

eurohealth



**Promoting
E-health in Europe:
Challenges and
Opportunities**

European integration and
health care systems

Promoting human capital in
central and eastern Europe

Ensuring the quality of health
care provision in the EU

The concept of health security

COMMENT

It is another time of change for *Eurohealth*, as sadly we bid farewell to Mike Sedgley, who is stepping down as editor. On behalf of all at LSE Health and Social Care, I would like to take this opportunity to thank Mike for all his hard work in continuing the successful development of the journal over the last three years. While Mike will now spend more time on his PhD, he is however, editing a special issue of *Eurohealth* looking at central and eastern Europe, which will come out later this year. I would also like to express our considerable thanks to Claire Bird, who is also departing. Claire has provided invaluable administrative support and we are sorry to lose her. We wish both Mike and Claire the very best in their future activities.

On a note of welcome, *Eurohealth* now has become a joint publication between LSE Health and Social Care, the European Health Policy Research Network, and our new partner, the European Observatory on Health Care Systems. We are also grateful for the Observatory's financial support, complementing that of our existing sponsors, LSE Health and Social Care and Merck and Co Inc.

Finally, I am delighted to welcome David McDaid as the new editor of *Eurohealth*, and look forward to the continued successful development of the journal.

Elias Mossialos
on behalf of the Editorial Team

Exploiting the potential of e-health

This issue is in part devoted to the increased interest in, and rapid development of e-health, and the resulting myriad of possibilities for application in Europe. A number of commentators have noted that the origins of the term e-health are inextricably linked to the dot com revolution in the same way as e-commerce, e-solutions, e-business etc. Suitable definitions of e-health have followed belatedly. The term can now be seen as not only encompassing the application of a broad range of information technologies to healthcare delivery, but also, as demonstrated in papers in this issue, it involves a radical rethink of the ways in which healthcare systems can be structured and managed. Telemedicine and home care monitoring systems for instance provide practical alternative options to traditional service provision. Potentially e-health can also fundamentally change the relationships between patients and healthcare professionals, increasing access to services, regardless of national boundaries.

The papers indicate that the challenges are great, in part e-health advocates must overcome the legacy of failed large scale investments in information technology in the public sector. To exploit the potential of e-health, the limitations of applications need to be recognised, and the context in which successful e-health solutions operate fully understood. Bodies such as the European Health Telematics Association can play a vital role in collating evidence of best practice. With such information e-health may exploit its potential, increasing efficiency in healthcare delivery, improving healthcare quality, promoting consumer choice and increasing equity of access to services.

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eurohealth

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Published by LSE Health and Social Care, the European Health Policy Research Network, and the European Observatory on Health Care Systems, with the financial support of [Merck & Co](#) and the [European Observatory on Health Care Systems](#).
News section compiled by [ENHPA](#), [EHMA](#) and [HDA](#).

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

The views expressed in *Eurohealth* are those of the authors alone and not necessarily those of LSE Health and Social Care, EHPRN or the European Observatory on Health Care Systems

The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

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

Printing: Seven Corners Press Ltd

ISSN 1356-1030

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eHealth for Europe

"eHealth will lead to a more coherent and ubiquitous delivery system for healthcare services throughout the EU."



Ricky Richardson

Telemedicine has had the potential to revolutionise healthcare delivery for many years, but widespread deployment of the technology has been held back by:

- Lack of broadband communication networks.
- Relative unavailability of computing and on-line connectivity.
- High costs of hardware and software.
- Lack of political conviction.
- Lack of a standard code of generally accepted practices and protocols, in particular for information security.
- Perhaps most importantly, resistance, from the healthcare professional body itself.

In recent years, there have been significant advances in all of these areas, particularly the first three. As understanding of technological capability has grown, telemedicine is now increasingly being thought of as only one component of eHealth, a much broader description of IT driven activities which can become a powerful tool for healthcare transformation. The emergence of IT as a way of adding value has been against a background of inexorably rising costs, increased demand for healthcare services, (driven partly by ageing populations), and increased patient awareness of healthcare possibilities, ironically, to a large extent due to health related websites, some of which are of dubious quality.

As a consequence, the healthcare sector across the world is undergoing a radical transformation as providers and patients at last begin to understand how IT, running across broadband communication infra-

structures and networks, can now be a core component in the enhanced delivery of healthcare. In the EU, this transformation is represented by the deployment of telemedicine and other eHealth projects in a number of countries, albeit on a piecemeal basis, and through the efforts of enthusiasts rather than as a result of considered strategic decisions.

The practical application of eHealth

eHealth has been defined as:¹

"a means of applying new low cost electronic technologies, such as 'web enabled' transactions, advanced networks and new design approaches, to healthcare delivery. In practice, it implies not only the application of new technologies, but also a fundamental re-thinking of healthcare processes based on using electronic communication and computer-based support at all levels and for all functions both within the healthcare service itself and in its dealings with outside suppliers. eHealth is a term which implies a way of working rather than a specific technology of application".

This is an excellent general definition. In practical terms, the potential applications of eHealth technologies fall into four categories (Figure 1):

Clinical applications

Hitherto known as telemedicine, this includes electronic medical records transfer, in order to obtain distant specialist opinions, interactive video conferencing for group consultations, clinical decision making support software (which should become the medical encyclopaedia of the modern age,) tele-homecare, e-prescription processing, and telehealth and vital signs monitoring, as well as linking healthcare services to other public services such as social security.

Healthcare professional continuing education

Education in various forms is a vital pillar of eHealth. All healthcare professionals need to maintain and develop their professional skills and knowledge levels through-

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out their careers through a programme of continuing medical and nursing education. The European Lifelong Learning programmes apply equally to the healthcare professionals and to the traditional targets of these programmes. Using web based technologies, such programmes can be personalised for individual healthcare professionals and delivered over the web, making it easier and more congenial, with less time lost from existing work patterns, less travel and less waste of human resources.

Public health information

Good evidence, drawn from Malaysia and other countries, indicates that by providing appropriate and widespread education on health matters to defined populations, it is possible to change healthcare demand patterns radically. Consequently patients treat themselves for more conditions, enabling a more focused demand profile for healthcare services and, obviously, a more cost-effective system.

With the rapidly increasing number of European internet users, it will become ever easier for governments to provide healthcare education to a wide audience via dedicated websites. The content of such health-online websites needs to be accurate as well as informative. They should meet the requirements of patient populations as well as conforming to individual member states' healthcare educational strategies.

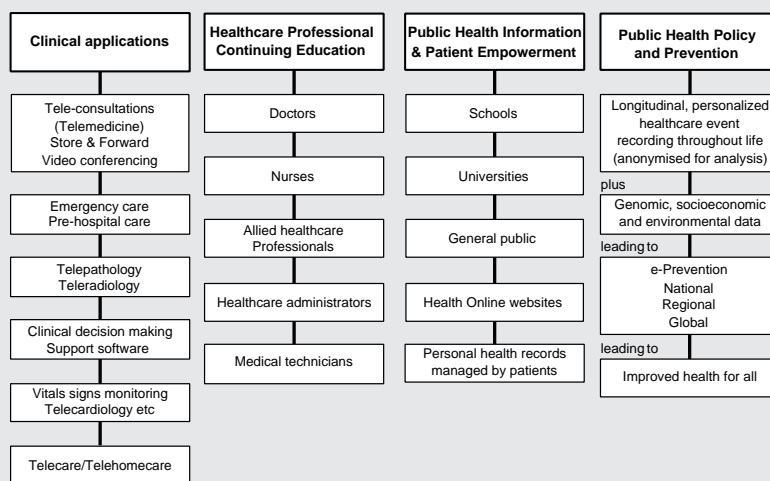
Health policy development

Healthcare trends are an important element in the decision making process for defining healthcare strategies for individual member states. With the blurring of national boundaries, it is more important than ever to develop a pan-European public health data base, so that predicted healthcare trends are based on hard data and e-prevention strategies developed.

This process has already started; David Byrne, Commissioner for Health and Consumer Protection announced the setting up of a pan-European public health information project at the European Health Forum in Gastein in September 2001. Commissioner Byrne also said that health is being placed at the centre of other European policies, such as nutrition, environment, food and agriculture. The Gastein initiative may herald the start of a pan-European perspective on healthcare delivery, which represents a major shift in policy.

The process, however, will not produce the comprehensive information expected of it

Figure 1 E-HEALTH



unless standardised electronic health records are deployed throughout Europe, recording personalised healthcare events from conception to death. Such records will also allow for other personalised data (such as genomic finger print data, or lifetime socioeconomic and environmental data) to be added to longitudinal healthcare event records. This information, subject to strict confidentiality and security safeguards, will be of vital importance to the pharmaceutical and insurance industries.

The need for a European eHealth strategy

In many of the countries about to join the EU, the standard of healthcare, and healthcare expectations, are significantly lower than in the existing member states. Not only is it inevitable that these expectations will increase sharply on accession, but there is also surely a moral imperative to deliver healthcare services in a more uniform manner to all EU citizens. This cannot be done without the application of all four elements of eHealth.

eHealth will help:

- Reduce duplication of expensive healthcare facilities (hospitals, etc) within member states.
- Lead to a more coherent and ubiquitous delivery system for healthcare services throughout the EU.
- Provide proper monitoring and regulation of increased migration of healthcare workers within the EU.
- Greatly improve efficiency when patients cross national boundaries to

seek treatment in other EU member states.

- Enable EU medical facilities and services to be made available to other countries, which have links to Europe, either through culture, history or common language.

It also offers the promise of bringing European healthcare services to patients in developing countries, where access to quality health services has long been denied.

To date, telemedicine and eHealth enthusiasts have been fighting an uphill battle in getting their message across to decision makers. Much of the reluctance to accept the technology has come not so much from individual government members, but from the healthcare profession itself, which saw how much of the early investment in healthcare IT was wasted because systems were proprietary, non-interoperable, and rapidly became obsolete. Additionally, bandwidth availability at the time was extremely limited and communication costs extremely high: take into account the large sums of money spent on software and hardware, and it is easy to see why there is more than a little cynicism within the profession at the prospect of a fresh investment in eHealth.

Now however, communication and computing costs are substantially lower, and broad bandwidth networks have been deployed, all of which makes the effective, and cost effective, introduction of eHealth eminently achievable. IT investment in healthcare has traditionally been much lower than in other areas such as banking and manufacturing. Some EU countries have invested less than one per cent in healthcare, compared with 10 to 14 per cent in other sectors. It is now time to bring healthcare IT investment levels somewhat closer to those in other sectors.

The regulatory and ethical environment

Healthcare provision in the EU remains the responsibility of national governments. One of the major barriers to the deployment of eHealth across Europe is the fragmented regulatory environment and the lack of uniform statutes and codes of practice to allow eHealth to be implemented uniformly. To clarify the framework for the practice of eHealth, and to accelerate market development, the European Commission will issue a publication on 'Legal aspects of e-Health in 2002'. The objective is to review and clarify existing

applicable legislation in order to provide confidence and stability to companies entering the market. Data protection and security will receive particular attention.

In order to ensure that decision makers, both in the healthcare professions and at the most senior levels of government, are aware of the potential that could be delivered through eHealth, the European Commission sanctioned the creation of the European Health Telematics Association (EHTEL). Over the last 18 months, the eHealth Working Group of EHTEL, T2 eHealth, has been aggressively marketing eHealth. This has been achieved by keynote addresses at prominent health and telemedicine conferences, and meetings with government ministers and others, to bring them up to date with successful eHealth experiences from countries such as Australia, Canada, Malaysia and the United States. In addition, T2 eHealth has successfully launched a website containing in excess of 50 examples of best practice in eHealth drawn from across the EU. This website will be further expanded and marketed, so that European institutions and healthcare organisations who wish to implement eHealth practices and solutions can draw on past experience and thus avoid costly mistakes.

Many EU member states have established national forums and sponsored other activities to promote eHealth and the establishment of nationwide health telematics infrastructures. In some nations healthcare professionals and policy makers have established umbrella organisations such as the 'Health Telematics Action Forum for Germany' or IPZorg (now NICTIZ) in the Netherlands. EHTEL is proactive in supporting the foundation and the work of these umbrella organisations by providing a common framework for them to operate within.

Additional support for eHealth is being established through national eHealth Associations; the UK eHealth Association, for example, is a thriving organisation, growing rapidly and attracting the attention of the Department of Health as the national resource on eHealth and IT. The implementation of such eHealth practices and solutions has thus become a powerful tool for healthcare reform in European healthcare systems.

Change management

Perhaps the biggest challenge facing the healthcare sector is how to manage the

"eHealth practices and solutions have become a powerful tool for healthcare reform"

change in practices and roles that will be brought about by the widespread introduction of IT. Medicine is an essentially traditional milieu and the healthcare professional body is deeply conservative and suspicious of change. The traditional model for healthcare delivery (Figure 2) has changed little for six thousand years!

This model is already changing. Healthcare services that have traditionally only been available within physical institutions such as hospitals and clinics, are moving into the retail environment and improvements in clinical technology are increasing the range of the services that can be offered in non traditional premises. This trend will increase and will further accelerate with the deployment of homecare services, including the installation of monitoring devices and video systems. However, new models for healthcare delivery made possible by an eHealth environment look very different (see Figure 3). This will create safe environments for the more vulnerable members of the community such as the elderly, and allow them to live independently, but with instant access to appropriate healthcare services.

Summary and conclusions

Europeans could benefit greatly from the widespread provision of quality healthcare services through a healthcare revolution powered by the deployment of eHealth practices and solutions. This process is already taking on a pan-European scale as national borders between member states become less of a barrier. The regulatory environment for healthcare services is changing across Europe and will require further changes to facilitate this process.

EU member states need to look at eHealth deployment elsewhere so that lessons can be learnt from existing successes (and failures). A knowledge base needs to be established of EU IT experts who can help governments take maximum advantage of these changes. Organisations such as EHTEL have been working to provide an evidence base in eHealth for the last three years. Various working groups representing the range of eHealth stakeholders under the umbrella of EHTEL contribute greatly to this process. Understanding of the potential for eHealth solutions and services, and the scope for market growth, has improved as a result of work already achieved.

Advances in technology, especially in the provision of broadband communication networks allows for the seamless transmis-

Figure 2 TRADITIONAL HEALTHCARE DELIVERY MODEL

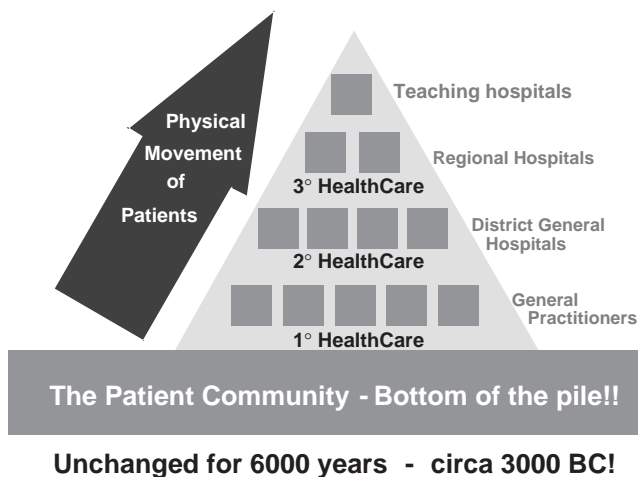
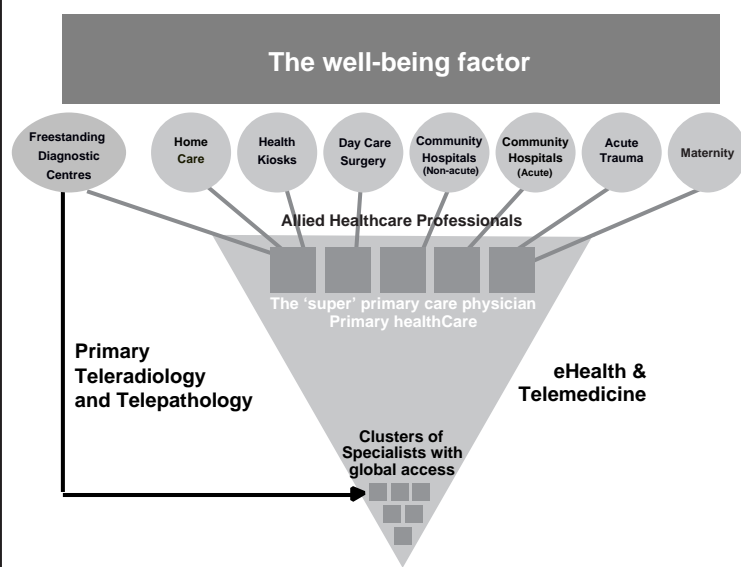


Figure 3



sion of medical data which, together with the widespread provision of public education on healthcare matters, make it certain that the accessibility and quality of healthcare services available to European citizens of the future should be both uniform and ubiquitous. This is especially important for pre-accession countries, whose healthcare provision is very different from that in EU member states. The Commissioner for Health and Consumer Protection is now in a position to drive this strategy forward for the ultimate benefit of all European citizens.

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E-health for Europe:

The possible and the practical



Paul P Freddolino

“Just because an innovative e-health solution worked well in one community does not mean that it can work well elsewhere.”

With internet access, an extensive array of further innovative e-health programmes can be located.¹ These exciting examples use a range of technologies from the relatively simple (such as radio and CD-ROM) to the complex (Internet websites with streamed videos, requiring broadband access). Applications include:

- Supporting patients to remain at home for longer periods – thereby delaying longer inpatient stays - by linking them to health and other care providers using telecare systems available 24 hours a day.
- Medical personnel utilising a wide range of technology-supported resources for training and continuing education, as well as for immediate use during sessions with their patients.
- Standardising electronic patient records to reduce the time and effort for medical staff when recording information. All involved medical staff can retrieve relevant patient data anywhere in the world.

Additionally, case studies 1 and 2 provide actual examples of e-health applications using existing technology. Each example represents a success (on some criteria) in real situations. Nevertheless, there are sometimes details that are not described in the reviews and case studies that will have a tremendous impact on how well a particular ‘successful’ model will operate in another setting. Just learning about the activities and products of a success story – the items that make the headlines – is not sufficient. Potential users of these innovative applications need to know the rest of the story.

For example, consider case study 1. The most obvious example is the technology itself. Establishing the Breast Cancer Support Group (BCSG) using video conferencing facilities could only happen because the three communities were already linked electronically as part of a region-wide fibre optic system connecting 14 hospitals for a range of telemedicine applications. This network was made possible by a government grant, actively pursued by a consortium of hospitals, clinics, and other organisations committed

to improving the regional technology infrastructure. Once in place, use of the system was encouraged and supported, with resources made available to train medical staff. Hospitals defined their role as providing health resources to their communities, so this type of outreach activity was a natural extension of their activities.

The nurse who started the BCSG in its primary location (Group 1) had become familiar with the technology through several other activities in the hospital. She noted that women from distant communities came to the central medical centre only when absolutely necessary for treatment. The time and risk involved in driving, especially during the long winters, kept most of these women from attending the face-to-face support group. The idea of using the video system to extend the BCSG to women in distant communities thus evolved. The success of the e-health dimension – bringing in other groups electronically – would have been much more difficult to achieve without the two-year experience of the core group (Group 1). According to interviews with members of the BCSG, Group 1 members provided the energy, the example, and the emotional support that made it possible for the other groups to get started.

The practicalities of e-health

Moving beyond the possibilities of e-health and considering the practicalities, there are some important questions that need answers before considering if e-health success stories provide viable possibilities in our own situations:

- What priority health needs were identified as requiring new resources?
- How prepared were the staff, patients, and organisations to handle a technology-based project?
- How stable and easy-to-use was the technology itself? What was the level of training and support resources committed to the project? Were they there when needed?
- Who were the medical staff and patients who actually used the system? Who

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were the staff and patients not able to use the system? Did the 'right' (intended) patients and staff use the system?

- To what extent was the project effective in addressing the specific prioritised needs of the community that justified the project initially? What areas of need remain to be addressed?
- Were other (less expensive and easier to implement) technologies considered? Why were they not chosen?
- What obstacles to implementing the project were encountered? What barriers remained to be addressed during the actual life of the project?
- What did patients and other key stakeholders say about the project and how well it was working?
- What recommendations for improvement did stakeholders make?
- What (if any) unintended consequences – both positive and negative – were identified by the various stakeholders?
- What requirements have been suggested by those involved as necessary for the replication of the project in other settings?

Conclusions

One of the most important lessons learned across the health and social care arena is that the interaction among policy, organisations, individual human factors, and technology make it difficult to find models easily replicated. Just because an innovative e-health solution worked well in one community does not mean that it can work well elsewhere. This makes careful planning in the initial stages absolutely essential. It also makes the use of ongoing evaluation extremely important as a component of any effort to replicate a 'successful' model in a new setting. Process evaluation can help to determine if things are in fact working as intended, and to provide guidance to make needed changes to improve the likelihood of success. We cannot assume that any model will work well in the new setting.

What this means is that those who are planning to look to innovative e-health solutions must be cautious as they move forward. There are many examples of what is possible in the literature. It is the job of the planners and developers to ensure that their recommendations and decisions reflect the practicalities of real world settings at the time they envision implementing new projects. This will greatly increase the likelihood that their efforts will be successful.

Case Study 1: Patient support and self-help groups run using videoconferencing.²

Setting: a room in a small town regional medical centre located in a large rural province in a very cold climate. 12 women, aged 22-70+, sit around a table looking at a TV screen (Group 1). In two other distant communities five and six women respectively sit around tables looking at their own TV screens (Groups 2 and 3).

Group 1 sees Group 2 or Group 3 on their screen, depending upon who spoke last. Groups 2 and 3 see Group 1. All but one woman has breast cancer; this is the monthly meeting of the Breast Cancer Support Group (BCSG). The women take turns talking about many topics: health status updates (symptoms and side effects); new supports, opportunities, community activities; and future agenda items. There is a lot of conversation back and forth – with lots of laughter and lots of tears. The conversation seems to be guided gently by a Group 1 member, an oncology nurse who started the BCSG five years ago, expanding it to the other two sites using videoconferencing two years later.

The planned agenda alternates each month between formal guest speakers (e.g., oncologists, cosmetic make-over specialists, prosthetics experts) and member-only dialogue. After about an hour of interacting on line, the connection among the three sites is intentionally terminated and each group continues meeting and talking. The women in the three groups have never met face-to-face.

QUESTIONS: Is this e-health application a success? If yes, in what ways? Does it provide a model for replication in other communities? How about for other health conditions (e.g., for different cancers, or for other illnesses)? Is it a model that can be used to support those who provide care to various types of victims such as cancer or stroke?

Case Study 2: Use of a website for e-health information.³

A website has been developed by the Ministry of Health in an African country. The first round of offerings available on the website includes:

1. Information about national health policies and strategic plans
2. Information about sources of health data as well as providing some data on the site
3. Updates on health-related programmes and activities around the country. At the time of a recent epidemic, the website was used to make accurate information quickly available worldwide.

Plans for future offerings are not finalised but may include information related to the most pressing local diseases and health priorities.

QUESTIONS: Is this e-health application a success? If yes, in what ways? Does it provide a model for other countries or regions?

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Knowledge management in the Canadian health sector:

An e-health case study



Andrew Szende

“the hospital came to recognise that its real product was not healthcare but knowledge”

Paediatric healthcare knowledge includes illness, wellness, treatment, and safety data that is useful to professionals providing care to paediatric patients. The professionals include physicians, nurses, therapists and dozens of other healthcare providers. The knowledge is useful to consumers: children and young people, as well as to their parents and other care givers.

Where does the knowledge originate? How is it packaged in useful ways? How can one gain access to the knowledge in an easy, user friendly manner? The Electronic Child Health Network (eCHN) has responded to these questions by developing practical applications that are designed to share knowledge among professionals within Canada’s publicly funded and administered healthcare system. The beneficiaries include professionals, non-professionals, physicians, non-physicians, children, parents or anyone who needs to know about child health.

Initially funded by the government, eCHN is operated by a network of hospitals, led by Canada’s leading paediatric institution, The Hospital for Sick Children (HSC) in Toronto.

Toronto is Canada’s largest city. Together with its feeder communities, the population is over 4.5 million. Tertiary and quaternary paediatric care is provided to this population by HSC, a 388 bed teaching hospital affiliated with the University of Toronto.

‘The hospital without walls’

Like many children’s hospitals, for many years, HSC has served as a magnet to families from considerable distances. While it was flattering to HSC’s professionals that children and families bypassed their local hospitals to go to HSC, the hospital began to question whether this model was really the best way to deliver care. People went to

HSC because of the knowledge and expertise that resided there. In reviewing its strategic direction, the leadership of the institution came to recognise that its real product was not healthcare but knowledge, and that it was fundamentally a knowledge-based institution. In order to have the greatest impact on children’s health, HSC needed to move knowledge out, not merely bring children in.

To accomplish this, HSC has linked with other hospitals, home care organisations, and physicians in order to provide a coordinated continuum of care. The goal is to provide children and families with high quality healthcare in the right place (as close to home as possible) and at the right time. Also, as patients move through the system, information can follow them seamlessly from one provider to the next.

In this model of care delivery, information needed to be patient-centred, not hospital centred. Even more important, the information necessary for professionals had to be more universally available. If the goal was to have children treated as close to home as possible – either in community hospitals or even at home, then current treatment protocols, drug information, and other knowledge tools had to be equally accessible across the network.

It soon became clear that an information backbone would be key to the success of the project. The concept of an eCHN was born. eCHN is a partnership among HSC, the provincial government of Ontario, and several member organisations, to electronically link hospitals, local paediatricians, home care agencies and other agencies that provide child health services.

eCHN provides three distinct services:

Health Information Network (HiNet) uses the Health Data Network, the patient information solution developed by IBM. It is a system that links diverse electronic health record systems from different providers, allowing all participants to share data in an electronic common health record. Shared data includes laboratory results, dictated summaries and consultations, and images (radiology, pathology). Information is provided to authorised users through secure connections. HiNet’s current database includes about 95,000 patients, about 350,000 patient encounters, and about 2.6 million transactions.

Your Child’s Health provides consumer information on a web site designed specifically for parents and children. Families

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have internet access to health promotion information, guidelines for treatment in acute situations, and a wide range of information on child health problems. Such topics include:

- What you need to know before your operation.
- What to do when your child is ill.
- Age-appropriate educational information and games for children with problems such as asthma or bed wetting.

The web site is currently attracting about 200 visitors per day, who view about 2,200 pages per day and has attracted a total of more than 1.2 million page views to date.

PROFOR, the Professional On-Line Forum, allows providers to tap into the knowledge base that exists within the network including protocols of care, patient information materials, and a library of recorded seminars and rounds. The health professional in a small community hospital or office can access resources that traditionally are based in teaching hospitals. It is available to registered users as a password-protected site. Currently, there are about 260 streaming video presentations of Grand Rounds and other lectures in this database. The site has more than 4,300 registered users and attracts about 25 visitors per day, viewing more than 400 pages per day. The site has attracted more than 290,000 page views to date.

Benefits of the electronic Child Health Network

HiNet spans the continuum of care linking home care to community agency to regional paediatric centre to tertiary/quaternary children's hospital.

HiNet enables immediate electronic access to a patient's cumulative medical record, aggregated from multiple hospitals and providers. This should reduce duplication of tests and ultimately improve both the quality and coordination of care.

HiNet provides fast access to information that allows consultations to occur without any need for children and their families to travel to other sites, from one provider to the next.

Your Child's Health allows easy access for parents and patients to health information including pre-admission information, discharge instructions, health promotion material and disease related information.

PROFOR allows healthcare professionals to exchange knowledge and information,

and attend seminars 'on-line'. This allows providers to learn from their partners across the entire continuum of care and facilitates clinical research across multiple network sites.

Rationale for the Health Information Network (HiNet)

Increasingly, in many patient encounters, information is recorded in an electronic format. However, computer systems in healthcare are usually specialised for each setting (hospital, private practice or home care), and even within the same healthcare facility setting there are a wide variety of incompatible systems. This means that sharing information between settings or between institutions can usually be done only by printing and faxing the information, negating the advantage of its original electronic form, except legibility. Even within an institution, specialised systems for different departments often are not integrated and consequently require a user to log on and locate the patient's information in each individual system in order to obtain a complete clinical picture of the patient.

The eCHN

The electronic Child Health Network (eCHN) has developed practical applications that are designed to share knowledge among professionals within Canada's publicly funded and administered healthcare system. Those who benefit from eCHN include professionals, non-professionals, physicians, non-physicians, children, parents and others who need to know something about children's health and wellness.

ECHN: IMPLICATIONS FOR EUROPEAN HEALTHCARE

The principles underpinning the eCHN initiative, linking the islands of data held by multiple organisations to provide a comprehensive health record, will be well understood by policy makers across Europe and, indeed, are reflected in many of the healthcare modernisation strategies currently being promulgated.

Issues such as client access to records and the requirement for explicit consent from the patient for inclusion in the database are pre-requisites of the British NHS Electronic Health Record strategy for example. What the Toronto Sick Children's Hospital has achieved is a pragmatic and highly effective realisation of these principles in a way that seems to be acceptable for patients, clinicians and politicians. The system delivers access to the *available* data about a patient – recognising that different institutions and practices will be at varying levels of sophistication in the quantity and quality of clinical data that they hold. A minimum standard is required of an organisation before it can join the network and there is recognition that the network itself provides an incentive to users to improve the depth of their own clinical data. Achieving 'perfection' at each site before linking them into the network can mean that real patient benefits are foregone, sometimes for many years.

Direct and active involvement of clinical staff in the design and management of a health network has been achieved by providing them with real value quickly – the 95,000 patients currently 'on' the system were all receiving treatment when their record was created in HiNet.

Discussions about what should constitute a European Health Record are constrained to some degree by concerns about content, standards and portability. What eCHN demonstrates is that a '*start simple and grow fast*' approach can provide real benefits without 'closing doors' in the future. Effectively the quite extensive clinical data held about each child can be further refined to provide a healthcare summary, once the definition of contents has been agreed and the very act of producing the more extensive record informs that debate.

Simon Stone, Healthcare Consultant, IBM Consulting, UK.

“as patients move through the system, information can follow them seamlessly from one provider to the next.”

A central repository of the electronic health record (EHR) can generate identifiers at the time patients, caregivers and institutions are enrolled in the system using algorithms to identify individuals uniquely on the basis of a set of demographic and other information. Similarly, data can be ‘normalised’ into a common type and format when it is delivered from the source. Using a set of look-up tables to translate data from each data source into common codes allows almost any system to feed patient information to the EHR. Once in the EHR, this data can be securely viewed in a longitudinal fashion with each episode of care from each setting integrated into one seamless patient record.

HSC and eCHN have successfully used this approach to create HiNet using the Health Data Network (HDN) application from IBM. HiNet was created in order to demonstrate the feasibility of creating a multi-institutional, longitudinal health record that integrates information from a variety of healthcare settings without requiring changes to current patient record systems. HiNet is a groundbreaking healthcare integration device. It currently receives information from existing patient record systems in seven different institutions and healthcare management platforms. Its architecture makes it possible and practical to join a secure network with minimum capital investment, effort and maintenance. It ensures the confidentiality, integrity and availability of the data. It utilises open health information standards (HL7) and is substantially more affordable and much easier to set up, integrate and maintain than existing systems.

A partial list of benefits of the integrated and shared EHR include:

Benefit to the patient

Patients receive more timely care due to reduced waiting time for physicians to access.

Patients receive better care when treatment decisions are based on more complete information.

Patients are subjected to fewer duplicate diagnostic tests due to the availability of results from multiple facilities.

Patients are not required to repeat the same information every time they visit a different facility.

Benefit to the caregiver

Caregivers are able to make more informed treatment decisions.

Caregivers are able to quickly review the care delivered by multiple institutions.

Caregivers are able to get immediate access to more extensive and integrated patient history.

Caregivers can focus their communications with other caregivers on patient care related issues rather than on the logistics of exchanging patient information.

Community caregivers can access information from hospital stays, including discharge planning, to facilitate the most appropriate care for the patient.

Benefit to the cost of healthcare delivery

Reduction in the duplication of tests or treatments.

Faster access to more and better baseline information should produce better clinical decisions and better outcomes, reducing costs.

Data captured automatically in a multi-institutional EHR in the course of delivery of care.

Reduce the cost of, and need for, separate data collection systems for research and management of healthcare delivery.

What does the future hold?

The architecture developed for HiNet has several significant advantages, such as:

- The network is scalable, meaning it can grow as new participants join.
- HiNet can interface with other electronic networks.
- The same architecture can be expanded beyond the paediatric population, in order to serve entire communities.
- HiNet does not require participants to change legacy information systems; instead it uses a common lexicon to interface with multiple information systems.

The Government of Ontario has provided additional funding to add more hospitals to the system, and it is hoped is that HiNet will ultimately become the backbone linking all hospitals in the province.

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Patients' rights in a European healthcare market



Herman Nys

“The growing mobility of citizens throughout Europe will reinforce from the bottom up the call for more equal protection of patients' rights.”

The rights of patients fall into two categories: individual rights and social rights. The most important social right of the patient is his right to healthcare. Within this right a distinction is made between the right to the protection and the promotion of health (preventative healthcare) and the right to have access to health services (curative healthcare).

The right of all European citizens to health protection can be derived from Article 152 of the Treaty of European Union. The other component of the right to healthcare, namely the right to have access to health services is not mentioned expressly in the Treaty. However, Articles 28 and 49 of the Treaty entitle community citizens to move to other Member States in order to obtain medical goods and services. Moreover, in *Decker* and *Kobll* the European Court of Justice held that the home country had an obligation to reimburse for a medical device and an ambulatory service obtained in another Member State on the basis that it otherwise contravened the Treaty provisions for the free movement of goods and services. Both recent developments (Article 152 originated in 1997 while the *Kobll* and *Decker* cases date from 1998) may explain why the European healthcare market has been discussed mainly from the angle of the social rights of patients.

However, while the social rights of patients are important, individual patients' rights deserve equal attention at EU level. A common approach to these rights is needed but, as is demonstrated here, the basis of such a common approach already exists.

Individual patients' rights

Individual human rights aim at the protection of the individual sphere and of individual liberty against intrusion by the state, by society and by fellow citizens. The basic rights of the patient are:

- The right to give consent for a medical investigation or a treatment, having received adequate information, or to refuse it.
- The right to know or not to know one's health status; the right to respect for private life in relation to information about personal health;
- The right to complain when a substantial patient right has been violated.

The need for a common approach

The most important argument for a common approach of individual patients' rights throughout Europe is the equality of treatment of all European citizens. All citizens are confronted from before birth (sometimes even before conception) until after their death directly and sometimes very deeply with the legal rules that govern the delivery of healthcare services. The core of these rules are the rights of the patients. It is becoming less and less acceptable for these rules to differ from Member State to Member State.

The growing mobility of citizens throughout Europe will reinforce from the bottom up the call for more equal protection of patients' rights. A retired Dutch citizen who stays during the winter in the south of Spain will export his expectations and experiences regarding his individual patients' rights to Spain. Even without growing mobility of patients, there will be more pressure in the future from patients and patients' organisations to be treated

“The right to be a patient has been considered more important than individual rights as a patient.”

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“It will become increasingly difficult to explain that the way services are delivered by physicians differs between the Member States.”

equally with respect to their individual rights. One may expect too that physicians and other providers of care together with their professional liability insurers will exert pressure to reach more harmonised standards of care, among which respect for the individual rights of the patient is central.

The emerging EU right to access to health services is also an argument for a common approach to individual patients' rights. In most Member States the social rights of the patient have been recognised much earlier than have individual rights. The right to *be* a patient has – to a certain extent rightly and understandably – been considered more important than individual rights *as* a patient. This two-track policy regarding social and individual patients' rights has created a great deal of tension. Although they had access to cheap and good quality healthcare, patients nevertheless have felt at the mercy of physicians and other providers.

A common approach to individual patients' rights at this stage of the development of a European healthcare market will avoid making the same mistake. The recent decision of the Court of Justice in *Geraets-Smits* and *Peerbooms* supports this view. According to the Court, the condition that treatment must be regarded as “normal in the professional circles concerned” should not be interpreted as normal according to national medical circles but as normal according to the state of international medical science and medical standards generally accepted at international level. If this standard is applied, it will lead towards a real harmonisation of the right to healthcare. It will become increasingly difficult to explain that while across Europe a patient has access to comparable services, the way these services are delivered by physicians differs between the Member States.

Finally, an important argument in favour of a common approach is that too a great difference between national rules in a Europe without frontiers will impede the emergence of a real European identity. Social and economic integration will also require an integration or at least a harmonisation of the rules governing the delivery of health services and the individual rights of patients.

The existing common approach

On 1 December 1999, the Council of Europe Convention on Human Rights and Biomedicine entered into force. The

Convention proclaims basic individual patients' rights such as the right to informed consent (Article 5), the right to respect for private life in relation to information about his health (Article 10.1), the right to know any information collected about his or her health and the right not to know this information (Article 10.2) and the right to complain (Article 23).

The Convention has succeeded in avoiding the mistake of regulating individual and social patients' rights at different stages. Article 3 contains an obligation for the Parties to the Convention to take appropriate measures with a view to providing equitable access to healthcare of appropriate quality, taking into account health needs and available resources. The Convention contains the core of a common approach to patients' rights in Europe.

Although the regulation of the rights of patients does not directly fall within the competence of the EU, internal market rules have been taken that are of direct relevance to the protection of individual patients' rights. These consist of:

Directive 95/46/EC on the protection of individuals with regard to the processing of personal data and on the free movement of such data.

Directive 98/44/EC on the legal protection of biotechnological inventions.

Directive 2001/20/EC on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use.

Conclusion

Both the Council of Europe and the EU have to strive towards more equal protection of individual patients' rights. The existence of common principles in Europe regarding the protection of individual patients' rights is important but by itself does not suffice to meet the need of equal treatment in this respect.

If EU Member States hesitate to bring their legislation and legal practice regarding patients' rights in line with the common approach – and no doubt some Member States will do so, referring to cultural and other traditions – more forceful, directly binding measures at EU level may be required. Although cultural and other traditions deserve respect they can never be used in order to legitimate violations of basic human rights.

Pharmaceutical policies in Germany and European competition law



Wolfgang Kaesbach

“[reforms] have almost all been attempts at controlling expenditure rather than introducing structural change”.

The statutory healthcare system in Germany

The organisation of national healthcare systems is not directly regulated by the European treaties. It remains the sovereign responsibility of individual member states, provided that European basic rights of free trade in goods and services are not violated. The German statutory healthcare system is now over 120 years old and is based on the principles of solidarity, subsidiarity, self-government and providing benefits in kind. Its characteristic features are:

- Legislation that only provides a general framework for the catalogue of benefits.
- A physicians and sickness funds’ self-administrative body that specifies in detail the entitlement to benefits.
- Collective contracts for services provided.
- Ensuring that services are supplied in the form of benefits in kind.

These features, it would appear, are unique in the European Union and not fully appreciated in Brussels.

A statutory health insurance for 90 per cent of the population financed by employees’ and employers’ contributions is not viable without regulation. Thus, the question is not whether to exercise control but rather how to do so.

In Germany, the pharmaceutical sector was spared any intervention for decades. It is only since the 1980s that it has become a central element of the various health reform efforts, each of which has coincided roughly with the four-year electoral cycle. Moreover, most of these reforms, are not worthy of the name, as to date they have almost all been attempts at controlling expenditure rather than introducing structural change. The need for structural change is now critical.

Reference pricing – the German way

Under the current system, statutory health insurance is left with no protection against the dictate of service providers – in the context of this article, the prices of pharmaceu-

ticals set by manufacturers. In order to, at least indirectly, influence these prices a system of reference pricing was introduced in 1989. Reference prices make it possible for:

Manufacturers to set their prices independently.

Physicians to choose their own therapies.

Patients to be prescribed all medicines deemed necessary.

Statutory health insurance companies to introduce an upper price limit for the reimbursement of pharmaceuticals.

The European Commission, in its statement on the completion of the European market (15 November 1999), concluded that reference pricing was an instrument which provided a result close to the market mechanism and was therefore preferable to state price controls.

As anticipated, reference pricing did introduce competition to the market. It was therefore no surprise that it was resisted from the outset by the pharmaceutical industry. After all it would profit most from a market essentially immune to competition. However, since 1989, all cases brought by the pharmaceutical industry against reference pricing have been rejected by the social welfare courts on the grounds that the stability of the healthcare system takes priority over the industry’s financial expectations.

Yet, as early as 1995, constitutional experts have questioned whether it was appropriate for the self-government of physicians and sickness funds to determine reference prices. Instead, they argue that as these prices, at least indirectly, have an influence on the pharmaceutical industry they should be subject to the legitimate and democratic controls of state authorities with legislative powers. The Federal Constitutional Court is expected to provide a ruling on this during 2002.

Moreover, since 1998, the civil courts have questioned whether the federal associations of statutory sickness funds (representing all 400 individual and independent sickness funds) by setting reference prices are akin

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“health needs of patients and consumer rights must not be sacrificed to the industry’s superficial and biased economic interests”

to commercial enterprises exercising monopoly power, in contravention to European competition law.

German regulations and EU developments

Neither the federal government, regardless of political persuasion, nor parliament have taken the warnings of German courts seriously. Since the Kohll and Dekker decisions, European Court of Justice (ECJ) rulings in this area have not been regarded as applicable to the German healthcare system’s principle of providing benefits in kind. For this reason re-examination of the regulatory framework of the German statutory health insurance system, within the context of community law, is not being discussed by politicians or the general public.

Other regulatory instruments must also be seen in the light of European developments. Thus, in 1998, Germany, in line with European law, discriminated in favour of its own pharmacies by banning mail-order purchases. Stakeholders, other than the pharmacies, are in favour of greater competition: lifting the pharmacies’ monopoly could cut distribution costs by at least 10 per cent.

The most recent decision by the ECJ which concerns the compatibility of the Austrian pharmaceuticals list (the *Heilmittelverzeichnis*) with the EU transparency guideline also raises questions about the German positive list. However, this guideline is not yet in force, and it is unclear whether it ever will be. Furthermore, the German positive list is not an instrument for directly controlling prices as manufacturers do not have to discount their products in order to be included.

As a result of European developments, the pharmaceutical sector continues to be an area of dispute for the statutory sickness funds. In July 2001, without waiting for the results of the G-10 committee (convened jointly with the Directorate General for Health and Consumer Protection in March 2001) the Directorate General for Enterprise initiated a comprehensive reform of European pharmaceuticals legislation. In short, the Commission aims to strengthen the competitiveness of the European pharmaceutical industry within the global market, speeding up entry for new products to a less restrictive market. In these circumstances, price controls remain indispensable, particularly in Germany, where drug prices are higher than the European average. Should the ECJ rule that

the German reference price system is incompatible with European competition law, the consequences would be dramatic. If the self-government of physicians and sickness funds can no longer exercise control, we will be left with only two extreme options, either complete deregulation or a state health system. Both options are incompatible with a health insurance system paid for by contributions from both employers and employees.

Moving successfully towards new German healthcare policies?

In November 2000, Ms Schmidt, the new German health secretary, took office under the chancellor’s orders to ensure that health maintained a low public profile. Politicians were to express full confidence in the system’s efficacy and continue to have faith in those involved in the system. Ms Schmidt stated that she had every confidence both in physicians’ ability to prescribe responsibly and economically, and also in industry pricing policies. She proceeded to abolish the drug budget and then, with the consent of the pharmaceutical industry, modified the reference pricing system, thereby reducing the amount of savings that would be realised by DM 550 million. However, just six months later this appeasement policy has failed. Compared with the same period last year, expenditure on pharmaceuticals has increased by over 10 per cent and the aggregate deficit of sickness funds will amount to over DM 5,000 million in 2001. In consequence, sickness funds will have no option but to increase their contribution rates generally by 0.5 per cent in 2002. For the first time, the average contribution rate of all sickness funds will be more than 14 per cent. Taken together, all social security contributions will thus amount to more than 40 per cent of individual incomes.

Summary

Without doubt, healthcare is a growth market creating and securing jobs. Even if one has sympathy with an economic policy aimed at supporting industry, one must take into account the implications for member states’ healthcare systems. While the pharmaceutical industry, by definition, aims at profit maximisation, sickness funds must be protected against excessive demands. The health needs of patients and consumer rights must not be sacrificed to the industry’s superficial and biased economic interests. It remains the task of politicians to ensure that citizens maintain faith in their social security system.

Ensuring quality of healthcare providers within the single market



Justin Allen

“Quality assured patient care must become the prime concern”

EU Directive 93/16¹ was introduced to further free movement of labour in the European Union, and ensures that there are no barriers to the movement of doctors between member states. Ensuring quality of healthcare providers for the benefit of patients is not part of this legislation. It is important that free movement of workers becomes secondary to patient safety and a satisfactory system of quality assured education providing safe doctors. This will become even more of an issue following enlargement, allowing free movement between more than 20 different healthcare systems.

The directive covers the length and place of training, but does not specify content or the competencies that should be acquired. Member states automatically accept qualifications obtained elsewhere in the EU, providing they meet these minimum requirements. The present system of European regulation has not kept pace with changes within medicine, within the profession, and in public expectations. Citizens are entitled to expect that doctors and other health professionals be trained to a satisfactory level of competence and quality.

Content of training

While many countries have training programmes for general practice that exceed minimum requirements, some for instance are of five years duration, others provide programmes that are only of minimum length. Even a simplistic examination such as this, does not reveal the true extent of the differences. In one programme four years are spent in a general practice setting, whereas in another four years are spent in hospital training. What is the difference in the competence of the doctors concerned? Should a doctor trained in one of these systems be able to work at a satisfactory level

in the other healthcare system? How do we know? For sure, under current regulations we are not entitled to ask the question.

Training content includes a common core for each medical discipline common to all doctors, and additional elements determined by the tasks required of doctors in a given healthcare system. Some of these tasks will be applicable to all healthcare systems, but some will be unique.

In order to demonstrate that practitioners have reached the required level of competence an assessment is usually conducted before training completion. Assessment can vary from country to country, using different methodology, and looking at different areas of competence and skill acquisition. If there is to be a move towards competency based judgements to inform free movement, then this process will need to be harmonised across Europe.

Quality assurance

What is meant by *‘shall supervise’* as far as competent authorities are concerned? In the United Kingdom the general practice competent authority, the Joint Committee on Postgraduate Training for General Practice (JCPTGP), carries out this quality assurance work, setting criteria for training posts and programmes.^{2,3} Only training which meets these criteria is acceptable towards certificates of training. General practitioner teachers are subject to rigorous assessment of their teaching skills and practice before appointment, and to three-yearly re-approval. Teaching posts in hospital are also subject to selection and accreditation.

The Joint Committee satisfies itself that its own national standards are met by monitoring regional teaching organisations.⁴ This is carried out every three years, by a visiting team of three or four assessors, appointed by senior educationalists in the discipline. Visits last three days, and sample one or two training schemes. All individuals involved in the teaching process are interviewed, from the school dean and hospital chief executive to the newest trainees in post. Offices, libraries, hospitals

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and general practices are visited, and extensive interviews take place. Reports are considered by the committee, and if satisfactory, training accreditation is extended for up to three years. The committee has the power to withdraw teaching recognition, or make it conditional on teaching improvements in any post, either in hospital or in general practice. This process has ensured that the education programme for general practice is of the highest quality.

Competent authorities

If this model can work successfully at national level is there any reason why it shouldn't work at a European level? Competent authorities are appointed by each member state to supervise training. Could they quality assure training?

There is no agreement on the degree of supervision required by each authority. Should they all be working to the same quality standards in education when they can only apply such quality assurance measures to those programmes that they supervise? If so what are these standards, and who should develop them? Should authorities be medical professional organisations, with skill and expertise in medical education? Currently there is no harmonisation in the composition, function, or method of working of the authorities themselves. More importantly there is no European forum for discussion, and very little contact or common understanding between these authorities.

In a report on the free movement of individuals, chaired by Simone Veil,⁵ a number of barriers to the success of the directives on free movement were explored. They found that there was a failure of trust and cooperation between officials and governing bodies across member states. Greater contact with, and understanding of, other competent authorities was recommended to individual governments.

There is no common pattern of quality assurance throughout the European Union. Each medical discipline concerned must, at a European level, be able to describe the content of its training, assessment, and quality assurance for this to occur. Work has been carried out in this area by a number of disciplines, and is currently under way in general practice/family medicine. Previously this work on harmonisation would feed-back to the Commission through the advisory committee structures, but these have now been suspended.

Many member states now exceed the mini-

mum training requirements. Some have created a special class of doctors, recognising this higher standard, and restricting access to this category of employment. They have also created an 'underclass' of doctors who have only been trained to the European standard. Any doctors wishing to make use of free movement legislation may find that they have to work at the lower level or agree to undergo further training, even though their home state regards them as fully trained. This clearly contravenes the spirit, if not the letter, of the free movement directives. Although one has some sympathy with the motivations for this move, which is to promote higher standards within healthcare systems, this issue would be better addressed by achieving agreement at a European level, improving the standards of training for all.

Re-accreditation

European legislation at present only deals with requirements on the completion of training, and does not address the issue of skill maintenance throughout a doctor's career through periodic re-accreditation. This is being addressed individually in some member states. This, as an area of concern for the continuing quality of healthcare, should be addressed as part of any review of healthcare regulation in Europe.

Conclusions

A number of conclusions can be drawn:

Quality assured patient care must become the prime concern of healthcare directives, and free movement a subordinate issue.

Any change to the directives must include a change to a competency base rather than a time base.

All aspects of the training of doctors and other healthcare workers should be subject to a rigorous quality assurance process by the national competent authorities.

At a European level the performance of competent authorities in carrying out their quality assurance should also be subject to scrutiny.

The medical disciplines should be supported in continuing work towards agreement on the content of each discipline and harmonisation of training and assessment methods.

A professional group at the European level is required to oversee these processes, utilising the work of European professional organisations already in existence.

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The use of mandatory regulatory practice guidelines in France



Pierre Durieux

“Some [physicians] will not accept guidelines because they perceive that their objective is to cut costs.”

Clinical guidelines have grown in popularity in France over the last two decades. Many medical societies have organised consensus conferences, largely promoted by the national medical evaluation agency, now known as ANAES. (*Agence Nationale d'Accréditation et d'Évaluation en Santé*). In 1992, at a time when consensus conference programmes were much criticised, the Agency's forerunner ANDEM (*Agence Nationale pour le Développement de l'Évaluation Médicale*) developed a clinical guidelines programme, modelled on the experiences of the US Agency for Healthcare Policy and Research.¹ Other guideline programmes were also developed by the Paris Public Hospital Network (*Assistance Publique-Hôpitaux de Paris*, AP-HP), the national federation of cancer centres (*Fédération Nationale des Centres de Lutte Contre le Cancer*) and several professional bodies.

In 1993 in an effort to control ambulatory care costs and change clinical behaviour, legally binding regulatory practice guidelines, RMOs (*Références Médicales Opposables*) were introduced following negotiations with the national health insurance system and medical unions. Fines

were levied on physicians who did not comply with guidance. What was the impact of this policy on costs, quality of care and physician behaviour? This article describes this policy and its potential implications for the development and implementation of clinical guidelines.

The implementation of guidelines

RMOs are defined as 'recognised scientific criteria that make it possible to define inappropriate care and prescriptions, and the frequency with which they are used by patients.' They can cover medical, surgical, and diagnostic areas as well as treatment protocols. Insurance funds and doctors' unions identify RMO topics. Criteria for selecting topics include cost, level of risk, disease prevalence and possible evidence of wide practice variations. For each of these topics, up to ten RMOs are selected from specific guidelines drawn up by ANAES and AFSSAPS, the French Drug Agency.²

RMOs, initially published in the *Journal Officiel de la République Française*, provide short prescriptive recommendations, identifying inappropriate treatment protocols (see Table). In 1998, a total of 165 RMOs in 43 areas were published for general practitioners; a further twenty RMOs were for specialists working in private practice, but they do not apply to hospital care. They are distributed by the major national health insurance fund (the *Caisse Nationale d'Assurance Maladie des Travailleurs Salariés*), to physicians working in private practice. They are also widely published and discussed in French professional medical journals.

Insurance funds can inspect a two-month period of prescriptions, comparing these with RMO guidance. If inspection indicates that a physician does not comply, a report is sent to a local committee of health insurance funds and medical unions, which may then levy a fine. The fine is determined by a weighted combination of indices of harm, cost of each RMO, and frequency of violation.²

Table SOME RMO GUIDELINES

Topic	RMO
Physiotherapy	Inappropriate to prescribe exercise therapy for patients with acute low-back pain.
Non-steroidal anti-inflammatory drugs	Inappropriate, due to the risk of haemorrhage, to prescribe a non-steroidal anti-inflammatory drug to patients who are treated with oral anticoagulants, heparin or ticlopidine
Type 2 diabetes mellitus	Inappropriate to perform glycosylated haemoglobin measurement in non-insulin dependent diabetes screening

Source : *Journal Officiel de la République Française*, December 5, 1998

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Impact on physician behaviour

There have been very few studies evaluating the impact of this policy, although some early studies have demonstrated that there was some impact on costs. One such study³ looked at the impact of ten and eight RMOs introduced in 1994 and 1995 respectively. This study was based on data from two thousand three hundred physicians collected between 1992 and 1995. One year after implementation of RMOs, it was estimated that approximately \$6m of drug expenditure was avoided. However, this impact on drug expenditures, was not observed for therapeutic RMOs published after 1994.⁴

To evaluate the level of awareness and knowledge of RMOs, we performed an observational study of 321 general practitioners asked to identify RMO topics and guidelines from a list which also contained fictitious information. Although 80 per cent of respondents stated that they sometimes consulted RMOs, (44.3 per cent during patient consultation), no evidence of significant awareness or knowledge of RMOs was found among physicians.⁵

Discussion

The long term impact of financial disincentives on physician behaviour depends on trust, legitimacy and quality control.⁶ Several factors might explain the failure of the existing RMO policy.

Firstly, most health professionals worry that efforts to reduce the cost of healthcare services could also decrease quality of care and they also resent fines. In one 1998 study, 60 per cent of physicians felt that the policy could adversely affect the quality of care.⁷

Secondly, the credibility of the inspection procedure has been questioned. Although more than 26 000 physicians (23.6 per cent of physicians working in private practice) had been inspected by the end of 1997, only 483 were reported, of which 121 were fined (0.1 per cent of French private physicians).⁴ Initially it was taking 300 hours to check prescriptions issued by one doctor over a two-month period.²

Thirdly, there has probably been too much emphasis on increasing the number of RMOs produced, and the usefulness of some has been questioned. In one study looking at the prescription of vasodilator agents in peripheral occlusive artery diseases, it was shown that 80 per cent of GP prescriptions were consistent with the RMO one year before its publication.⁵

Lastly, the use of RMOs was challenged in 1997 when the rules were changed as part of ongoing healthcare system reform.⁸ These reforms extended coverage to physicians working in private practice, and meant that they could also be collectively fined, if they overspent the annual budget set by Parliament. This policy was considered to be incompatible with the French Medical Association (*Conseil National de l'Ordre des Médecins*) code of ethics, which allows physicians to prescribe whatever care they deem necessary. This reform therefore raised an important conflict between the French government, the social security system and the medical unions, which consequently had a negative impact on the implementation of the RMO policy. In 1999 a legal ruling of the *Conseil d'Etat*, not only dismissed the concept of fining physicians if they did not comply with guidelines, but also rejected the idea of collective penalties for physicians. Thus, at present it is impossible to predict the future of the RMO policy.

Issues for debate

The simultaneous development of clinical guideline programmes to improve quality alongside the instigation of regulations to control medical practice and contain costs can lead to misunderstandings between clinicians and health policy makers. The use of clinical guidelines consensus conferences, involving well recognised experts, did play an important role in increasing acceptance of clinical guidelines. Physicians are now aware of the role of both current scientific and economic evidence, but some will not accept guidelines because they perceive that their objective is to cut costs.⁸

It has been suggested that most approaches aimed at changing clinical practice are based more on beliefs than on scientific evidence.⁹ The programme of mandatory medical guidelines failed to control the costs of outpatient care, despite broad dissemination to all physicians working in private practice, coupled with the threat of fines for non-compliance. The objectives of a clinical guideline programme therefore should be clearly stated before implementation. Successful implementation of practice guidelines requires good knowledge of structural and personal factors that may motivate actors within the healthcare system to accept or obstruct change. The French experience tends to support the notion that more information is needed on the impact of disincentives on physician practice.

The idea of health security



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"a number of current health policy debates appear in a decidedly different light when viewed in terms of health security or insecurity."

A healthcare system can be viewed through a variety of different conceptual or disciplinary lenses. To physicians and nurses it is a set of clinical services and their providers. It is also where they work and the source of their livelihood. To organisation and management theorists it is a complex organisation, often dysfunctional and in need of re-structuring. To health economists it is a set of fiscal flows and balance sheets, typically inefficient when measured against theoretical models. To national officials it is a political structure that increasingly requires unpleasant and occasionally unpopular decision-making.

Patients, however, tend to view healthcare services as one part of a broader social concern. To an individual who becomes ill or incapacitated, sufficient income support is equally as important as access to appropriate and affordable care. From the patients' perspective, it is this combined health-services-plus-transfer-payments picture which ensures that an episode of illness does not lead to a reduction in their standard of living, and which thus provides them with what can be termed 'health security'.

Health security

The idea of health security is both simple and far-reaching.¹ Defined simply, it "incorporates those funding and service elements... that either protect against or alleviate the consequences of trauma, illness, or accident".² Defined more far-reachingly, it involves coordinating disparate and often fragmented components of curative and preventive healthcare, social care, rehabilitative care, occupational health services, employee's accident compensation, sickness pay, and disability pensions such that the individual's combined need for services and income are met.

Providing health security for all citizens does not necessarily mean providing public funding for all services, and it certainly

does not necessarily mean providing exclusively publicly operated facilities to deliver those services. In most situations, the healthcare and income support functions that comprise health security are undertaken by a variety of entities including national, regional and local; public, private not-for-profit, and occasionally, private for-profit. Health security does, however, depend upon public responsibility to guarantee that all citizens have access to appropriate services at a suitable standard; that the funding structure for those services reflects ability to pay; that providers serve the needs of citizens in a consistent, reliable, and sensitive manner; that adequate replacement income is provided in a non-discriminatory manner; and that the entire structure is integrated and coordinated to reduce unnecessary stress on the individual and duplicate cost to society.

Health insecurity

An alternative approach to understanding the idea of health security is to contrast it with health insecurity. The nature and consequences of health insecurity are readily apparent. Citizens worry that episodes of ill health may jeopardise their physical or mental health on the one hand or their financial stability on the other. Individuals who do not have access to necessary or affordable services, or to sufficient income support, during a temporary or permanent period of ill health, may lose either their health and/or their household. Inability to pay for medical expenses is the primary reason for declaring personal bankruptcy in the United States.

Stewardship

When assessed in terms of these two contrasting concepts, a number of current health policy debates appear in a decidedly different light when viewed in terms of health security or insecurity. The broad governance issue of stewardship in the health sector, for example, involves the application of both sound normative values and efficient expenditure of revenues to the activities and decisions of the state.³ The role of the state in forming and implementing efficient, efficacious, and responsive health policy, and in the regulation of

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health sector actors, should also be to improve the population's level of health security. Measures which might improve the technical functioning of health systems but which move the health system toward greater health insecurity would, arguably, not reflect good stewardship except in the most dire policy circumstances (for example war or depression).

Co-payments

Although comprehensive review of the evidence demonstrates that cost sharing is both financially inefficient and socially inequitable,⁴ some health economists persist in promoting it to policymakers. One explanation is the surface plausibility of the market-incentive based argument. This suggests that co-payments encourage patients to become price conscious shoppers for healthcare and not incidentally to also reduce their demand for 'unnecessary' services. Co-payments are similarly described by some health economists as a device to reduce the 'moral hazard' that accompanies the provision of third party payments for healthcare services.

A health security approach views cost sharing as intentionally increasing the 'health insecurity' of citizens, and thus as an undesirable instrument in terms of core health policy objectives. Abel-Smith labelled all forms of cost sharing as "partial de-insurance".⁵ Medical Savings Accounts, for instance, which seek to return all but catastrophic health services to a fee-for-service basis by removing the third party payer, not only decimate socially responsible risk pooling⁶ but also, at the individual patient level, dramatically increase both financial and clinical forms of health insecurity, and would thus be viewed as unacceptable policy. Policies that promoted cost-sharing, referring back to the first point, would be perceived as bad stewardship.

Rationing

An emphasis upon health security raises a similar question with regard to policies that explicitly ration services. Rationing involves setting criteria for decisions to eliminate certain clinically necessary services from coverage by a third party payer. Proponents of rationing argue that there is infinite demand for scarce healthcare resources, and that only limited access to certain services can be afforded by publicly funded or publicly regulated third party payers.

Focusing on health security highlights the differential consequences of rationing

individuals with high as against low personal incomes. Whereas high income individuals would be able to privately purchase services no longer covered by a third party payer, low income individuals would be forced to go without the rationed care. Rationing necessarily increases the health insecurity of only less well off individuals. Adopting a health security approach highlights the danger that priority setting can deteriorate into a socially regressive solution to the problem of inadequate health sector resources.

Conclusion

Taking these debates together (stewardship, co-payments, and rationing) suggests the potential usefulness of a health security lens, in seeking to assess the broader societal implications of specific health policy strategies.

It is not difficult to imagine that the concept of health security could help illuminate the clinical and social implications of a variety of emerging health-sector issues. One could, for example, view various European Single Market questions in terms of their likely impact on health security. One might well conclude that allowing individual patients to seek cross-border care could enhance health security, while allowing the financing of healthcare services to become a fully commercial commodity would have the opposite result. Similarly, one could assess the likely impact of alternative internet and information technology strategies on health security. Such evolving initiatives as telemedicine, patient-physician internet communication, electronic patient monitoring, and other potential arrangements may take on a different character when viewed from a health security perspective.

It is also possible to imagine that the concept of health security could become a more systematic tool by which to inform future health policymaking. Assuming appropriate tracer variables can be identified and that valid data could be generated, we could map the current level of health security within European Union countries. This could support national policymakers by highlighting best practices in a manner that helps them identify alternative policy options. It may also lead to the development of a Health Security Impact Assessment that, like environmental impact statements, could explore the expected consequences on health security of potential or proposed health and/or social policy initiatives.

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Human capital for accession

A proposal for the EU



Wolfgang Hager



Nicholas Jennett

Health and enlargement

The link between health and enlargement was first addressed in a European Commission staff paper in 1999.¹ The following issues were identified as deserving particular attention in relation to accession preparations:

- the lack of clear, modern public health policies equal to the challenges facing the health system and the relatively low priority given to this sector;
- the increasing level of communicable diseases, and the decline in vaccination coverage and the increase in drug use;
- the low social and economic status of health professionals and the consequent potential pressures on migration;
- the continued negative impact on health of poor environmental conditions.

However, in respect of direct intervention in the health sector, the Paper's list of possible actions reflects the narrow scope allowed by subsidiarity. A working party of the Centre for European Policy Studies (CEPS) has recently looked at the health status of EU Member States compared with the accession countries of central and eastern Europe (CEECs) in the context of enlargement. Its conclusion is that the importance of health in the enlargement process is not adequately captured by reference to the *acquis* (the combined body of Community law). In particular, adequate investment in human capital will be a critical factor in the ability of the accession countries to meet the economic goals of accession. This identifies the need for urgent action on the part of the EU.

The economic challenge

The economic challenge of enlargement should not be underestimated. The success of accession will depend not on *acquis* implementation, but on the rate and quality of economic growth. As Table 1 shows, substantial rates of growth are required to bring the accession countries to levels of income of 75 per cent of the EU average. To put this in context, over the next 20 years, the CEECs will need to achieve a rate of growth which is twice that which has been achieved over 20 years in the existing Union. Given how problematic the convergence of poorer regions within the EU has been, this is a very demanding target.

Human capital and development

What is required to meet this challenge? There is now considerable evidence that, in parallel to the development of infrastructure and industrial investment, economic growth requires societies to invest in their people. In the developed countries, the value of the human capital stock is now some three to four times the value of the stock of physical capital. Additionally, it is also increasingly recognised that human capital investments have greater value at the margin than physical investments. In other words, investment in human capital is a driving force of growth and development.

The World Bank has recently published a major, multi-country study of the drivers of sustainable growth and development in

Table 1
ECONOMIC GROWTH RATES REQUIRED TO REACH 75 PER CENT OF THE EU AVERAGE IN 20 YEARS

Slovenia	2.4%
Czech Republic	3.1%
Hungary	4.1%
Slovak Republic	4.4%
Estonia	5.6%
Poland	5.7%
Latvia	6.6%
Lithuania	6.6%
Romania	7.3%
Bulgaria	8.1%

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The views in this article reflect those expressed in a recent report by the Centre for European Policy Studies, Hager W, Suhrcke M. *A European Bargain: Investing in CEEC Health*. Report of a CEPS Working Party, Brussels, 2001. Views expressed here do not necessarily represent those of the European Investment Bank.

“Over emphasis on investment in ‘traditional’ physical infrastructure to the detriment of investment in ‘human capital’ distorts economies and jeopardises development potential.”

the modern world. Its conclusions are unambiguous: “No country has achieved sustained development without investing substantially and efficiently in the education and health of its people.”²

The study cites inter alia a review of the growth experience of 20 mostly middle income countries over the period 1970 to 1992. There is clear evidence that market reforms can accelerate growth. But if the reforms are not accompanied by investments in human capital, growth is likely to flag. A further study cited in the World Bank report of 70 developing countries confirms that human capital, on average, boosts the rate of economic growth. Furthermore, as human capital increases, the positive link to economic growth becomes larger. Over emphasis on investment in ‘traditional’ physical infrastructure to the detriment of investment in ‘human capital’ distorts economies and jeopardises development potential.

Private and public returns

In the context of health, the private returns from investment in human capital come from the value individuals enjoy from additional years of healthy life. Some individuals will choose to devote a part of their additional healthy life years to market activities (working longer, more productively or with lower levels of absenteeism) and so directly boosting their incomes and gross domestic product (GDP). Better health also affords individuals more time for non-marketed activities, which will include essential production activities such as raising children and caring for older relatives. Recognising these other activities lies behind the increasing interest in the use of broader measures of development than those measures, such as GDP per head, that capture only the marketed aspects of output.

But in addition to these private benefits, there are also important public returns from investment in health and healthcare. Investment in efficient health services will ensure that the long term budgetary cost of care of a given quality is lower than it would otherwise have been. The improved output of these services (better health) should also reduce the costs of future social interventions (in health itself, disability, unemployment and so on).

Health and development

The CEECs have a far lower population health status than Member States of the EU. Life expectancy is lower than in the EU, and the gap has widened – the gap

between the EU and accession countries was two to three years in the 1970s, and is now over six years. This reduction was particularly marked in the countries of the former Soviet Union, which include the Baltic States. The gap in infant mortality has narrowed but this remains significantly higher than the EU. The rate of abortions per live birth is two to three times the level in the EU³ and there is evidence of a growing burden of disease.⁴

The record in relation to morbidity (or illness) and disability are also important in an assessment of the relative health status of the accession countries. The World Health Organisation’s (WHO) World Health Report 2000 provides comprehensive information on these aspects of the countries’ records.⁵ Using measures of the loss of disability adjusted life years (DALY) and disability adjusted life expectancy (DALE), the WHO shows that the CEECs perform much worse than EU Member States.

Resources for investment in human capital

The need for human capital investment within the accession countries is both clear and more pressing than the need for further physical capital formation. To develop, accession countries need investment in education and healthcare services. But although the CEECs have greater health needs than the EU as a whole, they commit fewer resources to addressing them. Just over 8.5 per cent of GDP is spent on health in the EU compared with around 4.5 per cent in the 10 accession countries. In the EU the average per capita spend on health is around €1500 compared with on average below €300 in the accession countries for which data are available.³

How to promote human capital investment

The two key issues in respect of securing capital for human capital investment within the accession countries are how to ensure that:

- capital is used efficiently;
- investments are affordable to the countries concerned.

A distinction is often drawn between grants and loans to support human capital development. But in principle there is no difference between a public sector loan (for example, from an international financial institution (IFI) such as the World Bank) and an effective grant. Both are paid by taxpayers, albeit different taxpayers. In the

case of a loan, taxpayers of the accession country ultimately pay. Taxpayers of the donor country may also share in the cost through providing guarantees for loans; in the case of grants, however, they bear all of the cost.

IFIs seek to add value to the planned investment expenditure by a combination of lowering the cost of borrowing (i.e. of buying time) and giving technical guidance on effective expenditure. However, in its banking role, the IFI must make sure that government, or other borrower, can repay the loan from computed savings on expenditure or future increases in tax revenue through improved overall economic performance. This, however, may not always be the best answer. IFI loans are a claim on future taxpayers in the accession countries. New public debt – for any purpose – is also subject to strict ceilings on public deficits which are part of the accession criteria. Grants, on the other hand, whilst not representing a direct repayment claim on future taxpayers, are treated as a ‘free good’ by the final recipients. For this reason, they do not maximise the incentives to use capital in the most efficient way.

The best way to avoid this problem is to associate grants with loans, using cost benefit analysis and allocation mechanisms commonly applied for IFI loans. This makes the grant component subject to a lender’s test of economic efficiency. Accordingly, these allocations can be fully justified as a contribution to economic development, whilst the grant element makes investments more affordable to the recipient than pure loans would have been.

The European Union has both the means and the mechanism to act in this way. The Union’s Instrument for Structural Policies for Pre-Accession (ISPA) funds, presently limited to investments in physical infrastructure (transport and environment) run at a level of 1 billion a year to 2006. There is growing evidence of bottlenecks in spending this money because of the technical problems associated with large projects. Transferring ten per cent of this amount to health investment would yield some 500 million over the period. This is roughly equivalent to the total value of World Bank funded health support programmes in the CEECs. There are also a number of other sources of Commission support which could be more closely aligned with need. PHARE* has a budget of €1.5 billion per

year available for pre-accession support beyond 2000. Further funds are available under the Special Preparatory Programme for Structural Funds, which are designed to pave the way to access to post-accession structural funding.⁶

The European Union also has readily available methodologies and institutions for investing in improved health provision in the CEECs. In terms of methodologies, valuable World Bank programmes, directed towards a mix of critical physical resources, knowledge and knowledge systems at central and local level, have already been established for most accession countries. In terms of delivery, the Union can also draw on the services of the European Investment Bank (EIB) – its ‘in house’ financing institution. The EIB has had a mandate to lend to economically worthwhile health projects in accession countries since 2000. Although EIB loans are typically available on the finest terms available in the market, even highly economically worthwhile projects may not be affordable to accession countries. The ability to draw on ISPA funding to ‘subsidise’ loans, whilst retaining existing economic tests of the viability of projects, could make a significant impact.

Time for action

Investment in health is a clear prerequisite for the accession countries and the EU to meet aspirations for enlargement. However, preparation for enlargement is presently following a single pattern centred around the adoption of the *acquis*. In such discussions, the accession countries are examined in terms of institutional and other shortfalls from full *acquis* capability, but the rationale or even quality of assistance to the health sector cannot be derived primarily from the *acquis*, especially if that is interpreted in narrow, legislative terms.

The concern with subsidiarity in this the most politically sensitive of all sectors is an important consideration but the legalistic approach to accession is flawed. This is not least because policy initiatives in the pre-accession phase need not be constrained by subsidiarity. The EU has, within its grasp, the means and mechanisms simultaneously to make a major impact on the quality of human capital formation within the accession countries and to protect the interests of the Union’s existing citizens and taxpayers. But time is now short to grasp this opportunity.

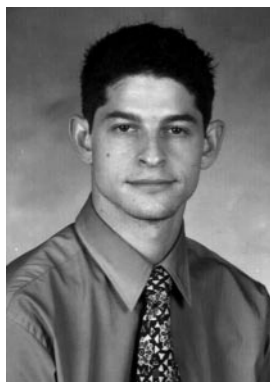
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* Originally, Poland and Hungary: Action for the Restructuring of the Economy programme.

Tackling high male mortality in Poland

Proposals for reform



Jesse Selber

“Incentives increasingly draw physicians out of public service, creating a poverty of quality in public facilities.”

Poland has been one of the Central European leaders in health sector reform. Sweeping changes have been introduced in financing, regulation and micro and macro organisation.

The progressive stance towards systemic improvement has produced palpable health gains. What has been lacking from an analysis of health sector reform in Poland is public health priority setting. High male mortality rates are a major problem and principal determinants are inadequate preventative services and unhealthy life styles.

Life expectancy

Currently, life expectancy for Polish males is only slightly higher than it was thirty years ago. Mortality rates are highest among working class, middle aged men. The three leading causes of death for this group are heart disease (50.4 per cent), cancer (20.5 per cent), and injuries and poisonings (7.5 per cent). Death from heart disease has increased by around 250 per cent in middle aged men over the last 30 years. Men suffer 760.8 deaths per 100,000 from heart disease, against 458.9 for women. Cancer mortality for men is 293.3 per 100,000, against 153.5 for women. Male mortality from injuries and poisoning is 132.5 per 100,000, against 35.7 for women.¹ This disparity in gender specific mortality rates is well in excess of countries with similar GDP per capita. This gap suggests that other forces besides income are negatively affecting the health of Polish males.

Causes of high male mortality

There are two broad categories of cause for the high male mortality rate. The first, and the one for which there is the most direct evidence, is unhealthy life style practices. Studies have shown that Poles are generally unwilling to adopt healthy life styles, uninterested in longevity, and fatalistic in their thinking.^{2,3} There is very little value placed

on exercise, diets are high in fat and low in fruits and vegetables, and alcohol and tobacco use is very high. Fifty per cent of Polish men smoke, and vodka consumption is at 8.9 litres/year per capita.¹ Drunk driving and alcohol poisoning are relatively common,⁴ and occupational injuries and exposures abound.⁵ Reforms aimed at changing the behaviour and attitude towards health of the Polish population are a necessary part of the reform process, but beyond the scope of this article.

The other broad category of cause for high male mortality is inadequate preventative care. The problems of heart disease, cancer, fatal accidents and poisonings, from a clinical perspective, are not very amenable to secondary prevention – once they have emerged as clinical problems, they are generally highly morbid. While heart disease is amenable to secondary prevention, the most effective therapy is similar to primary prevention: diet, exercise and other behaviour changes. This suggests that the high rates of these problems are a failure in primary prevention, not treatment, an inference supported by studies that have shown identical case fatality rates for patients hospitalised for acute myocardial infarction (MI) in Poland and the United States. Once hospitalised in Poland, medical care is adequate.⁶

Recent reforms

The Polish healthcare system has already undergone sweeping policy reforms. The reform process began shortly after the end of the communist regime, with devolution of power and decision making from the Ministry of Health to the voivodships (regions), and three years later, to the local councils. Greater autonomy was given to hospitals, and a process of public sector privatisation was initiated. Family practice was emphasised over the use of specialists,

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and innovations in physician payment were instituted, with fee-for-service replacing salaries in some areas. Healthcare markets were liberalised and different provinces and regions within Poland have initiated reforms in a variety of directions.

The most recent national legislation involved the establishment of 17 National Health Insurance funds (NHIs), financed through taxes and employer payments to replace regional budgets. Publicly owned health facilities have been allowed to function as independent units, consisting of government owned but relatively autonomous institutions that enter into contracts with the NHIs for services. Improved quality of care and improved patient satisfaction has emerged in certain regions.⁷ Unfortunately, a trend of rising healthcare costs has also become apparent, stimulated by physicians moving into the private sector and incentives for increased throughput due to fee-for-service payment. Some vovoidships have gone into significant debt as a result. Other localities have been unable to muster the human resources and technical expertise to manage effectively the new financing system and have progressed very little.

Improving preventative care: recommendations

There is a great deal yet to do in order to improve the performance of the health system. First, it is unclear how contracts between payers and providers will improve health system performance per se, particularly if the problems of cost-efficiency that have plagued the system in the past are not addressed with better management control. Although there is greater regional and facility based autonomy, the human resources and capacity to effectively manage are still not in place. The informational and evaluative tools do not exist, or are just beginning, to supply the sort of feedback needed for measurement of quality and efficiency. Capability development needs to take place in human resources, management control and programme evaluation to tighten operational costs and improve performance. Information on cost accounting and patient provider encounters needs to be collected, and interpreted analytically. Some of the healthcare budget should be set aside for this training and infrastructure development.

Payments and provision

Additionally, there are problems with multiple practice roles for physicians.

Thirty per cent of physicians are involved in both public and private provision.⁸ Incentives increasingly draw physicians out of public service, creating a poverty of quality in public facilities. Informal payments continue to be an uncontrollable source of financing that creates inequity and inefficiency. For instance, total Polish health expenditure is quoted at between four and five per cent of GDP. This is unusually low, but it has been estimated that an additional 2.5 per cent in uncharted payments are being made.⁹

Out of pocket payments constitute nearly 38 per cent of healthcare expenditures, mostly for ambulatory services. Meanwhile, 24 per cent of regional budgets is spent on outpatient care, 80 per cent in the form of salaries. Taken together, this suggests that public funding should be diverted to inpatient facilities to increase physician salaries and stem the exodus of physicians from the public sector. The reservoir of funds from informal payments can then be used to legitimately fund the more privatised outpatient services.

Although contracts and modest privatisation of services has improved the quality and access to individual physician services, it has broken up a formerly well integrated system. With rising costs and finance problems on the horizon, a fractured system of provision is likely to pose enormous cost containment problems.

Specialists and gate keepers

Adding to cost containment problems, specialist services have been historically overused in Polish healthcare with very little importance placed on primary care. For instance, by the early 1990s, over 75 per cent of physicians were specialists, compared to 50 per cent in OECD countries.¹⁰ This can be handled from the supply side in a way that also deals with the problem of service disintegration. There needs to be physician gate keeping at all levels of provision to prevent specialist overuse and counteract fee for service treatment incentives. Referrals should be required for all public and private specialist care. Additionally, user fees might be instituted for tertiary care. Plans to define a primary care benefits package should also be undertaken to ensure that public health goals of primary prevention are met.

New fee-for-service payment incentives in certain localities have also exacerbated the cost containment problem. Although there have been gains in quality and patient

“Poles are generally unwilling to adopt healthy life styles, uninterested in longevity, and fatalistic in their thinking.”

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- satisfaction, it will probably be necessary to impose capitated payment for physicians in the near future. Recent payment reforms in certain regions have created mixed fee-for-service and capitation for gatekeepers. Some of this payment is for the extent of preventative services offered by the physician. Since prevention has been identified as the primary health system failure leading to high male mortality, this policy could be nationalised. It may be useful to add health outreach to this reimbursement package, including worker safety counselling, anti-drunk driving education, and blood pressure and cancer screening drives in the community, to combat some of the deep rooted preventative shortcomings. Not only must there be incentives to practice primary care, but there must be adequate training. Medical education is currently geared towards specialist care.
- The integrated health provision units were formed under state financed bureaucratic conditions that encouraged capital investments and increased capacity. As cost efficiency measures and local autonomy over healthcare institutions increases, excess capacity needs to be reduced. Competition between autonomous health provider units would ideally eliminate the units that couldn't contain costs and operate efficiently, but because of the legal structure of localities, it is unclear whether managers have the authority to close facilities.¹⁰ There is a reluctance to reduce personnel even in the face of performance based incentives. Local governments should be encouraged through a mandate of clear authority to furnish local solutions to excess capacity, including closing facilities and reducing personnel.
- There are far too few physicians in rural areas, and too many in urban centres. Innovations in payment have reduced some of the work force in urban areas, but more physicians need to reach the rural communities. There should be mandatory intervals of rural service for new medical graduates, as well as financial incentives for rural practice. Finally, because of variations in health and income by region, there are bound to be fairly wide gaps in horizontal equity among the NHIs. There should be some sort of equalisation fund to correct for variations in regional income and healthcare requirements.
- Implementation and technical feasibility**
- One of the most pressing problems following recent reforms is the level of control hospital managers have over the facilities they operate. If market forces are to truly increase efficiency and provide cost containment measures for local institutions, the repercussions of uncompetitive facilities must be felt. Because local governments own the local hospitals, it is unclear whether or not managers have the authority to close these facilities, or sell assets. The question of ownership will have to be settled.
- A related problem has to do with the ability of the NHIs as buyers to create efficiency through contracts in rural areas where provider facilities constitute a monopoly. If managers do gain the authority to control assets and reduce capacity then, in certain rural areas where facilities cannot meet contractual agreements, populations may find themselves without access. There is a lack of capacity in rural areas, and some facilities represent the only care available. NHI funds may have difficulty developing competitive contracts with these facilities if managers threaten to close them. NHIs may be forced into less than cost-containing contractual agreements with regional monopolistic providers and local governments may have to continue to assume debts for these providers.
- Limited capability is perhaps the most apparent difficulty that the reform process now faces. In order to manage effectively funds and run regional facilities in a way that improves efficiency and reduces capacity, effective managers and skilled gatekeepers that understand how to allocate resources will be required. In the absence of such individuals, instead of competitive contracts that create incentives for cost containment and provider behaviour, historical budgets have remained the standard.
- The need for a high volume of accurate information on patient-provider behaviour and cost accounting will be essential in enforcing contracts and altering provider and facility behaviour. Gatekeepers will need intelligible feedback about referrals and resource allocation decisions in order to improve performance. Advanced information systems will be required so facilities can measure their own effectiveness and cost variance. Market research will be required to direct consumer messages. Each of these measures will require new ways of gathering and processing information. Systems of this type have begun to emerge in Polish healthcare, but it is yet to be determined how effectively the flow of information that follows will be used.

The permanent crisis in German healthcare



Klaus-Dirk Henke

The diagnosis

The pressure for reform of the German healthcare system continues unabated. The chronic deficits in the finances of the social health insurance system, the demographic challenge, the increase in chronic diseases, medical progress and the growing freedom of movement in the European Union are only a few of the symptoms that call for more analytical and political attention.

Current problems include a lack of transparency in the billing of healthcare services, excess capacity, especially in the hospital sector, which remains isolated from the ambulatory sector, and too little emphasis on prevention. Underdeveloped health awareness, in combination with difficulties in providing the public with necessary medical information has also given rise to the current problems in the healthcare system.

The issue of ancillary wage costs is a growing problem, as contribution rates continue to rise in the social health insurance system. Previous attempts to deal with this have proven ineffective, budgetary restrictions, which are once again the principal political solution, no longer seem so convincing as rationing becomes more of a reality. Rising expectations and the development of a health and fitness sector in the context of rapid advances in nursing, treatment and medical technology have turned healthcare into a labour-intensive growth sector. The potential of this sector, however, has not been adequately exploited due to faulty financial mechanisms and a lack of political tenacity.

These symptoms are typical of the ailments that currently plague the German healthcare system; a system still known for its high level of care and comprehensive social protection, ensuring access to appropriate healthcare services independent of social

status, income and place of residence.

Given these obvious problems and deficiencies, the German healthcare system must be reformed in preparation for future challenges. If any credence is given to the analysis of these deficiencies and the ranking of international comparisons, then a comprehensive reform of the organisation and financing of the German healthcare system is needed in order to maintain or regain its position as one of the world's leading healthcare systems.

The many deficiencies and widely discussed problems of the system can be summarised, briefly, and constitute the starting point for the further development of the healthcare system and perhaps even for its reform. There is a broad consensus that deficiencies include:

- The compartmentalisation of the healthcare sector (ambulatory care, hospital care and prescription pharmaceuticals).
- Disparate and complicated financing and reimbursement mechanisms.
- Lack of cross-sectoral incentives for healthcare.
- Lack of outcomes-oriented reimbursement for the provision and documentation of healthcare services.
- Inadequate quality assurance of healthcare services.
- The simultaneous existence of oversupply, undersupply and inappropriate care for specific diseases.
- A high number of avoidable diseases and accidents.
- Ambiguous conditions for health insurance coverage.
- Lack of incentives for goal-oriented action by all participants (the insured, patients, families, healthcare professionals) and institutions (insurers, manufacturers, pharmaceutical industry etc.)
- Lack of individual autonomy and self-responsibility.
- Underdeveloped competitive market conditions.

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“The provision of healthcare would occur on a competitive basis and under regulatory control.”

This ‘probable diagnosis’, as physicians would say, is confirmed by the many ailments that beleaguer the healthcare system; a system that consumes more money each year than the federal budget, where more than four million people are employed, having created more new professions than any other sector in recent decades.

The damages arising in the largest public enterprise in Germany can be limited through continuous symptomatic therapy. Alternatively, the system could undergo radical therapy, to tackle the root causes of these problems. The support of patients, whose health awareness and autonomy must be reinforced, is needed in both cases. The media must also transcend simple slogans such as ‘two-tiered medicine’ and ‘cream skimming’ so that this growing market is not undermined, but instead allowed to develop in line with the preferences of the population and the potential of an industrialised nation.

Continuous symptomatic treatment

If there is a consensus to improve the existing healthcare system and thus to remain within the given framework, then the following requirements would be generally recognised as valid:

- More quality assurance based on the certification of healthcare facilities and evidence-based medicine as the foundation for the provision of healthcare.
- More transparency of all treatment protocols and their prices or reimbursement levels.
- More networked, patient-centred and appropriate healthcare structures.
- More health education and information.
- More prevention and health promotion.
- More self-responsibility for the insured.
- More competition among health insurers and among healthcare providers.
- Increased efficiency in hospitals and the privatisation of ownership at local level.
- More projects for the promotion of approaches to healthcare and modes of finance that cross sectoral boundaries and focus on outcomes (group practices, day clinics, gate keeping models, office-based clinics, etc.)

In addition, there is general agreement that the mobilisation of the so-called ‘efficiency reserves’ is also a priority objective; and the slogan ‘rationalisation before rationing’ implies, especially at this general level of discussion, ‘rationalisation before the

utilisation of new sources of finance’.

Although from an economic perspective self regulation appears attractive given that the system is funded equally by employers and employees, this leads to a situation where both parties strive to influence the health system. If this system remains intact, then there is little chance that the reform process will do much more than muddle through.

Since spring 2002, steps in line with these requirements are being discussed in six working groups, where issues such as integrated care, hospitals, pharmaceuticals, disability aids, physical therapy, evidence-based medicine, prevention and ambulatory care are on the agenda. Revenue sharing across social health insurance funds, which was introduced to create conditions for fair competition in the social health insurance system, is also a topic for discussion. The current reform plans call for the introduction of morbidity-based criteria mechanisms for revenue sharing by the year 2007. This will be based on the introduction of disease management programs for three or four diseases in the existing revenue sharing scheme. The Federal Insurance Office (*Bundesversicherungsamt*) will be responsible for the administration of the scheme and the National Insurance Institution for Employees (*Bundesversicherungsanstalt für Angestellte*) for managing the flow of funds (approximately €15 billion). The ruling coalition is also in the process of reforming the regulations on individual and collective contracts between social health insurance funds and healthcare providers and re-defining providers’ service mandates. Finally, legislation for the repeal of the pharmaceutical budget is being drawn up and economic analysis of pharmaceutical therapies undertaken. However, the upcoming national elections and the opposition majority in the Bundesrat may limit reform opportunities.

Radical reform with a gradual transition

A reform, worthy of the name, must focus on problems which traditional structures and approaches cannot solve. This includes the relationship between private and social health insurance and the competitive forces between these components in the ‘multi-payer’ system. The artificial and arbitrary distinction between those who compulsorily subscribe to social health insurance and those who do so on a voluntary basis is just as much at issue as the difference in the financial basis of each system: risk-oriented

premiums used in one system, and a social security 'tax' on income in the other. One must ask in this context what solidarity in health insurance really means? Is it the compensation by the healthy for damages incurred by the sick? Is it solidarity between the generations, or between families (children, co-insured dependents)? Is it the redistribution of income, or is it concerned with providing free access to medically necessary care regardless of income, residence and social status?

A systematic new approach to health insurance should provide answers to these questions. What is needed are conditions and financial incentives for an enduring solution that provides the population with appropriate and affordable healthcare and counselling. One solution would be to require that the entire population have basic health insurance, provided by a variety of health insurance funds.

The present distinction between private health insurance and social health insurance would be replaced by a multitude of health insurers providing a high level of basic health insurance coverage. Additional services could be purchased by patients on the basis of their personal preferences. Insurance companies would shift gradually from current income based financing to financing determined by this principle. The transition would be made by keeping the existing finance system in place for all who are 50 years of age and older. Younger population groups and individuals who fall under a clearly defined formula would be insured on the basis of age-related premiums. The compensation of male and female premiums could occur on a public basis or be based on industry agreement. There could also be a compensation mechanism for very costly cases. If cross-subsidisation of health insurance companies were also to be avoided, this compensation mechanism could be organised on the basis of reinsurance.

There would also be a one-off payment of the employer's contribution and equivalent payments within the social health insurance system to the insured. The insured would be protected by a limit on the proportion of income that could be spent on healthcare (for example 15 per cent of income). This necessary social element would also apply to children. Adjustments to cover children should occur by transfer payments, but could be organised using contracts among the private insurers.

Open enrolment regulations should

“The present distinction between private health insurance and social health insurance would be replaced by a multitude of health insurers providing a high level of basic health insurance coverage.”

prevent risk selection so that differences in risk are adequately covered by the reserves for each cohort. Furthermore, if the present approaches to disease management are to be avoided, the premiums for men and women should be equal, children should be entitled either to public support or 'subsidisation' across companies, and reinsurance should be used to cover the most expensive diseases.

The provision of healthcare would occur on a competitive basis and under regulatory control. Capital accumulation is possible at the level of the individual healthcare provider or in networks, so that any additional benefits would be passed on to the insured. Basic care would be subject to a new form of control, namely that healthcare providers who do not abide by the rules of evidence-based medicine would not be reimbursed under the terms of basic health insurance coverage. The conflict between basic and optional services would not be so acute, since the level of care would be based on the status quo, in a manner similar to the Swiss model. It would no longer be necessary to discuss the benefits schedule, as this would not exist in the German Social Code, instead being determined by the regulatory authorities using evidence based clinical guidelines. The authorities thus would decide which procedures are obsolete and which should be included in the benefits package.

The gradual transition to a health insurance system based on a capitation funding principle would mean that both systems would have to co-exist for approximately 50 years. Over the course of this period, social security legislation would gradually be replaced by private law. Such a model was envisaged when long-term care insurance was introduced in Germany. Bringing this model to fruition would provide an answer to the demographic challenge and the need for medical progress in a labour-intensive service sector.

A version of this paper originally appeared in Berthold N and Huber B (eds). *Volkswirtschaftliche Korrespondenz der Adolf-Weber-Stiftung* 2002;41(1).

Recent reforms in the Greek NHS



Mamas Theodorou

“Current and proposed healthcare reforms differ markedly from previous attempts in the 1990s, in terms of both the speed and rate of implementation.”

A National Health System was established in Greece in 1983 following the election of a new socialist government, and within three years much of the system framework was in place. The core principles of the new system were that healthcare was to be provided in state owned institutions, doctors were to be full time public employees, and that the private sector should diminish.

Before the reforms, access to public healthcare was linked to compulsory enrolment in one of more than 35 public social health insurance funds. Today, by contrast, more than 70 per cent of the system is financed through general taxation. Although the 1983 reforms are acknowledged to have been the most significant in the country's history, many proposed changes were never implemented. These included restructuring of the decision making process, establishment of primary healthcare in urban areas, and healthcare finance reform. Nevertheless, overall performance of the system was an improvement on that in the pre-NHS period.

The continued need for healthcare reform

In the first 16 years of the NHS the public healthcare sector underwent significant expansion in terms of capital infrastructure, introduction of new healthcare technologies, and increased personnel, resulting in significantly increased healthcare spending from 3.8 per cent of GDP in 1980, to 4.8 per cent in 1990¹ and 5.2 per cent in 2000.² This in turn has improved availability, access and utilisation of healthcare services, and raised the quality of care. The private sector has also expanded significantly,

mainly through the establishment of numerous private diagnostic centres and private practices. This was a consequence in part of the underdevelopment of public primary healthcare services in urban areas, and also because of the large numbers of newly qualified medical personnel, the majority of which could not be employed within the public system.

The organisation and coordination of the social health insurance system and the provision of primary healthcare services have not been affected. Differences in entitlement and access to care remain between different insurance funds. Each health insurance fund has its own mechanism for financing primary healthcare services and remunerating physicians, which creates a system of blurred financial incentives between healthcare professionals and different population groups. Funds still have different arrangements on the provision of primary healthcare. For instance the rural population have access only to NHS facilities (public hospitals and rural health centres); manual workers use only their funds urban polyclinics, whereas public servants, bank employees and the self-employed access physicians contracted from the private sector.

There was an increase in the black market within healthcare, including bribes and unethical practices. The decision making process also remained highly bureaucratic and centralised in the Ministry of Health, including daily operational issues. Lack of managerial control, quality assurance system, accreditation of institutions and continuous assessment of medical professionals have also led to quality deficits in the system.

In the 1990s these problems led to financial waste and the highest levels of public dissatisfaction with the healthcare system in the European Union.³ Healthcare

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reform remained both controversial and high on the political agenda in the last decade. A number of proposals for healthcare reform were put forward by local and international experts. The main features of the proposed reforms were:

- Establishment of a primary healthcare system and introduction of gate keeping by general practitioners.
- Unification of healthcare financing under one purchasing authority
- Introduction of a managerial and accountability culture within the system, by appointing trained management teams in public hospitals.

Many of these proposed reforms have been included in legislation approved by parliament, but they have not been implemented. The reasons for this include power conflicts and opposition from those affected by the proposed changes, and the inability of the public health system bureaucracy to introduce managerial reforms. Furthermore each health minister has found it politically more attractive not to implement any law approved by his predecessor, instead putting forward new legislation, which again would be changed by successive ministers. Thus different ministers approved three similar laws, none of which were implemented.

The recent attempt for healthcare reform.

The most recent reforms were introduced in June 2000, legislation has now been introduced by Parliament (Law 2889), and measures are still being implemented. The health minister put forward a list of 200 interventions and measures for discussion. The most important aspects of the proposals were:

- Decentralisation and development of regional structures.
- Establishment of new managerial structures within public hospitals.
- Modification of the terms of employment for NHS doctors.
- Unification and coordination of healthcare financing agencies.
- Development of public health services.
- Services accreditation and quality assurance.

The major difference between these latter reforms and their predecessors does not relate to content, but rather in the political

will and pragmatic approach to implementation of reforms. A special team responsible for implementation operates within the Ministry of Health, and has been successful in enacting some provisions of the new legislation including

- Introduction of 17 Regional Health Authorities (Peripheral Systems of Health, PeSYs).
- New hospital managers appointed to almost all public hospitals.
- University hospital doctors prohibited from engaging in private practice if their university clinic is located in NHS hospitals.
- Public hospitals now use all-day schedules as doctors can meet patients privately on site.

“The most important reform measures relate to decentralisation, changes in public hospital management structures and new terms of employment for NHS doctors.”

Moreover, a plan for vocational assessment of physician qualifications is being prepared. A new legislative proposal for reforming healthcare financing mechanisms, organising a new system of primary healthcare, and improving public health programs is to be discussed in parliament imminently.

Of course, the implementation of legislation has not proceeded without reaction and obstruction from those losing power and privilege. A major challenge has come from hospital doctors who have protested and held strikes over the last six months, as well as opposition from some political parties. However political will and the government’s determination to change the healthcare system has started to produce identifiable results, and it seems that the pace of reform cannot be reversed.

Provisions of new reform legislation

The most important reform measures relate to decentralisation, changes in public hospital management structures and new terms of employment for NHS doctors. These reforms are outlined below.

Figure 1 THE ORGANISATION OF SERVICES PRIOR TO LAW 2889

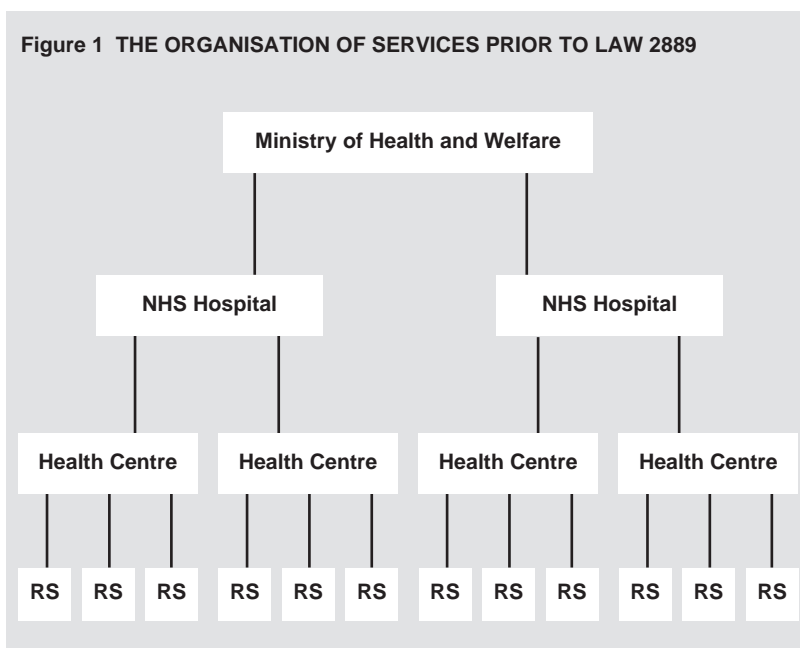
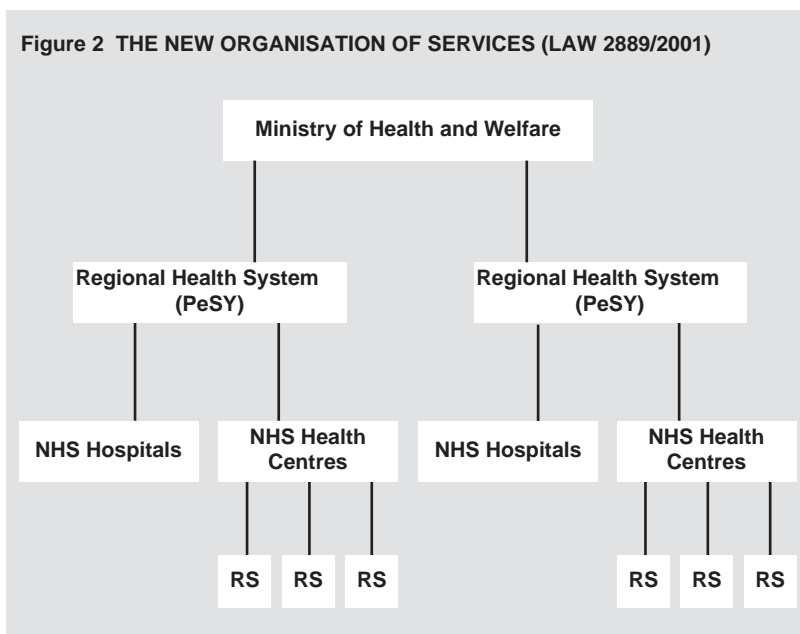


Figure 2 THE NEW ORGANISATION OF SERVICES (LAW 2889/2001)



RS are small medical offices, usually staffed by only one doctor, linked with health centres in rural areas.

Decentralisation and regional structure of the NHS

Greece is now divided into 17 Regional Health Authorities or Regional Health Systems (PeSY). Each PeSY is a public entity, managed by a nine member board, chaired by a President-Executive Director appointed by the Minister of Health, subject to parliamentary approval. PeSY board responsibilities include service planning and coordination, financial control and quality supervision of all healthcare services in a region. Previously all these responsibilities rested directly with the Ministry of Health.

Before the reform public hospitals were individual public entities, supervised directly by the Ministry of Health. Now they have become decentralised subsidiary units of each PeSY, with managerial and financial autonomy. The changes in the health system structure are presented here in figures 1 and 2.

The new system architecture purports to achieve more local based needs assessment, better responsiveness to local problems and immediate solutions to patients' problems at the local level. Under the previous structure, these functions rested with the Ministry, whose heavy bureaucratic mechanisms did not adequately respond to service needs. It is envisaged that the Ministry will now be able to focus on strategic and planning issues, and the initial experiences with implementation are encouraging.

New hospital management structures

NHS hospitals have now become subsidiary to, but administratively independent of each PeSY, governed by a new management structure, which enjoys a larger array of responsibilities than in the pre-reform period. Hospitals now have a five member management team, consisting of the managing director and divisional directors for medical services, nursing, administration and finance, and the hospital scientific committee. Under the previous system, hospital boards members were mainly politically determined community representatives. The new management teams consist of hospital staff members who can directly implement managerial decisions.

Hospital managers are appointed for a five year term, by independent committees, who assess candidate's managerial expertise and knowledge of the healthcare system. Under the previous system hospital managers were political appointees, and largely relatively inexperienced managers. Performance contracts are now agreed with the PeSY Executive Director. Assessment is based on both quantitative and qualitative indicators. This is expected to be a significant improvement on the previous system, where no specific priorities were set.

To further establish a managerial culture in hospitals, the law allows for the appointment of management advisors, the introduction of departmental budgeting systems, and requirements for PeSY directors to approve business plans. It also provides support to management, from specific teams working at the PeSY level, such as those responsible for quality assurance or health infrastructure.

New employment conditions for hospital doctors

Newly appointed NHS doctors do not enjoy permanent tenure as in the previous system. They are given five year contracts and obtain permanent tenure after three successful assessments and ten years of full service in the NHS.

Under the previous system, university based doctors could exercise private practice, now all NHS doctors are prohibited from working in private institutions or practices. They can only see patients privately twice a week inside NHS hospital facilities. Fees are set by the Ministry of Health and vary according to grade of personnel, public hospitals retain 40 per cent of private patients' fees. Patients pay for these medical visit costs, whereas resulting diagnostic routines or treatments are covered by social health insurance. This measure was opposed by university based doctors who lost the privilege of independent private practice.

New legislative proposals

In addition to Law 2889/01, a new set of legislation is being drafted. This covers healthcare financing, primary healthcare, public health and accreditation/quality assurance. These measures will be instrumental to the success of the reform process. A brief description of planned reform measures is now presented.

Healthcare financing

Draft legislation will unify the five largest social health insurance plans under a new Health Insurance Fund, 'Organisation for the Management of Healthcare Financial Resources' (ODIPY). These five organisations cover about 90 per cent of the total Greek population and include blue-collar (IKA) and rural workers (OGA), the self employed (OAEE), civil servants (OPAD) and sailors (House of the Sailor).

ODIPY will manage healthcare resources and act as a purchaser for primary healthcare and hospital services from each PeSY and the private sector on the basis of cost and quality. It will also reimburse pharmaceutical care. Existing differences in entitlement and coverage will diminish and ODIPY will offer a comprehensive package of services to the insured population.

Primary Healthcare

Draft legislation indicates that the NHS will gradually absorb primary health services, both publicly owned and those contracted by the individual social health

insurance funds. The law provides mainly for the publicly owned polyclinics of the largest social insurance agency, IKA. These will be transformed, using additional capital where necessary, into urban primary healthcare centres for all ODIPY members. All ODIPY members will have access to general practitioners, who will be independent contractors to PeSYs, remunerated on a per capita basis. ODIPY will also retain the right to contract additional private services if necessary.

Conclusion

Current and proposed healthcare reforms differ markedly from previous attempts in the 1990s, in terms of both the speed and rate of implementation. All major provisions of Law 2889 have been implemented within one year of enactment. In addition new laws have been prepared to accompany initial reforms.

"It is evident that for the first time in 16 years the power structure within the Greek NHS is shifting."

The Minister of Health has often stated that the reform process will last for six years. Apart from political determination and will, adequate financial resources especially for the implementation of reforms in primary healthcare are absolutely essential. These resources are not as yet secure. Nevertheless, the reform process is underway. While there have been improvements, much remains to be done. It is evident that for the first time in 16 years the power structure within the Greek NHS is shifting. Who the winners and losers will be remains to be seen.

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COMMISSION PROPOSAL FOR RECOGNITION OF PROFESSIONAL QUALIFICATIONS

The European Commission has put forward a proposal for a Directive to simplify the rules covering the free movement of professionals, including health professionals, within the EU.

The proposed Directive seeks to replace some 15 directives relating to general and specific professions including doctors, nurses, dentists and midwives. The proposal is the first comprehensive modernisation of the EU system since it was created forty years ago. The proposal aims to make the system more user friendly in order to facilitate greater and more rapid free movement, increasing flexibility in European labour markets.

The Commission also plans to bring forward further proposals to abolish Advisory Committees, until now set

up for each health profession, and covered by separate 'sectoral' directives, with a single committee for professional qualification recognition.

The proposal is available at:
http://europa.eu.int/comm/internal_market/en/qualifications/com02-119_en.pdf

Publication of the proposal follows a consultation exercise launched in June 2001. Responses were received from some 300 organisations including health professional groups. Health professions under-

lined the need to guarantee quality of education and training in order to ensure high professional standards. They stressed the importance of taking into account the quality of education and training, rather than only the duration of studies, in the automatic recognition of qualifications, especially in view of EU enlargement.

The results of the consultation are available at:
http://europa.eu.int/comm/internal_market/en/qualifications/02-02-06cons_res.pdf

Launch of G10 Report on Innovation and Provision of Medicines

The final report of the EU High Level Group on Innovation and Provision of Medicines was presented in Brussels by members of the G10 Medicines group.

The group, chaired by European Commissioners Liikanen (Enterprise) and Byrne (Health) aimed to bring together representatives of the pharmaceutical industry, Member States, payers and consumers of pharmaceuticals to improve industrial competitiveness in Europe while ensuring high standards of public health.

Concern has been expressed about the extent to which patient and payer views have been taken into account in the G10 discussions, alongside industrial concerns on ensuring rapid access to new medicines. In a review of its involvement in the G10 process, the Association Internationale de la Mutualité (AIM) reported in its March newsletter, that 'It is to be deplored that the issue of financial sustainability of health protection systems was not sufficiently addressed'. AIM is concerned that expenditure on pharmaceuticals has been rising at a higher rate than average health-

care expenditure; pharmaceuticals taking a significant share of the total health budget (up to 40%) and so obstructing investment in other pressing areas such as elderly care. This steep increase is, says AIM, is mainly related to the introduction of new medicines at higher prices, yet these higher prices are not necessarily justified by significant added therapeutic value in the treatment of diseases.

AIM believes that the objective of stimulating pharmaceutical innovation requires a critical appraisal to distinguish advance from "mere innovation" and concludes that "Faster development and approval to give patients rapid access to new medicines could only be justified for medicines that constitute a significant therapeutic advance".

Further information about the G10 group is available from
<http://pharmacos.eudra.org/F3/g10/g10home.htm>

MOVE FOR HEALTH! WORLD HEALTH DAY 2002

World Health Day 2002 was dedicated to 'physical activity and health'. According to Dr Marc Danzon, WHO Regional Director of Europe, "physical activity should be acknowledged as a pillar of a healthy lifestyle and integrated into the routine of everyday living. The secret is encapsulated in 30 minutes of movement on an average day.

A simple way of doing this is walking and cycling for short journeys." Dr Roberto Bertollini, Director of the Division of Technical Support at WHO's regional office, stated that citizens need to become more aware of the importance of moving for health, while policy-makers should facilitate behavioural change through appropriate decisions, making the practice of walking and cycling easier. This means reducing 'barrier' effects created by fear of traffic accidents, air and noise pollution and lack of infrastructure.

More information at
www.who.int/world-health-day/index.en.shtml

TOBACCO

Tobacco consumption and control in Europe

The European Commission's Directorate-General for Health and Consumer Protection has published a fact sheet on tobacco consumption and control in Europe.

It includes a review of the current legislative situation on tobacco advertising, product content and labelling, as well as new European rules on additives and addictive substances contained in tobacco products. The Commission's public health measures to combat tobacco related illnesses are also reviewed. It also seeks to reinforce arguments to end EU subsidies for tobacco production and, importantly, notes that these subsidies are neither in line with the health objectives of Article 152 of the Treaty nor the public health activities of the European Commission.

Fact sheet available from:

http://europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=MEMO/02/57\0RAPID&lg=EN&display

Ministerial Conference for a Tobacco-free Europe

Health ministers and high representatives of 51 countries met 18–19 February in Warsaw at the European Ministerial Conference for a Tobacco-free Europe, organised by the World Health Organisation.

The conference was held in support of the development of a Framework Convention on Tobacco Control, a global initiative to curtail tobacco use. The conference aimed to strengthen the political climate for international action, discuss new measures to reduce tobacco consumption, prepare a global anti-tobacco treaty and to identify a common position prior to the fourth session of the Framework Convention on Tobacco Control.

A European Report on Tobacco Control Policy was drawn up for the conference to provide up to date information on tobacco use in

Europe. This report provides an overview of smoking prevalence in recent years and is a review of the implementation of the Third Action Plan for a Tobacco Free Europe (1997–2001). It reveals major weaknesses and challenges in tobacco control throughout the European Region; no country, for example, has shown a significant decrease in smoking by young people since 1997. Such findings are of importance to the development of the Fourth Action Plan.

The report is available at

www.euro.who.int/document/tob/tobconf2002/edoc8.pdf

4th Session of the Framework on Tobacco Control

The fourth round of negotiations on the International Framework Convention on Tobacco Control, took place from 18–23 March, discussing amongst other things, duty-free sale of tobacco, illicit trade in tobacco and agricultural subsidies to tobacco growers. Advertising and promotion for tobacco products and passive smoking were also on the agenda. Its adoption is anticipated in 2003.

During a speech made at the conference, EU Health Commissioner David Byrne stated that he believes that tobacco advertising has a major influence in encouraging young people to smoke. He wanted to see the rules on tobacco advertising harmonised in Europe and noted that a proposed directive on this topic is currently before the European Parliament. Byrne also said that the Commission is working on a proposal for a Council Recommendation on the prevention of smoking and on an initiative to improve tobacco control. This non-binding initiative, which aims to cover issues such as indirect advertising, not addressed in the proposed advertising directive, is expected shortly.

The speech is available on internet site: www.europa.eu.int/comm/health/ph/programmes/tobacco/index_en.htm

Green light for greater EU cooperation on healthcare

EU leaders met at the European Council in Barcelona, March 15–16 and agreed to pursue further cooperation between Member States in areas, yet to be identified, in order to exchange best practice and information, to achieve European 'added value' in finding solutions to common healthcare challenges.

The European Commission Communication published in December was reviewed. This outlined some of the key issues for discussion, and called on the Commission to examine more thoroughly, questions relating to accessibility, quality and financial sustainability of healthcare systems.

The Commission Communication was drawn up in response to calls made by EU Member States at the Göteborg European Council in June 2001, which discussed the extension of the so-called 'open method of coordination' between Member States to healthcare and care for the elderly. The 'open' method seeks to achieve commonly agreed objectives through a process of policy exchange, cooperation and collective review. It is a non-binding procedure and a 'lighter' version than that used for the EU employment strategy for example which issues recommendations. The Göteborg discussions were in the spirit of an earlier Member State position taken at the Lisbon European Council in March 2000. This stressed that social protection systems need to be reformed in order to continue to provide good quality health services.

The Commission Communication is available at:

http://europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&d oc=DOC/01/8\0RAPID&lg=EN

The Conclusions of the Barcelona European Council are available at:

<http://ue.eu.int/newsroom/makeFrame.asp?MAX=&BID=76&DID=69871&LANG=1&File=/pressData/en/ec/69871.pdf&Picture=0>

EU public health programme moves forward

In May the new EU public health programme will go into the last stage of the 'conciliation' process of talks between the three main EU institutions, hopefully the last hurdle before adoption by the Health Council in June.

The two main issues to be resolved in the talks between representatives of the Council of Ministers, European Parliament and European Commission are the budget and ensuring that the Commission has the appropriate expertise and institutional capacity to deliver the new programme.

The budget proposed by the Commission was €300m, but the Council of Ministers favours reducing this to €280m. In contrast, the European Parliament has proposed €380m. Compromise must also be reached on new areas of work for the health programme such as developing vaccination strategies, bio-terrorism and setting quality standards.

The proposal for the programme of Community action in public health (2001–2006) is available at:
http://europa.eu.int/comm/health/ph/key_doc/ke05_en.pdf

New Dutch ruling on cross border access to primary care

A Maastricht Court ruled in April that the cost of pharmaceuticals, GP visits, and physiotherapy received across the border in Belgium must be reimbursed by Dutch national health insurance providers whether or not a patient has been granted prior authorisation.

The case concerned a patient who received treatment during a visit to family in Belgium but whose insurance provider, CZ, refused to reimburse her as the treatment was not deemed urgent and because CZ had no contract with the Belgian GP to provide such services. Moreover, elements of the treatment were not recognised in the Netherlands.

The Dutch court ruled that under EU law CZ cannot refuse to reimburse the patient given that there would be no serious adverse effect on the finances of the Dutch social security system – a condition highlighted by the European Court of Justice in the earlier Smits/Peerbooms case. CZ is to appeal the ruling, arguing that their contracting system would be redundant if patients are allowed to obtain primary care in other Member States.

GREEN WEEK EMPHASISES CHILD HEALTH

The European Commission's Environment Directorate-General hosted a Green Week in Brussels for the second year running from the 15–19 April.

Opening Green Week 2002, Romano Prodi, President of the European Commission, WHO and the European Environment Agency (EEA) jointly launched the monograph *Children's Health and Environment: a Review of the Evidence*. This states that up to 40% of the global burden of disease attributable to environmental factors is estimated to fall on children under the age of 5 years. Children are particularly vulnerable to the impact of environmental pollution. They are therefore likely to be the most 'sensitive indicators' of the environmental health of populations.

According to Domingo Jimenez-Beltran, EEA Executive Director, "children are at risk of exposure to more than 15,000 synthetic chemicals, almost all developed in the last 50 years. They are also exposed to a variety of physical agents, such as polluted indoor and outdoor air, road traffic, contaminated food and water, unsafe buildings, contaminants in toys, radiation and tobacco smoke." As a result, in many cases, the spread of disorders possibly associated with environmental factors (asthma, neuro-developmental disorders, cancer, and food/ waterborne diseases) are reaching unacceptably high levels.

Several agencies, including WHO and the EEA are working to address the urgent need to evaluate and reduce children's exposure to environmental hazards. They are, for example, establishing a monitoring and reporting system for the whole European Region, based on key indicators relevant to all countries. These key indicators should be used to evaluate the impact of environmental policies on children's health; improvements in their health should be one of the measures of the effectiveness of policies.

2ND WORLD ASSEMBLY ON AGEING TAKES PLACE

The Second World Assembly on Ageing took place in Madrid from the 5–12 April.

An international action plan was developed, with medium and long-term strategies to confront the problems associated with an ageing population in all regions of the world. The plan contains recommendations organised into three priorities: older persons and development, advancing health and well-being into old age, and ensuring and enabling supportive environments.

WHO unveiled a new policy framework on ageing in Europe, endorsed by the EU. The framework presents demographic trends, explores the rationale for active aging as a goal for policy and program formulation, and presents evidence about the factors that determine whether or not individuals and populations will enjoy a positive quality of life as they age. It also presents challenges associated with an ageing population and provides a policy framework for active aging and concrete suggestions for key policy proposals.

In addressing the Assembly, Commissioner Diamantopoulou (Social Affairs) described how the EU has established 'High quality health and long-term care' as a key objective along with increasing employment rates for older Europeans.

Information on the Assembly is available at www.madrid2002-envejecimiento.org. The WHO Report "Active Ageing" is available at www.euro.who.int/document/hea/eactagepolframe.pdf.

The Commissioner's speech is available at www.europa.eu.int/comm/dgs/employment_social/06_02_en.html

News in Brief

EU public health projects funded in 2001

The European Commission has released details of public health projects funded in 2001 within specific programmes. These are available at:

Cancer

http://europa.eu.int/comm/health/ph/programmes/cancer/fp01_sommaire.htm

Drug Abuse

http://europa.eu.int/comm/health/ph/programmes/drugs/fp01_list.htm

Pollution

http://europa.eu.int/comm/health/ph/programmes/pollution/ph_poll_fp01_sommaire.htm

Health Promotion

http://europa.eu.int/comm/health/ph/programmes/health/proj01indx_en.htm

Quality of healthcare in Europe

Medical Authorities from all EU Member States, as well as representatives from the European Commission, the Council of Europe and WHO met March 7–8 in Valencia, Spain to discuss the quality of healthcare in Europe and to consider the relationship between dental care and health. At the meeting the Ministers agreed that the future EU Public Health Programme should include information on the quality and cost of healthcare.

EU takes action against France over doctors qualifications

The European Commission has asked France to change its policy towards the recognition of doctors' qualifications obtained outside the EU which have already been recog-

nised by other Member States. The French authorities have failed to recognise such qualifications and the Commission considers this practice to be in contravention of EC Treaty rules on the freedom of establishment (Article 43). If the French authorities fail to respond satisfactorily to the Commission's request within two months, the Commission may bring the matter before the European Court of Justice.

Launch conference for 6th Framework Research Programme

From 11–13 November 2002 the European Commission will hold a major conference in Brussels to mark the launch of the EU's Sixth Framework Programme for research (2002–2006). It will present the objectives and priorities of the Framework Programme and explain the rules for participation. The conference will also include presentations of research projects carried out under past EU research programmes and other programmes involving international cooperation.

Registration and conference programme are available at:

http://europa.eu.int/comm/research/conferences/2002/index_en.html

EU consultation on better medicines for children

On February 28 the European Commission published a consultation paper on improving the availability of suitable medicines for children. It notes that over half medications used to treat children in Europe today have never been specifically evaluated for this population group. The consultation paper lists the objectives that any new

rules aiming to remedy the shortage of child specific medicines should meet, and suggests ways to attain them.

Further information available from: pharmacos.eudra.org/F2/pharmacos/docs.htm

WHO conference to focus on child health

The forthcoming WHO Fourth Ministerial Conference on Environment and Health in Budapest in 2004, will focus on the health of children and future generations in the broader context of sustainable development. Scientists working in this area are invited to contribute their comments and suggestions to initial findings.

More information and details of the findings in 'Children's Health and the Environment: a review of the evidence' can be found on WHO's Regional Office website:

www.euro.who.int

6th Annual Observatory Summer School

GLOBALISATION, EUROPEAN UNION ENLARGEMENT AND HEALTH: MAKING HEALTH POLICY IN A CHANGING WORLD

The sixth annual observatory Summer School will take place from 25–29 August in Dubrovnik, Croatia. This is a joint venture between the European Observatory on Health Care Systems and the Andrija Stampar School of Public Health in Croatia. The school will again bring together around 70 health professionals from over 30 countries.

It has four objectives:

- To provide an overview of the changing global and European health policy environment
- To explore what level of policy cooperation is needed to address different issues
- To consider examples of international policy making and examine their effectiveness
- To review strategies for ensuring a coherent national health policy at all levels

More information can be found on the Observatory website at www.observatory.dk

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