primary health care is financed through taxes levied by the county councils. Elderly people, like anyone else in Sweden, have the right according to law, to have access to a general practitioner (GP). When the need arises for nursing in assisted living environments, experience shows that patients tend to lose contact with their GP. Special local agree-

In 1991 there were approximately 93,000 beds available under county council management, or 10.8 beds per 1,000 inhabitants.* Slightly more than 30,000 beds were transferred to the municipalities in connection with the change in 1992. During following years, the number of county council beds was reduced by a further 33,000 by 1998, corresponding to 3.8 beds per 1,000 inhabitants.** The figures should be seen in light of there being approximately 135,000 persons in so called assisted living environments in 1997 — a collective name for nursing homes, service flats (also known as sheltered accommodation) or group dwellings in the municipalities. In the same year, just over 145,000 persons with physical disabilities received some form of home-help service or care in their own homes.***

This development has been made possible not only because the municipalities have taken over a large share of the county councils' healthcare responsibility but also, among other things, technological development has facilitated shorter healthcare times. Day surgery and home care have, for example, become more common through refined operation and anaesthesia methods. New IT has improved communication between different healthcare units, also as far as healthcare in the home is concerned.

* Statistics — Health and Medical Care, Yearbook of Health and Medical Care 1998. The National Board of Health and Welfare, Stockholm 1998.

** County Council Statistics Yearbook 2000. Federation of County Councils, Stockholm, 2000.

*** Statistics — Social Welfare, Service and Care to Elderly and Disabled persons 1997. The National Board of Health and Welfare, Stockholm, 1998.

“Community Chief Nurses are unique to Swedish healthcare.”

ments between the municipalities and county councils are therefore needed to ensure that the elderly in these settings receive proper medical care. A survey has shown that collaboration works best where there are written agreements regarding the contributions from the physicians. In the same survey, directed towards the Community Chief Nurses, 70 per cent of them replied that such agreements exist but that there is still room for improvement.¹

2. that decisions to delegate responsibility for care activities are compatible with patient safety.

Follow-up:

A survey directed at the country's approximately 384 Community Chief Nurses (86 per cent response) showed that 72 per cent consider that the delegation of nursing assignments functioned well or very well, while 22 per cent consider that it functions less well or badly. When this is the case, this depends primarily on the fact that the assignments are delegated to too many individuals or that there are too few nurses in the enterprise.²

*3. that a report is made to the board in charge of medical services if a patient, in conjunction with care and treatment, is affected by, or exposed to the risk of being affected by serious injury or disease - Lex Maria.**

Follow-up:

In the years following implementation of the Care of the Elderly Reform, municipal healthcare noted a considerable increase in the number of Lex Maria complaints. The complaints primarily concerned mistakes or faults related to pharmaceutical treatment, surgical or pharmaceutical measures, and nursing issues. The greatest number of complaints was noted in 1994 – after this the numbers have diminished in the municipalities. The reduction here consists mainly of a reduction in the number of

pharmaceutical incidents. This reduction has progressed over several years and cannot be regarded as random, but almost certainly corresponds to the introduction of safer procedures in dealing with pharmaceuticals in assisted living environments.³ Other explanations may also be found, for example that, at the outset, the Community Chief Nurses reported incidents unnecessarily. Awareness of what is and what is not to be reported to the National Board of Health and Welfare** has improved.

Another statute requires the Community Chief Nurse to be responsible for the following:

1. that patients receive safe and appropriate care and treatment of good quality within the field of responsibility of the municipality.

Follow-up:

In the 1999 survey, 37 per cent of the Community Chief Nurses replied that it is possible always to guarantee safe and appropriate care and treatment. Fifty-two per cent state that they can only sometimes do this and only two percent consider that they can seldom do this. If there is a problem with guaranteeing safety, this is primarily due to inadequate resources and collaboration with other levels of care.²

2. that patient records are kept in accordance with the Patient Records Act.

Follow-up:

The patients in the municipalities are frequently in need of both health and social care. In Sweden this means that different occupational groups work according to different statutes implying that differing preconditions apply for the care. This also applies to the documentation. As far as the patient is concerned it is of little interest that this is the case. Regardless of the rules, one has the right to receive safe and appropriate care and treatment. A large part of the work of Community Chief Nurses has been to provide the requisite safe documentation. A survey from 1997 shows that 84 per cent of the Community Chief Nurses questioned work with quality related to documentation.⁴

The same statute also states that *patients shall receive the care and treatment prescribed by a physician and that there shall be appropriate, properly functioning procedures for handling pharmaceuticals.*

Follow-up:

As seen earlier, various surveys indicate that there are shortcomings with regard to physician participation and pharmaceutical handling in the municipalities, but that the

* Lex Maria – the regulations are to be found in the Health and Medical Services Act (Professional Activity) (1998:531) on occupational activities in the field of healthcare, and in directions and general recommendations in this field issued by The National Board of Health and Welfare (SoSFS 1996:23). A report is to be filed if a patient undergoing healthcare suffers or encounters the risk of suffering serious injury or illness. A great number of complaints regarding a certain activity need not indicate that the activity is extremely bad, but rather that the care provider has a properly functioning quality system capable of tracking and noting faults and deviations.

** The National Board of Health and Welfare is the governmental authority responsible for health and medical care issues, and serves as the expert body on these issues for the Swedish Government

Community Chief Nurses are working to bridge this with the aid of agreements and guidelines, etc.^{1,2,3}

Discussion

It can be established that the municipalities, during the 1990s, have been given several new roles and a particular responsibility in the issue of healthcare and nursing. Community Chief Nurses have had considerable importance for the safe and successful implementation of the changes.

However, with the detailed regulation of the function that only exists in municipal healthcare, Community Chief Nurses are unique to Swedish healthcare. They have a comprehensive responsibility while at the same time it is not a question of an executive function in its traditional meaning. A primary responsibility for the individual patient is not included in the function. On the other hand, they are liable to intervene in individual cases if this is needed to provide safe and appropriate care. The responsibility may be designated as supervisory and when carrying out the statutory assignments, the Community Chief Nurses are neither subordinated to the head of the enterprise, nor any other in the municipality.

The status in the organisation of the Community Chief Nurses varies considerably, which means that they still play many different roles. Twelve per cent of Community Chief Nurses are also heads of enterprises² with budget responsibility, which means that in this case the Community Chief Nurses supervise their own functions. There is presently an intensive discussion underway concerning the expediency of such an organisation.

Ever since the introduction of the Community Chief Nurse function, the Swedish Association of Health Professionals*** has maintained that the function is so comprehensive, that the potential to perform supervision is weakened if the function is splintered into a number of different roles. Initially it was

common that the municipalities employed the Community Chief Nurses on a part time basis, with employment, for example, as a nurse at a nursing home at the same time. The 1999 survey fortunately shows that the municipalities make better use of the potential provided by the Community Chief Nurses' function. The Community Chief Nurses are in general responsible for the presentation of reports to local political committees regarding healthcare issues.²

However, there remains potential to render healthcare more effective. A recently completed report, initiated by the Ministry of Health and Social Affairs, therefore proposes that municipalities and county councils shall have the right to form joint committees to solve their common assignments in the field of healthcare. One may assume that a solution that attempts to originate from the needs of the patient can greatly contribute to facilitate the tasks of Community Chief Nurses to ensure safe quality in healthcare.

The operations in the municipalities are exposed to constant development, as are the role and function of the Community Chief Nurses. The municipalities' healthcare and nursing responsibilities and the importance of this sector as a labour market for the occupational groups organised by the Swedish Association of Health Professionals, will play an increasingly important part in the near future. The Swedish Association of Health Professionals therefore follows and participates continuously in the discussions and development of municipal healthcare. As part of this, the Association has developed a standard: ProCare – proper care of elderly patients, consisting of a number of quality criteria that together express what the Swedish Association of Health Professionals believes is the minimum quality acceptable for healthcare of the elderly.

“The status in the organisation of the Community Chief Nurses varies considerably, which means that they still play many different roles.”

*** Swedish Association of Health Professionals organises 93 per cent of all registered nurses, registered nurse midwives, biomedical scientists and radiographers in Sweden. The purpose of the Association is to represent its 110,000 members in professional and labour issues. Welcome to our web site!
www.vardforbundet.se/english/english.htm

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3. *Risk Rounds Special – Information Concerning Risks in Healthcare* no. 1, Örebro: The National Board of Health and Welfare, 1998. In Swedish only.
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NICE SUMMIT

The European Council convened an Intergovernmental Conference (IGC), held in Nice 7-11 December, to address issues left open in the Treaty of Amsterdam that need to be settled before the enlargement of the EU.

Five main themes were on the agenda; the size and composition of the EU, the weighting of votes in the Council, the possible extension of qualified majority voting in the Council and other amendments regarding the European institutions and pending enlargement. Some issues remain unsettled, including for example the size of the Commission following enlargement.

The Nice Council led to some positive developments in the area of social affairs. Article 137 of the Treaty drawn up at Nice, for example, gives the EC greater competence to complement and support actions

to fight social exclusion and to modernise social protection systems. This does not, however, entail the harmonisation of laws and regulations between Member States, as the EC must respect Member States' rights to define the fundamental principles of their systems. The Social Policy Agenda (which was accepted during the Social Affairs Council on 28 November 2000) was also formally adopted during the summit.

The Nice Treaty and the Presidential Conclusions of the Summit are available on the Council website:
<http://ue.eu.int/en/summ/htm>

European Commission and World Health Organisation to intensify their cooperation

On 14 December 2000 Dr. Gro Harlem Brundtland, Director-General of the World Health Organisation (WHO) and Health and Consumer Protection Commissioner David Byrne signed an agreement to strengthen and intensify cooperation in the field of health between their two institutions. According to Dr. Brundtland, "Whist the nature, means and procedures (of the two institutions) are different ... Member States of the European Communities and those of the WHO have repeatedly stressed the need for cooperation that will help reduce unnecessary duplication in the effort to reach common objec-

tives." The WHO and the EU have been working together since 1982, which has produced positive results in areas such as health research, development and humanitarian aid, environment, chemical products and food safety, surveillance of communicable diseases and health monitoring. The Agreement reflects a major political commitment to intensify this cooperation.

The letters exchanged between the WHO and the Commission concerning the consolidation and intensification of cooperation can be viewed on website: http://europa.eu.int/comm/health/ph/key_doc/who_letters_de.html

Swedish Council Presidency

On 1 January 2001 Sweden for the first time assumed the Presidency of the EU Council of Ministers, a position it will hold until 30 June 2001. The Swedish Government's initiatives will focus on three principal areas – the 'three Es' of Enlargement, Employment and Environment. The Swedish Presidency also intends to strengthen the Union's profile in public health issues. A document outlining the programme states that Sweden

will aim to ensure that the new public health framework programme is adopted and that efforts to ensure a high standard of health protection are intensified. The Government's public health initiatives will focus on alcoholism, drug abuse amongst young people, tobacco and blood safety.

Sweden's programme is available on the Swedish Presidency website: www.eu2001.se

French Presidency Health Conference

The French Presidency and the European Public Health Association (EUPHA) organised a Conference in Paris on 14-16 December 2000 on *Access to Health Care for the most Underprivileged* and on *Nutrition and Health in Europe*. Amongst the aims of the Meeting were to collate Europe wide experience on access to healthcare for the most disadvantaged sections of society and to initiate a European network on access for all. During the Meeting, EUPHA put forward proposals to develop a European policy to reduce inequalities in morbidity and mortality rates.

A detailed account of the meeting, speeches given and the topics covered is available on website: www.sfsp-publichealth.org/page-congres.htm

World AIDS day: Commission pledges action

While attending World Aids Day on 1 December 2000, European Commissioners Poul Nielson, Pascal Lamy, Philippe Busquin and David Byrne confirmed their commitment to combat the disease by all means at their disposal. Trade Commissioner Lamy pledged that the Commission would pursue its campaign to make safe, affordable medication available. Research Commissioner Busquin stated that the European Science community and vaccine industry are working together to develop vaccines.

Information:

DG Development's policy on Health, AIDS and Population programme at http://europa.eu.int/comm/development/sector/social/health_en.htm

DG Trade Action for Access to Medicines at <http://europa.eu.int/comm/trade/csc/med.htm>

DG Research's vaccine and drug research, contact Stephane Hogan (+32 2 299 1860) or Michel Claessens (+32 2 295 8220)

DG Health and Consumer Protection "Europe against Aids" programme at www.europa.eu.int/comm/health/index_en.htm

HEALTH COUNCIL

The Health Council met on 14 December 2000.

The Council approved the extension of the six existing Community action programmes in the field of public health until 31 December 2002 as the new programme (2001–2006) due to replace them will not be adopted in time. The Health Council also held a policy debate on the new programme. The European Parliament has not yet adopted its opinion regarding the programme and key questions such as the budget, the idea of setting up a Community structure for health monitoring and the scope of the programme (notably concerning work on health systems) remain unresolved.

A draft Council Resolution on **Health and Nutrition** was put forward for adoption. The Resolution invites the Commission to investigate ways to promote better nutrition in the EU and present appropriate proposals.

The Commission informed the Council on three different matters regarding **tobacco**. It reported on its intention to submit, during the first half of 2001, a new proposal for a Directive on tobacco advertising to replace Directive 98/43/EC, which was annulled by the European Court of Justice last October. The Commission also informed the Council of the outcome of the European Parliament's vote at a second reading on 13 December concerning the draft Directive on the Manufacture, Presentation and Sale of Tobacco Products. Finally, the Commission submitted a report on the outcome of the first meeting of the WHO Framework Convention on Tobacco Control that is under negotiation in Geneva. This Convention will require ratification by Member States and the Community to enter into force. *Minutes of this meeting are available on website: http://europa.eu.int/comm/health/ph/programmes/tobacco/who_en.htm*

The Council also discussed a proposal by the Swedish Presidency for a Council Resolution on **Paediatric Medicines**. The draft resolution outlines that there is currently a lack of suitably adapted medicines available for children and that a European approach to resolving this issue is required. It invites the Commission to make proposals in the form of incentives, regulatory measures or other supporting measures to ensure that medicinal products for children already on the market as well as new ones are fully adapted to the specific needs of children.

The Commission informed the Health Council on progress made on the health aspects of the e-Europe 2002 Action Plan approved by the Feira European Council. The Action Plan includes a **health online** section, which provides for measures aimed at collecting and circulating examples of good health practice online, establishing the quality criteria applicable to websites and linking up existing data networks. The Health Council emphasised the importance of cooperation among Member States in implementing this Plan. A document containing a preliminary list of indicators for monitoring the e-Europe Action Plan was adopted by the Internal Market Council on 30 November 2000 and formally noted by the Nice European Council. *More information regarding this initiative can be found on website: http://europa.eu.int/comm/information_society/europe/actionplan/index_en.htm*

The Health Council approved by a qualified majority all of the amendments that the European Parliament adopted at its second reading concerning the draft Directive on **Clinical Trials on Medicinal Products for Human Use**. There is currently a lack of binding legislation on the conduct of clinical trials in the EU. The proposed Directive therefore sets technical standards and harmonises administrative procedures used in the conduct of trials. It covers regulations concerning the informed consent of participating patients, authorisations by the competent authorities, safety standards (monitoring, inspections etc.) and also codifies a number of terms in order to facilitate the dissemination of results of clinical trials.

The Council held a detailed discussion on the report presented by Health and Consumer Protection Commissioner, David Byrne, on the epidemiological situation of **BSE** in

Member States. Following the discussion the Council concluded that while respecting Member States' powers, efforts regarding research, monitoring, assessment and eradication of BSE and the provision of medical care and social support to patients and families should be concentrated at the Community level. Commissioner Byrne also insisted that although Member States have chosen to confine discussions regarding BSE largely to the Agricultural Council, Health Ministers must also have a leading role in decisions on BSE.

The Commission also presented two new texts to the Health Council. The first was a Proposal for a Council Recommendation on **alcohol and young people**, which was adopted by the Commission on 27 November 2000. This is a first step towards combating the problems associated with alcohol consumption by children and adolescents, which is a growing phenomenon in some Member States. Under the Recommendation, Member States will have to implement measures on health promotion, education and information, and measures relating to codes of conduct aimed, inter alia, at the producers and retailers of alcoholic beverages. The proposal will be put for adoption on the agenda of the Health Council under the Swedish Presidency. *This proposal is available on website: http://europa.eu.int/comm/health/ph/key_doc/ke04_en.pdf*

The second text presented was a Proposal for a Council and European Parliament Directive on the **safety and quality of blood** and blood components. This Proposal aims to ensure that EU citizens can rely on safe medical treatments wherever they go. The Proposal was adopted by the Commission on 13 December 2000 and will be examined in detail under the Swedish Council Presidency.

RESEARCH

Europe funds a scientific world first: breakthrough in sequencing the plant genome

The first full sequencing of a plant genome has been completed with the help of a EUR 26m European research grant. This scientific breakthrough is the longest and most complete sequencing of a genome yet achieved. Fifteen laboratories from the European Union, the United States and Japan sequenced 115 'base pairs', encoding nearly 26,000 genes – more than any other genome to be

completely sequenced so far. This represents a major breakthrough in the scientific understanding of plants, including how they cope with pests and diseases and how they interact with their environment. The sequence was made available to the international scientific community through publication in the Scientific Journal *Nature* on 14 December 2000.

Conference on genetics and the future of Europe

As part of the Commission's initiative to stimulate scientists to communicate with society (politicians, industry and social leaders), a Conference on Genetics and the Future of Europe was held on 6–7 November 2000. The aim of the Conference was to generate debate on the responsible use and exploitation of genome information in health, food, environment and society. It was the first event arranged by the Life Sciences

High Level Group that was assigned by European Research Commissioner Philippe Busquin to advise him on any likely developments of life sciences and technologies.

More information about the Conference and its outcomes is available on website:
<http://europa.eu.int/comm/research/quality-of-life/genetics.html>

Commission stimulates 'science-society' debate

Commissioner Busquin has introduced a discussion paper entitled Science, Society and the Citizen in Europe to European Research Ministers that proposes initiating a wide ranging debate on the role and place of science in society. The paper raises questions about the relationship between the public and science, society's expectations of research and the responsible use of technological progress. The debate is part of the initiative to establish a European Research Area.

Further information on the European Research Area is available on website: <http://europa.eu.int/comm/research/area.html>

Commissioner Busquin reinforces genomics research

Research Commissioner Philippe Busquin has launched an initiative to reinforce European activities in genome research related to human health. On 8 November 2000 the European Commission and Member States' experts agreed to create a Forum of Genome Research Managers to develop synergies between European level and Member States' activities and to help network national programmes. Over EUR 100m is expected to be available for this initiative in 2001.

Full details are available on the Quality of Life website: www.cordis.lu/life

The European Group on Ethics opinion on 'therapeutic cloning'

The European Group on Ethics in Science and New Technologies, a Committee mandated by the EU to give opinions on ethical aspects of scientific developments, issued an opinion on human stem cell research on 24 November 2000. The group considers therapeutic cloning to be premature.

The opinion can be viewed on website:
http://europa.eu.int/comm/secretariat_general/sgc/ethics/en/opinion_15.pdf

Parliament proposes a committee on genetics

The Parliament has proposed the establishment of a temporary enquiry committee on human genetics and other new technologies in modern medicine that will examine new and potential developments and uses of genetics and examine their ethical, legal and socioeconomic implications.

EUROPEAN ECONOMIC AND SOCIAL COMMITTEE (ESC) OPINIONS

On 29 November the ESC adopted an opinion on the new programme of Community action in the field of public health proposed by the Commission. The ESC was concerned about the absence in the action programme of formal proposals and resources dealing with Community analysis of health issues and their relevance to other policy areas. Rather than the Commission's proposal of a

European Health Forum, the ESC suggested that official bodies responsible for health services, together with regional and local authorities and social stakeholders, be given an adequate say and the chance to help frame relevant schemes. Other recent ESC opinions have been issued on the following:

- the proposal to extend certain programmes of Community action in the field of public health;

- the role of the EU in promoting a pharmaceutical policy reflecting citizens' needs;
- the new Social Policy Agenda;
- the programme of Community action to encourage cooperation between Member States to combat social exclusion.

The full texts of the ESC's opinions are available on website: www.esc.eu.int

NEWS IN BRIEF

Report of the EU-US Biotechnology Consultative Forum Available

The EU-US Biotechnology Consultative Forum presented its report at the EU-US summit of 18 December 2000. The purpose of the Forum was to examine a broad range of issues of concern to the European Union and the United States regarding biotechnology. It has produced a consensus report on the complex and critical issues related to the use of biotechnology in food and agriculture.

*The report is available on website:
http://europa.eu.int/comm/dgs/external_relations/index_en.htm*

Commission adopts new Community guidelines on state aid for environmental protection

The Commission has adopted new guidelines that establish the conditions under which Member States may grant firms aid to promote environmental protection. The guidelines prevent States from providing firms with assistance that interferes with competition or undermines the 'polluter pays' principle.

Commission adopts proposal for establishment of a European Food Authority

On 8 November the European Commission adopted a Regulation that establishes the fundamental principles and requirements of food law and sets up a European Food Authority (EFA). The proposed Regulation defines the general objective of food law as the protection of human and animal health and the environment and the supply of correct information to consumers. The Regulation also sets up the EFA. *More information regarding food safety can be found at website:
http://europa.eu.int/comm/food/fs/intro/index_en.html*

Commission proposes registry to run '.eu' domain

The European Commission has adopted a proposal to create a registry to run the Internet top level domain '.eu'. Enterprise and Information Society Commissioner Erkki Liikanen has stated that whilst national extension codes will continue to exist, the '.eu' top level domain will provide European companies with the additional possibility of identifying themselves as European or pan European companies on the Internet.

Commission adopts exceptional measures to address BSE

The Commission formally adopted a range of radical measures in December to halt the spread of mad cow disease across the EU, such as a temporary ban on feeding protein based meal to all farm animals.

*A document on main EU legislation on BSE is available on website:
http://europa.eu.int/comm/food/fs/bse/bse19_en.html*

Commission White paper on chemical testing

According to experts, there are between 30,000 and 70,000 chemicals in use across the EU that have not been subjected to Union level safety checks. These are products that have been in use since before the Treaty of Rome was signed in 1957. The Environment Commissioner Margot Wallström and Enterprise Commissioner Erkki Liikanen are currently drawing up proposals to update existing rules on the use of chemical products and to overhaul the EU's chemical policy.

EU Health programmes: annual work plans

The Commission published the annual draft work plans of a number of EU health programmes:

The annual 2001 draft work pro-

gramme of Community action on health promotion, information, education and training is available on: http://europa.eu.int/comm/health/ph/programmes/health/docs/work2001_en.pdf

The annual 2001 work programme of Community action on the prevention of drug dependence is available on:

http://europa.eu.int/comm/health/ph/programmes/drugs/work01_en.pdf

The annual 2001 work programme of Community action on the prevention of AIDS and certain other communicable diseases is available on:

http://europa.eu.int/comm/health/ph/programmes/call/aids/work2001_en.pdf

The annual 2001 work programme to combat cancer within the framework for action in the field of public health is available on:

http://europa.eu.int/comm/health/ph/programmes/cancer/wrkprog2001_en.pdf

For information regarding how to participate in the EU's public health programmes consult:

<http://www.europa.eu.int/comm/health/ph/programmes/call/how.htm>

NOTICES

The Collaborative Centre for Economics of Infectious Disease invites you to an International Conference on the Economics of Infectious Disease to be held at the London School of Hygiene & Tropical Medicine 29 & 30 March 2001. For further details please contact: kate.archibald@lshtm.ac.uk
Tel: +44 (0)20 7927 2222

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If you wish to publish a short notice of between 20 and 60 words in the next issue of *eurohealth* please contact the editor: m.d.sedgley@lse.ac.uk

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