

eurohealth

**Looking beyond Kohll
and Decker**

***Cross border healthcare
after Smits/Peerbooms***

HIV/AIDS and TB in Eastern Europe and the CIS

Devolution in the Italian health service

Geriatric care in the Czech Republic

COMMENT

Smits/Peerbooms: A clarification of confusion?

There can be no doubt that the European Court of Justice's judgements on Smits/Peerbooms and Vanbraekel are significant in one way or another for the future of European healthcare delivery. Whether they change a lot or a little is of course the key point but aside from that, it is significant in itself that the Court has sought to define the relationship between European citizens' right to healthcare and national governments' and insurance systems' obligations to fund it.

In attempting some sort of balance between a right to receive and an obligation to provide, the judgements seem to grant to citizens the right to cross border care, as long as the operational integrity of national systems is not undermined by large numbers of people acting on their right.

If this were all the judgements did, they would in effect amount to nothing more than a description of the underlying clash of principles that the cases have brought to light (and were inspired by) – national healthcare delivery in the context of free movement of services. They would, in other words, be nothing more than a clarification of confusion.

However, as the articles here collectively show, the rulings are not simply a matter of restating the anomalies that are inherent in the unique configuration of legal competencies and distribution of rights that constitutes the European Union. The Court has sought not just to clarify the status quo but to move *Member States* to clarify the entitlements to healthcare that they give to their national citizens. The Court judgements represent an important instance of judicial activism. As Nickless makes clear in his article, the key point is that each Member State must now be transparent about what services its citizens are entitled to. Citizens then have the right to receive those services in any EU Member State if their home country cannot provide them.

The new right ascribed to Europe's citizens is in effect a 'framework right'. The content of the right in terms of entitlement to actual healthcare services is one that remains firmly within the jurisdiction of the Member States. If a national healthcare service assigns an entitlement to service to its citizens and cannot physically provide the service, it will now be liable to fund the provision of the service in another Member State. Any national system may still declare that a service is not available (under public funds) to the citizens of a country. The judgements are not themselves a clarification of the status quo but they mandate Member States to clarify healthcare entitlements and to remove the confusion that their citizens face inside Europe's single market. In doing this, Member States will be pressured to change the status quo and EU citizens should benefit from this process.

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Health in other EU policies or an EU health policy?

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Currently, there is a strong focus at European Union level on 'health in other policies' – looking at how the board range of EU policies impact on health. This awareness of health in other policies is an important step forward and, in the absence of a broadly-based and developed EU health policy, it may make sense to concentrate on ensuring that other policies place sufficient emphasis on integrating health concerns into their work.

Indeed, it has proved to be quite a successful strategy – health now plays a prominent role in all new EU cross-cutting policy initiatives: in sustainable development, in the *e-Europe* initiative on introducing information technology into key sectors in Europe and in the process of reorienting the EU's pharmaceutical policy. However, fostering health in other policies will not be effective without developing a coordinated and comprehensive health policy to give a coherent shape to the way that health issues are implemented.

Until now, the emphasis – as enshrined in Article 152 – has been to make sure that a "high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities". However, there is a pressing need to ensure that other policies, such as those connected with the European Single Market – which, at first glance, might appear to have little connection with health – should take account of the wider health dimension to include health systems as well as public health considerations. Following the European Court of Justice's *Peerbooms* ruling on access to cross border care, it is clear that health systems fall within the scope of the European Single Market. At the same time, cross border healthcare issues – viewed previously as a 'social protection' issue for EU Social Affairs and not Health officials – are now being discussed by Health Ministers at the EU Health Council. These developments illustrate a two-

way process: health must be considered in other policy areas such as the European Single Market and social protection, but these other policies particularly those affecting health systems, must now be taken into account in developing health, not just public health, policy.

"the time has come to make a solid move towards establishing a meaningful and coherent health policy for the European Union. Concentrating on influencing 'other' policies is just not good enough."

The first steps towards a more coherent view were taken when the European Commission published its future health strategy communication in 2000. But that was no more than the beginning of a larger process. Its main purpose was to set out the need for a health strategy at EU level, but not to define it. Today, there is a pressing need to develop the conceptual framework set out by the communication and to put flesh onto its bones. There are several dimensions in this process.

First, a health policy framework setting out policy objectives and goals for the EU needs to be developed urgently. This would cover both generic health policy responsibilities – policy on public health, health systems, health professionals and health-related products, such as pharmaceuticals and medical devices – and a number of principles applied to 'other policies'.

Second, there needs to be a health policy lead on how to address major EU health challenges – in areas as diverse as the Court of Justice's rulings on patient flows, impact of the WTO on health services, actions on disaster preparedness or the health challenges of enlargement.

Third, health policy should refocus on the benefits for the individual

citizens of Europe. There is little in the current – or planned – strategy that provides real added value to the ordinary citizen, but there is much that could be offered – centres of excellence, real opportunities to avail of the best healthcare wherever it might be, and ensuring that citizens know which hospitals meet international standards by overseeing accreditation of hospitals throughout Europe. In this post-*Peerbooms* era, with greater acceptance that Europe has a role to play in health systems, the European Commission must develop a proactive stance in making health benefits part of the 'Citizen's Europe' – a European slogan which has largely bypassed health.

Fourth, internal organisation within the Commission should be reviewed to achieve greater 'joined-up' government and to ensure that the Health Directorate-General assumes policy areas typically dealt with by a national Ministry of Health. The changeover to the next Commission could be an obvious point to put into force such changes.

Finally, discussion is required on how to revise Article 152 on public health to create a less restrictive and improved basis to legislate in health areas, such as tobacco, which currently require other Treaty articles as their legal base. Moreover, revision is needed to take into account the EU's increasing impact on national health systems via other areas of the Treaty, which makes somewhat meaningless the Article 152's restriction on an EU role in healthcare services.

As future EU health strategy begins to unfold, we must overcome the dichotomy between public health and 'other policies', while bringing the wider dimension of health systems into a health policy context. Today, the time has come to make a solid move towards establishing a meaningful and coherent health policy for the European Union. Concentrating on influencing 'other' policies is just not good enough.

Public health in the European Union

Breaking down barriers



David Byrne

*European
Commissioner for
Health and Consumer
Protection*

At the present time the European Union stands on the threshold of a new approach to public health issues. I would like to concentrate on three aspects of the theme of 'cross border health'.

First, health is determined across the borders of many different policy areas. In the 1993 Maastricht Treaty, public health was for the first time granted an explicit legal base in a European Treaty. In responding to the new obligations, the Commission presented its communication on the framework for action in the field of public health. Key elements were the establishment of a first set of eight public health programmes, but the framework also included work in other areas. The establishment in 1998 of a network on the surveillance and control of communicable diseases should be mentioned in particular. The Amsterdam Treaty brought the matter further forward and commits the EU to a high level of health protection across the whole range of its policies and actions. Forging these cross-policy links will be centre stage in future efforts in the Union.

Second, as diseases travel across borders, a considerable amount of future efforts will also be devoted to monitoring emerging health threats and communicable diseases

"no national health system can be regarded as exempt from the Treaty obligations"

which can be linked to trade and the free movement across borders of people and goods.

Finally, discussions of cross border health have been given new resonance by the recent judgements of the European Court of Justice (ECJ) concerning access of patients to healthcare in other Member States.

Now in 2001, the central feature of the EU's new health strategy is to ensure a high level of health protection across all policies and actions. This commitment is set out in Article 3 of the Amsterdam

“it has to be for the Member States themselves to solve problems relating to the organisation and financing of their healthcare systems”

Treaty, and reiterated in the public health article, Article 152. The European Commission has already taken initiatives towards the kind of collaborative working which is necessary. At the recent EU summit in Göteborg, we announced a new sustainable development strategy for the Union and health forms part of this. This initiative was the result of a wide ranging collaboration and consultation across a large number of different policy directorates in the Commission who will continue to liaise to monitor the progress of the initiative.

Health Action Programme

The main plank in the Commission's health strategy is the new public health action programme, whose adoption by the European Parliament and the Council is imminent. The new programme moves away from the fragmented approach of the past, where resources were spread thinly across a multitude of one-off projects. The new health strategy is a six year programme with three major strands of action: The first strand will put in place a comprehensive data system on the major determinants of health in the EU (such as tobacco and alcohol consumption), together with mechanisms to evaluate this data.

The second strand aims to ensure that the Community is in a position to counter threats to health which cannot be tackled by Member States in isolation, such as transmittable diseases. This includes 'rapid

reaction capability' which will build on our existing communicable diseases surveillance networks. This network allows for immediate information about events which could create a health threat in the EU. The system also permits an exchange of views on risk assessment and risk management crucial for timely public health action. The system has already proved to be a useful tool during a number of outbreaks and incidents but the operation of the system needs to be further strengthened and enhanced on the basis of experience. As recent events have shown, mechanisms need to be in place to ensure that the EU is able to respond effectively and in a coordinated way to potentially serious threats to public health. This strand was given a sharper focus recently when the European Council in Ghent in October this year asked the Council and the Commission:

“to prepare a programme to improve cooperation between the Member States on the evaluation of risks, alerts and intervention, the storage of such means, and in the field of research. The programme should cover the detection and identification of infectious and toxic agents as well as the prevention and treatment of chemical and biological attacks.”

Closer links will need to be considered between our communicable diseases network and other early warning systems in place, such as those for food and animal health, as well as to the civil protection coordination mechanism. We will need to give attention to how best to achieve these links. Creating these mechanisms will mean not only harnessing the resources of health and surveillance authorities and centres of expertise, but also building up the necessary capacity in EU Member States and Candidate Countries. This is an enormous challenge but we can, with good cooperation, set in hand the process to respond to the request made in Ghent.

The third strand of the new programme will put in place strategies to identify the most effective policy for combating disease and promoting health and healthy lifestyles. The aim is to target the causes of public health concerns instead of dealing with the symptoms. Patients rightly expect a high quality of information and the programme will help to get an intelligent system in place where best practices are identified and the up to date information is available.

National health systems and the European Court of Justice

In the past, the health impact of Community legislation has been confined to health services inputs, for example pharmaceuticals, procurement and the mutual recognition of professional diplomas. For a long time it appeared that delivery of services to patients were exempt, as article 152 of the Amsterdam Treaty explicitly rules out the involvement of the Community in the organisation of Member States' health services when taking action related to public health.

The 1998 Kohll and Decker rulings of the ECJ have altered some perceptions. These rulings imply that at least some health services – in those particular cases the purchase of spectacles and dentistry – are subject to the internal market rules governing the free movement of goods and services. The question was, how widely could these rulings be applied?

The most recent ECJ rulings – the Smits/Peerbooms judgement (case C-157/99) and the Vanbraekel et al. judgement (C-368/98) from July this year – imply that no national health system can be regarded as exempt from the Treaty obligations. The ECJ also implied that hospital treatment can be considered a 'service' under the terms of the Treaty. However, the Court continues to recognise that distinctive arguments may apply to the provision of hospital care which would justify keeping the current pre-authorisation procedures that allow for the issue of E112 forms when a patient seeks selective care abroad.

In any case, it seems rather unlikely on current evidence that large increases in flows of patients will suddenly materialise. Even in the EU's internal border regions, where barriers to cross border care are much lower than in other parts, patients do not seek cross border care in large numbers. A recent study estimated the expenditures on cross border care in the EU to be less than half of one per cent of total EU expenditures on health.¹ Much of this is accounted for by emergency care required on business or tourist travel.

What the ECJ has now done, however, is to indicate that the pre-authorisation procedures already in place have to be used consistently by all Member States, and with due regard to patient welfare. It is now clear that patients' freedom to receive normal and necessary treatments in other Member States cannot be arbitrarily refused.

Disseminating best practice

How to respond to the Court's judgements at EU level? Under our new public health programme we will be working together with Member States to identify and disseminate best practices so that people can profit from ideas in use elsewhere. But it has to be for the Member States themselves to solve problems relating to the organisation and financing of their healthcare systems, such as inadequacies of provision, or waiting lists. This is a clear subsidiarity issue. On this issue I am in close contact with my colleague Anna Diamantopoulou, who is responsible for the Employment and Social Affairs portfolio, and hence the coordination of security payments under which authorised cross border care is currently financed.

“difficult legal issues are raised by the use of telemedicine across boundaries”

I am aware of the developing attempts in internal EU border regions to establish collaborative cross border working so as to enhance patients' access to care, to rationalise the efforts of scarce professionals and even to economise in the use of expensive medical plant and equipment. At the same time we are also aware of the many difficulties faced by patients and professionals operating at the interface of different types of healthcare systems and cultures. I am aware, for example, that difficult legal issues are raised by the use of telemedicine, in its various forms, across boundaries. A forthcoming Commission paper on legal issues in eHealth, as part of the eEurope initiative, will seek to clarify these problems and to set out possible solutions.

In addition, the new EU public health action programme, and especially the data system, will play a major role in relation to collecting, analysing and disseminating information about how health systems are working. It will give input to 'better' policy making – both at Community and national level – by providing facts, background information and trends not only to health professionals but also to the public.

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ECJ in the driving seat on health policy

But what's the destination?



Matthias Wismar

In 1998, forty years after the foundation of the European Economic Community, the European Court of Justice (ECJ) ruled that the principles of the Single European Market may also apply to the health services of Member States. This means that, in principle, European citizens are entitled to purchase medical goods or receive medical services in other Member States of the European Union funded through their competent financing institutions.

Yet health policy has historically been rigorously defended by actors in the field as the exclusive and rightful domain of domestic policy making. It took more than three years and a number of court cases for this paradigm to be superseded (see Table 1).

In the light of the recent rulings of the ECJ, the well documented Kohll and Decker rulings appear trivial and straight forward. The current cases are serious if not tragic, carry many implicit consequences and are extremely complicated. The Kohll and Decker cases concerned the prescription of glasses and orthodontic treatment, while the Peerbooms judgement concerned coma

therapy.

Aside from the immediate differences between the cases, there are more systematic distinctions between the cases of 1998 and the recent court rulings:

- The free cross border choice of medical services does not only apply to the ambulatory sector but also (with some restrictions) to the in-patient sector, since these services are explicitly considered as services in terms of the Treaty.
- The free cross border choice of medical goods and services does not only apply to countries which provide for cost reimbursement (as previously argued) but also to countries with a benefit-in-kind system.
- Service providers are not allowed to discriminate in their billing between the domestic population and citizens from other Member States.
- A benefit-in-kind may not be denied to citizens living in another Member States as long they have acquired an entitlement to this benefit.
- If the costs incurred by an in-patient treatment in another Member State are lower than in the country of the competent institution, under certain circumstances the patient is entitled to keep the difference.
- Patients may have full access to services in other Member States, even if these services are not listed in the benefit package of the competent domestic institution, provided that these services are scientific and internationally accepted standards.

Clearly, there are more issues involved in the ECJ rulings. However, these developments already point to the fact that there are some immediate and some very far reaching consequences stemming from them.

First, the 'E111 procedure' which guarantees cross border service provision in terms of the benefit-in-kind principle is comple-

Table 1
ROLE OF THE ECJ IN THE DEVELOPMENT OF EUROPEAN HEALTH POLICY

ECJ-code	Parties	Country of service	Country of insurance	Medical service/good
C-117/77; C-182/78	Pierik I & II	D	NL	
C-120/95	Decker		LB	Glasses
C-158/96	Kohll	D	L	Orthodontic treatment
C-160/96	Molennar	F	D	Long term care
C-368/98	Vanbraekel	F	B	Orthopaedic hospital treatment
C-411/98	Ferlini	L	(EC)	Discriminating billing
C-157/99	Geraets-Smits Peerbooms	D A	NL NL	Inpatient Parkinson treatment Coma therapy
C-385/99-1	M Iler-Faur van Riet	D B	NL NL	Denture/implantable Athrosopic treatment

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mented by a cost-reimbursement option. This complementary procedure entails that citizens may travel intentionally to receive medical goods and services in other Member States. This was not the purpose of the E111 procedure which would only guarantee service provision if immediate care was necessary (whatever this meant). Second, the restrictive handling of the 'E112 procedures' by the competent institutions in the Member States has to be abandoned and replaced by clear eligibility

criteria and a greater choice for patients. Third, according to the rulings, an inherent trend towards a virtual European healthcare basket is observable, which comprises the domestic plus all additional medical goods and services listed in the other Member States. Fourth, if this trend towards a virtual European healthcare basket proves to be sustainable, the definition of the healthcare basket will no longer be under the discretion of the individual Member State.

"In the light of the recent rulings of the ECJ, the well documented Kohll and Decker rulings appear trivial."

Impact of the ECJ judgements on national healthcare delivery

The case of the UK



Nick Boyd

"NHS commissioners now have wider scope to access treatment for their patients"

The recent rulings of the European Court of Justice (ECJ) in the joined cases C-157/99 Geraets-Smits and Peerbooms, and Case C-368/98 Vanbraekel have led to a change in the UK's long standing policy concerning purchasing healthcare overseas. The 1977 NHS Act has traditionally been interpreted as precluding the possibility of the National Health Service accessing healthcare abroad, except under strictly limited circumstances.

Following the Court's rulings however we have had to look again at our policy. Secretary of State Alan Milburn announced on 27 August that Health Authorities and primary care trusts could legally commission services from other European Economic Area countries as part of their wider efforts to reduce waiting times for NHS patients. Domestic legislation is being amended to clarify this point and the working of the E112 (prior authorisation) system is also being reviewed.

Although the Government has some concerns about aspects of these judgements it welcomes the fact that NHS commissioners now have wider scope to access treatment for their patients. Last year the Government published the NHS Plan, an ambitious ten year plan for modernising

the NHS in England. The Government is investing huge sums in the NHS, investment which will reach £68.7bn by 2003-04. However, modernising the NHS to meet the needs of the 21st century will take time. Whilst we wait for that investment to bear fruit it is simply common sense to use surplus capacity to bear down on waiting times, whether that spare capacity may be the private sector in the UK, or overseas.

The Government recognises that sending NHS patients overseas for treatment does raise genuine legal, clinical and quality issues which need to be addressed. Mr Milburn has therefore asked officials to work with three test-bed sites in South East England, Portsmouth, East Kent and West Sussex/East Surrey, to work through these issues. The focus will be identifying patients who have been waiting considerable periods for relatively low risk elective conditions such as major joint repairs and who are fit for travel. These patients will then be offered the opportunity of being treated in mainland Europe. No patient will be forced to take up this opportunity. Our aim is to start sending patients before Christmas and to produce guidance for the NHS by the end of the year.

In due course the Department of Health intends to establish through an open tendering process a list of approved foreign providers to assist primary care trusts (PCTs) planning to commission treatment abroad. It will take a number of months to put this in place. We will keep interested providers informed.

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Smits / Peerbooms: Clarification of Kohll and Decker?



Jason Nickless

The European Court of Justice (ECJ) decisions in Kohll and Decker left many questions unanswered. Was their application confined to social healthcare systems that operate through a system of reimbursement or just to outpatient treatment? Did these decisions allow the EC to interfere with the scope of social healthcare treatment in the Member States? Some of these issues were resolved in the recent ECJ decision in the joined cases of Geraets-Smits v Stichting Ziekenfonds VGZ and Peerbooms v Stichting CZ Groep Zorgverzekeringen.¹ This article analyses this new decision and explains what it means for the scope of the application of Kohll and Decker and its impact upon the various models of social healthcare in operation in the Member States of the European Union. First, a theoretical model is established by which to describe the provision of social healthcare before analysing the new ECJ decision and its impact on European healthcare.²

A model for the provision of social healthcare in the EU

The model is based upon the premise that every social healthcare system operates within defined boundaries. As soon as a patient steps outside these boundaries s/he is no longer covered by the social system and becomes a private patient. Private

patients pay for the full cost of their treatment, either through private insurance or from their own finances. The boundaries of social healthcare vary from one state to another but they are always defined by three basic elements. These elements are:

Personal scope: the range of people covered by the social system, which may exclude certain groups of the population such as those rich enough to afford private insurance.

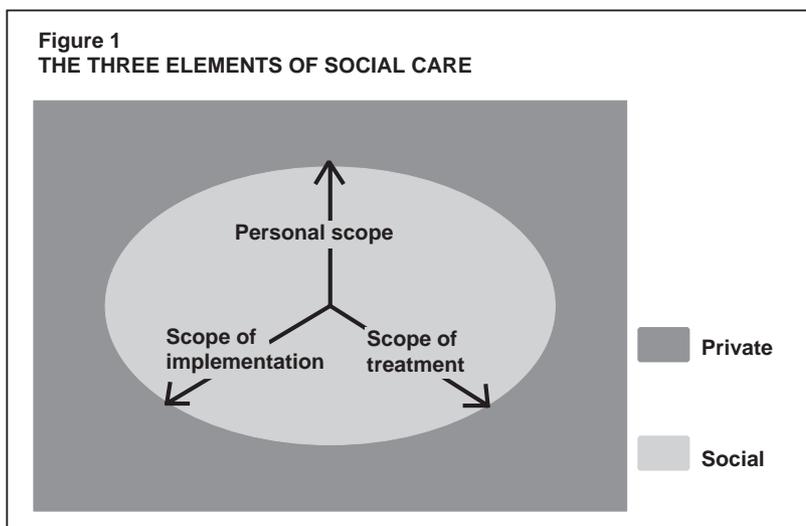
Scope of treatment: every social system places some limits on the type of treatment available, for instance many systems will not cover the costs of purely cosmetic surgery.

Scope of implementation: the range of providers to whom the patient is entitled to visit, for example the social system may only cover treatment provided by doctors who are employed by the state or hospitals that have a contract with a social health insurance fund.

These three basic elements may be visualised as illustrated in Figure 1. If a patient is expressly excluded from the personal scope of the national system then s/he falls outside the social field and enters the private one. As soon as a patient demands a treatment that is not covered by the social system or attends a provider who is not authorised by that system, then the patient steps from the social domain and into the private one.

The model applies to all social healthcare systems but the practical administration of the systems within the EU may be divided into two kinds. The first are benefits-in-kind systems. These provide the patient with treatment that is essentially free, although the patient may have to make a small contribution towards the costs. The benefits-in-kind may be provided through a national health service such as those in operation in the UK or Spain, or through a social insurance system such as the one used in Germany. In either case the treatment is usually provided through ‘authorised’ providers who have some contractual relationship with the national health system or the social insurer.

The other system of social healthcare pro-



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vision is delivered through a reimbursement mechanism. This involves patients paying their doctors for the full cost of treatment and then receiving a majority of this amount back through a social insurer. Systems of this kind are in operation in Belgium and Luxembourg. When the patient requires very expensive treatment the health insurer will cover these costs directly with the provider. Reimbursement mechanisms will often operate with a very wide scope of implementation, typically allowing the patient to visit any family doctor, orthodontist or ophthalmologist in the country.

The cases

The joined cases of Smits and Peerbooms both concerned Dutch nationals covered by the personal scope of the Dutch social system. In the context of the Smits/Peerbooms decision the Netherlands social healthcare is organised by social health insurers who enter into contracts with providers (such as doctors or hospitals). Insured persons are then entitled to treatment from those providers who have a contract with the insured person's health insurer. The patients do not have to pay their doctors the full cost of treatment but may have to make a small co-payment. In this regard the Netherlands therefore operates a benefits-in-kind system, restricting its scope of implementation to contracted providers. Non-contracted providers can be used as long as patients receive prior authorisation from their health insurer. The scope of treatment in the Netherlands includes that provided by a general practitioner or a specialist "the [extent of which] shall be determined in accordance with what is normal in the professional circles concerned."³

Mrs Smits suffered from Parkinson's disease. She went to Germany in order to receive a special multi-disciplinary treatment that dealt with all of her symptoms at the same time, it integrated programmes of physiotherapy, medical treatment, ergotherapy etc. When she returned to the Netherlands she sought a refund of the costs of her treatment under the Kohll and Decker procedure. She was refused because the multi-disciplinary treatment was not covered by the Dutch scope of treatment, it was not considered 'normal'.

Mr Peerbooms was a 36 year old man who had fallen into a coma. He was taken to Austria by his family in order to receive a special neuro-stimulation treatment. The treatment was a success and when Mr

Peerbooms returned to the Netherlands he tried to use the Kohll and Decker procedure in order to obtain a refund of his medical costs. He was refused on the basis that his treatment was still considered experimental in the Netherlands and only available to people under the age of 25 years.

Impact on the EU model of social healthcare

The ECJ began its decision by confirming that although Member States have a significant degree of discretion in the operation of their social security systems this discretion is still subject to the rules on the free movement of goods and services. It then went on to determine whether the free movement of services applied to hospital treatment. Submissions had been made that hospital treatment was not an economic activity provided for remuneration and therefore not classified as a 'service' according to the EC Treaty.⁴ If it was not a service then it could not be subject to the rules on the freedom of services.⁵ Despite indications to the contrary in its Kohll decision (paragraph 29), the ECJ declared that hospital treatment is a service.

Previous jurisprudence had indicated that medical treatment was certainly a service in the sense of the Treaty⁶ and the special nature of a service does not always exclude it from the application of the fundamental freedoms.⁷ More pressingly when patients use the procedure laid down in Kohll they pay the full cost of their treatment to the provider in the foreign state and then return to be reimbursed as if that treatment had been provided in their state of insurance. This means that hospital services in this context were both economic and remunerated. The ECJ thus confirmed that Kohll and Decker do apply to both hospital treatment and systems that do not operate with a reimbursement mechanism.

It was then decided that by refusing to reimburse the treatment received in another Member State, the Netherlands had violated the free movement of services, effectively making it harder to receive treatment abroad than at home. However, it is well established case law, as in Kohll paragraph 41, that a Member State can justify a restriction of the freedom of services if such a restriction is necessary in order to maintain the balanced financing of the social security system. The ECJ decided in Smits/Peerbooms (paragraph 81) that states were allowed to restrict treatment to contracted providers and only allow patients to see non-contracted providers if they receive

"the ECJ accepts that states are allowed to determine the scope of implementation of their health systems"

“by refusing to reimburse the treatment received in another Member State, the Netherlands had violated the free movement of services”

prior authorisation:

“it is clear that, if insured persons were at liberty, regardless of the circumstances, to use the services of hospitals with which their sickness insurance fund had no contractual arrangements, whether they were situated in the Netherlands or another Member State, all the planning which goes into a contractual system in an effort to rationalise, stable, balanced and accessible supply of hospital services would be jeopardised at a stroke.”

Therefore the ECJ accepts that states are allowed to determine the scope of implementation of their health systems. The case also confirmed that the balanced financing of social healthcare requires the rules on the freedom of goods and services to respect each system's scope of treatment. Every Member State is allowed to establish 'limitative lists' of the treatment provided (paragraphs 86 and 87),⁸ the ECJ went on to explain (paragraph 87):

“It follows that Community law cannot in principle have the effect of requiring a Member State to extend the list of medical services paid for by its social insurance system: the fact that a particular type of medical treatment is covered or is not covered by the sickness insurance scheme of other Member States is irrelevant in this regard.”

Euro-speak

The Member States are therefore free to determine the scope of treatment and implementation of their social healthcare systems. However, the ECJ made it clear that these are not blanket justifications. The justification of balanced financing can only be relied upon if the restriction on free movement is fair, free from discrimination, transparent, subject to appeal and thus effectively translated into 'Euro-speak', and therefore interpreted in a non-discriminatory European context. So states are free to define their scope of treatment or implementation. They are free to restrict the range of providers or services* as long as the way in which these restrictions are applied comply with the standards outlined above.

The concept of 'Euro-speak' is the central principle of the ECJ's position. In Luxembourg the scope of implementation

dictates that the social patient is allowed to visit any orthodontist in Luxembourg. Translated into 'Euro-speak' this means any orthodontist in the EU. In the Netherlands the scope of treatment is determined by what is considered "normal in the professional circles concerned". This is then translated as normal according to international professional circles and not just those in Holland. It is important to note at this point that the ECJ did not say that all social healthcare systems should provide treatment accepted by international standards. This is just the particular scope of treatment selected by the Netherlands. It has now been translated into 'Euro-speak'. Other states remain absolutely free to determine their own scope of treatment, with the provision that this too will be translated into Euro-speak.

So what does Smits/Peerbooms mean for the scope of Kohll and Decker? Firstly these principles do apply to hospital treatment. Secondly, the ECJ will respect the scope of treatment and implementation of the national system provided that that system is fair, free from discrimination, transparent, subject to appeal and translated into 'Euro-speak'. The essence of Kohll and Decker is that the patient pays his/her foreign provider in full and then returns to his/her state of insurance in order to be reimbursed as if the treatment had been provided in that state. If the patient would not be entitled to reimbursement in their home state because they have received treatment that is not covered by their own system or visited a provider who is not contracted to their own system then they will not be entitled to reimbursement. They will have stepped outside the boundaries of social healthcare.

What does this mean for the various types of system? It means that there can no longer be any discrimination in the way that states define the scope of treatment and implementation. For reimbursement mechanisms that allow patients to visit any doctor in their territory this now means any doctor in the EU. For benefit-in-kind systems that limit implementation to contracted providers it means that it should be just as easy for a foreign provider to obtain a contract as it is for a domestic one. Furthermore, it should be just as easy to obtain treatment from a non-contracted provider in another Member State as it is to obtain care from a non-contracted provider in the state of insurance. All Member States must be aware of the potential impact of Euro-speak, this means that states which

* Although the EC rules on the free movement of goods and services cannot affect the scope of treatment or implementation, the Member States should remember that they are bound by other international agreements to provide adequate levels of healthcare.

develop clear limitative lists of available treatments are under less pressure than those relying upon more abstract limitations such as those imposed in the Netherlands.

Conclusion

The Smits/Peerbooms case has answered some of the questions raised by Kohll and Decker. It has gone a long way in clarifying the interrelationship between the economic rules on the free movement of goods and services on the one hand and the provision of social healthcare on the other. Policy makers should now ensure that the boundaries of their social healthcare systems are fair and free from discrimination. They should also be aware of the fact that the boundaries they create can and will be translated into 'Euro-speak'.

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Integrating care in the border regions

An analysis of the Euregio projects



Alain Coheur

Europe's border regions (Euregios) represent a unique area of experimentation. In fact, what is involved is no longer reflections on worker mobility but pressure exerted by each citizen in order to benefit from the care which is most appropriate to his or her state of health. This constant pressure is the result of a European process which has put the emphasis on freedom of movement for persons, goods and services as a fundamental value in the creation of a single area. It would be paradoxical to encourage only the creation of a free trade area without accepting its indirect consequences and therefore wishing to reduce mobility when it is not possible to manage all its aspects. This is particularly true in the field of health.

We are only beginning to obtain information on the social and health characteristics of the Euregios and on the mobility potential of the resident populations. It has to be said that the initiatives which have been

undertaken are the result of the wishes of grassroots actors, insurance funds, hospitals etc.

However, not all border regions lend themselves to the development of the same kind of policy action project. Each region must, in fact, be evaluated in accordance with its geographical, economic and demographic determinants and infrastructure capacity (excess equipment or lack of equipment, medical oversupply, waiting lists etc.). Hence there are areas with a low patient flow and underdeveloped health facilities, and there are areas with a high flow linked to high worker mobility and highly developed infrastructure.

Intentional mobility

The most significant results, and the greatest progress achieved, in cross border accessibility to healthcare have been under the Interreg programme.* The most relevant question relates to assessment of the

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* In 1992, the European Commission launched a major Community initiative known as INTERREG. Community Initiatives are specific instruments of the Union's structural policy which the Commission proposes to the Member States to support activities which contribute to solving problems which have a special impact at European level. The general principle underlying the Initiatives was and continues to be that national borders should not be an obstacle to balanced development or to integration of the European territory.

**MEDICAL SPECIALITIES ON THE BASIS OF THE E 112+ CZ GROEP
(period from 1 January 98 to 1 December 98)**

	Belgium	Germany	Total
1 Ophthalmology	50	119	169 (17%)
2 Gynaecology	1	120	121 (12%)
3 Orthopaedics	8	101	109 (11%)
4 Internal medicine	2	100	102 (10%)
5 Dermatology	40	53	93 (9%)
6 Scan	5	75	80 (8%)

“the composition of the population plays an important role in establishing the dynamic of a region”

intentional mobility of patients when the prior authorisation procedure is removed. This assessment should make it possible to evaluate the scale of care flows even if it initially gives little information on the cost of such liberalisation or on the behaviour of the providers.

On the basis of the results involved, we shall be able to identify the motives for this mobility and determine whether the Euregios can, within a geographical area, constitute a suitable response to the needs and expectations of citizens. Thus, is a patient seeking local care as a matter of priority? Are the language barriers an obstacle? Are medical services available and if so for what types of care and with what technologies? Do external factors such as waiting lists encourage resort to care abroad? And so on.

Apart from the European and national legal and institutional frameworks, these complementarity projects have given rise to:

- An easing in the administrative procedures for the authorisation of care abroad.
- Partnerships between care establishments.
- Bilateral agreements between neighbouring social security schemes.
- Exchanges of knowledge and know-how.

In the context of cross border experience, we have been able to highlight two types of projects implemented: one covered practices relating to state health service contracts and the other covered full mobility for citizens. Only the results relating to mobility and in respect of a frontier region will be dealt with here.

* IZOM is a project of free movement for the citizens living in the Euregio Meuse-Rhin who want to cross the border for medical care supported by the mutual health organisation.

** NZI: Nationaal Ziekenhuis Instituut.

Mobility and administrative simplification

The Meuse-Rhin Euregio

The aim of the ‘IZOM’ project* which brings together all of the insurer bodies is to facilitate access to care for all populations residing in this geographical area for general care provided by specialist doctors, on both the diagnostic and the therapeutic levels, the prescription of medicines within the framework of this treatment and the relevant hospital care. This unique experimental project is implemented within the framework of international agreements (EEC Regulations CEE 1408/71 and 574/72), as a result the legal provisions on health insurance, the tariffs and the procedures in each country are applicable. In practice, the insurer authorises the cross border care with the aid of a specific form, IZOM EMR E112+ without prior agreement from the consultant. This project is based on the results of a previous experiment carried out in the region under the name of Zorg op Maat (‘made to measure’).

Results of the Zorg op Maat project.

This is a Dutch ZOM project monitored by the NZI** in the Meuse-Rhin Euregio.¹ This latter, on the basis of a form, E112+, authorised Dutch patients to benefit from outpatient care from specialists in Belgium or in Germany. The project ran from April 1997 to December 1998.

Scope of mobility

The CZ groep (a mutual) assessed the number of insured persons who benefited from the project in relation to the total population of the CZ in the region (four per cent in Zeeland Flanders) at a minimum of one per cent, on an annual basis, and estimated the number of potential beneficiaries at three per cent.

The type of medical specialties (n=989)

In the hit parade of medical specialties, the results show that ophthalmology comes in first, followed by gynaecology and orthopaedics.

These figures have been compared with the national data for waiting lists. They do, in fact, show that ophthalmology is in first place and orthopaedics in second place for the specialties on waiting lists, gynaecology only comes in sixth and dermatology in tenth. On a regional level, there are no waiting lists for gynaecology and for dermatology, only one hospital (AZ Maastricht) has this speciality available, hence the congestion effect.

Reasons for cross border care (n=280)

Of the main reasons for recourse to cross border care, first comes the existence of a waiting list (88.7 per cent), then comes a detailed examination of the state of health (77.8 per cent), in third place (71.7 per cent) is a different system of medical care. This latter point can, for instance, be explained for orthopaedics by a more overall system of care, so in Germany physiotherapy care is part of the treatment as a whole, for oncology Germany offers a number of therapeutic alternatives and not only hospital establishments, for ophthalmology Germany is quicker to use the laser treatment technique. The insured person's knowledge of the treatment plays a positive and considerable role in recourse to cross border care

Geographical accessibility

The further away the beneficiary lives from the service provider, the more he tends to have recourse to these services. So, in the Zuid Oost Limburg part, proximity is mentioned in 73 per cent of cases. The inhabitants of Maastricht tend to travel within Belgium and the inhabitants of Vaals, Kerkhade, Heerlen choose to go to Germany. In the Midden Oost Limburg region geographical proximity is only involved in nine per cent of cases. According to the type of population, in particular for German cross border pensioners residing in the Netherlands, there are other factors involved, such as a system of payment suitable for their own circumstances (43 per cent), having already benefited from care abroad (32 per cent), the language used also reinforces these two latter factors (23 per cent of cases). For other groups such as the elderly and the disabled, only having to travel a short distance to obtain care is an important qualitative element.

Consumer profile

More than half of beneficiaries had received care abroad on one occasion and more than 1/3 had received care for at least five times. There are three groups of people which emerge from this. Pensioners who used to work across national borders and who continue to travel due to the fact that they trust the service provider, a group based on the existence of waiting lists and a third, group of people who travel because care on offer abroad can offer more value or for reasons related to discontent or in order to obtain a second medical opinion.

One interesting development which can be seen is the trend towards a growing diversity in cross border circulation. When the

European regulations on the coordination of social security were established, the legislator had only planned for a very limited number of categories of insured persons within the framework of cross border circulation, insured persons who, at the time, also had to be employees. Since then, the diversity of the types and categories of insured persons and patients who can obtain aid abroad with or without the prior authorisation of their insuring bodies has become extremely large. However, it is not a question of a growth in cross border circulation in all of the existing categories. The studies carried out in the Euregios show that in many cases patients receive abroad complementary care which is either not available at all or else only barely available in their own countries.

Current trends

Cross border circulation is becoming more and more a matter of guaranteeing insured persons who live in the Euregio that they can receive care which is 'nearby over the border'. In many cases, the care which the insured people require is available just over the border in the neighbouring country, in the bordering part of the Euregio, whereas, in their own country, these insured persons would have to travel further in order to obtain the same care. For services which are also covered by the social security system in the insured person's own country, the obtaining of aid abroad, when this is either not available or not sufficiently available in his own country, does not generally pose a problem.

It is important to underline the fact that the composition of the population plays an important role in establishing the dynamic of a region. Amongst the inhabitants of the various Euregios, we find many insured persons who are originally from another country. For instance, in the Meuse-Rhin Euregio many people of Dutch origin live in the Belgian Limbourg area near the border, insured persons of German origin live in the part of the province of Sud-Limbourg close to Germany and people of German origin also live in the German-speaking part of the province of Liege, in Belgium. These insured persons have greatly encouraged and stimulated the particular dynamic of the Euregio, especially recently.

As the image obtained in this way is extraordinarily complex and as the results are specific to each Euregio as such, they cannot be generalised to cover all of the Euregios, and even less so to cover the systems in general.

"It would be paradoxical to encourage only the creation of a free trade area without accepting its indirect consequences."

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Migration patterns of nurses in the EU

The international mobility of nurses has become a contentious issue in the context of a growing and critical global shortage of nurses.^{1,2}

Josie Irwin

“Recruiting nurses from abroad can be a very expensive short term fix.”

The shortage of nurses has been caused by changes in both demand and supply. The demand for nurses has been affected by several well documented factors, including increased need related to advancing technology, shifts from hospital to primary care and an ageing population requiring longer term healthcare. Decreasing supply is a further factor. This is attributed to factors such as more career options for women, an increasing number of mature students with reduced potential years of practice, an ageing nursing workforce and significantly, a poor image for the profession.¹ Nurse shortages are a powerful motivator to look to international recruitment as a solution.³ Against this background, the PCN (the Standing Committee of Nurses of the European Union) is examining patterns of nurses' migration within Europe: which countries recruit nurses from overseas and which countries export nurses and why. A series of workshops have considered issues raised for both importer and exporter countries.

Europe in crisis?

The International Council of Nurses (ICN) has reported shortages of nurses in many parts of Europe.^{1,2} In the Netherlands, there are now 7,000 fewer nurses than required and there is an estimated shortfall of 3,000 generalist nurses in Switzerland. In Poland, whilst 10,000 nurses graduated each year ten years ago, this had declined to 3,000 in 2000. The problem in the UK is particularly acute with a shortage of 22,000 nurses reported in 2001. National nurses' associations (NNAs) from all parts of Europe report significant recruitment and retention difficulties. Almost without exception, the number of entrants to nursing courses is falling and qualified nurses are leaving the profession citing poor pay, workload and inflexible working practices as reasons. In addition, demographic

change means that the nursing workforce in Europe is ageing. Only in Germany is age apparently less of an issue but the age profile is younger only because the average nursing recruit remains in the profession just three to four years before leaving.

In the UK, with 22,000 vacancies, nursing shortages are the worst they have ever been. UK employers recruit heavily from overseas countries with Australia (1,771), South Africa (1,114), the Philippines (972) and Nigeria (920) supplying the largest number of nurses in 1998–89. Numbers have increased dramatically. Figures released in May 2001 by the UK Central Council for Nursing, Midwifery and Health Visiting showed a 71 per cent increase in overseas nurses applying to join the register during the 12 months to March 2001. They included 13,750 from the Philippines, 2,459 from India, 2,065 from Nigeria and 2,056 from South Africa – despite NHS guidelines⁴ warning that in view of current nursing shortages in South Africa and the Caribbean, NHS employers should not consider recruiting in these countries.

Within Europe, the UK government has signed an agreement with Spain to supply 5,000 nurses to the NHS in England. However, the Spanish NNA has concerns that the significant differences between the Spanish and UK health systems could impact on retention. Ireland is also recruiting from abroad. Almost half the nurses who registered for the first time in Ireland in 1999 were from overseas. This is a new development for Ireland which has exported significant numbers of nurses to the UK and US in the past. Central and Eastern European NNAs also are concerned about the possible impact of European enlargement for nurses presented with a choice between poor working conditions and pay in their home country and higher salaries and standards of living in Western Europe. However, shortages are not just confined to Europe; the figures set out by the ICN in April 2001^{1,2} describe an emerging global crisis and a world-wide shortage of nurses.

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Emerging issues

The migration of nurses between countries and health systems is likely to have significant implications. Issues raised by both importing and exporting countries include:

Quality of information: Identifying exactly how many nurses joining domestic registers are actually working as nurses is a problem for all NNAs. There are issues about the reliability and accuracy of data collected by registering bodies and national government departments. Equally, there are issues about identifying how many nurses are leaving to work abroad. Data tends to tell a story of what has happened already rather than providing a basis for forecasting trends.

Impact on salaries and wages: NNAs report concerns that the recruitment of nurses from countries with lower standards of living could impact negatively on the efforts of NNAs in countries importing nurses to improve domestic salaries and working conditions.

Depletion of qualified nurses in exporting countries: Within Europe, Eastern European NNAs are particularly concerned about retaining qualified nurses. Accession countries such as Poland are worried about the impact of increased mobility of its nurses on becoming a full member of the EU. Beyond Europe, health authorities in South Africa are particularly concerned about a drain on scarce skilled staff attracted to work in the UK.

Membership of NNA and joining a trade union: If working in a country for a short time only, internationally recruited nurses do not always join the NNA/trade union.

Induction: Nurses do not always receive appropriate information about living and working in the importing country and the quality of adaptation courses is variable.

Language: There is no proper European Union system of language competency assessment to help nurses and employers decide if they have the language skills to give safe nursing care.

Racism: This could be from patients, local communities or colleagues.

Cost: Recruiting nurses from abroad can be expensive both in absolute terms (the cost of the agency or employer travelling abroad to recruit) and relative to recruitment and retention measures; for example, compared to improving the work environment or simply paying nurses more. Recruiting nurses from abroad can be a

very expensive short term fix.

Issues for EU policy makers

There are issues policy makers at the EU level also need to consider. One is reliable data on the mobility of labour. Knowing whether there will be sufficient healthcare staff to deliver planned health services is important. But national data on the nursing workforce is patchy at best and at EU level, it is practically non-existent. A session at the 2001 European Health Forum in Gastein in September considered whether healthcare human resource planning at European level was a useful or feasible tool to predict and plan movements of healthcare personnel including nurses.

“national data on the nursing workforce is patchy at best and at EU level, it is practically non-existent”

There are also ethical dimensions to whether recruiting from poorer countries, accession countries and countries outside Europe may conflict with EU policy on freedom of movement. For example, a person's choice to work wherever they wish could conflict with the need to deliver healthcare in the country the nurse chooses to leave. How might the Commission respond to this issue?

Finally, cultural and language differences may impede the integration of nurses recruited from abroad and could also impact on the quality of care.

Solutions through collaboration?

The PCN has considered a case study from the UK examining collaboration between the Royal College of Nursing (RCN) and the UK Government on good practice guidance in recruitment, selection and the induction of nurses from overseas.

The nursing shortage in the UK grew throughout the 1990s. NHS employers turned to international recruitment agencies to find nurses and some paid large sums of money to agencies to recruit abroad. While there are some very competent agencies, which operate high professional standards, too many have little experience in recruiting nurses. Some agencies and employers, who went abroad themselves to recruit (rather than using an agency in the country of origin), failed to check the English language competency of

“... *there is no instant aspirin for the headache of nurses’ mobility and migration.*”

the overseas recruits or to obtain professional references before employing them. Moreover, recruited nurses often were given incomplete or incorrect information about work permits, registration, the region in which they would be working, the jobs they were to do, their pay and conditions, orientation in the workplace and their career prospects. In many cases, this led to recruits leaving the UK after only a short while. This was especially the case with recruits from other EU countries.

In 1999, the Secretary of State for Health invited the RCN to be involved in developing guidelines for NHS employers on international nursing recruitment.⁴ As well as describing good practice in recruitment, selection and the induction of overseas nurses, the document makes a strong ethical statement about not recruiting from countries with their own pressing health needs and nursing shortages. The guidelines also give employers clear information on registration requirements and states that professional organisations should have a role in helping overseas recruits adapt effectively to providing patient care in the UK.

The PCN has also considered work done by NNAs in collaboration with governments to improve domestic recruitment and retention. For example, the Irish Nurses Organisation has worked with the Irish government to encourage part-time degrees and to increase financial support for nursing students. In Belgium, older nurses have been encouraged to stay on at work through an initiative allowing them to reduce their working hours but maintain their salary level in the last years of their careers.

At the EU level, key outcomes from PCN’s work include proposals for possible models of collaboration on advice for nurses between national nurses’ associations. In addition, a workforce monitoring forum at EU level, which would include all the key actors could perform an important role in capturing information about movements of nurses within Europe and thus assist with health services planning. Problems with data collection by national and regional government suggest that any such workforce monitoring should not aim at being too sophisticated and should identify flows and trends rather than attempting detailed measurement. Currently, there is no model capable of interpreting the complex flows of nurses’ movements to produce accurate assessments of future changes. An exchange

of information at least would help prevent ill-informed recruitment in countries where there are shortages and help prevent countries from fishing in the same pond. Moreover, some national governments have developed imaginative recruitment and retention strategies. Exchanging examples of good practice could be another role for a workforce monitoring forum.

There may also be scope for collaboration on the ethical dimensions to international recruitment. The evidence suggests that nurses will continue to seek new challenges and career development opportunities which may be located abroad. Nurses are entitled to make this choice. Addressing concerns that recruitment by countries with nursing shortages displaces the scarcity to the exporting country and/or leads to deteriorating health services, and finding possible solutions (such as schemes where nurses work abroad and return to their home country to practice their new skills by arrangement) could be a fruitful focus for further collaboration.

Opportunities to share information and develop collaboration on these key issues may seem like ‘muddling through’ but there is no instant aspirin for the headache of nurses’ mobility and migration. If a workforce monitoring forum does no more than assist development of a common understanding of the complexity of the flows and what influences them, this could advise effective policy interventions at EU and national government level. A common protocol on international recruitment might address overly aggressive recruitment and help ensure the recruitment ‘experience’ for the individual nurse is positive.

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The challenge of professional freedom

“... it is important to ensure the equal quality of physicians throughout Europe ...”



Mia M Mäkinen



Markku Äärimaa

One of the basic freedoms of the European Union, freedom to move and work in all member countries, was made possible for doctors through the ‘medical directives’ in 1975. The medical profession is regulated by law in all countries and specific requirements regarding registration or other forms of authorisation are a prerequisite for practising. Following the liberalisation of the medical market it was important to ensure the equal quality of physicians throughout Europe, with the key issue being the harmonisation of doctor training. An Advisory Committee on Medical Training (ACMT) was set up by the European Commission to assist in this task but after a quarter of a century of good work and its financial backing now being reduced, the fate of the ACMT is in jeopardy. Given the importance of continuously updating directives, and having a body responsible for this task, can the profession now take care of the necessary functions?

The single market

The four freedoms of the European Internal Market, labour, services, goods and capital, have been the goals of European integration since the Treaty of Rome in 1957¹ and the right to practise a profession and establish a business in another European country has given people the opportunity to move around freely in the EU. Professional recognition is based on general and sectoral directives, with most being dealt with through the former which allow Member States to define their own requirements for recognition. Sectoral directives, on the other hand, define the minimum requirements for education and

the procedures for recognition of seven regulated professions, with doctors, dentists, nurses and architects belonging to this group. All member countries are obliged to give equal recognition to the diplomas of these professionals where awarded in another Member State.

The sectoral directive on the mutual recognition of doctors’ diplomas in the EU was established by medical Directive 93/16/EEC, first introduced in 1975.² The directive applies to EU/EEC nationals who have acquired their medical education in the Community area and outlines the mutual recognition procedures designed to ensure that other EU doctors are treated in the same manner as local doctors. It also defines educational requirements: the minimum length of doctors’ basic training; the division of theoretical and clinical training; the minimum length of specialist training; the classification of specialists; and the minimum training requirements for doctors working within national social security schemes.

The ACMT

The Commission has several advisory committees to aid it in updating sectoral directives. The advisory committee for the doctors’ directive, the ACMT³ aims to assist the Commission in ensuring comparable standards in basic and further medical training and proposes amendments to the directive. The ACMT membership was designed to serve the harmonisation requirements of medical training. Each Member State is represented in the ACMT by three partners representing the universities, the authorities and the profession, with members nominated for a three year period. The European Commission provides secretarial support and the committee chairperson, who calls meetings and sets the agendas. The ACMT has three tasks:

- To exchange information on medical training
- To develop common standards
- To review the adaptation of training to current scientific developments

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“Enlargement poses a huge challenge”

In the past, the ACMT usually met once or twice a year and its representatives gradually gained knowledge of one other's medical training systems, procedures and the policy makers involved in the field. Even though the ACMT is a consultative committee and does not have legislative powers, its cumulative knowledge base and opinions are a valuable resource in addressing identifiable problems in European wide medical training.

New challenges for the ACMT

EU enlargement certainly poses a huge challenge for the ACMT. Enlargement brings with it the possibility of further free movement of doctors from new member countries. With enlargement expected to take place in the next few years – 2004/2005 – the European Union stands to gain new Member States from Central and Eastern Europe. A transitional period for the mobility of workforces is expected to be flexible, with a seven year maximum, but as the gross national product of proposed new Member States is significantly lower than the European average, it is certainly possible that significant numbers of highly educated professionals such as doctors will seek to move within the current countries of the Community to attain higher living standards.

Given the possibility of significant mobility, it is important to ensure that the quality of medical training in the applicant countries is comparable to the training in current Member States. Applicant countries have not been able to invest as much money in education or in healthcare as the existing members of the European Union. Whilst this does not mean that the education of doctors is not as good as that of EU countries in general, there are certainly differences and there probably will be a need for the ACMT to ensure harmonisation.

The ACMT today

During the past few years the Commission has tried to simplify legislation for internal markets. In particular, there have been discussions on the possible conversion of the professional recognition sectoral directives into general directives.⁴ The implication is that in future, there would be no need for advisory committees. There has also been a specific proposal to review the ACMT, suggesting a reduction in the number of representatives and the committee's term. So far, this proposal has been unsuccessful and a recent communication from the Commission (May 2001) assesses new pos-

sibilities for current systems of recognition for the professions and tries to involve stakeholders and include their views.⁵

However, through its actions the Commission has indicated that it wants to freeze the ACMT and its work. The ACMT has not been convened for almost two years and its current term came to an end on 28 June 2001. Whilst the Commission appears to want to increase the free movement of doctors, the issue of quality of training has been neglected. The medical profession has carefully observed the diminished role of the ACMT, and doctors' associations at the European level have registered their concern with the Commission, especially regarding the consequences for the quality of medical training and the potential dangers to patients' safety.

The profession strikes back

The Standing Committee on European Doctors (CP), an umbrella organisation for all national medical associations in Europe and other European level medical associations decided to study the possibility of the profession taking over the tasks of the ACMT. A working group was set up, directed by the CP and consisting of associated organisations, representing general practitioners (the European Union for General Practitioners, UEMO), medical specialists (the European Union of Medical Specialists, UEMS) and doctors in training (the Permanent Working Group of European Junior Doctors, PWG). The working group delivered an answer to the Commission's consultation on the future regime on professional recognition, which was signed by all the associated organisations of the CP, including the hospital doctors, salaried doctors and medical students organisations.

The view of the CP is that the medical directive has to be preserved. Besides, harmonisation and development of medical training and medical specialities continues to be of high importance. For the consumer it ensures safety and quality of medical care throughout the European Union. If the ACMT becomes defunct it is important that its work will still be done. As professional organisations have the expertise, structure and interest, the initiative of the CP will probably be well accepted by national authorities. However, many things still need to be resolved, one of the most important being what status within European legal frameworks, if any, is to be given to any alternative body created by the profession.

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Avoiding catastrophe

How to deal with HIV/AIDS in Eastern Europe and Central Asia



*Nicoletta
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*“infection is spreading
at a much faster rate
than it did in Western
Europe”*

Europe and Central Asia include countries with the lowest HIV prevalence rates in the world, including Norway or Kyrgyzstan, but also countries that have witnessed the highest exponential increase of HIV infection in the nineties, such as Ukraine.

The regional HIV/AIDS statistics of the Joint United Nations Programme on HIV/AIDS (UNAIDS)¹ showed, at the end of 2000, a total number of 700,000 adults and children living with HIV/AIDS in the Eastern Europe and Central Asia region. Of the adult population 0.35 per cent is HIV infected. This seems a low figure but if compared to the figures for Western Europe where 540,000 adults and children are living with HIV/AIDS and the adult prevalence rate is 0.24 per cent, it is clear that the situation in Eastern Europe and Central Asia is worse.

The most alarming fact however is to be found in the short timescale in which these figures have developed. Western Europe has been confronted with HIV/AIDS since the early eighties, Eastern Europe and Central Asia only since the early nineties. This means that the infection is spreading at a much faster rate than it did in Western Europe. The number of HIV infected people has almost doubled in Eastern Europe and Central Asia between 1999 and 2000.

Characteristics of infection

The epidemic in Eastern Europe and Central Asia is characterised by specific features, such as the specific group affected, the alarming spread of other sexually transmitted infections (STIs), the lack of information on sexual and reproductive health and the lack of modern methods of contraception such as condoms. The region has also to deal with a number of negative con-

sequences of the sudden change in the socioeconomic structure of the society, including the phenomenon of commercial sex and the lack of funding for sexual and reproductive health.

Most of the quarter million adults who became infected in 2000 are men, the majority of them injecting drug users. After an epidemic of HIV among injecting drug users in the Moscow region in 1999, new epidemics among drug injectors emerged in Uzbekistan and in Estonia in 2000.

Sexually transmitted infection

In some parts of the region, STI prevalence among the sexually active population has become as high as 70 per cent.² Belarus, Kazakhstan, Kyrgyzstan, Moldova, Ukraine all reached a rate of over 50 per 100,000 of the population infected with syphilis, while in western countries the rate has remained below two per 100,000. Between 1989 and 1995, the infection rate in the Russian Federation increased 50 times reaching 172.1 per 100,000. In some urban areas in the north western part of the country the incidence is 300-400 per 100,000.³ Similar rises in other STIs can also be expected although less information is available. The high increase of HIV infections is not isolated from other STIs, in particular syphilis. Increasing STIs infection rates have proved to be a forerunner of increasing HIV infection where not properly treated.

Information

Pornography coming from the west has been for many young people the main source of information about sex. Young people do not have access to information on sexual health and rights, particularly about the risks linked to unsafe sexual behaviour. Even where individuals are aware of this, this has not often led to attitudinal change.

Modern methods of contraception are poorly available and accessible, and when

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they are available the prices are prohibitive, mainly for young people and in particular for male and female condoms. Moreover, the sudden social and economic decline of the region has hit women even harder than men. Commercial sex has become more and more common in the region as a way to survive. Furthermore, in 1998 the Ukrainian Ministry of Interior estimated that 140,000 Ukrainian women had been trafficked in the last decade.⁴ Women lack the power to negotiate safer sex practices, and are often faced with sexual violence, they are more and more victims of sexual abuse, in particular in the war and refugee situations that have characterised parts of the region in recent years. Furthermore, healthcare is not a priority for the cash-strapped government of the region.

The causes

Multiple behavioural and socio-cultural factors have played a role in the rapid spread of the infection in Eastern Europe and Central Asia.

The opening up of society, the breakdown of political institutions and diminishing social cohesion has certainly facilitated a change in sexual behaviour. The fall in GDP has led to increased poverty and unemployment, driving young women into prostitution, and young men into drug and alcohol abuse. The opening up of borders has contributed to cross border sex trade.

Although Eastern Europe and Central Asia have a well established structure for healthcare, the existing structures are not meeting the needs of the population and in particular of the young people. They have curative instead of preventative approaches to healthcare; they are uniform, not reaching out to marginalised groups, and are judgmental; they are not client friendly, and the wellbeing of the client is not taken into consideration in the way medical treatment is provided; counselling is lacking in most cases. Moreover there are often hidden costs for clients: although officially healthcare may be free for all, health staff may request payments unofficially.

The need for knowledge

A decade of experience in Eastern Europe has demonstrated that in order to effectively fight against STIs and HIV/AIDS it is necessary to adopt a holistic approach, integrating STIs and HIV/AIDS programmes into existing and new sexual and reproductive health programmes. Holistic services must include the implementation of education and behavioural change pro-

grammes, sex education, condom promotion and safer sex campaigns, social support for vulnerable groups and treatment of all STIs.

In Western Europe there is a long tradition of providing sexual and reproductive health services. Therefore the integration of STIs and HIV/AIDS prevention in already existing sexual and reproductive health programmes has occurred quite quickly and easily. Generations of young people had already been educated about safer sex, in the beginning solely from the perspective of avoiding unwanted pregnancies, gradually integrating the prevention of STIs, including HIV/AIDS.

Eastern European and Central Asian countries have not had time to build up programmes gradually and to learn step by step. They have to quickly apply a holistic approach towards sexual and reproductive health from the beginning, in order to meet the urgent needs of the population.

Such an answer should be based upon the Programme of Action of the International Conference on Population and Development (Cairo 1994), which called for increased activity and commitment to the issue of reproductive health, including family planning, and STIs and HIV/AIDS prevention and treatment.

The incorporation of STIs and HIV/AIDS into family planning services has been hampered by cultural norms and attitudes to sexuality, which are not often addressed by traditional family planning programmes. In some countries STIs and HIV/AIDS prevention and treatment activities, especially when addressed to specific target groups such as sex workers and men who have sex with men, can negatively affect the image of the organisation implementing them.

Increased knowledge alone will not necessarily result in safer sexual behaviour, and a more intensive approach is needed towards the groups that are particularly at risk of practicing unsafe sex. Targeting these groups concerns the 'core transmitters', such as drug users, people with a recent history of STI infection who are likely to infect a number of sexual partners, sex workers and urban street children, men working away from home and women who provide sexual favours as a means of survival. Men in general are a critical audience of education activities, as their behaviour is also likely to affect women. Among all these groups young people are the largest and most important target. Universal, early and relevant sex education both in and out-

“Young people do not have access to information on sexual health and rights.”

side schools is key in the prevention of STIs and HIV/AIDS. Sex education must include the promotion of condom use, as the only prophylactic method protecting against the infections.

Projects – and constraints

Family Planning Associations (FPAs) throughout Eastern Europe and Central Asia implement sexual and reproductive health and safe sex projects targeting groups at risk in innovative ways:

Ukraine – peer education projects are organised for sex workers and men who have sex with men.

Moldova and Latvia telephone hotlines provide information to young people.

Bulgaria information, education and communication materials and group discussions are organised for marginalised groups such as children in care and their carers, blind and deaf people and the Roma community.

Albania following Sweden and UK experience, youth services are integrated within youth and leisure services.

Poland safe sex projects are specifically addressing drug users and a weekly radio broadcast answering young people's questions about sex and sexuality is coordinated.

New projects are being developed adapting activities that have been tried in Western European countries. Some of them include the dissemination of information in tourist areas, resorts and beaches, festivals, fairs and discos.

The alarming STI/HIV/AIDS situation in Eastern Europe and Central Asia is better documented but there are still major constraints for making a comprehensive and coherent preventative approach possible. In many countries there is still a lack of political and state support reflected in bad coordination between state and NGO activities and programmes, as well as insufficient financial resources. This means that external donor commitment for prevention programmes is still key. Also in many countries, strong opposition to sex education, condom provision and reproductive health initiatives still exists and is increasingly vocal.

EU enlargement and sexual health

The European Commission produced a 'Staff Working Paper on Health and Enlargement' in May 1999,⁵ with the aim of helping to "identify potential issues related to health and accession". The spread

of communicable diseases, especially STIs, is highlighted as an issue of particular concern in this document, which furthermore recognises the possible association with other important social problems, poor family planning and health education, mainly affecting women. Some of the European Union (EU) Programmes do include projects aiming at improving women's health, particularly in the area of sexual and reproductive health, but they account for a very small percentage of the overall budget of these programmes. Little attention has been paid to sexual and reproductive health and rights in the negotiation process with the candidate countries seeking membership.

The EU has a major role to play in improving sexual and reproductive health in Eastern Europe and Central Asia. The EU should take into consideration the sexual and reproductive health and rights situation in candidate countries during the negotiation processes. It should also substantially increase financial resources to support health systems, in particular those dealing with sexual and reproductive health, in all the Eastern European and Central Asia countries.

In order to face the tragedy of HIV/AIDS infection and avoid a public health catastrophe, national governments and policy makers in the EU and in the candidate countries need to recognise the link between poverty and sexual and reproductive health and rights. Governments should regulate and implement legal and economic protection for young women so they can avoid prostitution, and they should protect women and children from trafficking for sexual exploitation. Governments need also to take preventative and punitive action against the criminal act of trafficking, and organise awareness raising activities for the population in general and for vulnerable groups in particular.

The EU and candidate country governments should support the principles of the Council of Europe's draft Recommendation on the Right to Free Choice in Matters of Sexuality and Reproduction. Health promotion policies should be implemented at both the national and European level, including sex education for young people and adolescents' sexual health and rights. Finally, civil society must be included in the development of policies and programmes in the field of sexual and reproductive health and rights and for a true partnership with the national and international NGOs.

“in many countries, strong opposition to sex education, condom provision and reproductive health initiatives still exists and is increasingly vocal”

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The HIV/AIDS explosion in Central and Eastern Europe:

Facing up to a decade of crisis



Gerald F Pyle

In December 2000, the United Nations reported 36.1 million persons worldwide with HIV/AIDS.¹ The global incidence (number of new cases) for the year 2000 was 5.3 million. In addition, nearly 22 million have died from the disease since such statistical tabulations were initiated. While the vast majority of HIV/AIDS infections are in sub-Saharan Africa, global prevalence continues to increase.

In some areas, including Central and Eastern Europe, the number of existing cases has grown dramatically. For example, in 1990 the 21 countries in Central and Eastern Europe, including seven CIS countries, had recorded a combined 30,000 cases of HIV/AIDS in a population of 450 million. While some of these early statistics may have under represented the extent of infection, the recent annual incidence of HIV/AIDS has nonetheless been striking. In 1999, the prevalence of HIV infection was estimated to be 420,000 and by 2000 that number was estimated conservatively at 700,000, with projections for the future equally ominous.²

A brief history

HIV/AIDS has followed a transmission pattern in Central and Eastern Europe similar to that found in Western Europe and, to a lesser extent, the United States. In both Western Europe in the late 1970s and the Soviet Union in the early 1980s, incipient cases of what we now know as HIV/AIDS were traced to blood products. Hence, for these areas, initial cases, while probably of African origin, were identified as neither homosexual males nor intravenous drug users. However, earliest identified cases of

North American origin were homosexual/bisexual males, and the disease spread quickly to some European men who practised sex with other men. The disease spread as a 'gay' disease from several western European foci to the east.³

This phenomenon was borne out by early identification of HIV/AIDS among homosexual men in the Czech Republic in 1985, Hungary in 1986 and Lithuania in 1989. Furthermore, due to strong contacts with the West, 62 percent of all HIV infection in Hungary before 1989 was in homosexual or bisexual men. While HIV/AIDS was on the increase in the Soviet Union by the late 1980s, many cases were still in children infected in medical settings.* Other similar aspects of early HIV/AIDS in Central and Eastern Europe and the West included hostility from the Roman Catholic Church because of associations with homosexual life styles, general homophobic attitudes in the population regarding homosexual behaviour, leading to discouragement of HIV testing, and various forms of discrimination and punishment accorded individuals who were HIV positive.

Shifting focus

By the early 1990s it was clear that the demographic locus of HIV/AIDS had started to shift from primarily homosexual/bisexual males in the United States and Western Europe to a mixed heterosexual model that also included disadvantaged minorities, injecting drug users, and prostitutes. Even by the early 1990s, concerns about AIDS as a 'gay disease' were superseded by this new focus. The primary mode of transmission of the HIV virus had



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* Transmission of HIV/AIDS among children increased in Western and Eastern Europe and the United States until 1993. Since then, improved testing of blood and injection technique has reduced the spread of paediatric AIDS.

shifted to injecting drug use, within a predominantly male population. Characteristically, this outbreak was followed by a second wave of HIV infection, especially among women, through heterosexual activity with HIV positive persons and children born of HIV positive women.

Beginning in 1995 the limited number of cases of HIV/AIDS in Eastern and Central Europe began to escalate exponentially. From less than 30,000 cases in 1995, HIV infections increased to 190,000 by 1997 and subsequently to 360,000 in 1999 and 700,000 in 2000. Ukraine, Russia and Belarus initially accounted for 90 per cent of all new cases. A drug trade route from Turkey to Western Europe, through Ukraine, may have played a pivotal role in the spread of HIV in the region.² In 2000, the Russian Federation recorded the world's highest rate of HIV reporting increase. Furthermore, HIV/AIDS in the countries of the former Soviet Union is expected to increase by another 60 per cent by 2002.⁴

Indigenous factors

During the 1990s, HIV infection emerged more slowly in the countries of Central Europe than in Eastern Europe, but by mid-decade, every country in the region was experiencing the epidemic to one degree or another. Meanwhile, the reporting of new cases of HIV infection in Western Europe had begun to decline. Within Central and Eastern Europe, increased reporting was primarily attributed to injecting drug use, reflecting dramatic growth in drug use throughout the region in the past decade.

Drug use patterns have indeed exacerbated the spread of HIV among injecting drug users. Re-using needles, front loading procedures, drawing drugs from shared containers and other complex techniques utilising multiple syringes to prepare drugs, called 'Syringe-Mediated Drug Sharing' (SMDS) provide highly efficient means of transmitting the HIV virus among many people.⁵ Other techniques indigenous to Central and Eastern Europe include cutting drugs with fresh blood to 'absorb' toxins found in home made substances, leaving all subsequent participants vulnerable to infected blood. In some countries, 'slaves' are hired to sample intravenous drugs to test the quality prior to sale. Their payment is another syringe of drugs, potentially passing contaminated blood both to and from equipment that will be used again by others. Once the HIV virus is introduced

into a community, prevalence of HIV infection rises rapidly among closed circles of drug injectors. UNAIDS (Joint United Nations Programme on HIV/AIDS) estimates that prevalence of infection among a cohort can increase to 40–50 per cent within one to two years.⁴

To some extent, various responses to the HIV/AIDS crisis reflect the status of public health prior to the onset of the disease. Early reaction to HIV in some countries incorporated local attitudes toward homosexual behaviour. Legislation in Romania in 1996 made homosexual activity punishable by one to five years in prison. Countries in the Russian Federation, with command and control approaches to public health, initiated mass compulsory testing that proved to be highly unreliable. In Russia, individuals with a positive test result were forced to sign a statement noting: "You are the carrier of a deadly disease and criminally liable for any contact that would pass that disease on to another."⁶ Compulsory testing without confidentiality and post-test counselling reduced the number of individuals willing to ascertain their status. In Hungary compulsory testing, begun in 1989, included organ and blood donors, juveniles arrested for criminal offences, injecting drug users, patients at STD (sexually transmitted disease) clinics as well as prostitutes and prisoners. HIV positive persons were eligible for healthcare, counselling, and some welfare assistance.

Intervention and prevention

Countries with historically more effective public health patterns have been more proactive in developing prevention and early intervention programmes. Mass compulsory testing has been abandoned in favour of HIV surveillance for 'sentinel populations', including injecting drug users, sex workers and individuals with an STD. Both Slovenia and the Czech Republic have adopted this method to identify and treat at-risk populations. The high cost of treating AIDS through anti-retroviral therapy, estimated at \$ 15,000 US annually, limits its utilisation and places renewed emphasis on prevention as the most cost effective approach to containing HIV infection. Even traditionally Roman Catholic countries like Poland have developed programmes that include needle exchange, methadone maintenance, sexuality education and condom distribution. A similar harm reduction programme in Belarus is estimated to cost US \$29 for each case of HIV infection avoided.¹

“the presence of HIV/AIDS is clearly associated with socio-economic instability”

“In some countries, ‘slaves’ are hired to sample intravenous drugs to test the quality prior to sale.”

Women are biologically four times more susceptible to STDs and the HIV virus than men.* This increased risk is exacerbated by social conditions and cultural mores that enhance female dependence upon men and support unequal gender relationships. Prevailing attitudes that discourage female participation in decisions about sexuality, including condom use, and those that condone multiple partners for married and unmarried men, put women at increased risk for HIV infection. Infections among women in Eastern and Central Europe increased from less than 10 per cent of the HIV population in 1990 to 25 per cent by the year 1999.⁷

Furthermore, the presence of HIV/AIDS is clearly associated with socioeconomic instability, especially high levels of poverty, and an increase in infectious diseases, associated with, poverty, drug use, sexual promiscuity and alcoholism. Following the political collapse of the Soviet Union, economic dislocation in Eastern and Central Europe increased dramatically. The Gini Coefficient, a common measure of inequality, is up 80 per cent in Russia and over 50 per cent in the CIS (Commonwealth of Independent States) countries, which have the highest incidence in the region.⁸ Social disruption and geographic dislocation following civil strife have also created conditions that support behaviour linked with HIV/AIDS transmission. Migrants, displaced by civil strife and war, are often seen as the source of transmission, yet they may actually be more vulnerable than the local population.⁹ It has been demonstrated that poor areas of Zagreb, with increased numbers of displaced persons, inferior housing, high unemployment and increased drug use, have had the higher incidence of Hepatitis B and the greatest potential for HIV/AIDS.¹⁰

Facing up to the problem

While Central and Eastern Europe had few cases of HIV/AIDS in the 1980's, reporting of HIV positive cases has accelerated in the past decade. What had been the scourge of other countries has become a medical, social, political and economic threat to the region. The United Nations General Assembly recently approved a far ranging Declaration of Commitment addressing the AIDS 'global emergency'. In spite of a growing problem, there were few representatives from countries in Eastern Europe in

attendance at the extraordinary meeting of this international body. Yet a key goal of a worldwide initiative is a 25 per cent reduction of HIV infection by 2005 to be accomplished through the development of nationally based strategies for sexuality education for married and unmarried persons, continued harm reduction efforts through condom distribution and needle exchange programmes, recognition and humane treatment of high risk populations including gays, injecting drug users and sex workers, and economic and social empowerment of women to support independent decision making.

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* Larger mucosal surface, higher levels of HIV in sperm and increased risk for micro lesions through coerced sex.

Drug resistant TB treatment in Siberia:

A window out of Russia's misery?



Tim Cullinan

Economic and political dislocation in the former Soviet Union has had a profound effect on public health. A rapid rise in the incidence of TB since the end of the Soviet period is now compounded both by the spread of HIV and AIDS and a steady increase in the proportion of TB cases resistant to simpler first-line drugs.

Tomsk in Western Siberia has become a crucible for developing cost-effective methods of treating drug-resistant TB, suitable to the whole of the Russian Federation. It presents exactly the same problems, with exactly the same causes, as other regions of the Federation – or at least those that have not yet experienced the impact of HIV infection that is spreading rapidly across the country. As far as can be ascertained, the problem of drug resistant TB has only risen during the last six years or so, as a result of the economic distress following the demise of the Soviet Union. Until then, TB as a whole was well, though expensively, controlled in Russia through a vast system of specialist hospitals and sanatoria, with long patient stays and a plethora of staff.¹

During the last ten years, homelessness, unemployment, alcohol dependency, malnutrition and destitution have all contributed to an inexorable rise in TB. Now at least 100 new cases for every 100,000 population are found each year in the civilian sector throughout the Federation. About 10 per cent of these are not susceptible to the relatively inexpensive drugs normally used to treat the disease and control its spread.

The prison crisis

In the prisons, the situation is far worse.² Until recently, the prison population numbered nearly a million in a total population of some 140 million, though during the last year two amnesties have reduced those numbers by about 160,000. Over 90,000 prisoners in Russia are known to have TB, of which upwards of 40 per cent have disease resistant to commonly used drugs. It is

without doubt the prisons that have unwittingly fuelled the crisis in resistant disease across the country and without controlling the problem in the prisons it is useless to suppose it can become controlled in the country as a whole.

Greatly reduced funding and intermittent drug supplies forced doctors in the prison sector to use whatever they could get their hands on in the treatment of TB with the inevitable result that much disease rapidly became resistant. The conditions for its spread could hardly be bettered in the confined spaces of the overcrowded gaols, and it is even worse in the remand prisons where individuals are thrown into contact with others who have not yet had a chance of diagnosis or treatment. To this must be added the nutritional deficiencies arising from budgets that allow hardly more than five US cents a day for each person's food.

Amnesties may be an excellent solution to prison overcrowding but they usually involve people near the end of their sentences and, if they have TB, far from cured of it. Such people are not keen seekers of the further long institutionalisation implicit in traditional Russian TB care and are much more likely to disappear into the general community than to sign up for yet more internment. This is especially the case when they know their drug resistant form of the disease is either beyond the local facilities to cure or will take 18 months to two years of painful and potentially unpleasant treatment if the facilities exist.

The Tomsk programme

Since 1995 the TB services of Tomsk in Western Siberia have slowly and steadily built up a reformed system of TB control, based on the WHO principles of directly observed short-course treatment (DOTS)

“Over 90,000 prisoners in Russia are known to have TB.”

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delivered largely on an ambulatory basis.³ In this they have had continuous help and support from the British NGO, Merlin, funded through the Know-How Fund of the UK Department for International Development (DfID) and, since 1998, from the Public Health Research Institute, New York (PHRI). Every aspect of a comprehensive control programme, including training, social support, financial management and public education, as well as laboratory and clinical capacity, has been explored and developed. All along necessary compromises have been made between what WHO has developed in other cultural contexts as a universal scheme and the accepted Russian practice that was so successful in the past. This is because the highly structured system of TB management, which is hospital dependant and employing high numbers of staff, is not amenable under present economic and political circumstances to the structural readjustments implicit in the DOTS regime. Nor is it considered appropriate locally to adopt en-bloc a system developed in the very different circumstances of developing countries.

However, by common agreement the stringent diagnostic and monitoring criteria built into the WHO protocols have been observed and used throughout. Control now covers the whole oblast (region), which is the size of Germany and has a population of about one million. Half of this population lives in Tomsk city; half lives in rural areas often scattered and isolated in the great Siberian forests. At first, it was hoped that for TB control the civilian sector and the prison service in Tomsk might unite into a single interactive structure but support in Moscow for this has not proved forthcoming, largely for budgetary reasons. However, close cooperation is maintained between the two systems, and a sharing of information, particularly at laboratory level. It has also proved possible, with intense and sympathetic social support, to ensure that three-quarters of those discharged from prison with TB are safely absorbed into the civilian treatment service.

Progress

The results of a long effort in Tomsk are beginning to pay off in a rapid slowing down of the disease and a local ability to identify precise patterns of drug resistance both in new patients and in those who fail treatment. Tight programme control has allowed Tomsk to be the first region in Russia to receive the support of the WHO affiliated Green Light Committee and so able to access second-line TB drugs at much reduced prices. Without such access it costs upwards of \$5,000 to treat each patient with drug resistant disease. Médecine Sans Frontière (MSF), the international medical charity, and WHO have negotiated prices with manufacturers for a limited number of courses worldwide (2,000 so far) which reduces the price to around \$1,200, so long as very strict protocols are observed to prevent the emergence of yet more resistance, for which no drugs presently exist.

In Tomsk, about 600 patients (combining the prison and civilian sector) have been identified as resistant to the two most important and effective drugs (rifampicin and isoniazid) and these are embarking on treatment in cohorts of 200, following a successful pilot trial of 50 patients. Partners in Health (PIH), supported by the Bill and Melinda Gates Foundation, have brought their recent experience in drug resistant control in Peru to Tomsk and much of the costs of the drugs are covered by ECHO (European Commission Humanitarian Office) funding, through Merlin.

Problems to overcome

The need to establish an affordable method of control of this serious problem that can be used elsewhere is urgent but the difficulties are manifold. Not all the drugs needed are registered in Russia and the process of doing so is long and costly. Importation is seen to challenge local manufacture and many of the processes of monitoring and outcome estimation are not easily accommodated in the strict directives that have always governed treatment in Russia. Nor is it usual for new ideas to travel from the periphery to the centre and to be

easily adopted as national policy. And even \$1,200 per patient is not affordable for long.

To treat all those with resistant disease presently in Russia's prisons would cost \$18million. in drug costs alone leaving nothing in the prison health budget for any other needs, or for establishing the precise laboratory and treatment standards necessary to attract support for price-reduced drugs. Despite the vast experience and sophisticated technology that exists in the country, there is no doubt that Russia will need outside assistance for its TB control programme for years to come. Marrying such assistance with local expectations and practices demands understanding and accommodation from both sides.

The wider implications of these problems are obvious, in the imperatives for research into new drugs, into global agreements about prices, patents etc. and in the overarching importance of economic prosperity as an essential for disease control. But one factor gives considerable hope. It is possible, even probable, that the great majority of patients identified with drug resistant disease, at least in the civilian sector, have acquired it as a result of poor practice in the past, and not *de novo*, as an infection from someone else. It does really seem that it is a 'hump' that has to be got over rather than a continually growing problem, and that, once over, things will be easier and a whole lot cheaper. Until, that is, HIV raises its hideous head.

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Devolution in the Italian health service: *Balancing diversity and equality*



George France

Devolution of competencies in healthcare financing and delivery is seen by the Italian national governments as a way of meeting budgetary constraints, but can increased regional responsibility deliver equality of service across the country?

In a referendum in October 2001, Italian voters ratified a law amending the constitution. While not using the term 'federalism', the amendment sets down the constitutional basis for a devolved system of government.¹ The amended constitution now formally recognises the sovereignty of the regions and lists the powers which are the exclusive competence of the state and those for which the state and the regions have concurrent responsibility; competences not specifically mentioned are the responsibility of the regions. The regions are to be fiscally autonomous and equalisation grants are to help compensate for interregional disparities in wealth.

In the specific case of healthcare, the amendment accords constitutional status to the considerable autonomy for the sector which the Italian regions have accumulated over the past 15 years.* They already had virtually complete responsibility for the organisation and administration of the national health service (Servizio Sanitario Nazionale – SSN) with the exception of negotiating SSN staff working and career conditions, remuneration levels of staff and contracted providers and prescription drug prices. Before the amendment the regions had also acquired significant fiscal autonomy for the sector. Healthcare is by far the most important responsibility of the regions, fiscally and politically, accounting for 60 per cent of total regional expenditure.

Pressure from the regions

Pressure for greater regional autonomy in the healthcare sector has been both bottom-up and top-down. The chief protagonists at first were the regions. They

appealed to the constitutional court contesting the right of the central government to intervene directly in the organisation and management of the regional health services. The court frequently found in favour of the regions, ruling as unconstitutional a series of central government measures aimed at obliging the regions to respect centrally set spending limits or to use staff and plant and equipment in particular ways. The regions also acquired real power owing to the political weakness of short-lived national governments. For many years the central government persisted in seeing the regions as its administrative arm and when the SSN was created in 1978 this was financed by central transfers. In the absence of a strong vertical line of command, this inevitably created accountability problems and regional deficits in health became chronic.

Italian public finances were in a precarious state in the second half of the 1980s and were threatening to get out of control at the onset of the next decade. This financial crisis coincided with a political one brought on by the uncovering of systematic irregularities in political party financing. From June 1992 until April 1994, two so-called 'technical' governments (ministers in Italy need not be elected provided they enjoy the confidence of parliament) had a broad mandate from parliament to bring public expenditure under control. Central government strategy changed from opposing regional autonomy to actively promoting it.

* There are five special regions, which have always enjoyed substantial autonomy, and 15 ordinary regions. This article is concerned principally with the latter, which have 86 per cent of the population.

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“How much diversity is compatible with the ideal of a national health service?”

Legislation in 1992 consolidated the transfer of power which had occurred in the second half of the 1980s and tried to reduce jurisdictional overlap; legislation in 1999 aimed at ‘completing the process of regionalisation’. A limit was set on the state’s financial contribution to the SSN. This was calculated as the amount necessary to guarantee a specified package of care to all citizens irrespective of place of residence, since 1999 called the ‘livelli essenziali e uniformi di assistenza’ (LEA). Regions could provide higher levels of care but had to finance this out of own-source revenue. Some minor revenue sources were ceded to the regions, but the major innovation was to give regions title to revenues raised from compulsory health contributions within their territory. Finally, the regions had the power to increase, up to specified limits, existing patient co-payments and introduce new ones.

In 1998, health contributions were abolished and replaced by a regional corporation tax. At the same time, regions were given the power to apply a surcharge to the national personal income tax. Private non-profit health funds could be set up which could cover services not included under the LEA and reimburse patient co-payments on LEA services. Bottom-up pressure for more regional autonomy continued, particularly from the northern (richer) regions.

Fiscal drivers

Pressure from the top mainly came from the Treasury, which was increasingly focused on expenditure containment. From 1999, Italy’s obligations under EMU to reduce its public debt from over 100 per cent of GDP to the EMU ceiling of 60 per cent meant that real public health expenditure could not be increased and might have to be reduced.

With the intent of shifting a large part of the responsibility for containing health expenditure on to the shoulders of the regions, a detailed plan for ‘fiscal federalism’ was announced in 2000. This applied to most sectors but health was the main target. Central transfers were abolished and replaced by a pre-established share of the revenues from the national VAT and some other minor taxes. Regions were obliged to guarantee the LEA. To ensure that they had the fiscal capacity to do so, an equalisation fund was created, financed by VAT revenues ceded by central government and using an allocation formula based on a per capita grant adjusted for fiscal capacity, healthcare expenditure needs and geo-

graphical dimension of the individual regions. The scheme is to be phased in over a period of 12 years and, after three years during which they have to spend what the central government calculates is necessary to ensure the LEA, the regions will be free to decide how much to spend on health.

Fears of fragmentation

Italian supporters of federalism seem confident that the merits of devolution will materialise – proximity to the people, respect for local preferences, greater accountability. The activism of the regional prime ministers is striking, particularly since 2000 when they were for the first time directly elected by the popular vote. However, it is far too early to be able to predict the precise form Italian federalism will assume or the effects it will produce.

A number of problems could emerge. The key question is what implications federalism may have for the SSN based on the principle of equity applied on a national basis. Fears have been expressed about the risk of the SSN fragmenting into 20 quite distinct regional health services. To oppose differentiation of regional services *per se* is to deny a distinguishing feature of federalism, namely diversity.

The issue is: How much diversity is compatible with the ideal of a national health service? Doubtless, there already is regional differentiation, but it is unclear whether federalism will increase these differences or whether it might institutionalise pressure for their diminution. The plan for fiscal federalism and the amended constitution require respect of a national health standard, the LEA. However, the notion of a basic healthcare package has proved difficult to define technically and difficult to enforce politically and legally. By law, the LEA is supposed to be based on four criteria: necessity, effectiveness, appropriateness and economy (in delivery). Agreement was reached on the provisional LEA between central government and the regions in mid October 2001.² It is yet to be seen if this is accepted by the medical profession.

The LEA is a national health standard but it is also a tool for calculating the central government contribution to the SSN. Will it prove capable of fulfilling this dual function? A multi-dimensional approach may be more appropriate, such as under the 1984 Canada Health Act which requires that, to be eligible for federal funds for health, the provinces must guarantee comprehensiveness (deliberately left vague) and

also portability, accessibility, universality and public administration. Inter-regional mobility of patients, no great problem in Italy when the national Ministry of Health paid, could create difficulties now that the bills will be sent to patients' region of residence. Equity problems will emerge if the individual regions start levying patient co-payments which are markedly different in amount or exemptions.

The dual economy

Likewise, it may be that not all regions will be able to support the LEA. Equalisation transfers are supposed to be made by the central government to individual regions from a fixed pot of money. If health expenditure were to rise faster than GDP, there would be inadequate resources at the regional level to support healthcare services.³ If so, either the central government will sooner or later have to increase the share of VAT revenues assigned to the equalisation fund (a move that would be at odds with the goals of expenditure containment and increased regional accountability) or the regions with inadequate fiscal capacity will have to increase their own taxes, cut back on non-health spending and/or reduce their contribution to the SSN by increasing patient co-payments and de-listing services, allowing these to be financed by non-profit health funds or private insurance.

The private financing option will be all the more tempting, the more vaguely the LEA is defined. The richer regions may also be unhappy about increasing the size of the equalisation fund since it is ultimately they who would have to finance this. In 2001, six regions, all central-north, were net donors with one region, Lombardy, bearing over 55 per cent of the total redistributive load.⁴ Indeed a problem for the stability of fiscal federalism is the persistent dualism of the Italian economy. Taking average Italian GDP per head as 100, in 1999 Lombardy stood at 128.8 and Calabria in the south at 61.6.⁵ In the medium term, this could lead to pressure from the richer regions to define the LEA more restrictively.

The central government may find itself caught between its desire to protect the national standard and its mission to contain public expenditure. In any case, under current law the central government lacks any real financial leverage to enforce the LEA given that the financial sanctions for non-compliance are very small and that the transfers are not earmarked. Richer regions may also be tempted not to comply if

meeting the LEA means neglecting other priority areas.

Popular indifference

The SSN does not command the committed popular support evident for some other European health systems.⁶ This may mean that the SSN lacks the built-in protection against attempts by regions to change key features of the kind which seems to have discouraged the Canadian provinces from contravening the highly popular Canada Health Act.⁷

Both the central government and the regions will have to learn to 'manage' federalism and this will require institution building, particularly for intergovernmental negotiation and dispute resolution. In this respect, the relatively poor administrative capacity of some of the southern regions may prove to be a problem. They already have a poor record in the design and implementation of capital expenditure programmes.⁸ Central government or inter-regional technical assistance schemes may be necessary.

The law amending the constitution, approved by the previous parliament and claimed by the then incumbent government to set the stage for a 'solidaristic federalism', is criticised by the Berlusconi government elected in May 2001 for not being federal at all. A new law is being drafted which is promised to grant much more power to the regions. The SSN faces uncertain times ahead!

*"after three years ...
the regions will be free
to decide how much to
spend on health"*

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Caring for an ageing society:

The consumption of hospital bed services by the elderly in the Czech Republic



Zdenek Kalvach

“Caring for the ‘post-productive’ populace is not viewed as serving vital macro-economic priorities.”

The Czech Republic has a population of 10 million people and ranks among countries with a high degree of human development (in the Human Development Index). Despite traditionally well developed healthcare provision, the country witnessed a stagnation in development parameters (e.g. life expectancy) in 1960–90, caused by an unhealthy lifestyle as well as the declining effectiveness of the healthcare system. Consequently, a call for more effective healthcare delivery, including reduction and re-definition of the hospital bed fund, has become one of the priorities in the transformation of the Czech healthcare system since 1989. The issue is all the more pressing because of the demographic shifts now taking place, which are producing ever larger numbers of dependent persons, requiring long term care in nursing facilities.

A demographic dualism

The Czech Republic now faces a more marked demographic shift than other European countries. The healthcare delivery system will have to serve an increasingly elderly population. According to a prognosis published by the UN, the Czech Republic will soon be the oldest community in the world, with 41 per cent of the population older than 60 years.¹ In this context, the development of effective geriatric healthcare is a pressing issue. The results of such developments can serve as a model (either positive or negative) for other countries in transition.

On the international scene we have been witnessing a clash of two tendencies: First, fears of an inevitable increase in morbidity and disability, followed by an increase in expenditure, resulting from prolonged life expectancy.^{2,3} Second, hope for a reduction in morbidity and dependency, owing to a healthier elderly population.⁴

Recent figures show a marked improvement in the public finances in the Czech Republic.⁵ This fact is important in enabling the appropriate allocation of resources to geriatric care, that is, to prevention and intervention rather than long term basic care.

Fear and discrimination

The approach to geriatric healthcare in the Czech Republic has tended to reflect fears of an uncontrollable increase in healthcare expenditure for the ageing population, in line with a traditional image of old age as a period of ill health, dependency and poverty. Such fears have fuelled discrimination against the elderly and the proper allocation of resources to their care. This tendency has been exacerbated by the stress placed on the country in catching up with the west. Caring for the ‘post-productive’ populace is not viewed as serving vital macro-economic priorities or contributing to overall economic competitiveness.⁵ Geriatric healthcare is therefore a key political issue.

The bottom line question to be answered by the countries in transition is whether to perceive geriatric issues within the traditional medical/social services (in which ‘saving’ then leads to the restriction of the ill to basic or social care), or instead to understand the complex issues that arise in an ageing population and the potential new approaches to healthcare that may spring from them. For example, the problem of ‘bed blocking’ by the elderly is solved in Western countries by means of acute hospital geriatric wards that improve prognosis and reduce the need for subsequent care,⁶ by comprehensive patient assessment, evaluation and management, and by increased responsibilities of non-doctor medical staff. In the Czech Republic, however, the same problem is perceived above all as a social issue that is to be solved by means of an increased capacity in social care.

Passive consumption

At this stage it is interesting to compare the impact of such ‘traditional’ efforts to reduce the geriatric healthcare expenditures and the occupancy of hospital beds. A comparison of the age-specific parameters (ratio of the number of hospitalisations and hospital days per 1,000 citizens of a given age) in 1986, 1992 and 1998 shows surprising results (see Tables 1 and 2). An absolute decrease of hospital care is achieved, as

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expected, due to health improvements in younger age groups. However, in elderly age groups, and especially in women, hospital care consumption actually shows a small increase. The likely explanation is that simplification of the health needs of frail geriatric patients leads to an increase in consumption of passive hospital care in traditional style services.

Geriatric patients move among the traditional medical branches, are transferred and sometimes re-hospitalised, they become dependent on hospital through induced immobility and delirium. They simply await transfer rather than being rehabilitated and prepared for discharge. Women, who are more likely to be widowed, suffer more from this situation. In patients over 75 years old, the percentage of hospitalisations which resulted in transfers to other health or social care was 18.9 per cent in married women but as much as 23.3 per cent in single women (16.9 per cent in married men and 23.0 per cent in single men) in 1998.

Need for a new approach

Countries undergoing transition should move beyond the simplistic cost cutting approach to geriatric care. The notion of 'dependency' should be replaced with the idea of 'frailty', and there should be a redistribution of competencies among medical staff. The issue of the over occupancy of hospital beds – bed blocking – should be reconsidered and greater stress placed on prevention. The alternative is continued discrimination, unnecessarily poor prognosis of medical interventions, and inadequate increases in what amount to ineffective expenditures on services for the elderly.

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Table 1 HOSPITAL BED DAYS PER 1000 FOR 1999² AND 1998 (in absolute terms and as a percentage of 1986)

Age	sex	1986	1992	%	1998	%
30-34	women	2031.8	1486.6	73.2	1105.0	54.4
	men	1180.1	812.0	68.8	595.9	50.5
45-49	women	2500.1	1776.7	71.1	1285.5	51.4
	men	2369.2	1662.9	70.2	1248.2	52.7
60-64	women	3160.4	2653.6	84.0	2192.3	69.4
	men	4121.2	3404.5	82.6	2793.2	67.8
65-69	women	4097.8	3584.3	87.5	3037.6	74.1
	men	5118.6	4525.0	88.4	3776.2	73.8
70-74	women	6320.7	4664.9	92.7	4153.8	82.6
	men	5031.3	5537.7	87.6	4861.3	76.9
75-79	women	5867.8	6123.0	104.3	6132.9	104.5
	men	7143.2	7066.0	98.9	6708.9	93.9
80-84	women	5930.1	7126.8	120.2	6318.0	106.5
	men	7664.4	7739.8	101.0	6390.1	83.4
85+	women	7349.2	7159.1	97.4	8450.4	115.0
	men	9628.8	7709.4	80.1	8201.2	85.2
75+	women	6110.0	6690.5	109.5	6741.2	110.3
	men	7527.4	7392.9	98.2	6901.2	91.7
65+	women	5284.2	5118.3	96.9	4846.4	91.7
	men	6391.4	5716.4	89.4	5089.1	79.6
Total	women	2677.1	2259.8	84.4	1861.8	69.5
	men	2315.8	1830.7	79.1	1542.2	66.6

Table 2 HOSPITALISATIONS PER 1000 CITIZENS, 1992 AND 1998 (in absolute terms and as a percentage of 1986)

Age	sex	1986	1992	%	1998	%
30-34	women	213.0	178.0	83.6	195.8	91.9
	men	87.9	70.6	81.5	83.0	94.3
45-49	women	182.3	166.2	91.2	184.1	101.0
	men	151.0	128.3	82.4	150.5	99.7
60-64	women	186.1	177.1	95.2	241.0	129.5
	men	241.1	226.6	94.1	302.5	125.5
65-69	women	228.7	222.1	97.1	308.8	135.0
	men	295.2	287.4	97.9	391.1	132.3
70-74	women	266.5	298.0	111.8	384.9	144.4
	men	356.7	380.2	99.0	489.1	137.1
75-79	women	301.4	316.9	105.1	525.0	174.2
	men	406.6	409.0	108.0	636.7	156.6
80-84	women	316.3	379.8	120.1	486.5	153.8
	men	428.5	489.8	112.4	582.0	135.8
85+	women	318.3	375.6	118.0	586.1	184.1
	men	451.5	498.1	106.0	705.6	156.3
75+	women	308.5	350.1	113.5	529.7	171.7
	men	417.1	447.9	110.3	635.5	152.4
65+	women	276.0	293.0	106.2	419.4	152.0
	men	359.8	363.6	100.4	497.7	138.3
Total	women	210.7	199.4	94.6	233.7	110.9
	men	178.6	146.6	82.0	187.9	105.2

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Young@heart

Working towards improved heart health

The Winning Hearts conference of February 2000 in Brussels focused attention on Europe's biggest killer – cardiovascular disease. In the UK, this has been followed up with a major heart health initiative: Young@heart, established by the National Heart Forum. It embraces the declaration made at the Brussels conference on 14 February 2000 as its aim: "every child should be able to live to at least the age of 65 free from avoidable heart disease".



Louise Sarch

Coronary heart disease (CHD) is the UK's biggest single killer. Every year 140,000 people die from coronary heart disease, 20,000 of them before they reach the age of 65. Currently in the UK there are 106,000 people under the age of 65 who have had a heart attack.

A preventable condition

As we know, heart disease is largely preventable – there is good evidence to suggest that at least 75 per cent of new cases of cardiovascular disease can be explained by the major risk factors of poor diet, physical inactivity and tobacco use. In developed countries like the UK, about 95 per cent of the adult population have some risk of chronic heart disease. Since CHD manifests itself in adulthood, prevention strategies have focused on modifying adult behaviours. Targeted prevention efforts in adults in the UK have been successful in reducing disease rates in recent decades. Indeed, based on current trends the UK government's target of a 40 per cent reduction in deaths from CHD in people under the age of 75 by 2010 will be easily reached.

However, there is an established body of evidence to show that the development of CHD starts early in childhood and continues throughout life. Foetal under nutrition and exposure to tobacco products via the placenta increase susceptibility to later disease. Lifetime dietary habits tend to be laid down in childhood and atherosclerotic lesions have been found in the arteries of children as young as nine years old.

Physical activity in childhood is important for weight control. Most smokers take up the habit before the age of 18 and people who have not started to smoke by the age of 20 are unlikely ever to do so.

Child poverty is also a major factor, with strong correlation between deprivation and risk of coronary heart disease. Over the last 30 years in the UK, growing inequalities have been closely mirrored by a widening social class gulf in coronary heart disease with the poorest members of society now suffering a risk three times greater than those who are better off. One in three children in the UK grows up in relative poverty – a higher proportion than in any other EU Member State.

The need to act

Given this knowledge, it is frightening that little is being done to promote the heart health of children and young people. Indeed, rates of teenage smoking appear to be increasing, particularly amongst young women, the diets of children and young people are nutritionally poor compared to thirty years ago – children increasingly eat too many fatty, sugary and salty foods and too little fruit and vegetables and do not take enough physical activity. So far in the UK, little has been done to tackle these risk factors in childhood, even though if current knowledge about the causes and prevention of heart disease were turned into effective policy action focusing on children and young people, death and disability from coronary heart disease among people under 65 could be substantially reduced.

The National Heart Forum's young@heart policy framework of recommendations sets out a blueprint for UK-wide action for the heart health of children and young people. Its key goal is that governments across the UK should demonstrate strong, visible and sustained leadership by establishing children and young people's health and well being units in England, Scotland, Wales and Northern Ireland to implement and develop national child health plans. This should be coordinated by the Cabinet Office, located at the centre of the UK government.

The young@heart policy framework comprises three core comprehensive strategies on nutrition, physical activity and smoking and complements and strengthens policies to eradicate child poverty. Particular emphasis is placed on involving children and young people in local and national decision making.

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For further information visit the NHF website www.heartforum.org.uk/young or contact the NHF by email at young@heartforum.org.uk

Young@heart: The start

The National Heart Forum (NHF), an alliance of over 40 UK organisations concerned with heart disease prevention, embarked on the young@heart initiative following the European Heart Network's (EHN) Winning Hearts conference in February 2000. The NHF, a member of the EHN, has been closely involved with the European Commission sponsored European Heart Health Initiative (EHHI), a project set up in 1998 to build networks of organisations involved with heart disease prevention in each Member State, to raise awareness of heart disease prevention and make it a priority for the EU and within Member States. In the first phase of the EHHI, networks were set up to raise awareness through a series of activities based on the theme of children. This work culminated with the Winning Hearts declaration. As signatories to the declaration, the NHF, committed to making this a reality, wanted to take it forward in the UK and created young@heart with the support from the British Heart Foundation, the Health Development Agency and the Nuffield Trust.

The first phase of young@heart, a life-course approach to prevention of heart disease starting in childhood, was made up of three strands:

- A review of evidence to assess the potential for reducing coronary risk from early life and through interventions in childhood.
- Consultation with experts to develop recommendations on policies and actions at national and local level to tackle the origins of coronary heart disease in early life.
- Children's views: to find out what children think about their health and influences on their health.

The first strand – the most recent comprehensive review of evidence on risk factors and determinants that influence children's health – was commissioned by the NHF especially for young@heart. The review looked at physical activity, diet and body weight, smoking behaviour, development in the womb and other physiological measurements. Papers were commissioned from experts in epidemiology and children's behaviour and provide the basis for an analytical review of the current evidence and recommendations for action.

In parallel, a policy group, made up of pub-

lic affairs experts from multidisciplinary backgrounds, were charged with developing a framework of policy proposals, including actions at local and national level, to tackle the origins of coronary heart disease in childhood. The policy group drew on the results of the research review and an audit of current UK policy initiatives which have an impact on child health, to develop their recommendations.

To ensure that the young@heart initiative took proper account of the practical experience of children's daily lives, the NHF commissioned a new review of studies that have looked at children's behaviour, attitudes and opinions. A video-recorded talkshop with thirty invited 11 to 17 year olds, was also held to explore the findings of the review, which relate to children's health, their wellbeing and some of the broader social, environmental and economic health determinants.

Policy summit

This first phase of young@heart culminated with a policy summit meeting in June 2001. Over 90 opinion formers and experts from multidisciplinary fields were invited to rigorously appraise the draft policy framework of recommendations. Following the summit, a policy statement was issued calling for the establishment of children's and young people's health and well-being units in England, Scotland, Wales and Northern Ireland to develop national child health plans. These are to contain comprehensive strategies, with targets, to improve child and young people's nutrition and physical activity levels and to tackle smoking. Moreover, current investment in family and child anti-poverty policies should be maintained, if not increased, and more research should be undertaken to develop anti-poverty policies and comprehensive anti-smoking strategies. These should be targeted at children and young people and complement adult campaigns and programmes.

Since the summit meeting, the NHF has updated, revised and restructured the policy framework in the light of discussion and has now sent it out for consultation to over 200 people. As we wait for the results of the consultation we have embarked on the second phase of young@heart – to advocate and implement the policy framework of recommendations across the UK. A comprehensive advocacy and communications strategy will follow the launch of the young@heart final policy framework at the Houses of Parliament on 14 February 2002, the second anniversary of Winning Hearts.

“Every child should be able to live to at least the age of 65 free from avoidable heart disease.”

EU HEALTH POLICY FORUM

The eagerly awaited first full meeting of the EU Health Policy Forum took place in Brussels on 21 November.

The Commission initiative is aimed at providing a forum for discussion of health policy issues relevant to the EU, and comprised over 40 European umbrella organisations and networks of stakeholders from professions, consumers, NGOs, providers and the social partners, while observers were present from the main EU institutions.

Participants were welcomed by EC Health Commissioner David Byrne, who highlighted what he saw as a growing political momentum for review of the key EU Treaty Article 152 concerning health. Possible changes are likely to be considered by the Forum in coming meetings, and the Commissioner drew attention to the role of the European Court of Justice in clarifying the limitations of the existing Treaty with reference to anti tobacco measures and cross border movements for health services.

The first meeting concentrated mainly on providing information about the elements of the forthcoming EU Health Action Programme, the G10 Pharmaceutical policy process and the eHealth elements of the eEurope Action Plan. However, an ambitious agenda is being

suggested for the next meeting scheduled for June 2002, including discussions on health and enlargement, health research, and medical devices legislation. Criticism was voiced by participants about some previous consultative practices which the Forum is intended to address, and strong calls were also made by participants for early and greater attention to health promotion and prevention issues, and to fast moving developments in cross border health services.

In addition, two wider elements of the Forum will be developed during 2002, a conference style event, possibly linked to an activity and promotion day; and a Virtual Forum to inform and involve citizens.

Furthermore, efforts are being made to create a 'platform' of groups who seek to represent the particular interests of patients in Europe, and a subsidiary meeting was held on 21 November to discuss practical aspects of that initiative.

Full information, documents and lists of participants are being made available for public information and consultation on a new website:
<http://forum.europa.eu.int/Public/irc/sanco/ebf/home>

G10 medicines group reports on progress

A series of measures facilitating stakeholder input to work on how best to enhance EU pharmaceutical industry competitiveness whilst safeguarding patient interests were discussed at the second meeting of the G10 Medicines Group on 26 September.

They include an eight week consultation, workshops and the launch of a G10 medicines website. Preparatory work has also begun on the final report, including recommendations, to be presented to Commission President Romano Prodi by April 2002. This report will take into account comments

received from the consultation of stakeholders and G10 workshops. The next meeting of the G10 Group is scheduled for 26 February 2002.

The G10 initiative, made up of European governments, industries, patients, sickness funds and Commission representatives from various Directorates-General, could provide a useful model for inclusive discussions in other health related policy areas.

Further information about G10 and a copy of the consultation paper are available from:
<http://pharmacos.eudra.org/F3/g10/g10home.htm>

Health on the agriculture agenda

Food issues were on the table at the latest high profile meeting between food producers, retailers, consumer experts and scientists on 5 November in Madrid.

The Round Table, attended by EU Health & Consumer Protection Commissioner David Byrne, was the latest of a series of such events held during 2001 at a wide range of venues including Stockholm, Berlin, Dublin, Vienna, Paris, Athens, Bologna and London. They form part of a significant joint initiative with Agriculture Commissioner Franz Fischler, as the EC did not have a designated Commissioner for Health during the previous round of Common Agriculture Policy (CAP) reforms.

The Round Table addressed in particular citizens' expectations of food production, how modern agriculture production techniques can be developed effectively to provide high quality food, and how the sustainability of agriculture can be promoted economically, socially and environmentally.

Commissioner Byrne acknowledged that "reconciling low price, high volume and top quality plus taking all ecological and ethical concerns into account is a major challenge." He said that the bottom line for the EU had to be that all food was safe.

The EC wants to use the review of the Common Agricultural Policy next year as an opportunity to make the agricultural sector more sustainable. The guiding forces behind policies was set out as "more information, more quality and guaranteed safety". The debate is being conducted in the face of increasing consumer concerns as expectations exceed what markets provide, and the stated objective is to identify issues requiring further investigation.

Further information on the Commission's food and agriculture initiative is available on website:
http://europa.eu.int/comm/agriculture/foodqual/index_en.htm

SOCIAL INEQUALITIES IN HEALTH

The end of the year has seen a succession of linked activities promoted by health and social ministers in Belgium to raise awareness about health inequalities and to suggest future health promotion actions at regional, national and European levels.

A seminar of international experts was organised in the European Parliament by the Flemish Institute for Health Promotion (VIG), with active support from the Minister of Health and Welfare for the Flemish Community and the European Network for Health Promotion Agencies (ENHPA). This brought forward a consensus document setting out recommendations, and a report highlighting national

activities in EU Member States and Norway.

This was followed by a Colloque in Brussels sponsored by the Minister of Health for the French speaking community which took forward relevant initiatives.

Finally, a Ministerial Roundtable was organised on 5 December in Brussels featuring the Federal Minister for Health and her two Community colleagues, at which the expert recommendations were set out for comment by national governments and EC Health Commissioner, David Byrne.

It is anticipated that one of the main 'pillars' of the new strand of the EU public health programme aimed at addressing health determinants will feature actions regarding health inequalities.

Further information on the outcomes of these events may be obtained from catherien.ancion@vig.be or the Brussels Office of the European Network for Health Promotion Agencies info@enhpa.org or www.eurohealthnet.org

G7 agree bio-terrorism responses

The EU and Member States played an active role in an agreement reached by leading industrialised countries to protect citizens against renewed threats from bio-terrorism in the context of the international crisis since 11 September. Commissioner David Byrne joined Health Ministers from Germany, France, Italy, UK, Canada, Japan, Mexico and US at a meeting in Ottawa on 7 November which backed international collaboration and agreed to "forge a new partnership to address the critical issue of protecting public health and security".

Objectives include cooperation in procuring vaccines, new rapid testing and research initiatives, support for the WHO disease surveillance network which includes the EU, closer links between laboratories and sharing of data and contacts. The EU Council of Ministers subsequently reached agreement on a range of complementary measures at its meeting on 15 November, including emergency management and information mechanisms, and vaccine stockpiling measures.

Further information about the Council conclusions may be obtained from website: www.eu2001.be/Main/Frameset.asp?reference=01%2D01&lang=en&sess=863707

Political agreement on blood safety

At their meeting on 15 November EU Health Ministers reached political agreement on a proposed EU Directive setting high quality and safety standards for human blood and blood products throughout the European Union.

This would set comprehensive and legally binding standards for blood and blood products from donor to patient and for related medical applications. The measures include requirements for testing, labelling and traceability of blood and blood products, for quality management systems in laboratories and other establishments handling blood and an EU-wide surveillance system. Member States are required to encourage voluntary and unpaid blood donations as the preferred source for blood and blood components. The proposed legislation is the first using the new EU competence in public health which was introduced in Article 152 of the Amsterdam Treaty.

The text of the proposed EU Directive is available from website: http://europa.eu.int/comm/health/ph/others/safety_blood/index_en.htm

Byrne calls for policy response to cross border care judgements

Speaking at the European Health Forum Gastein on 28 September, European Health Commissioner David Byrne emphasised the need for effective policy responses to the recent European Court judgements on cross border healthcare.

After the judgements on Smits/Peerbooms and Vanbraekel, the Commissioner said it was clear that health services fall within the European Single Market's meaning of services provision. He called on policy makers at national and European levels to rise to the challenge by engaging in a structured policy discussion across the policy spectrum.

In particular, at European Union level he highlighted the important role played by Social Affairs Commissioner Diamantopoulou in facilitating an inclusive discussion

of cross border healthcare issues. Administratively, such issues fall within the social security agenda of the Social Affairs Directorate, not the Health Directorate, of the European Commission. This recognition of the need for greater 'joined up' working is aimed at bridging the gaps between the many EU policy areas and Directorates-General that impact on healthcare.

Commissioner Byrne's speech is available on website: http://europa.eu.int/comm/dgs/health_consumer/library/speeches/speech121_en.pdf

LACK OF FUNDING FOR HEALTH RESEARCH REVEALED

On 29 October the European Commission adopted a proposal by Research Commissioner Philippe Busquin to allocate 440 million euros from the future EU research budget to one of the key elements of the EU's Sixth Framework Research Programme (2002–2006) on 'Anticipating the EU's scientific and technological needs' (the so-called 'priority 8').

The proposal also earmarks a further 440 million euros to be allocated at a later stage as needs develop and new subjects emerge. Eighty million euros has been allocated to policy orientated research on 'Providing health, security and opportunity to the people of Europe', to be shared between public health and consumer policy as

'Providing health, security and opportunity to the people of Europe'

Research in this category responds to policy requirements relating, in particular, to the implementation of the European social agenda, public health and consumer protection and the creation of an Area of Freedom, Security and Justice. It will focus on methods to evaluate the need for, and performance and efficiency of, social and consumer policy measures. These will include:

"Methods to evaluate the need for, and performance and efficiency of, social and consumer policy measures, including aspects related to consumer satisfaction, unfair practices and impacts of other EU policies; the transformation of the labour market, and the cost of 'non-social Europe', development of coordinated approaches and a comparative European knowledge base for policies to ensure sustainable pension and health care systems, in particular with respect to the impact of demographic change and ageing; development of improved methods for risk assessment, including non-animal test methods for chemical substances, measures related to product safety, and communication of emerging threats to consumers' and workers'

well as security and crime prevention.

Critics say that the 80 million euros falls far short of the support required to undertake research in the health policy priority areas outlined in the proposal (see extract below). Therefore, it is hoped that health policy will benefit from the remaining 440 million euros to be allocated later. In contrast to the new proposal, the current Fifth Framework Research Programme has allocated 483 million euros to its policy relevant research section on 'Generic Activities' which is shared out between seven health and social policy areas, one of which is 'Public health and health services research including drug-related problems'.

health and safety.

Comparative assessment of health determinants, including nutrition, gender-related and socioeconomic factors, of health services and eHealth systems, and methods for intervention quality assessment; development of improved incidence measurement and understanding of transmission paths for emerging, rare and communicable diseases, including in the international context; development of safe and secure procedures for blood and organ donation, storage and use; methods to assess the distribution, and socioeconomic impact, of disabilities.

Comparative research on factors underlying migration and refugee flows, including illegal immigration and trafficking in human beings, improved means to anticipate crime trends and causes, and to assess the effectiveness of crime prevention policies; assessment of new challenges related to illicit drug use."

To see the full proposal, please consult the following web address http://europa.eu.int/eur-lex/en/com/availability/en_availability_2001_12.html

Parliament continues health debate

The second reading of the Community action programme in the field of public health (2001-2006) was voted in the European Parliament's Environment, Public Health and Consumer Policy committee on 21 November.

Amendments accepted included those advocating greater support for NGOs in public health, actions on complementary medicines and vaccination in the programme and quality control and guidelines for health services. Rapporteur Professor Trakatellis MEP (PPE-ED, Greece) persuaded the Committee to reinsert support for his increased budget proposal of 380 million euros. As Eurohealth went to press the amended text was due to be voted in the December Plenary session. It will then be sent to the Commission and Council for their response. It is anticipated that the Spanish Health Council will adopt the programme in June 2002.

For the full list of amendments by the European Parliament see website: www.europarl.eu.int/meetdocs/committees/envi/20011120/ENVI20011120.htm

CARMEN project on health and social services for older people

The European Commission has published details of the Fifth Framework funded EHMA research network on 'Health and Social Services for Older People' (CARMEN).

This network of research and service delivery organisations is examining how services for older people can be better managed by exploring the efficiency, quality and user acceptability of different modes of health and social care services for older people.

Details are available on the Europa website at: http://dbs.cordis.lu/cordis-cgi/srchidadb?CALLER=EI_EN_PROJ&ACTION=D&QF_EP_RCN_A=58258

COMMISSIONER MONTI DEFENDS EU PHARMACEUTICAL POLICY

Speaking on 'European Competition Day' on 11 October, EU Competition Commissioner Mario Monti defended Commission policy on pharmaceuticals in the face of recent challenges by the pharmaceutical industry.

One of the key issues he dealt with concerned parallel trade in medicines. Because of the influence of public authorities over pricing, medicine prices differ widely between Member States which causes parallel trade to occur between low price countries and high price countries. Mr Monti stressed that the Commission would resist pharmaceutical companies which seek to

limit parallel traders. Following legal challenges brought by the pharmaceutical industry, he said that the Commission resisted charges that parallel trade in medicines harms consumers and brings no benefits for consumers in the high price countries. He also spoke of the necessity to balance the need for patents to recoup drug investments costs with the need to allow newcomers into the pharmaceuticals market.

Commissioner Monti's speech is available at: http://europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=SPEECH/01/450101RAPID&lg=EN

Product safety rules come into force

The European Parliament's endorsement of the revised Directive on General Product Safety during October has completed the institutional passage of an initiative that will update important consumer health and safety protection legislation.

Previous rules had been in place since 1992 and had become outdated. Their reform had proved controversial until a balance was struck through the conciliation process between the Parliament and the Council of Ministers.

The overall aim is to impose a general obligation to market only safe products, while the main features of the revision include clarification that rules will apply to all consumer products; better definition of the responsibilities of producers and distributors; increased rights and rapid response measures for consumers in the case of dangerous

goods; a new European Product Safety Network; and tougher criteria for assessing product safety.

Commissioner Byrne welcomed the agreement: "This shows our determination to improve risk management tools. It is now up to producers, distributors and national authorities to make sure the new rules will be respected in day to day practice." Member States now have two years to implement the new rules at national level.

Further information is available on website: http://europa.eu.int/comm/dgs/health_consumer

MENTAL HEALTH PROGRESS

European policy makers gave a particular focus to mental health issues during the autumn.

Following soon after the publication of the WHO World Health Report 2001, 'Mental Health: New Understanding, New Hope', the Belgian Presidency and the European Commission organised a conference in Brussels 25-27 October on 'Coping with stress and depression related problems in Europe'. Keynote speeches were made by the Belgian Minister for Public Health, Magda Alvoet, EC Health Commissioner, David Byrne, and WHO Director General, Dr Gro Harlem Brundtland. A panel of ten health ministers and other policy makers discussed how mental health policies are being taken forward within the EU.

The main themes of the subsequent expert conference were: work related stress; depression in young people; the effects of societal transition; prevention actions; the influence of stress and depression on premature death; and monitoring and evaluation.

This work was reinforced and given institutional impetus in conclusions unanimously adopted by EU Health Ministers in the Council on 15 November. It is expected that a number of new actions will be contained within the anticipated EU Public Health Action Programme and other initiatives.

Further information may be obtained on website: www.eu2001.be

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