eurohealth

Making publicly funded health services more responsive

COMMENT

Common values, shared experience

Too often attention is focused on issues of division, whether they are related to the proposed European Constitution or other areas such as foreign policy, rather than on the common values and shared experience that binds Europe together. John Hutton and Lars Engqvist, ministers of health in England and Sweden begin their contribution to this issue stating that "Our health care systems have very different origins and histories, but they share a fundamental commitment to the provision of services according to need, not ability to pay." This commitment, together with the view of the opportunity of good health being a right rather than a commodity, are core values long held across the continent.

Societies continually change, today Europeans increasingly demand not only the highest possible standards of health care, but also much more flexible and patient centred care, providing fully informed individuals with treatments of their choice at a time of their choosing. Rising to this challenge to improve responsiveness and promote patient choice whilst maintaining equity in access is of critical importance in ensuring the viability of publicly funded health care systems. As Hutton and Engqvist simply state, "Delivering depersonalised, one-size-fits-all services are [no longer] sustainable, people will simply opt out if they can afford to." Innovative approaches to extending patient choice in both countries are outlined, with an emphasis placed on how they can share and learn from experiences. Understanding the context in which such reform and quality improvements take place is also vital, and Nancy Mattison in the first article of a series related to quality in health care discusses this issue.

In sharp contrast to the ideals of equity, solidarity and individual choice, there are still individuals across Europe struggling for basic human rights. A powerful article by Judith Klein and Camilla Parker highlights the profound neglect and mistreatment of people with learning disabilities in some parts of central and eastern Europe. While much positive change can be found, they argue that a more active role must be played by governments, by not only providing services, but also removing barriers to social inclusion. Let us hope that enlargement of the European Union will also act as a further catalyst to change.

David McDaid
Editor

Contents

Monitor

Contributors to this issue

I H MONRAD AAS is based at the Work Research Institute, Oslo, Norway.

PAULA CORABIAN is a Research Associate at the Health Technology Assessment Unit at the Alberta Heritage Foundation for Medical Research, Edmonton, Canada.

DAN ENACHESCU is Professor Consultant, Department of Public Health and Management, University of Medicine and Pharmacy 'Carol Davila', Bucharest, Romania.

LARS ENGQVIST is Minister for Health and Social Affairs, Ministry of Health and Social Affairs, Sweden.

PAUL DE RAEVE is Secretary General of the Standing Committee of Nurses of the European Union.

DAVID HAILEY is Senior Adviser at the Health Technology Assessment Unit at the Alberta Heritage Foundation for Medical Research, Edmonton, Canada.

CHRISTA HARSTALL is Assistant Director at the Health Technology Assessment Unit at the Alberta Heritage Foundation for Medical Research, Edmonton, Canada.

JOHN HUTTON is Minister of State for Health at the Department of Health in England.

DON JUZWISHIN is Director of the Health Technology Assessment Unit at the Alberta Heritage Foundation for Medical Research, Edmonton, Canada.

JUDITH KLEIN is Director at the Mental Disability Advocacy Program, Open Society Institute, Budapest

NANCY MATTISON is President and CEO of The Mattison Group, Inc., a global health policy consultancy.

MARK MCCARTHY is Professor of Public Health, University College London, UK, and President, EUPHA Section on public health policy and practice.

CARMEN MOGA is Assistant Professor in the Department of Public Health and Management, University of Medicine and Pharmacy 'Carol Davila', Bucharest, Romania.

SALIH MOLLAHALILOGLU is Principal of the School of Public Health, (Hifzissihha Mektebi), Ministry of Health, Turkey.

CAMILLA PARKER is Legal and Policy Consultant at the Mental Disability Advocacy Program, Open Society Institute, Budapest.

MIKE SEDGLEY is a health and pharmaceutical policy consultant.

HANS STEIN was former head of the EU Health Policy Unit at the Federal Ministry of Health in Germany.

Making publicly funded health services more responsive

John Hutton

Lars Engqvist

John Hutton is Minister of State for Health at the Department of Health in England.

Lars Engqvist is Minister for Health and Social Affairs, Ministry of Health and Social Affairs, Sweden.

First presented at the 2nd meeting of the International Forum on Common Access to Healthcare, London 22nd May 2003

Our health care systems have very different origins and histories, but they share a fundamental commitment to the provision of services according to need, not ability to pay. This common value is what underpins the way we finance health care: risk is pooled, access to care is separated from wealth. This is both fair and efficient. We must therefore make the case for equitable funding as persuasively as possible.

So the method by which health care systems are funded is vital, but this is only part of the story. It has become increasingly apparent that if we are to deliver the health care that people want and deserve, we will need to make services far more responsive to the needs and preferences of patients. This reflects both social changes and developments in the ways in which health care is delivered. Patients are no longer willing to be passive recipients of care: they require much more involvement in the decisions being made about their treatment, and much more control over the way it is delivered.

This is not an optional extra and neither should it be available only to those who can afford private health care treatment. An equitably financed system delivering depersonalised, one-size-fits-all services is not sustainable, people will simply opt out of it if they can afford to. The reassurance that equitable financing brings must be combined with reform to make health care far more patient-centred. This is the challenge facing all of us who are committed to the values on which publicly funded health care is based.

In both Sweden and the UK, programmes of reform are underway to meet this challenge. We are learning from each other and from other countries, including the other participants in the International Forum on Common Access to Healthcare: Canada, Chile, Germany, Greece, New Zealand and Slovenia. These countries have come together to affirm their commitment to the value of equitable funding systems and to seek out new ways to reform their health systems. We all accept the argument that we must reform our systems so that they serve the needs and choices of patients, we cannot afford to confine our search for solutions to within our own systems: international cooperation and sharing of experience will be essential. This article is a contribution to that process.

Access to healthcare: equity and responsiveness

Both the Swedish and UK governments share a commitment to ensure equity of access to health care for the population. This means people having equal access for equal need. It means universal access to comprehensive services independent of ability to pay.

Despite our countries' different historical development, these are shared values. The expression of these values is through our publicly funded health care systems. The solidarity principles underpinning health care financing are central to the social democratic tradition. We value a society in which those who fall ill, who need medical attention, can receive the care they need without having to worry about how to meet the cost of this treatment themselves.

There are those who argue that these principles are no longer important in modern societies. They espouse the principles of the market as the efficient way of financing health care. And yet, international evidence suggests that public financing of health care is both equitable and efficient, and commands widespread public support.

Our modern society also demands that services are more responsive to the consumer. People are able to make choices in many areas of their lives. As patients, however, they may not be able to exercise a similar level of choice over health care decisions. Limited choice is not a necessary feature of a publicly funded system. As we have

already seen, choice can be extended within our health care systems.

Here we set out the arguments and evidence to support our governments' efforts to improve access to health care for patients by ensuring equity while at the same time increasing responsiveness of services.

Ensuring equity
Public financing is important to ensure fair financing

In Sweden and the United Kingdom, the majority of health care for the population is funded from tax revenues. Indeed public sources of financing for health care account for over 80% of total expenditure on health in both countries: higher than the EU average of 74%.

Health care funded through direct taxation (whether national or local) ensures that there is a fair distribution of the financing burden for health care. The poor pay proportionately less of their income than the rich do for health care. Taxation in both the UK and Sweden was shown to be progressive in an international study of health care financing.[1] Social insurance contributions are also related to income. In contrast private payments are regressive, with the poor paying proportionately more of their income towards health care than the rich pay.

Out of pocket payments for health care mean that the individual must pay at the point of access, when they are sick and in need of treatment and consequently least able to afford it. If care is bought in the private market the patient must pay the full cost of the treatment. In modern health care, costs to the individual can be significant. For example, a heart bypass costs between £10,500 to £14,250 and a hip replacement between £6,750 and £11,750 in the private sector in the UK.[2]

Private health insurance premiums are usually related to individual risk and not income and are therefore regressive. Those with a higher risk of ill health such as those with a personal or family history of disease, with a genetic predisposition, already suffering from chronic illness and the elderly face higher premiums. Often these patients find that private insurance is either unaffordable or that they are simply refused insurance. Furthermore, certain services or conditions may be excluded from cover as policies are usually 'tailored' to the individual. As both private health insurance and out of pocket payments contribute less

than 20% of total health expenditure in both Sweden and the UK, the systems of financing overall are fair.

Public financing is important to ensure fair access

Unlike out-of-pocket payments and private health insurance, where those who are sick pay more, public financing separates the need for health care from the ability to pay for care. It minimises the financial barriers to health care and ensures health care is affordable and accessible for all.

A survey by the Commonwealth Fund showed how in the USA 26% of people did not fill a prescription due to cost compared to just 7% in the UK. Where care is free at the point of use for medical care in the UK this went down to 3% compared to 24% in the USA where most people even with private health insurance have to make significant co-payments at the point of use.[3]

It is also important in any healthcare system that charges for clinical services are set at low levels in order to ensure equitable access to health care. Exemptions for vulnerable groups in the UK and annual out of pocket maximums in Sweden (set at a maximum of SEK900, approximate £60 per year) ensure that the limited co-payments that already apply to health services have minimal impact on access. Further extension of co-payments, however, is not on the agenda of either government.

Public financing of health care is more efficient than private insurance

Public financing of health care is an efficient way of collecting revenues for health care because the administration costs are

"We need to make services far more responsive to the needs and preferences of patients"

Figure 1: Percentage of total health expenditure from public and private sources in UK, Sweden and the EU average, 2000
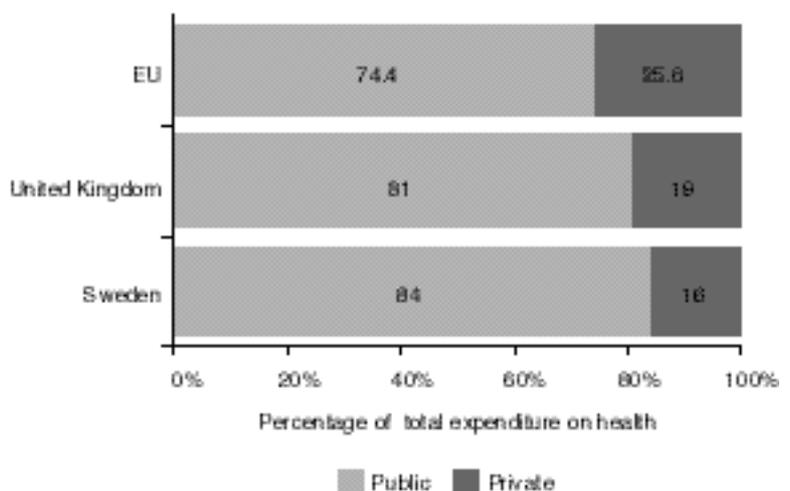
Source: OECD Health Data 2002

"Limited choice is not a necessary feature of a publicly funded system"

lower and there are no marketing and selection costs. Firstly, under private health insurance administration costs tend to be higher because of the extensive bureaucracy required to assess risk, set premiums, design complex benefit packages, and review, pay, or refuse claims.[4] Private health insurers also need to spend money on advertising, marketing, and reinsurance. An estimated 14% of private health insurance benefits in the United States is spent on administrative costs, marketing expenses, profits, and taxes, compared with 3% in the public insurance systems (for example, Medicare and Medicaid) and 1% in Canada's provincial health plans.[5] In 1998, the administrative costs of one private insurer in the United Kingdom PPP Healthcare were even higher, at 16.9% of premium income.

Secondly, there are no marketing or selection costs. Private health insurers incur costs associated with attracting customers. In a recent study (covering 30% of the Dutch insurance market), the non-medical costs of both public and private health insurers in the Netherlands were measured. Selection costs are defined as the costs of selling insurance policies and marketing costs. Other costs include administrative costs and costs for dealing with claims. Public insurers' selection costs were €10 per capita in 1998 while private insurers were spending €28 per capita. In total, non-medical costs of public insurers averaged €60 per capita compared to €89 for private insurers.[6]

Universal coverage for health care ensures access for everyone

In both Sweden and the UK, everyone's resources are pooled together and everyone's risks are covered: healthy and sick, young and old. This principle of solidarity is central to the values of our health systems and our society more generally. Health care benefits are a universal entitlement. In both countries the right to benefit from medical care is not dependent on whether you have enough money or hold an insurance policy. In the USA, where private health insurance is relied upon as the main form of cover for the majority of the working-age adult population, at any one time as many as 40 million people are without insurance cover. Over the course of a year, as many as 75 million people (over a quarter of the population) are uninsured at some point. This means they have no access to health services except in an emergency. In most social health insurance systems coverage has been extended gradually to groups of the non-working population such as dependants, the unemployed and pensioners to attain near universal coverage. Indeed since 2000, in France access to health care has also been declared a universal right under the Universal Health Coverage Act. Both Sweden and the UK place the highest value on maintaining a universal system of health care.

Not only is public finance equitable and efficient but it is also commands a high level of public support. In a survey conducted by Eurobarometer in 1996 the majority of the population in the UK and Sweden supported higher spending on health services (80% and 60% respectively). In a follow-up survey in 1998 the population were asked where extra funding for health care should come from. There was very little support for private insurance or higher charges in any of the countries. In fact in Sweden and the UK there was considerable support for higher taxes or social insurance contributions (see Figure 2).

Increasing responsiveness

Traditionally public financing has been associated with a 'take it or leave it' approach to delivering health care services; in the UK the NHS owning and managing health care facilities while in Sweden, county councils owning and running hospitals, health centres and other health care facilities. Patients are only able to 'leave it' if they can pay for a private alternative. However patient choice should not simply be confined to those who can afford to buy

Figure 2: Responses to question "Where should extra funding for health care come from?" in a population survey of EU Member States
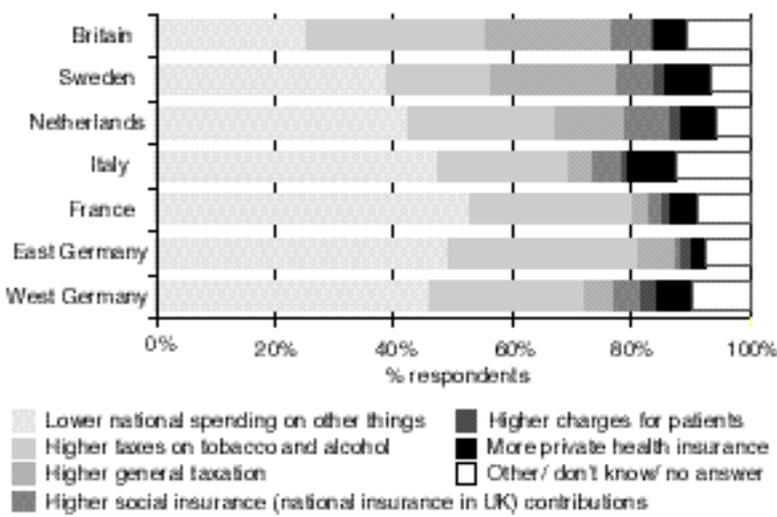
Source: Eurobarometer 49 1998[7]

alternative provision. Choice should and must be available within publicly funded health care systems as well.

Our health systems in terms of financing care treat everyone the same, regardless of their ability to pay, but they must also treat everyone differently recognising that all patients have different needs. We believe that health systems can and should be more responsive to patients.

This means:

– Ensuring patients access to *high quality services* by setting national standards;

– *Devolving responsibility* for managing and running services;

– Placing patients and their *choice* at the centre;

– Offering *flexible* care systems that cater to changing health needs.

In this century people's expectations are higher than ever. They are used to a service industry that is designed around the customer. People are able to access services 24 hours a day, seven days a week. It is no longer acceptable for us to see patients as grateful recipients of whatever they are given. Our health systems must respond to the needs of individual patients. By putting the patient at the heart of the health service we can begin to ensure that services are designed to fit the patient, not the other way around. This has benefits not only in terms of satisfaction but also for health outcomes. Happier patients are also usually healthier patients. Responsive services can mean a number of things, here we highlight the need for services to be of a high quality, run and managed at a local level, patient centred and flexible to meet changing needs.

High quality services

Patients have a right to expect safe, high quality services. This means ensuring the highest standards of care across all providers. In England the work of the Commission for Health Improvement has been designed to ensure all hospitals attain the highest possible standards and to investigate cases where services have failed patients. National Service Frameworks set out the standards of care that patients can expect in a number of clinical areas including cancer, coronary heart disease, mental health, diabetes and care for older people. In addition the National Institute for Clinical Excellence produces clinical guidelines, undertakes technology appraisals and clinical audit to ensure that the most effective and cost effective treatments are

provided within the NHS.

Similar developments are taking place in Sweden. The Swedish National Board of Health and Welfare is responsible for the supervision of medical care and social services in order to ensure quality, safety and the rights of the individual. The Board's other important tasks include certain health care personnel matters, training and development, and disease surveillance.

In order to strengthen patients' access to evidence-based medical care the Board is currently developing national guidelines in a number of areas including diabetes mellitus, stroke and coronary heart disease. These guidelines will provide comprehensive and up-to-date scientific advice on best practice as well as highlight economic and organisational implications. They will be useful to both policy makers and professionals and should also provide the basis for patient information.

In collaboration with the Federation of County Councils and the Swedish Association of Local Authorities, the Board is also working to improve the monitoring of implementation of national plans and priorities. In particular they are monitoring care for groups of patients such as the elderly, people with psychiatric problems and those suffering from back pain.

High quality care also means timely care. Lack of funding in the past has often led to delays in treatment. Too many patients have had to wait for too long, causing pain and anxiety. Waiting to see a general practitioner, waiting to see a specialist and then waiting for inpatient treatment. In Sweden, there is a new commitment to ensuring timely access to services. Patients will have guaranteed waiting times: contact with the health care clinic the same day, to a doctor within 7 days and receive treatment within 90 days.

In England under the NHS Plan, patients will be guaranteed a primary care appointment within 24 hours; an outpatient consultation within 3 months by 2005 and inpatient treatment within 6 months by 2005, falling to 3 months thereafter. In addition all patients will be able to book hospital appointments at a time of their choosing by 2005.

Devolving responsibility

In Sweden, the responsibility for financing and planning health services has traditionally been devolved to county councils. Provision of services has also been through publicly owned and managed hospitals and

"Public finance is equitable, efficient and commands a high level of public support"

"Sweden and the UK have learnt much from each other"

health centres with a small number of private organisations offering services under contracts with county councils. However, the Swedish government together with the Federation of County Councils and Association of Local Authorities is now supporting the development of a diversity of management forms. It intends to enable a diversity of private, cooperative and non-profit entrepreneurs to be involved in the delivery of primary care. Delegating responsibility to local managers of facilities will enable greater innovation and allow adaptation to local needs and circumstances. This is matched by an ongoing process of development of the local and regional impact of health care, including care of the elderly. At the same time specific measures are being developed to improve coordination in order to ensure equal access to high quality and cost-effective tertiary care throughout the country.

In England, some of the best performing hospitals will be given greater operational independence and stronger links to their local communities as NHS Foundation Trusts. Over the next 4–5 years, all hospitals will have the opportunity of achieving this level of autonomy. By shifting the balance of power away from central government towards local health organisations such as Primary Care Trusts, the health services can become more responsive to local communities. Through patient forums and representation in the governance structures of health service providers, patients and the public can have a greater say in shaping the development of services.

Patient centred

In Sweden patients are able to choose their first contact with a primary care provider. At the start of 2003, the county councils introduced free choice of health care provider. It is now possible for all Swedish patients to seek care throughout the entire country. A special database is available to the public who can compare the waiting times of all hospitals.

In England patients also have a choice of primary care provider and increasingly patients who have been waiting more than 6 months are being offered a choice to be treated sooner by an alternative provider. In England patients who have been waiting over 6 months for cataract surgery in London or a heart operation are already being offered a choice of alternative provider. Initial results have been encouraging with patients valuing choice and evidence of improving quality and reducing

waiting times. Almost half of the eligible patients waiting for heart surgery chose to move to another provider. Over 90% of those who were offered choice and treated in their chosen hospital said they would recommend the scheme to other patients. Amongst London cataract patients take up of choice was even higher with around 70% of patients choosing to move to an alternative provider. In 2003/04 it is expected that around 100,000 patients will be offered choice.

Choice will be extended so that by the summer of 2004 all patients waiting for 6 months for elective care will be offered the choice of treatment with an alternative provider and by December 2005 all patients will be offered a choice of 4–5 different providers at the point their general practitioner refers them to secondary care. There will be an increasing diversity of providers from which patients may choose. In England, the choice to be treated by an alternative provider has traditionally been available to those who can pay either directly out of pocket or who have private health insurance (10% of the UK population). Increasingly, Primary Care Trusts are commissioning services from a range of providers including private hospitals, diagnostic and treatment centres, voluntary sector providers and overseas providers (mainly for hip and knee replacements). Opening up choice to all under a publicly financed system, means extending the capacity to benefit from choice to everyone regardless of where they live, their income or social capital.

Extending choice will have two main benefits that are important to those of us who share a commitment to equity. First, it will overcome the unfairness that arises when responsive patient centred services are only available to those with the wealth to pay for them. Second, it will help strengthen the public's commitment to collectively-funded public services by making them more responsive to the needs of today's society.

Of course there are limits to choice. In certain situations, such as an emergency, people will want the nearest and fastest service. However, where appropriate, and if patients want it, choice should be available to ensure that patients' needs and preferences are responded to by the health care system.

Flexible care system

Health care continues to change at a fast rate. New technologies, developments in

genetic medicine and other advances in scientific knowledge present challenges to all health systems. Health systems must be flexible enough to respond to these changes and harness benefits for patients. By giving greater autonomy to local providers in England, it is expected they will be in a better position to adapt and improve services.

The health system must also be flexible to respond to changes in disease patterns. Chronic diseases are becoming more prevalent. Services must enable chronically ill patients to manage their own conditions, supporting them with formal services where appropriate. This has begun through the expert patient programme in England. It also requires health and social care providers to work closely together to ensure continuity of care as well as investment in intermediate care to enable patients to regain their independence more quickly.

Finally, the system must be able to respond flexibly to the needs of individual patients; delivering care where and when it is needed, by the most appropriate people. One innovative pilot in England focuses on developing greater flexibility in the roles and responsibilities of the health and social care workforce in the care of older people. It demonstrated that by developing new roles continuity and coordination can be improved, delays reduced and productivity improved. Creating a stimulating environment for health care workers is also very important. New ways of working are needed that will realise the full potential of individual staff and the health care team. This calls for a long-term approach involving all categories of staff. One way of encouraging creativity and innovative thinking being developed by the Swedish county councils is permitting alternative forms of management in primary health care. Private, non-profit and cooperative care providers bring experience of organisational change that can increase opportunities for personnel to design their own working environments.

Conclusion

Already Sweden and the UK have learnt much from each other's health care systems. For example, the Adel reform in Sweden was designed to ensure that patients, particularly the elderly, are transferred to the most appropriate care setting as soon as possible. The municipalities took principal responsibility for home care for older people and people with disabilities. In many respects it signalled a renewal of care for older people and was confirmation of a new, and broader, way of approaching the interface between social and health care.

Similar proposals to ensure local authorities take full responsibility for ensuring the timely discharge of patients from an acute hospital setting are being introduced in England. Swedish health care is already decentralised with both financing and provision of services in the hands of the county councils. Devolution of health care to primary care trusts in England and increased localism in the NHS are key to the government's reforms.

Following the success of NHS Direct in England, Sweden is introducing similar support and advice for patients. During this term of office the Swedish Government will take action, in association with the Swedish Federation of County Councils, to introduce a single national telephone number for health service information. Citizens will be able to gain speedy access to qualified guidance and advice on how to deal with their health problems. The health line will actively support the development of primary health care services. The strength of primary care services in the UK have for some time been emulated by Sweden, recognising their potential to offer good continuity of patient care.

Whilst holding on to our common values of equity of access and solidarity, we want to move forward together to make our health systems more patient-centred. How these responsive services will be delivered may vary between countries. We have set out here how Sweden and the UK are reforming their health systems to achieve this end. The public's confidence in a publicly funded health service will depend on the success of these reforms. Securing equitable access to health care services requires a fair and efficient system of financing. At the same time we must ensure that health care services are responsive to the needs of the population. Here we have set out the vision that the Swedish and UK governments share for our health systems.

In order to ensure equity in health care we are committed to:
- Publicly funded health care
- Universal coverage
- Furthermore, we will continue to reform health systems so they are more responsive to patients by:
- Improving quality
- Devolving responsibility
- Increasing choice, and
- Building in flexibility.

"Creativity and innovative thinking need to be encouraged"

REFERENCES

1. Wagstaff A, van Doorslaer E et al. Equity in the finance of health care: some further international comparisons. Journal of Health Economics 1999; 18: 263-290

2. Dr Foster Guide, Sunday Times, April 6 2003.

3. Blendon RJ, Schoen C et al. Inequities in health care: a five country survey. Health Affairs 2002; 21 (3): 182-191

4. Mossialos E, Thomson SMS. Voluntary health insurance in the European Union: A critical assessment. International Journal of Health Services 2002; 32(1):19-88.

5. Woolhandler S, Himmelstein DU. The deteriorating administrative efficiency of the US health care system. N. Engl. J. Med 1991;324: 1253–1258

6. Douven R, Westerhout E. Reimbursement systems in Dutch sickness funds. Quarterly Review of CPB Netherlands Bureau for Economic Policy Analysis 2000; 3: 51-55

7. Mossialos E, King DR. Citizens and rationing: an EU survey. Health Policy 1999; 49:75-135.

Putting policies in context –

Achieving and sustaining better health care quality

Nancy Mattison

"Context is critical to determining whether efforts to improve quality succeed or fail"

Since the middle of the 1990s, health care quality has been commanding close political attention at the national level throughout most of Europe. Although the resulting legislation, regulation, funding and other activities aimed at improving quality have had some positive impact, progress has been uneven and gains often short lived. Many explanations are possible, but one that stands out across countries is insufficient attention to context, or milieu, in policy debates about direction and approach. Context is critical, determining whether efforts to improve quality will arise in the first place, and then succeed or fail. Policies that take issues of context fully into account are much more likely to be efficient, effective and lead to lasting improvements in health care quality.

Identifying policy challenges

Policies intended to improve quality, and sustain those improvements, must directly take account of a far greater range of concerns than they do now. Critical issues that policy makers must begin to address include the following:

Goals: What should quality improvement goals look like? Should they be limited to process improvements, such as shorter waiting times, or should they also aim at health targets, such as reduced cancer death rates? If both, what should be the mix and how can priorities be set openly and fairly? How can quality improvement goals co-exist with attempts to contain health care costs?

Inclusiveness and balance: What groups should be involved in deciding about goals and in developing and implementing programs? Will society accept the exclusion of some groups? Do some important groups need financial and other assistance to ensure that their opinions are fully considered – patients' groups, for example? How

can all groups become part of an iterative improvement process that adjusts approaches to take account of change? What is the appropriate balance between the public and the private sectors, including commercial interests?

Coordination: What are the key barriers to achieving coordinated approaches to quality improvement? If compartmentalised budgets or other administrative arrangements are a problem, can these be eliminated or ways found to neutralise their negative effects?

Indicators and standards: Having identified the goals, what indicators are needed to determine whether progress is occurring? What steps may be necessary to ensure that the indicators are valid? How can standards be set so as to encourage continuous movement toward the goals? How often should the indicators and standards themselves be reviewed to ensure their continued usefulness?

Evaluation: How can the process of evaluation be designed to ensure that results are accurate and unbiased? What resources need to be brought to bear to create the data and other information necessary to perform accurate evaluations?

Accountability and transparency: Who should be held accountable for progress toward health care quality? Should good performance be rewarded, or bad performance punished, or both? How can the evaluations and reports on which accountability is based be made transparent so that sound-bite reporting does not misrepresent the facts?

Resources: What resources will it take to attain goals and where will they be found? Reaching goals is one task, maintaining these gains is another. What provisions can be made to attempt to ensure that the necessary resources will be available down the road?

Persistence and continuity: What programmes, policies or series of activities can

Nancy Mattison is President and CEO of The Mattison Group, Inc., a global health policy consultancy. E-mail: NM@MattisonGroup.com

be devised to help maintain a focus on health care quality? What provisions can be made to avoid unnecessary change and ensure that new initiatives have a chance to succeed or fail before they are dropped or replaced?

Defining the concept of context

Agreeing that there are a series of issues where context plays a critical role is far simpler than mapping its components. At first glance, it might seem that the context for quality improvement is quite obviously the health care system and that analyses of it already reveal the the important issues. Context is more important than that, however another view is that what really matters is the 'how to' of quality improvement, ensuring the quality of the efforts themselves. Success is likely, however, only in a favourable environment, no matter how well a programme may be designed.

Although the impact of context on prospects for successful change has long been recognised in other fields, it is only recently that interest in context has appeared in the health care quality field. Thus far, moreover, observations about context largely have been tangential to analyses of other aspects of quality. Adjusting policy making to take due account of context requires a more complete understanding of what comprises context.

A necessary first step in defining context is devising a manageable number of categories that capture most variables related to it. Ideally, these should be applicable across countries, rather than tied to the particular characteristics of any. The eight conditions outlined below provide this starting point. In offering a framework for analysis and policy discussions, they are not meant to be formulaic. Thus, not 'doing well' on any one or more condition does not necessarily lead to 'failure', nor does doing well on most inevitably lead to 'success'. Nevertheless countries that address contextual issues head on are more likely to achieve and sustain improvements in health care quality than those that do not.

How each country (or region or locality or given site of care) approaches aspects of context, moreover, depends entirely on its own set of values and sociopolitical landscape. Accountability, for example, is perceived and addressed quite differently in the market-driven US health care system compared to Germany's social insurance system or the UK's national tax funded

health system. Because accountability though can provide powerful incentives that affect quality improvement in all three, it is an essential aspect of context.

The eight conditions that comprise the framework for discussing context are summarised in the table and explained briefly below. Examples from experiences in European countries are provided for illustration. Neither the discussion of the conditions nor the examples, however, is meant to be exhaustive.

Clear and realistic health care quality goals

A set of clear reasonable national goals that can accommodate legitimate regional and local differences is important for sustainable national progress. Goals must reflect national values, culture and priorities.

National goals are important in guiding resource allocation, measuring progress, and promoting consistency both over time and across administrative or geographic regions. Although these may be supplemented, or further defined, by regional and local goals, national progress will depend on commitment to an overarching set of goals. The German development of health targets provides an example of the

"Goals must reflect national values, culture and priorities"

DEFINING CONTEXT: EIGHT CORE CONDITIONS

Clear and realistic health care quality goals	A set of clear reasonable national goals that can accommodate legitimate regional and local differences is important for sustainable national progress. Goals must reflect national values, culture and priorities.
Inclusiveness and balance in health care quality processes	All relevant interest groups should be involved in order to build the trust and credibility necessary to overcome serious barriers, but no one interest should dominate consistently.
Coordination of quality improvement efforts	Quality improvement efforts will be most successful when effective coordination occurs across types and sites of care, and across government agencies and sub-units.
Agreed indicators and standards for health care quality	Valid indicators and standards that reflect goals are critical, providing providing both guidance and gauges.
Evaluating progress in health care quality	Determining whether progress is occurring requires assessment of the state of quality at the start of the process and periodically thereafter.
Accountability and transparency in health care quality processes and outcomes	Objectives are more likely to be realised fully if clear accountability is established and complete information about efforts aimed at quality improvement is widely available.
Sufficient resources to encourage and sustain health care quality efforts	Adequate resources devoted specifically to encouraging, implementing and sustaining efforts to improve health care quality are critical.
Persistence and continuity in pursuing health care quality	Significant, lasting quality improvement is unlikely to be achieved in a short time frame; sustaining quality gains requires continuing attention.

"Synchronisation across government agencies and other administrative units is important"

perceived importance of a central, coordinated approach. In 1999, the conference of ministers of health of the Länder passed a resolution specifically asking the federal ministry of health to 'moderate' the process of developing and working toward health targets.[1] This is particularly noteworthy because of the strong historical resolve of the Länder to safeguard their prerogatives.

National values and priorities will determine the particular set of goals adopted and may support a range of possibilities, from short-term process goals such as reducing waiting lists, to long term objectives aimed at population health, such as reducing the cancer death rate. Detailed goals, however, are less important than sustained political commitment. Italy, for example, is one of the few European countries to develop a comprehensive national health care quality plan, but it has not been implemented.[2]

Even in the absence of explicit quality goals, some progress toward improving health care quality may occur. In such cases, however, indicators and standards are likely to substitute for goals. Movement toward quality may be fragmented as a result and resources directed to minor targets or those advocated by the most influential interests.[3]

Inclusiveness and balance in health care quality processes
All relevant interest groups should be involved in order to build the trust and credibility necessary to overcome serious barriers, but no one interest should dominate consistently.

Equity is a strong value in European societies and equal access to health care is a core objective. Arguably, then, the processes meant to encourage progress in health care quality also should aspire to equity. Seeking to be inclusive and to balance interests, however, should not be confused with achieving absolute consensus, which is likely to be both impossible and unnecessary. Instead, the process should encourage full and open discussion of necessary trade-offs, leading both to decisions that can be accepted by all, if not heartily endorsed, and to a sense of ownership in the outcome.

Countries will vary in their approaches to this task, reflecting national preferences and values. For example, Germany, The Netherlands and Sweden have enacted national legislation that establishes the 'right' of particular groups to be involved in policy decisions about health care. The United Kingdom is more likely to set national objectives, assigning the details of implementation to specific agencies or regional bodies.

What varies less across countries is the list of groups and interests that have a relevant stake, principally including politicians (presumably as representatives of citizens), government agencies, the medical professions, health care institutions, suppliers from the private sector, consumer groups, and patients.* No one group has an evident superiority of interest although some argue that patients, who have the most at stake personally, should have a dominant voice. However, it is patients, and private-sector suppliers, who are most likely to be excluded, intentionally or otherwise.

Coordination of quality improvement efforts
Quality improvement efforts will be most successful when effective coordination occurs across types and sites of care and across government agencies and subunits.

Research repeatedly demonstrates that integrated patient care leads to better outcomes, often at lower costs. Health care policies aimed at improving quality need to follow the same pathways. Effective, coordinated quality improvement efforts, however, face a powerful barrier: health care administration and budgets continue to be highly compartmentalised, discouraging real coordination.

Synchronisation across the range of government agencies and other administrative units is equally important. As quality improvement programmes and experiments proliferate, providers and others involved in health care may be urged or required to participate in multiple programmes. Without sufficient coordination, participants may be overwhelmed by requirements that are duplicative or even conflicting. In England, for example, at least six regulators for health and social care have been created since 1997. Although each has its own role, each also adds to existing auditors and regulators. Over 35 bodies now inspect, regulate or audit the National Health Service,[4] understandably leading to complaints of overload in responding to, let

---

* Defining 'patient' is tricky. Often this is limited to advocacy organisations representing chronic-disease patients with symptomatic illnesses. Of course, this omits large numbers of other types of patients – most acute care patients, for example, or those with life-threatening, chronic but non-symptomatic conditions, such as hypertension.

alone complying with, a plethora of requirements focused on 'quality.'[5,6]

Agreed indicators and standards for health care quality

Valid indicators and standards that reflect the goals, providing both guidance and gauges for measurement, are critical.

Indicators and standards are intended to stimulate improvements in health care quality and serve as the basis for evaluating and reporting progress. In essence, they are the translation of goals (and, so, values) into the requirements and actions that are relevant to daily health care practice. Their development is a critical, complicated and contentious process. Indicators and standards that are poorly crafted or applied may produce unintended and unwanted results. Inaccurate or inappropriate indicators, moreover, can mislead policy making and resource allocation.[7]

Examples of the unexpected results of poor indicators undoubtedly could fill many pages. The United Kingdom's well-intentioned attempts to reduce waiting lists and times have provided a number of examples. A recent investigative report, for example, revealed that some hospital managers and staff made 'inappropriate adjustments' to meet government waiting list targets, potentially adversely affecting the health of an estimated 6,000 patients.[8]

Evaluating progress in health care quality

Determining whether progress is occurring requires assessment of the state of quality at the start of the process and periodically thereafter.

Evaluation, based on agreed indicators and standards, provides the information and insight needed to adjust programs and policies so that progress toward quality goals occurs. It is an inherent aspect of many quality improvement efforts, for example clinical governance and hospital accreditation, and an essential part of accountability and transparency. The process, however, is anything but straightforward and presents complex challenges in both measurement and interpretation.

The extent of progress toward better quality can be assessed at virtually any administrative level and may include a variety of activities and outcomes. Worthwhile, constructive assessments at all levels and in all sites face similar challenges. For example, data must be relevant, valid, reliable, credible and both comparable and consistent over time and across the units being analysed. Developing and maintaining such data requires considerable resources and often requires cooperation across sites of care or administrative units. Data analysis and interpretation are equally demanding and may require digging below the surface. For example, one performance measure in the United Kingdom, required that patients be seen in emergency departments within five minutes. Although data appeared to show progress, patients in fact were being greeted within that time by a 'hello nurse,' thus meeting the standard, but then were left waiting for hours.[9] In this case, the evaluation demonstrated the deficiency of the standard itself, an important result.

As is true of indicators and standards, evaluations may develop a momentum and rhythm of their own, tending over time to become ritualistic. The criterion for determining what and how much evaluation is appropriate is whether the potential advances in quality that society values outweigh the potential costs of the evaluations themselves. Moreover, enough latitude for variation must remain to encourage innovation in quality improvement programs and approaches. A comprehensive review of European hospital programs, for example, found that where a single accreditation model is made mandatory, continual improvement in the model itself is less likely.[10]

Accountability and transparency in health care quality processes and outcomes

Objectives are more likely to be realised fully if clear accountability is established and complete information about efforts aimed at quality improvement is widely available.

Theoretically at least, quality improvement is possible even in the absence of accountability and transparency. Without them, however, the rate and direction of change will be more difficult to shape and problems may remain hidden longer. France, for example, has undertaken an extensive program under the Agence Nationale d'Accréditation et d'Évaluation en Santé, ranging from the development of clinical practice guidelines to hospital accreditation and quality assurance in primary care. Although the volume of effort is impressive, independent evaluation of impact appears minimal; whether and what desirable progress is being made is largely unknown.

"Evaluation is an inherent aspect of many quality improvement efforts"

The issues and pitfalls involved in accountability are intricate and likely to be politically charged. All the groups that have participated in setting goals, determining standards and indicators, and working toward defined objectives will have a keen interest in what progress has or has not been made and why. This highlights the fundamental importance of both valid standards and indicators and objective, accurate and transparent evaluations.

Equally critical are the processes of accountability, that is, how responsibility for results, good or bad, is determined and communicated. Deciding who is accountable for what actions, with what rewards or punishments, should be treated as a major undertaking. In Europe, governments may still be ultimately accountable, but responsibility is increasingly being shifted to providers, sickfunds, and regional governments or health authorities, along with greater responsibility for cost containment, a questionable combination.

"Less attention has been given to determining what resources are needed to sustain quality efforts"

Sufficient resources to encourage and sustain health care quality efforts

Adequate resources devoted specifically to encouraging, implementing and sustaining efforts to improve health care quality are critical.

Arguments about the need for sufficient resources to provide quality health care are familiar; far less attention is given to determining what resources are needed to develop, implement, evaluate, refine and sustain quality improvement efforts themselves. The last decade's increased political attention to health care quality has had an equivocal effect on resource availability for this purpose. In Germany, for example, health care reform laws repeatedly mandate new quality efforts, but do not allocate sufficient resources to fund them. 'Quality' in Germany appears to be most attractive politically when it coincides with potential cost control, as with disease management programs for the chronically ill.[11] French approaches have aimed at both quality and cost control; success has been least likely when the two objectives are combined or when 'quality' is used to justify cost control.[12]

Sufficient resources are fundamental to each of the other seven conditions. For example, ensuring that a range of interests participates in the process requires iterative communication and interaction; providing sufficient incentives for coordination and integration may include direct or indirect

financial components; making information available about the extent of progress requires an investment in both careful evaluation and accurate dissemination of results to the relevant audiences. The private sector should continue to provide extensive expertise and some financing. Still, steady progress toward better health care quality throughout Europe unquestionably requires the political will to ensure that adequate resources are available consistently.

Persistence and continuity in pursuing health care quality

Significant, lasting quality improvement is unlikely to be achieved in a short time frame; sustaining quality gains requires continuing attention.

Modern health care systems are extremely complex and are evolving constantly in response to both new technology and changing demands. Improving overall quality, and maintaining gains, then, requires recurring evaluation and consequent fine-tuning, with an emphasis on the 'fine'. Barring some unforeseen discontinuity, attaining and ensuring quality in health care rarely will require major shifts in approach; in fact, excessive change can threaten progress. Over the past decade in the United Kingdom, for example, the health service has been reorganised and adjusted repeatedly, swinging back and forth between heavily socialised medicine and elements of competition. Over the past five years, added to those disruptions has been a dizzying array of 'new initiatives' imposed in the name of health care quality, many with amazingly short life spans. Even if these changes generally go in the right direction, the extent of disruption created threatens to overload the adaptive capacities of health care providers, administrators and patients.

The Netherlands' persistent approach is a strong contrast to the UK experience. Quality initiatives have been a combination of efforts from the private and public sectors, but government involvement consistently has been both moderate and supportive. Persistence is evident, for example, in the development of the Netherlands Institute for Accreditation of Hospitals (NIAZ), a voluntary accreditation organisation. Efforts that began among a small number of hospitals in 1989 led to a system of 35 standards, tailored to the Dutch system, and the creation of NIAZ in 1998 by the major hospital organisations and the medical specialists' organisation.[13] The effort received financial support from the

Dutch government, as have other quality initiatives during their development phases.

The disparity in the two examples above is partly the result of different political systems, but competitive party politics do not necessarily lead to rapid change. The key difference may lie in leadership, both within and outside government. In the history of quality improvement, moreover, it is the private sector, particularly professional associations and academia that has been largely responsible for relentlessly pushing forward with innovative approaches. Some risk is inherent, then, in the greater national political attention that has been paid to health care quality in Europe since the mid-1990s. When any endeavour becomes wrapped up in political fortunes, the temptation of governments to increase control, and politicians to argue over details, can become almost irresistible. Since most political time frames are anything but long-term, the risk of counterproductive change is great.

Refining and testing the concepts

Working through the entire list of policy challenges outlined at the start of this article, even as incomplete as they are, would be a major task. Policy makers may not be easily convinced that the potential gains are worth the expenditure of time, effort and financial resources. No proof exists that quality improvement depends on addressing all these issues or even that the end result would be 'better' in some sense. The obvious, then, may not be so obvious in practice.

Testing the importance of these policy considerations and determining their possible impact can proceed in a number of ways. Perhaps one of the most immediately manageable is to use existing or recent quality initiatives as case studies. These might be drawn from experiences in one country or be based on comparisons across countries. They might provide an overview of the impact of all eight conditions or delve in more depth into the implications of a few. Such research need not start from scratch, of course, as a considerable body of knowledge already exists for each of the eight conditions. (Subsequent articles in this publication will draw on existing expertise to examine key aspects of context in greater detail.)

What is new about the current approach, then, is not the issues it raises, but the holistic approach it suggests. No matter how desirable better health care quality

may be, progress will be hampered if the context for improvement does not encourage attempts and sustain gains. Identifying the positive and negative aspects of today's milieu is an essential starting point in every country.

REFERENCES

1. Stein H. Germany. In: Marinker M (ed). *Health Targets in Europe: Polity, Progress and Promise*. London: BMJ Books, 2002: 89–102.

2. Ministry of Health, Republic of Italy and EcfEaH, World Health Organisation. *Health in Italy in the 21st Century*. Rome: World Health Organisation, European Centre for Environment and Health, 1999.

3. Klazinga N, Stronks K, Delnoij D, et al. Indicators without a cause. Reflections on the development and use of indicators in health care from a public health perspective. *Int J Qual Health Care* 2001;12:433–38.

4. Shaw C. External assessment of health care. *BMJ* 2001;322:851–54.

5. Timmins N. Nicholas Timmins: health regulation needs level playing field. London: *Financial Times* 2002, May 9.

6. Walshe K. The rise of regulation in the NHS. *BMJ* 2002;324:967–70.

7. Casalino LP. The unintended consequences of measuring quality on the quality of medical care [Sounding board]. *New Eng. J. Med* 1999;341:1147–50.

8. House of Commons Committee of Public Accounts. *Inappropriate Adjustments to NHS Waiting Lists. HC 517.* Forty-sixth report of session 2001–02, 2002.

9. Thomson RG, Lally J. Performance management at the crossroads in the NHS: don't go into the red [Editorials]. *Qual Health Care* 2000;9:201–2.

10. Heaton C. External peer review in Europe: an overview from the ExPeRT project. *Int J Qual Health Care* 2000;12:177–82.

11. Wörz M, Busse R. Structural reforms for Germany's health care system? *Euro Observer* 2002;4:1–3.

12. Or Z. Improving the performance of health care systems: from measures to action (a review of experiences in four OECD countries). *Labour Market and Social Policy Occasional Papers No. 57*. Paris: Organization for Economic Cooperation and Development, 2002.

13. van Gennip EMSJ, Smitt PAES. The Netherlands Institute for Accreditation of Hospitals. *Int J Qual Health Care* 2000;12:259–62.

"lasting quality improvement is unlikely to be achieved in a short time frame"

Dreams versus reality:

The EU constitution and health

Hans Stein

"It is dangerous to hope for better results with further negotiation"

Dr Hans Stein was former head of the EU Health Policy Unit at the Federal Ministry of Health in Germany. E-mail: dr.hans.stein@gmx.de

"National governments…have not had any interest in a really meaningful EU Public Health article. They are quite satisfied with protecting national health responsibilities against unwanted EU intrusion"

It is a dangerous to disagree with such giants of *Eurohealth* as Paul Belcher, Martin McKee and Tamsin Rose. I though have to do it, because I like controversial debates and fear that with their article *"Is health in the European Convention?"*[1] they have raised the unrealistic expectation that the Intergovernmental Conference (IGC) that began in October and stalled recently in Brussels, might revise the Public Health Article 179 (ex Article 152) to a text that transforms their dreams into a legal reality.

Of course there are plenty of good reasons to revise the health article in the Constitutional Treaty, just as there plenty of reasons to revise a lot of other articles as well, but can it be done? Will it be done? I fear reality suggests otherwise. Reality would guard against any changes in the health article, or against any changes in the constitution. We should be realistic.

Realism

It is sometimes necessary to have dreams. Contrary to its beginnings Europe today lacks vision. Advisors, journalists, scientists and health campaigners are fully entitled to have dreams and visions, but to become a reality even the best visions need a majority in decision making institutions. EU majorities are hard to get. With 25 Member States sitting at the table instead of 15 this is even more difficult. In the EU majorities are not reached on account of evidence based necessities demonstrating how to solve common problems. They are reached by meeting national interests, regardless of how divergent, unreasonable, selfish and even stupid these sometimes might be.

National governments sitting at the IGC negotiating table in the past have not had any interest in a really meaningful EU Public Health article. They are quite satisfied with protecting national health responsibilities against unwanted EU intrusion. There is no reason why they should change their mind just because Paul, Martin and Tamsin ask them to, even if they have good arguments. At IGCs people do not listen to arguments, they protect interests.

The Convention by way of compromise has agreed on a complete constitution text including quite a number of health components and not just one isolated health article. It is dangerous to question this agreement hoping for better results in further negotiation. The German foreign minister Joschka Fischer defining compromise said *"nobody is really happy with it, but everybody can live with it."*

There is no reason to be happy with the health article. One might even be angry and sad, that despite of a number of good proposals the convention has produced a text in the tradition of the Maastricht and Amsterdam treaties. They have in no way taken account or even recognised the developments that have subsequently taken place on the European health scene. However, it is of no use to lock the stable door after the horse has been stolen. We have to live with the proposed text, and I believe we can live with it quite well. It is the best we can get.

Paul, Martin and Tamsin deserve our credit too and I am all too willing to give it. First, because they have informed us comprehensively on how health is covered in the Constitution. The convention has not attracted great public attention, and indeed one poll showed that more than 50% of the European population did not know about its existence, let alone about the proposed

text. We have the usual gap between the perception of European politicians and everyday citizen interests. As far as the health competence is concerned, knowledge is even lower, only a very limited number of experts know the text or care about it.

Shortcomings and solutions

The second credit they deserve is for pointing out the many short comings in the text. I agree with most of their criticism, but I in no way share their optimism that these wounds could be healed within the IGC. Let us look at these shortcomings, see how far the criticism is justified and consider what solutions might be available.

Firstly, *health is not an "objective" of the EU*. It is not mentioned in Article 3 of the Convention draft listing EU objectives. Of course naming health as an explicit EU goal might have improved the position of health in the daily battle between different European policy areas. However can health really be a European objective considering the instruments the EU has to contribute to improve or to protect health? Certainly not. Is it essential to give it the status of European objective? Again I would say no. What constitution in the world names health as a state goal? I can think of none. The most they do is to guarantee some kind of equal access to health care, but no more. The Constitution as a whole does just that.

Moreover there are a number of EU objectives including the EU Single Market that have health implications. Article 179 picks up the existing Article 152 stating that "*A high level of human health protection shall be ensured in the definition and implementation of all of the Unions policies and activities*" What more can one want? The present lack of sufficient political power and will to enforce this, the non-existence of adequate instruments to implement it in a meaningful way, cannot be healed by naming health as an EU objective.

EU competence

Secondly, the Convention has created three kinds of EU competences. "*Exclusive Competences*" (Article 11) for the EU, "*shared competences*" (Article 13) between the EU and the Member States with the possibility of binding EU legislation and "*supporting competence*" (Article 16) where the competence lies with the Member States, but where the Commission can give them support, ruling out EU legislation. This division seems quite feasible as long as

a policy area is placed with sufficient clarity under the different competences. Health obviously is not an EU exclusive competence. It will never be one. There is no reason why it should. Total confusion arises out of simply clamouring for the European Court to entangle itself in health, when these health powers are divided into two parts : "*Common safety concerns in public health matters*" as a "*shared competence*" on the one hand and "*protection and improvement of human health*" as a "*supportive competence*" on the other. The text refrains from explaining what the difference might be.

To make matters worse, at the very last minute, (I suppose shortly before midnight) of the Convention negotiations, an earlier text was dropped, that had described common safety concerns needing shared competence and binding legislation, namely those "*to combat communicable diseases – such as SARS and bio-terrorism*". The Commission has pointed out this obvious mistake as after the events of September 11, 2001 all Member States at Council or even Summit level had agreed to face any potential new threats together. This bureaucratic error can though be amended using a type of technical correction without opening substantive negotiations. Therefore there is no need to visit the oracle of Delphi as Paul, Martin and Tamsin suggest, because there can be a very simple albeit bureaucratic solution.

Charter of Fundamental Rights

The *Charter of Fundamental Rights* as adopted in December 2000 has been fully incorporated in Part II of the Treaty. As this is going to be an integrated part of the treaty, its contents have to be interpreted in the light of the Charter's other chapters and the way in which the European Court of Justice (ECJ) has ruled on them. That means that Internal Market regulations and ECJ jurisdiction apply to Article 35 of this Charter, where the right of access is given to every European citizen.

This implies that Member States are not only free to determine how their own citizens have access to health care within their own territories in a way they desire, but they also have to guarantee, regardless of nationality as long as they belong to an EU Member State, free movement and access for patients and professionals who want to cross borders. The drafters of this article, the Convention group who framed the Charter, were well aware of ECJ jurisdiction. The Constitution as a whole therefore

"We have to live with the proposed text.... It is the best we can get. "

"The open method of coordination is a tremendous step forward"

clarifies that health care issues under the heading Internal Market are of concern to the EU. The words of the Charter being incorporated are thus not at the disposal of the IGC.

The Public Health Article 179 except for adaptations to the general language of the Constitution is nearly identical to the old Article 152, except for one important 11th hour improvement. The so-called *"open method of coordination"* has been acknowledged in all but name to be applicable to health, something the Member States have been reluctant to accept. This is a tremendous step forward, opening the possibility of establishing guidelines on all kinds of issues including *"best practice"*. I fear some would prefer to have this dropped if new negotiations were to take place.

Stepwise change

There may be criticism that health issues are spread all over the Constitution and not covered in one or two inclusive articles, but to find the right words for such a text would not have only been extremely difficult, but achieving a satisfying political agreement almost impossible. The EU being what it is we have to continue to live with health policy being developed in a disjointed, incoherent, inconsistent, sometimes fairly accidental way, using limited logic and rationality. Nevertheless it led to a process of stepwise denationalisation of health policy, which can and will continue. This would have never happened if this had been stated openly as an objective.

To illustrate my point I cite from a *Times* editorial by Anatole Kaletsky. Under the heading *"Snacking on Europe-Lite is better for our health"*[2] he writes:

"If France, Germany and Belgium want to merge their countries into a federal Europe modelled on the Holy Roman Empire, Britain cannot and should not stand in their way. But they should create their own institutions and treaties to do this. What Britain

must ensure, alongside its growing list of allies in Scandinavia, Eastern Europe and the Mediterranean – is that the EU's present structures continue to serve all member nations equally to achieve the limited objectives on which they can all agree."

On what can they agree? Anatole has an answer:

"The British preference for a slimmed down EU, which concentrates on the efficient administration of the essential freedoms of the single market- free movement of people, capital and goods- with a minimum of interference in the internal affairs of member states." It seems that Anatole doesn't realise what this means for health.

Jean-Claude Juncker, the Luxembourg Prime Minister and a stalwart European asked by the German magazine, *Der Spiegel*, what he thought about the Constitution replied:

"We have been told, the Constitution must become more readable than the previous EU treaties. The text presented by the Convention is totally unreadable. European citizens have the right to know when the treaty is signed, from when, in what form, and who in Europe is responsible for what. Only insiders can find this in the proposed articles."[3]

He meant the whole treaty, but every word applies to health. When the IGC started, his country Luxembourg as well as the other founding members, France, Belgium, the Netherlands, Italy and Germany, were the only ones who accepted the whole text word by word as it was, even though they had quite a lot of reservations about many of the articles. They refused to reopen negotiation on any article, knowing from long experience how difficult it is to find agreement on such a document and how essential it is for the enlarged EU to agree on a constitution. I hope they stick successfully to their position. It can only get worse.

REFERENCES

1. Belcher P, McKee M, Rose T. Is health in the European Convention? *Eurohealth* 2003; 9(2):1–4.

2. Kaletsky A. Snacking on Europe-Lite is better for our health. *The Times* 2003, 18 September.

3. Juncker J-C. Gespenstische Wanderung. *Der Spiegel* 2003. 16 June. Available at www.gouvernement.lu/salle_presse/Interviews/20030616juncker_spiegel/index.html

Epilogue

How much worse things can get has been demonstrated by failure of the December 2003 Summit in Brussels to reach agreement on the Treaty. Using, as predicted, unreasonable, selfish and even stupid arguments, two countries, one not yet a member of the EU, succeeded in blocking the Treaty. Of course the Health Article did not cause these difficulties, but rather the desire to protect voting rights that could block European integration where this might not be fully in line with national interests. Nobody knows if, when and with what results the negotiations will be reopened, or whether the Irish or the Dutch will be more successful than the Italians. A worse case but not impossible scenario would be the failure of the Treaty completely. This would reduce the EU solely to market issues, leaving those who want to move towards some kind of political union, with no other choice than to create a Europe of varying speeds. As bad and destructive as this would be for the EU as a whole, looking just at health this could even be the best solution. In this situation it may even be advisable, to forget the text of the Treaty and work instead on achieving consensus on the vision of a "Healthy Europe" among those more progressive nations. Dreams could yet lead to better results.

Making social inclusion a reality:

The challenge for people with mental disabilities in Central and Eastern Europe

Judith Klein

Camilla Parker

"…The human rights perspective on disability means viewing people with disabilities as subjects and not as objects. It entails moving away from viewing people with disabilities as problems towards viewing them as holders of rights. Importantly, it means locating problems outside the disabled person and addressing the manner in which various economic and social processes accommodate the difference of disability – or not, as the case may be. The debate about the rights of the disabled is therefore connected to a larger debate about the place of difference in society"[1]

For over half a century official governmental policy in Central and Eastern Europe (CEE) has been to place people with 'mental disabilities' (this term includes both people with mental health problems and intellectual disabilities) in large institutions such as psychiatric hospitals, social care homes and orphanages. Such institutions are typically isolated from society, being situated in rural areas where access to them is virtually impossible. Residents often live in inhuman and degrading conditions with little or no means of communication with the outside world. Such exclusionary practices and human rights abuses have been highlighted by international organisations in their reports on the condition of institutions in the region.[2–4] Furthermore, the exact number of people living in such conditions may be underestimated as many are run by social welfare ministries and therefore are generally not included in health-related statistics.

Those individuals with mental disabilities who have not been institutionalised are often trapped in their own homes. This is not only due to the lack of available community-based services but is also a result of societal prejudice, with family members keeping the person at home either in order to protect them from potential abuse or to avoid bringing shame on the family. This forced exile to long-term institutions or isolation at home fosters prejudice in the general population, thereby reinforcing prevalent exclusionary public policies.

The fact that appalling conditions prevail within long-term institutions is by no means unique to CEE. Reports highlighting institutional abuse were a factor in, if not a driving force behind, the beginning of de-institutionalisation in both the UK and the USA. However, the barriers to effecting positive change are more complex in the countries of CEE. The transition from state-domination to more open societies has created economic and political instability. High unemployment rates averaging 14.5% compared with 8% in the EU are just one example of the challenges faced by the new governments.[5]

Promotion of the rights of people with mental disabilities and the development of policies and practices for their care and support is rarely high on the governmental agenda. Furthermore, the current fiscal crises threaten to make the already unacceptable conditions in these institutions much worse. Nor has the gradual advent of market economies automatically brought any relief. The networks of community-based services that are essential to the social inclusion of people with mental disabilities remain drastically underdeveloped, particularly in rural areas. These factors illustrate the urgent need for change.

Accordingly, the Mental Disability Advocacy Program (MDAP) of the Open Society Institute (see Box 1, overleaf) has, for the past eight years, supported the development of community based alternative services. This is in order to facilitate the reintegration of people with mental disabilities into the community as well as to prevent the need for institutionalisation in the first place. MDAP provides support

Judith Klein is Director, and Camilla Parker, Legal and Policy Consultant at the Mental Disability Advocacy Program, Open Society Institute, Budapest

For further information about MDAP or the MDAP/EUMAP project contact mdap@osi.hu or euaccession@osi.hu

<div style="border:1px solid">

Box 1

THE OPEN SOCIETY INSTITUTE

The Open Society Institute (OSI) is a private operating and grantmaking foundation based in New York City that serves as the hub of the Soros foundations network, a group of autonomous foundations and organizations in more than 50 countries. OSI and the network implement a range of initiatives that aim to promote open societies by shaping government policy and supporting education, media, public health, and human and women's rights, as well as social, legal, and economic reform.

</div>

<div style="border:1px solid">

Box 2

EU MONITORING AND ADVOCACY PROGRAM

The EU Monitoring and Advocacy Program monitors compliance with the European Union's political criteria for accession in the candidate states of Central and Eastern Europe. The primary objective of the Program is to promote public awareness and debate regarding the role, content, and significance of these criteria during the ongoing EU accession process. The Program works with national experts and nongovernmental organizations (NGOs) to compile reports examining candidate states' efforts to meet the criteria with respect to minority protection, judicial independence, equal opportunities for women and men, and corruption.

</div>

<div style="border:1px solid">

Box 3

WHAT IS INTELLECTUAL DISABILITY?

The term 'intellectual disability' (also known as 'learning disability', 'learning difficulty' or 'mental retardation') refers to a lifelong condition, usually present from birth or which develops before the age of 18.

It is a permanent condition, characterised by significantly lower than average intellectual ability and results in significant functional limitations in intellectual functioning and in adaptive behaviour as expressed in conceptual, social and practical adaptive skills.

A person with intellectual disability usually requires support in 3 or more of the following areas of major life activity: self-care, receptive and expressive communication, and economic self-sufficiency.

People with intellectual disabilities generally need a combination of special, interdisciplinary, or generic services, individualised support, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

When applied to infants and children, "intellectual disability" refers to an individual from birth to age 9, who has a substantial developmental delay or specific congenital or acquired condition, and may be considered to have an intellectual disability without meeting 3 or more of the criteria above if the individual, without services and supports, has a high probability of meeting those criteria later in life

</div>

to a range of non-governmental organisations (NGOs) which provide community based programs such as inclusive education, early intervention, supported employment, de-institutionalisation and crisis intervention throughout the CEE. Some of these organisations are MDAP model sites providing training for the development of quality services to other organisations in the region. Through its work, MDAP seeks to strengthen the capacity of NGOs so that governments recognise them as legitimate partners in the provision of community based services.

While support for community-based service provision is central to the work of MDAP, the ultimate goal is to ensure that people with mental disabilities can participate as equal citizens in society. This is an enormous challenge: not only is there widespread prejudice and discrimination against people with mental disabilities but there are also significant legal and policy barriers to their social inclusion. Although general human rights standards apply to all people, there is insufficient recognition that these apply to people with mental disabilities.[1] For this reason, an increased focus on activities highlighting the need for governments to develop policies and legislation promoting and protecting the human rights of people with mental disabilities is essential.

Monitoring Access to Education and Employment

Although adherence to human rights standards is a fundamental requirement for admission to the EU,[6] the accession process has provided little opportunity to scrutinise the human rights violations perpetrated against people with mental disabilities. A joint initiative of MDAP and the EU Accession Monitoring Program (EUMAP) (Box 2) of the Open Society Institute seeks to address this gap by monitoring access to education and employment for people with intellectual disabilities. (A full definition of intellectual disabilities is provided in Box 3) This research project will include the EU accession candidate countries of CEE, as well as Croatia and four EU member states, Greece, Italy, the Netherlands and the UK.

The focus of this research is people with intellectual disabilities. This is because while there is increasing interest in the need to challenge human rights abuses within the long-term institutions and to develop alternative community-based care, such work has tended to focus on mental health.[7] (One notable exception though is the work of Inclusion Europe, the European Association of Societies of Persons with Intellectual Disabilities and their families which has produced a series of reports on the human rights of people with intellectual disabilities in many of the EU accession countries.) In fact there are tens of thousands of people with intellectual disabilities throughout CEE who are detained in closed institutions. While the research focuses on people with intellectual disabilities, many of the findings and recommendations made will be equally relevant to people with mental health problems.

Education and employment have been chosen because they are fundamental to participation in society, and the lack of access to them leads to social exclusion. With little or no education, it is almost impossible to find employment. Lack of financial resources prevents the unemployed from engaging in many social activities. While the expectation is that laws should prohibit discrimination on the basis of disability, generally, EU Candidate States have not adapted their domestic legislation accordingly. Where some measure of domestic anti-discrimination legislation exists, in practice it has rarely been applied to protect the rights of people with intellectual disabilities. Though many CEE constitutions contain equal treatment clauses, none has comprehensive anti-discrimination legislation, with an explicit prohibition of discrimination against persons with disabilities (including mental disabilities). Furthermore to date there has been no comprehensive review of the practical implementation of existing standards and legislation.

Non-governmental organisations working in CEE countries have raised the following concerns about access to employment:

– There is a general societal perception that people with intellectual disabilities are "unemployable".

– Restrictive and discriminatory labour laws make it very difficult to employ people with intellectual disabilities. People with disabilities lose their state benefits if they receive income from another source, i.e. employment.

– There is a severe lack of (re)habilitation/ training to help the transition to employment from special schools and institutions.

– A tiny fraction of individuals with disabilities who could work are actually employed in the open market

NGOs have also raised the following concerns in relation to education:

– Children with the most severe disabilities are commonly either institutionalised or isolated at home with no access to even special education.

– Medical pedagogical commissions throughout the region, generally consisting of physicians and special educators are responsible for diagnosing mental disability in children. They use outdated and over broad modes of diagnosis, and in practice, there is no real opportunity for meaningful review

or challenge to their decisions.

– Where special education is available, it tends to be poorly adapted to the needs of individual children and is generally not geared toward maximising their potential.

– There are very few examples of inclusive education due to overly rigid educational systems and prejudice, in spite of the EU resolution on the integration of children and young people into ordinary systems of education.

– Vocational programs for young adults are uncommon and where they exist are generally not adapted to the needs of people with intellectual disabilities

In the light of these concerns, the MDAP/ EUMAP research will include an assessment of the level of compliance with existing international human rights standards. It will also examine the adequacy of national legislation against those standards, and evaluate the efficacy of governmental policies and practices relating to the rights of people with intellectual disabilities. The findings of the research will be published in the form of country reports. These reports will include clear recommendations for the development of policies that will provide equal access to education and employment for people with intellectual disabilities.

MDAP/EUMAP will work with NGOs in the region in planning research, developing recommendations and stimulating public interest in the findings and recommendations of the reports. In 2004 and 2005, NGOs in the target countries will play a critical role in developing and implementing advocacy strategies to achieve the necessary legal and policy changes both at national and European levels.

Conclusion

While there are excellent examples of quality community based services in CEE, the current challenges to achieving the goal of equal citizenship for people with mental disabilities are substantial. If this goal is to be achieved, governments must not only accept responsibility for the provision of support and services for people with mental disabilities but also remove the existing barriers to their full inclusion in society. Initiatives such as the MDAP/EUMAP project seek not only to highlight the ongoing human rights violations, but also aim to offer practical solutions to CEE policy makers on how to introduce changes that will make a positive difference in the quality of life of people with mental disabilities.

References

1. Quinn G, Degener T, Bruce A et al. *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability*. Geneva: United Nations, Office of the High Commissioner for Human Rights, 2002.

2. Mental Disability Rights International. *Human Rights and Mental Health: Hungary*. Washington D.C: MDRI, 1997. Available online at www.mdri.org/report%20doc uments/Hungary.doc

3. Mental Disability Advocacy Centre. *Liberty Denied*. (Forthcoming)

4. Amnesty International. Bulgaria, *Far From the Eyes of Society, Systematic Discrimination against People with Mental Disabilities*. 2002. Available on line at http://web.amnesty.org/ library/Index/engEUR150052 002?OpenDocument&of= COUNTRIES\ BULGARIA?OpenDocument &of=COUNTRIES\ BULGARIA

5. Infobase Europe. www.ibeurope.com

6. See the Copenhagen European Council membership criteria at www.europa.eu.int

7. World Health Organisation. *The World Health Report, 2001, Mental Health: New Understanding, New Hope*. Geneva: World Health Organisation, 2001. Available on-line at www.who.int/whr2001/2001

Integrating public health practice in Europe

Mark McCarthy

"The expression 'public health' remains confusing"

Europe has been a region of the world health organisation since 1946. Six countries in 1956 formed the European Economic Community, and by 1991, with the Treaty of Maastricht, the European Union had extended to 15 countries. In 2004, the Union will increase to 25, with three EEA countries (Iceland, Liechtenstein and Norway) and programmes for collaboration across the wider borders to countries of the former Soviet Union and around the Mediterranean. The forces of European integration are moving rapidly. What is the place of public health practice within this movement?

This paper is written in English, my native language, and English has become an international language far beyond international diplomacy. Most scientific experts read English and many write and speak fluently. Politicians also increasingly address each other across borders in English, and English language media are highly influential. Yet the expression 'public health' remains confusing. Even in England we are not sure what it means. 100 years ago, public health was about preventive measures of urban planning, sanitation, housing, and hygiene. Twenty-five years ago, the words were dropped and a new concept of 'community medicine' was introduced, to cover the wider practice of chronic disease control through prevention and health services. These words though did not agree with some people, and 'public health' returned… but now meaning both civil planning (environmental and social determinants of health) and also health services planning (health promotion and disease control).

Worse, public health in translation gets confused with public health-care, as opposed to private health-care. Or, in more common understanding, between services paid for and provided by the state, and health services paid for privately or provid-

ed by private practitioners. (There are several combinations of the 'public/private mix') Some administrators and many politicians (concerned with funding) use this meaning. In countries with a strongly privatised approach to health care, 'public health' is only a residual activity. In some countries translation gets in the way because of historical associations of words: in Germany, the untranslated English words 'public health' are now used by some to describe a new specialty joining sociological and epidemiological traditions with practice.

Interestingly, the USA, which provides a benchmark in many fields of medicine, has a welfare system very different from European models, and public health practice there is also different. Federal public funds are available for privately-provided health care for people age 65+ through Medicare, and for poor people through Medicaid, while State public health services fill other provider gaps, for example emergency services, communicable disease control, maternal and child health services. Thus, although the USA has a strong public health sector, it is not immediately suitable to look across the Atlantic and simply import the American model.

For this account I wish, like *Alice in Wonderland*, to use the words 'public health' as I mean them. I see public health as '*taking responsibility for the health of a practice defined population*'. The role is analogous to all doctors in defining a presenting problem, making a diagnosis, proposing treatment plans, undertaking 'treatment' and follow-up. Public health (in my viewpoint) similarly has five tasks: population needs assessment, resources assessment (funding, staffing, legislation), policies to meet needs, interventions; and evaluation. This process may be for a large or small population, and across all diseases or for a specific area, for instance cancer or HIV. Note that I am implying a relatively senior, conceptual role for public health. Its implementation will be through a range of services and structures, but the thinking and approach is generic

Mark McCarthy is Professor of Public Health, University College London, UK, and President, EUPHA Section on public health policy and practice.
E-mail: m.mccarthy@public-health.ucl.ac.uk

Training

How do you start working in public health? Should you enter from within a public health organisation, or should you 'convert' from another field? Particularly in medicine, should you start public health with an academic training, or should public health be one of the areas of professional practice at junior doctor level like orthopaedics or neurology in which you develop skills 'on the job'? This calls into question whether public health is taught adequately at undergraduate level for doctors to be able to practice adequately (under supervision). I personally would say it is both possible and desirable.

Is university training in public health adequate? This, of course, varies both within and between European countries. Epidemiology has taken over from hygiene in many but not all courses, and approaches to sociology differ between countries (or are missing). Statistical methods are increasingly understood, but knowledge gained from health services research doesn't always enter courses. Health economics in a course may variously mean supply/demand theory, QALYs, or payment systems. Crucially, teachers may or may not be themselves engaged in public health work, or prefer research away from the real world. A European Masters in Public Health is now available through the Association of Schools of Public Health in the European Region (ASPHER), using standard modules and a requirement to train in at least two countries, but only a small minority of public health trainees currently take this route.

How do we train for sub-disciplines? If public health is 'taking responsibility for the health of the population', then what are the components that make this task possible? The one that stands out is infectious disease control. Should this be a subdiscipline of public health, or its own specialty? The EU has for several years funded international training secondments in communicable diseases, and the Union's Second Public Health Programme has proposed a European Centre for Prevention and Disease Control. Perhaps this is to rival the US centre at Atlanta, which is a world reference point. Perhaps it is because infectious diseases are perceived to 'cross' borders (although there is currently more Europe-wide control of animal than human infections; while the concept of chronic disease crossing borders through media, commercial forces, or transport is not discussed). Perhaps it would be useful

to define, at an early stage, other subspecialities. My list would include:

– Environmental health (ie pollution and 'wider determinants' such as social inequalities, housing, transport etc).

– Health planning and management to include primary, intermediate and hospital care, and 'disease group' specialties that cut across these including cancer, CHD, maternal/child health, etc.

– Health promotion (implying services at local level that integrate with health care and also communicate directly with the population).

– Information/analytic epidemiology that brings together routine data with special studies and evaluation.

The training question is how much of each of these do you need to know to be generically trained before sub-specialisation?

Structures

Do you need to be a doctor to practice public health? There are different personal and national interpretations to this. In most countries the state officer responsible for local health is a medical doctor trained in public health. In England (but not Scotland, Wales or Northern Ireland), the requirement for medical qualification has been legally withdrawn, and in the process of increasing the number of local responsible officers from 100 to 400 the government made these posts equally accessible to people with other relevant backgrounds (health promotion, health service administration etc.). The mantra of the current English Department of Health is 'choice and diversity', and a condemnation of the 'old' NHS as 'one-size-fits-all'. This difference has roots in the 'social' model critique of medicine and a desire by other health workers to attain the status and income of doctors.

On the other hand, the view since 1974 that public health doctors were equivalent with hospital doctors (both as salaried NHS employees) has been broken, and hospital doctors and GPs can no longer expect public health departments to take a medical perspective, they have finally merged with the administration. This raises the question of whether public health practitioners retain professional independence while employed in the State service, or should they be entirely controlled by the public administration? More generally, there is also a question of European equivalence.

"It is striking how little public health practitioners in different countries know of each other's practice."

What tenure does a public health professional hold? In the UK for 100 years to 1974, the Medical Officer was appointed by the local authority with the right not to be dismissed. This was to allow some protection for the doctor to speak out where self-interest conflicted with the public good. [Ibsen's play '*An Enemy of the People*' is often cited as representing this issue, although the doctor portrayed by Ibsen is moralistic and vain, as well as 'fighting' commercial interests and corruption.] In the last few years, with public health practitioners being engaged in management, the potential for conflict has increased. Strong advocacy by a public health practitioner can be highly uncomfortable to a chief executive whose pay, and contract, depends on delivering government objectives. I have personally experienced similar pressures in a previous director of public health role. In the UK, NHS consultants are normally appointed with tenure up to the age of 65. In the past 15 years, various reorganisations of NHS structures for management purposes have made casualties of many public health doctors. The concept of tenure against the powerful state seems lost. Is this the situation in all European countries now?

What is the accountable population? Most public health services follow the boundaries of the public authority. In the UK, new units of local NHS administration have been created that are not co-terminus with local authorities; indeed, by using GP lists rather than local authority populations, the boundaries are 'fuzzy' and unclear. This makes for administrative confusion and difficulty in normal public health numerator/denominator data, and, while elected politicians represent populations at the local authority level, the new NHS structures are more independent of politicians than when they were co-terminus. So, who are the population and how do they hold public health practitioners to account?

What is the broader legitimacy of public health? First, it would be welcome to compare the legislation for public health practitioners, to know what each country expects and how far the structures are enshrined in law. Second, where is a public health practitioner legally recognised to practice? In most European countries, the public health practitioner works within a municipal department, which may manage some medical services (for example, maternal and child health, infectious disease control, screening, primary care, specialist mental

health services), but there are alternative forms of professional practice. In the UK, some doctors trained in public health have taken roles as medical directors in hospitals (the UK has not developed any career structure or training programme for medical directors, as the administration of hospitals has for many years been in the hands of non-medical directors). Public health doctors also work in independent practice as short-term consultants, and in Ministries of Health (up to the post of Chief Medical Officer). There are also a majority of public health trained staff in senior posts in the WHO.

What is the status, progression and pay of a career-grade public health practitioner? Is there similarity between countries? In the UK, there has been parity for the last 30 years between public health and hospital doctors, but opening senior public health posts to non-medical staff is likely to develop disparities. Are doctors working within the central Ministry of Health ever trained in public health; or is this a requirement only for local practice, while Ministry doctors enter from clinical posts?

In the future, what will be the structure of the European public health 'market'? In principle, it is already possible for people to work across borders and to register to practice in other European countries, but could a public health doctor be registered to work in all European countries? In my experience, the current medical practitioner 'mutual recognition' regulations work rather unevenly for public health doctors, with quite a lot of 'fudging' of requirements. Is there a 'shortage' of European public health practitioners, or an 'excess'? Will enlargement of the EU lead to migration of staff, and indeed will there be recruitment by existing EU countries? Perhaps we should be starting to plan for the public health workforce across Europe, since the skills are essentially transferable. Then, do people trained in public health continue their careers fully, or do they 'drop out' or return to other parallel fields. These are issues that might be related to the structures or conditions of service within these countries?

Practice
It is striking how little public health practitioners in different countries know of each other's practice. There have been no adequate descriptive studies, and there is no basic medium for communication, the European Journal of Public Health is the nearest, but the papers within it generally

"There is relatively limited collaboration between countries at the European level"

take a 'scientific' detached view, rather describing practice warts-and-all. There is no database of practice to draw on.

The knowledge base of European public health is still, to some extent, contained within countries, bound by language and tradition. Are the standard text books on public health in each country, in local languages, equivalent and in agreement with each other? Apart from the work of the WHO European region, it is not clear that much knowledge derived from practice is transferred between one country and another except where they share by a common language, or from USA to Europe. This is in contrast to the private sector, where standardisation is driven by market competition and incentives. How much attention is paid to existing or completed cross-country research on public health topics? Each Ministry of Health should have criteria for good public health practice. Do standards match, and if not, do Ministries of Health have plans to improve services? Are they measurable, are they measured at either department or individual levels, and are criteria compared against knowledge-based evidence or at least by peers?

Academic and service public health practitioners have an ambivalent relationship. Academics in public health rarely have a large service commitment, and are recognised by publications and international work, in comparison with many clinical colleagues where private practice is a complement of academic success. Are there appointments that formally cross the divide? Do academics take on service responsibilities, do service staff engage with academic aspects of their work (for example, gaining knowledge from evaluation of service interventions). Should academic staff be equivalent to service staff in status and income? Interestingly, some universities in the US have ventured into public health, or at least community health care services, because of a lack of public structures and opportunities of franchising to insurance systems. Some 'parallel' activities (information analysis, laboratories, consultancies etc) can be important parts of departmental income. Local epidemiological surveys can be undertaken, if service staff commission them. Are there academic departments in medical schools and non-medical university faculties? Does public health academic research range across other disciplines, including sociology, economics, and informatics? Is there a senior national training centre or a programme with academic input required for administrative promotion?

Equally, there are questions about public health practitioners' performance as service managers. They need professional appraisal, but this should be by colleagues and not within hierarchical management. How is it organised now, professional or managerial? Is this routine and mandatory and will it protect the public health?

The form of interaction between public health practitioners and health service administrators is crucial. While patients are typically respectful of their doctor's opinion (although litigation is increasing), public health professionals frequently encounter colleagues who challenge their advice and seek to impose organisational (or their own) objectives. How do administrators and practitioners relate to each other, and who has control over the allocation of resources for public health? What tasks are included in the budget available to the public health practitioner? Would this allow the practitioner to fulfil the task of assuring the health of the population? Since the task of the public health practitioner is the health of the public, there should presumably also be public accountability, both in decisions on resource use and policies.

Yet it is doubtful that local populations are given much information about the comparative size of an 'ordinary' public health department, and its performance. How do public health practitioners advise on health care spending priorities for their population? How do they advise on the reduction of health inequalities in the population? How do they assess the performance of hospitals on chronic disease control? How is health promotion managed, and how are preventable conditions, such as accidents, reduced?

Integration in Europe

Although the 1991 Maastricht Treaty, and 1998 Amsterdam Treaty, require that all Community policies achieve a high level of human health, the policies emanating from the European Commission have led to directives in rather narrow areas, such as tobacco advertising and labelling, and the regulation of blood and human tissues. Until recent judgements of the European Court of Justice, health services were regarded as outside the domain of the EU. However, recent Court judgements have shown that the cross-border trade directives apply to health care and impact on health financing. While attention has been

"National public health associations should look closely at reciprocal recognition for medical public health practitioners, and equity in training, accreditation and appraisal"

given to comparison of health systems, through supported research and conferences, the European Commission has given relatively little support to studies of public health. Two pieces of research have been funded. One, paid to ASPHER, reviewed aspects of training in public health; a second, currently being undertaken by the International Union for Health Promotion and Education (IUHPE), is describing nation-level health promotion.

How do European structures respect public health practitioners? The European Public Health Association, EUPHA, consisting of national public health associations, has been invited to join the EC's Health Policy Forum, which meets twice-yearly, and has a particular input at that setting on issues of research. Training and practice have not been considered at the Forum. Funding was made available from the Commission for various materials for health promotion, but mainly seeking to support prevention areas such as smoking control and AIDS (which had identified budget streams). These projects did not address the broader issue of joining prevention with treatment for disease control, nor did they reach the majority of local public health departments within EU countries.

Moreover, there is relatively limited collaboration between countries at the European level. The Commission has a High Level Committee, in which officials discuss issues presented by the Commission. Currently there is a Reflection Group concerned with cross-border patient flows. Recently also the Commission has linked with WHO in the fields of anti-terrorism, the environment and health. Overall, there is little encouragement of Ministries of Health to work together to resolve public health problems. Thus, for example, information is being defined in terms of what Eurostat wishes to collect in a standardised way rather than what might be most suitable for local public health management (remembering that the WHO Health for All database is at national level). Public health observatories are collaborating to develop expertise in more local information, but not systematically within a clear system. This has become institutionalised, as WHO EURO has given greatest attention to its least healthy parts, the countries within the former USSR, while looking to the EU and member states for project funding.

Enlargement provides a challenge to this balance: first, because the health status of countries joining the EU is mostly below

"One way for progress would be a cross national working group, with points of reference to bodies such as EUPHA and WHO could make progress"

the EU, although many have shown improvements in response to economic stabilisation; second, because the new border countries outside the EU have significantly worse health problems, and form the remainder of WHO EURO; and third, because migration may strongly influence the capacity of accession countries. Public health practice can:

– Prioritise major health needs and suggest suitable policy responses.

– Offer reasons for limiting expenditure on drugs, and increase health promotion and environmental improvement.

– Assist in improving efficiency and quality in hospital and advise on controlling commercially-led expansion of hospitals.

– Support better general practice.

– Develop information systems that record health outcomes as measures of system performance.

Conclusion
We need to address the opportunities and deficiencies of public health practice in Europe. Since Ministries of Health provide funding for much public health practice, one would expect Ministries to wish to understand their performance and to learn about practice from each other. In the absence of activity at EU or Ministerial level, it is possible for EUPHA to lead this, while working to engage Ministries and WHO.

One way for progress to be made would be a cross-national working group, with points of reference to key bodies such as EUPHA and WHO. A survey providing some of the answers to the questions above could lead to recommendations on how to structure a more integrated public health service in Europe. A champion Ministry of Health could bring the issue to the attention of other European ministries, perhaps through the meetings of the Chief Medical Officers. National public health associations should look closely at reciprocal recognition for medical public health practitioners and equity in training, accreditation and appraisal. There should be concern to develop adequate measures of public health performance, that show the effect of public health services as well as the impact on population health status. Finally, Europe needs to keep contact with North America and other national public health systems for benchmarking and learning. There is much to be done.

The free movement of nurses:

A *win-win* situation if based on ethical recruitment guidelines

Paul De Raeve

"Comparable information on nurses and and nursing across Europe is still needed"

Within the liberalisation process of the Single European Market, the cross border movement of goods, services, professionals and patients is a priority for the European Commission and Member States. The proposal for a Directive on the Mutual Recognition of Professional Qualifications COM (2002) 119 Final 2002/0061 (COD), discussed in the Legal Affairs and Internal Market Committee of the European Parliament, will shape the future mobility of health professionals within Europe. The seven professions, each covered by a Sectoral Directive, emphasise the importance of a clear separation between the sectoral and the general regimes, a better protection of public interest and public health in the free provision of services and legal certainty for the direct input of the professions within the future consultation mechanism. While this political discussion is still going on, the health professions, in specific the national nursing organisations, face significant challenges:

The increase in unemployment within the EU is the main source of poverty and social exclusion, and has an impact on the health of European citizens. Nurses have a pivotal role to play in identifying those vulnerable groups and implementing policies to prevent poverty and social exclusion.

The increased cross border movement of health professionals leads to regional shortages of nurses. A European platform to facilitate cooperation for the better use of health resources within the EU is urgently needed. The nurses from the 52 Member States of the WHO European region are regarded as a 'supplementary' source of health care staff leading to a "skill and brain drain". The most qualified nurses will be the first to migrate, while the European region is still facing enormous differences in health status, life expectancy, social

inequalities and poverty. The issue of enlargement and how this process will impact on health demands across the EU needs to be visualised together with recognition of qualifications for health professionals because there is already free movement within the general system.

The reform of health care systems should be based on the achievements of the Member States and the exchange of information between the European health professions, patients and policy makers. Policy development and implementation necessitates a 'bottom-up' approach in order to reconcile national health policies of Member States with European obligations and to facilitate access to medical and nursing care in the EU.

These challenges deserve detailed analysis especially given that health is an important economic and social factor in an enlarged Europe. Nurses provide around 80% of direct patient care and it is essential, when designing new policy in the social and health area, to include nurses and nursing to obtain a full picture of care.

The PCN strategy

Although there is already free movement for generalist nurses across Member States, we are still struggling with different levels of basic education, different programmes and different outcomes. Comparable data about nurses and nursing is required at a European level to inform health policy, to study and improve the quality/effectiveness of patient care, and to manage nursing resources. The single most common reason in all countries in relation to the current labour crisis in all health professional groups is a lack of information in respect of the number of health service employees, the healthcare needs and the delivery of services. Systematic information is needed about nursing practice, which is featured by a diversity of patient population (age, demographic features, pathology, and patient's need of care) and variation

Paul De Raeve is Secretary General of the Standing Committee of Nurses of the European Union (PCN). E-mail: pcn@village.uunet.be

between care (different nursing care, medical treatment).

Assessing a surplus or shortage of nurses necessitates the development of benchmarks in Europe to fit nursing resource requirements with health service demands. Systematic information should enhance the quality of decisions, financial performance and obtained results. A real human resources policy can only be made when there are comparable data available.

Therefore the Standing Committee of Nurses of the EU (PCN) has called on European stakeholders and institutions to:

Set up a European Workforce Monitoring Forum capturing information about health professionals and their services in order to make predictions on future trends and support workforce and health service planning. By doing this, we prevent substitution of 'expensive' nurses for 'cheaper' care assistants or aides.[1,2]

Concentrate on problems in relation to recruitment and retention of an ageing nursing workforce in Europe. Political objectives regarding human resources in the health sector are needed. The nursing profession and career end need to be more attractive.

Develop further the implemented ethical and practical recruitment guidelines for nurses at a European level for all health professions. All European stakeholders play a significant role in helping to promote these ethical guidelines. Aggressive recruitment practices are not the answer and will lead to under-resourced and disrupted health services affecting further reforms of Member States health care systems.[3]

Development of educational standards and accredited programmes at a European level for the better protection of public interest and public health in the free provision of health services. There is ample evidence that a higher educational level will lead to high quality of care and patient satisfaction.[4]

Members States should be assisted and encouraged to *collate accurate and comparable quantity and quality data*. The nursing workforce, competences and mobility is essential within a single market but needs to be related to the quality of care and safety of patients.

Good practice with ethical standards

PCN members have concrete examples of partnership projects on developing a

framework for mobility. This involves assessing contribution to provision of health care in the host country, development of competencies, and facilitating nurses' re-entry for added value to the country of origin. This win-win situation is obtained using guidelines for the ethical recruitment of nurses, and setting out standards for employers and agencies to follow.

The UK has currently 42,000 internationally recruited nurses (7.5 % of all UK-based nurses) of which 4053 (0.7%) are from EU and EEA (European Economic Area) countries.[5] With these numbers it clearly is not exaggerating to state that some health care organisations would cease to function without international nurses. Although language, differences in clinical and technical skills, racism in the workplace, and the reaction of patients are the main challenges, the process of recruitment has become more systematic, planned and strategic in recent years. Whilst the contribution of internationally recruited nurses should be welcomed and valued, the UK Royal College of Nursing (RCN) has recommended that the main focus of the UK's recruitment activity should now be to grow nursing capacity from within the UK.

The UK code of conduct on international recruitment states that "NHS employers should not target developing countries for recruitment of health care personnel unless the government of the country formally agrees via the Department of Health". Although there are still problems with the code's implementation, the RCN has also issued good practice guidance to health care employers on the recruitment, induction and retention of internationally recruited nurses. The majority of these nurses come from outside Europe (the top three countries are The Philippines, South Africa and Australia) but there are also examples of successful recruitment from Eastern Europe, for example from Bulgaria, a future accession country.

Three years ago 33 Bulgarian nurses, from across the whole country and not just one hospital/city, were recruited to a hospital in Nottingham, England. The hospital used a planned recruitment approach with proper induction, not just in relation to work and clinical issues, but also in respect of the challenge of settling in England, for instance, assessing services in Nottingham where they were living, etc. After induction there were monthly 'recall' days organised to pick up any other issues, such as language ability, cultural differences in

handling/dealing with patients and difficulties in getting used to working in a multidisciplinary environment, with primary care, social services, etc. These differences have to be recognised but they are not insurmountable problems. Development opportunities were given to these Bulgarian nurses along with other staff and most of them have advanced their careers in three years to a higher grade and the retention rate is very high.

Less than 100 Polish nurses have been recruited to Norway since the end of 2001, as part of a formal agreement with the Polish government. The recruitment has taken place among those few who completed a three year programme in line with the Sectoral Directive in the mid-1990s and among those who have a masters degree. As Poland has changed its three year programme, recruitment is now limited to those with a masters degree (5% of Polish nurses). Polish nurses recruited are all given 16 weeks of language training (full time) prior to their departure for Norway, but additional courses are given after arrival. A temporary license for up to two years, successful completion of a three week course on Norwegian legislation and additional training in the care of older people are requirements for authorisation.

If migration is only temporary, qualifications acquired abroad may intensify the international exchange of experience and result in raising the quality of care if migrants return to their home countries. Currently, though we do not have any information on how many nurses have returned or will return to Poland, but recruitment only occurred recently in late 2001. This government programme ends in 2003, and the same goes for government recruitment of nurses from Germany and Finland. No official reason so far has been given, but it could prove to be too expensive, given the extensive need for language training.

Considering that the Netherlands has a significant shortage of nursing and caring personnel, and in Poland a 'growing number of nurses are unemployed', the Polish and Dutch Governments agreed to facilitate the temporary employment of Polish nurses in the Netherlands. The objective is to pave the way for mutual recognition by bridging the gap in the level of competencies. Two year employment contracts, additional in-service education provided by employers and meeting minimal European requirements are key criteria to participate in the project. Within the context of this pilot project, the competence of the Polish nurses will be monitored in order to assess the actual qualification level of the Polish education system for nurses in comparison with the Dutch education system for nurses (BIG-register). The Polish government will then ensure that these nurses on their return are given an equivalent job in the health care sector.

These concrete examples show that exporting 'redundant' health care staff may result in a win-win situation for for both countries. Qualifications acquired abroad can ultimately raise care standards when migrants return to their home countries. Ethical recruitment is about how staff can be recruited abroad without endangering nursing care in the countries of origin and how to overcome difficulties when only a small number of nurses have qualifications which meet the criteria for EU free movement.[6] Therefore the EU has a particular role to play in helping to promote ethical guidelines within Member States governments and health care organisations.

Conclusion

Through twinning projects, PCN members have gained important experience on the exchange of information, building excellence, and providing input to policy development on the mutual recognition of professional qualifications as well as implementing ethical guidelines for the recruitment of nurses.

For the nursing workforce competence and mobility is essential within a single market and needs to be related to the quality of care and safety of patients. Countries are currently competing in the recruitment stakes and it becomes clear that recruitment from other countries is not the answer. We are "robbing Peter to pay Paul", taking the more experienced professionals from countries that have a surplus, but these most experienced nurses are needed to develop their own national and local health service.

Due to the fact that aggressive recruitment practices lead to under-resourced and disrupted health services, European stakeholders working on health and social policy need to endorse ethical guidelines and standards in the recruitment for all health professionals and develop a European labour market with better workforce planning and monitoring based on comparable data. By doing this, the free movement of health professionals and patients can be a win-win situation for all.

"Stakeholders need to endorse ethical guidelines and standards for recruitment for all health professions"

REFERENCES

1. Buchan J. Nurse Recruitment: going places. *Health Service Journal* 2002;112 (5816):22–25.

2. Buchan J, Parkin T, Sochalski J. *International Nurse Mobility; Trends and Policy Implications*. Geneva: World Health Organisation, 2003.

3. De Raeve P. The nursing shortage, a European perspective. *Journal of Advanced Nursing* 2003;43(4):1–16.

4. Aiken L H, Smith H L, Lake F T. Lower Medicare mortality amongst a set of hospitals known for good nursing care. *Medical Care* 1994;32:771–87.

5. Royal College of Nursing. *Here to stay? International Nurses in the UK*. London: Royal College of Nursing, 2003. Available on-line at: www.rcn.org.uk/ publications/pdf/ heretostay-irns.pdf

6. Gaillard A-M, Gaillard J. Brain drain to brain gain. *Sources* 2001;132:4–6.

What are the objectives of the new Health Transformation Programme in Turkey?

Salih Mollahaliloglu

"A universal health insurance system is planned"

After being declared the winners of the Turkish general election in November 2002, the Justice and Development Party announced a "Programme of Urgent Action" to deal with a number of pressing problems in the country. Within this framework the Ministry of Health prepared a "Health Transformation Programme" to promote and broaden the scope of health services. This new programme of transformation does not differ greatly from previous health reform initiatives. However, it is intended to provide support for the findings of these previous studies, so as to reduce the disappointment often experienced in the past when promised reforms have come to very little.

In establishing this programme the key fundamentals are to place a high priority on achieving patient satisfaction and improving the morale of service providers. Other objectives of the programme are to present, provide, finance and organise health services in a fashion consistent with the principles of effectiveness, productivity and equity. There is a focus on a patient centred approached, and consideration of sustainability, continuous quality improvement, levels of participation, division of power, decentralisation and competition within the service. All the aforementioned objectives and principles are in line with both the 'Health for All in 21st Century' Policy of the World Health Organisation and the 'Accession Partnership' document prepared by the European Union.[1]

Health service delivery

Health service delivery in Turkey is complicated and has a fragmented structure. While the Ministry of Health is responsible for planning services, in reality this has not been undertaken in recent years, because the Ministry is also responsible for providing services. Service delivery resembles a patchwork quilt, being provided by many institutions, while financing also is provided through different resources, as the state has many social security institutions each with their own procedures. Administration is highly centralised, making the promotion of quality difficult, as most of the administrative staff are professional civil servants.[2]

The new programme includes solutions for these problems. The structure of the Ministry is to be orientated towards policy making, monitoring and setting standards, and utilising resources in an effective, productive and equitable way. While the process of restructuring is underway, the Ministry will also give priority to strengthening primary care and prevention services in a manner consistent with that of a socially focused state.

A universal health insurance system is also planned where individuals make contributions based on their ability to pay. Although a large number of the population are already covered by the existing social security arrangements, the intention is to ensure that all in society are covered, and that all services will be provided within the same system.[1] At the same time the need to learn from the experience of other countries is being emphasised, with attention also on differences in the socioeconomic and cultural way of life. This can help in planning a broad, friendly and accessible health care system. Having a more formal system of referral from primary to secondary care is also emphasised to promote the service quality, decrease the costs and expand the service scope.

Hospitals as key service providers will have greater autonomy for management and financial responsibility. Establishing a health information service to improve access to information for effective decision making, introducing modern management practices and ensuring that there is availability of a more educated workforce also have important roles to play in the programme if reforms are to be implemented successfully.[1]

Salih Mollahaliloglu is Principal of the School of Public Health, (Hifzissihha Mektebi), Ministry of Health, Turkey. E-mail: salih@hm.saglik.gov.tr

Initial Steps and Outcomes

Personnel working in health centres and hospitals are civil servants, receiving governmental salaries, supplemented by bonuses from 'revolving funds' at their institutions. An initial step in the health transformation programme has been to link payment of these bonuses to performance. This system has in the past not worked as well as it might have done, as unlike within the new framework additional payments were not made for administration. The new system has thus encouraged the growth of administration.

Moreover chief doctors in Turkish hospitals are generally medical specialists or surgeons, working part time, and spending the remainder of their time in private clinics. These doctors do not receive hospital management training during their initial or postgraduate education; thus the management of hospitals has at times been problematic, and furthermore the incentive of private practice has meant that they have spent much time away from their institutions.

This new revolving fund system ensures that staff working hard at their institutions, will receive a greater share of revolving fund bonuses in comparison with colleagues who only work part time because of their commitments to private clinics. By increasing payments to full time doctors fivefold compared to part time staff, it is hoped that this will act an incentive to doctors to work at their hospitals rather than in private clinics.

Another advantage of this new system is that staff will receive a share from the revolving fund commensurate with the level of service provided. This is dependent on the number of points that staff can accumulate through the provision of services, thus providing a further incentive. With this system, monitored and continuously improved, hospitals can avoid having many staff working in areas where activity is low, while it will identify areas where additional medical specialists are required.

For instance if medical specialist 'A' receives only a small share of the revolving fund, this indicates that such a specialist may not be needed, when considered from the perspective of services provided. On the other hand if certain medical specialists receive a high share of the revolving fund, then it may be that the number of specialists is so insufficient that need cannot be met. This provides the Ministry and hospital administrators with a more rational

mechanism for determining staffing mix and the need for services. Moreover administrators now have an incentive to monitor staff and encourage them to be more productive as their own bonuses from revolving fund income are dependent on staff performance.

It is aimed to increase vaccination coverage rates, family planning, pre and post natal care services and child health services through the linkage of payments from the revolving fund to such preventative care service performance. Targets are set and staff need to reach a minimum level of preventative service performance set at 70% in order to gain a share from the revolving fund. In this way, carrying out preventative health care is encouraged by the state, and payments now more satisfyingly reflect this focus.

Access to services

One of the studies conducted under the health transformation program examined how to extend access to services at all health facilities regardless of which social security scheme applied to an individual. In Turkey social security contributions are made through a number of different schemes, while access to non-emergency treatment may be restricted to specific institutions depending on social security scheme. While different social security schemes such as the SSK (Social Insurance Organisation) can use Ministry of Health institutions, they also run their own hospitals providing services to employees insured under their scheme. This has led to the establishment and maintenance of multiple institutions to provide services to different groups of employees within the same province.

The type of service, quality, human resources and inpatient bed occupancy ratio in these hospitals varies. For instance the lack of staff in an SSK hospital might mean that patients had to be referred to another SSK hospital in another province or to receive treatment privately. Under the new programme, individuals enjoy the right to receive services from different institutions and are also free to choose their institution. This helps to improve patient satisfaction and provides competition in service quality. Institutions that wish to increase income from their revolving funds have therefore begun to introduce steps to increase patient satisfaction and thus encourage more individuals to use their services.

"Priority is given to strengthening primary care and prevention services"

"Health centres are becoming gatekeepers [to secondary care services]"

Furthermore a chain of referral can be included in the system and a pilot study is underway in six provinces. Individuals covered under the different social security schemes are beginning to be required to first consult with a doctor at a local health centre before they can be referred on to hospital. While this is not obligatory, without such a consultation individuals cannot be reimbursed under the health insurance scheme. In this way health centres are becoming 'gatekeepers' and now 30% of patients are referred to hospital in this fashion. In future it is thought that the level of referrals from health centres will decrease, through the increase in staff within these centres and use of detailed laboratory analysis.

Another advantage of this programme for primary health care is that the job satisfaction of general practitioners is heightened. Traditionally the view has been that health problems could only be solved by medical specialists, but as the new reforms have been introduced people have started to observe that many problems can be resolved within general practice. An increase in the revolving fund income of health centres can be seen, and the income gap between general practitioners and medical specialists has lessened. Implementing this programme nationwide in Turkey will provide important resource savings, as costs within health centres are much lower than those in hospital. Studies are also being carried out regarding how resource savings might be used to help introduce a universal health insurance scheme.

Other initiatives

Another study underway is looking at how to increase the number of health care professionals working in the less developed regions of the country. Government employed health professionals have had periods of compulsory service within these areas, but these time periods are limited and individuals tend to leave the area leading to problems sustaining services and maintaining quality. Obligatory service which led to these problems is being done away with, and a voluntary scheme is now being introduced, where salaries will be three times greater than those for government employees elsewhere, but personnel will not be allow to take up appointments in other areas for a period of ten years.

Within the framework of this programme, civil servants have also been allowed to refer individuals to private hospitals and also to purchase health service. Health

services thus can be obtained not only from state hospitals but also from the private sector either on a unit-by-unit basis, or through service packages negotiated by the social security institutions. In this way public hospitals will work even more so in a competitive environment. A service procurement system has also been introduced, intended to reduce heavy but unnecessary investment in expensive medical technologies such as CT scanners and Magnetic Resonance Imaging scanners. It will be possible to rent this equipment rather than buy it.

Over the last eight months progress has been made in reorganising the Ministry of Health and establishing a Drug and Medical Equipment Institute and introducing related legislation. A series of programmes to improve primary health care have begun, focusing largely on maternal and child health care, and there are plans for training professional health administrators. The School of Public Health has also begun operating under the auspices of the Ministry of Health and is expected to have a vital role to play in realising the ambitions of the Health Transformation Programme.

Conclusion

Health reforms long expected have begun to be implemented one by one. Both the Government and Ministry of Health have expressed determination to see this task through, raising our hopes. Studies and interventions introduced so far are important milestones for the improvement and promotion of health services. There is also a need for both monitoring and improving these activities continuously augmented by implementation of further projects and reforms. As in every country, turning health reforms into reality in Turkey is a challenging task, requiring patience and much effort, and administrators need to give priority to these issues. Establishing a family physician system and introducing a universal insurance system are still arduous tasks for this programme. It will take time to overcome all these problems in a country that has had two economic crises in recent times. It should be noted that to mitigate some of these problems, and help establish a universal health insurance system the Ministry of Health has undertaken a series of studies looking at how to promote cost effectiveness, and improve quality of care, reduce unnecessary expenditures, encouraging rational drug use and promote the overall working of the health care system.

REFERENCES

1. Akdag R, Unuvar N, Aydin S. *Health Transformation Programme*. Turkish Ministry of Health, 2003.

2. Serder Savas B, Karahan O, Omer Saka R. *Health Care Systems in Transition. Turkey*. (eds) Thomson S, Mossialos E. Copenhagen: European Observatory on Health Care Systems, 2003. Available at www.euro.who.int/document/E79838.pdf

Paula Corabian, Carmen Moga, Christa Harstall and Don Juzwishin

Dan Enachescu

David Hailey

Developing Health Technology Assessment in Romania

Carmen Moga,

Paula Corabian,

Christa Harstall,

Don Juzwishin,

Dan Enachescu,

David Hailey

Romania is a country emerging from four decades of centralised government control over the planning and delivery of preventive and curative health care services.[1] Major reforms were introduced in 1989 and by 1997 the centralised, tax-based health system was evolving towards a decentralised and and pluralistic social insurance system. The health care system continues to undergo rapid transformation and health reform is part of the country's broader transition to political pluralism and a market economy. Important steps have been undertaken on the road to reform but there are still many opportunities for improvement.

Romania faces a high demand for health services that includes the acquisition of new and costly technologies. This is due to improved access to information by both health professionals and the general public and to the recent demographic changes characterised by an ageing population. The manner in which these new technologies are introduced needs to be improved.

Learning and implementing new methods for setting priorities based on evidence of clinical and cost-effectiveness and improvements in the use of the equity principles in the resource allocation process are targeted as important future actions.

Health Technology Assessment (HTA) is recognised as a useful, transparent and reliable public policy tool that can be used in the decision making process. It can contribute to the improvement of quality of health care by promoting safe, effective and cost-effective technologies.[2-5] Although Romania has expressed an interest in using HTA since the early 1990s, HTA activity at a national level has not yet been established.

This article presents a history of the process of developing HTA in Romania. It also describes actions, achievements and future steps, as well as thoughts and expectations from a group of professionals who have dedicated their time in the hope that all activities to date have not been in vain.

History

The need to develop HTA in Romania was identified as early as 1992. At that time, a group of experts from the World Bank evaluated the state of health technologies in the country as part of a larger project. Approximately two hundred Romanian stakeholders were interviewed on different subjects including health technologies. The resulting report revealed such issues as

Carmen Moga is Assistant Professor, and Dan Enachescu Professor Consultant, Department of Public Health and Management, University of Medicine and Pharmacy 'Carol Davila', Bucharest, Romania. Paula Corabian is a Research Associate, Christa Harstall Assistant Director, Don Juzwishin, Director and David Hailey Senior Adviser to the Health Technology Assessment Unit at the Alberta Heritage Foundation for Medical Research, Edmonton, Alberta, Canada.

E-mail: carmen.moga@lycos.com

ineffective acquisition, distribution and utilisation of health technologies and deficiencies in access to the latest scientific information. Based on their findings, these experts indicated that national HTA activity might address some of these issues.

However, due to political, organisational and financial factors, the most relevant activities relating to the process of developing HTA only started in 1998. Progress was delayed by a high turnover within the Ministry of Health including the post of the minister, a lack of a clearly defined role for a group to implement recommendations, an absence of funds dedicated to this activity and competing health care issues that needed immediate attention.

Activities of a developing HTA initiative

In 1998, a mentoring relationship was established between the HTA unit of the Alberta Heritage Foundation for Medical Research (AHFMR) based in Edmonton, Alberta, Canada and the Department of Public Health and Management (DPHM) within the University of Medicine and Pharmacy 'Carol Davila' Bucharest, Romania. The contact between partners was initiated at a workshop 'Technology Assessment and Quality Improvement in Health Care' held in Csilleberg, Hungary.

Activities conducted by an initiative group consisting of representatives from the DPHM Romania in collaboration with the Canadian specialists (AHFMR and Institute of Health Economics Edmonton) were undertaken mainly through e-mail and telephone communication. Two seminars in HTA were held in Bucharest with the intention of bringing together health professionals and decision-makers at various levels within the Romanian health care system to hear presentations and to participate in discussions on the potential role of HTA. The main objectives of the seminars were to provide an introduction to fundamental issues, present methods used,

emphasise the potential role of HTA in the decision making process and discuss how existing HTA reports might be adapted to a local context. The College of Physicians from Bucharest and the DPHM organised both events.

The first seminar ran over two days in June 1999 for 19 participants. The second seminar for 70 participants in November 2000 was three days long, and included a round table discussion with decision makers on the necessity and value of developing a HTA function. Participants concluded that there was indeed a need to develop, promote and sustain HTA activity and to collaborate with HTA agencies from other countries, particularly those in central and eastern Europe.

A web page on HTA in Romanian developed in 2001, was posted on the Bucharest College of Physicians website (www.cmb.ro/hta/index.html). It presents a brief overview of HTA, a glossary of concepts and terms used, information about HTA agencies worldwide, links to other sites and Romanian initiatives in the field. Other communication channels used to spread information and to increase awareness about HTA included the presentation of papers at different local scientific meetings, workshops and conferences. Also, an introduction to HTA was included in an international summer school for decision makers in Romania in 2001.

A major step occurred in 2002 when basic aspects of HTA were included within the curriculum of continuing education courses and the Masters programme in public health and management at the Carol Davila university. Two introductory chapters to HTA were written for management books used for training postgraduate students in the public health and management programme. Achievements and results of studies developed and conducted in collaboration with the AHFMR were also presented at annual meetings of the International Society of Technology Assessment in Health Care [6–9] and at a scientific meeting in Bucharest in 2003.

Furthermore establishing links with agencies specialising in HTA such as AHFMR, the Institute for Health Economics in Edmonton, the Canadian Coordinating Office for Health Technology Assessment (CCOHTA), and the Catalan Agency for Health Technology Assessment helped facilitate access to valuable up-to-date information and training.

Table 1
MEMORANDUM'S OBJECTIVES

To establish a legal framework for HTA.

To examine the capacity for initiating HTA activities.

To nominate a HTA commission.

To create a national HTA web page.

To train personnel.

To develop national clinical practice guidelines.

Formalising HTA development

An important stage in the process of developing HTA in Romania was participation of the National Health Insurance House in 2002 in a project with the German Federal Association of the Regional Health Insurance Funds (AOK Bundesverband). The objective of this project was to create an organisational model to facilitate the implementation of Evidence Based Medicine and HTA activities in Romania.

As part of this project, a two-day seminar was held with decision-makers. All participants agreed on the usefulness of establishing a HTA Romanian committee characterised by high competence, transparency and unbiased activity. A report describing the necessary steps to establish the HTA committee and terms of reference was drafted. In November 2002, the Minister for Health and the Family, the President of the National Insurance House and President of the National College of Physicians signed a memorandum to establish HTA activity. This was an important and essential event because for the first time HTA was officially recognised and endorsed. The Memorandum's objectives are presented in Table 1.

Actionable steps and opinions on developing HTA

To better define the current situation and determine the next steps to take a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis was undertaken in 2002 and a survey conducted in collaboration with Canadian specialists. The SWOT analysis[8] followed a model previously applied.[10] The outcome of the SWOT analysis is presented in Table 2.

A discussion of these results yielded a set of action points that have the potential to establish national HTA activity (Table 3).

Survey findings

The survey questionnaire for middle level decision-makers in Romania was conducted in 2003[9] with the following objectives:

– To describe and evaluate the level of knowledge about HTA concepts and the interest in developing HTA in Romania.

– To identify factors (pros and cons) that might influence implementation of HTA.

– To determine the level of access of scientific information.

– To determine the potential for using scientific evidence in the decision-making process.

Table 2
SWOT ANALYSIS CONDUCTED IN ROMANIA, 2002

Strengths

Increasing interest expressed by different stakeholders (ministry, university, health insurance houses, physicians, etc).

"Initiative groups" skilled and committed, with contacts in the ministry, universities and at the college of physicians.

Important work done for raising awareness about HTA, and its necessity in Romania.

International contacts made.

External support obtained (potential financial support from the World Bank; agencies from Germany and Canada).

Infrastructure created for training (at the DPHM).

Links established within the HTA community.

Access provided to a good resource centre (university library) and internet.

Weakness

No legislative framework.

Poor communication between stakeholders.

Low decision-making transparency.

Limited awareness of HTA.

Inconsistency in following expert recommendations.

Poor data availability.

Limited number of information specialists.

Difficulties in accessing published information, the internet and other data sources.

No needs assessment done.

Opportunities

Decentralisation.

Health reform initiated, still in transition.

Limited resources (argument for developing HTA).

Bring together multiple stakeholders.

Academic growth (training in research methods).

Ongoing development of health technologies worldwide.

Increased demand for acquisition and provision of better and newer health technology in Romania.

Demand for more transparent decision-making.

Good timing (international support; World Bank Health and PHARE Projects; European network).

Threats

Lack of funding.

Financial disincentives.

Attitudes of decision-makers (bureaucracy).

Complexity of the local context and decision-making process.

No broadly accepted priorities in health policy.

Table 3
ACTIONABLE STEPS

Develop a proposal for a HTA body and pursue potential funding sources.

Continue to raise awareness about and increase interest in HTA.

Initiate training of a core group in research methods.

Initiate HTA activity.

Develop a system to analyse needs for health technology and inform decisions about future investments.

Join international networks.

A list of 18 open-ended and closed questions was sent to a convenience sample of 85 individuals. Respondents included medical doctors, economists, managers and students from the Masters and continuing education programmes. Of the 85 questionnaires sent out, 63 were returned, a response rate of 74%.

One question asked about sources of information used in the process of decision making. 65% of respondents declared that they had easy access to research information and 75% stated that they applied scientific evidence to the decision-making process. The main sources of information were scientific journals, books and information received from colleagues working in the same institution. Few stated that they used national clinical guidelines primarily because they were just being developed.

"Successful implementation of HTA at the national level depends on political, financial and educational support"

Respondents declared that they learned about HTA from different sources: HTA seminars (44%), individual study (36%) or from colleagues (10%). Even so, only 63% reported that they had detailed knowledge about the concepts and methods applied in HTA. 10% of respondents heard about HTA for the first time on receiving the questionnaire.

To determine participants' opinions on the utility of HTA in Romania, a five-point Likert-type scale was developed. Opinions ranged from 1 (strongly disagree) to 5 (strongly agree). From all respondents 57% strongly agreed that HTA is useful for the decision-making process. Almost all (98%) considered it would be an opportune time to begin HTA in Romania. These responses provided a positive insight that past activities were indeed fruitful. Respondents also identified factors that might influence HTA implementation in Romania, among these financial, political and educational support were identified as being most important.

Among the advantages for using HTA in the decision-making process, respondents listed improving efficiency in resource allocation, increasing effectiveness and quality of services and making informed decisions. As disadvantages respondents identified the lack of financial resources and political interest, absence of criteria for decision-making, and few experts trained in the field of HTA. These questionnaire responses were similar to those identified during the SWOT analysis.

Lessons learned and future action
The experience gained throughout this process of developing a HTA initiative demonstrates that the success in implementing HTA activity at a national level depends on key factors such as political, financial and educational support. Due to a lack of financial and political support, the HTA initiative group that emerged from the university level focused their activities mainly on presenting information about HTA and creating a forum for discussion of its utility for the decision-making process in Romania. Information about HTA was provided to different categories of professionals and decision-makers. These efforts were successful in creating and increasing awareness of HTA in Romania. Currently, HTA is recognised as a useful tool by decision-makers and there is a need to establish a mechanism that could regularly and systematically support its use in the decision-making processes.

The activities initiated within the collaborative project with German colleagues received financial support from the European Union and was able to command the attention of senior decision-makers who subsequently provided political support through the memorandum.

In the near future, there is still a need to identify a champion that can help take these initiatives a further step forward and help actions for HTA obtain the necessary political and financial support. Activities aimed at promoting HTA to health care and policy decision-makers at various levels are important and must be maintained.

HTA activities must continue to be supported and nurtured in order to maintain the existing momentum, as well as to generate greater awareness and interest. These should focus on using existing HTA reports, generated and published by other HTA agencies that could be of immediate assistance to decision-makers in Romania. The overall findings from HTA studies performed in other countries may also be applied to Romania. However, some issues remain country-specific and must be addressed separately. There is also a need for training of a core of specialists in evaluation methods and in the process of developing reports for a successful commencement of HTA.

REFERENCES

1. European Observatory on Health Care Systems. *HiT summary: Romania.* WHO Regional Office for Europe, 2002.

2. Stevens A, Milne R, Burls A. Health

technology assessment: history and demand. *Journal of Public Health Medicine.* 2003;25(2):98–101.

3. Menon D, Fung F, Harstall C, O'Connell P. The development of a health technology assessment program. The case of Alberta. *International Journal of Technological Assessment in Health Care* 1995;11(1):93–101.

4. Juzwishin D, Olmstead D, Menon D. Hospital-based technology assessment programmes: two Canadian examples. *World Hospital Health Services* 1996;32(2):2–9.

5. Hailey D. Health care technology in Australia. *Health Policy* 1994 Oct-Dec;30(1–3):23–72.

6. Corabian P, Moga C. *Mentoring a developing Health Technology Assessment initiative in Romania.* Oral presentation. 16th Annual Meeting of The International Society of Technology Assessment in Health Care, Hague, June 2000.

7. Moga C. *The Process of Implementing Health Technology Assessment in Romania.* Panel session. 18th Annual Meeting of The International Society of Technology Assessment in Health Care, Berlin, June 2002.

8. Moga C, Corabian P, Enachescu D, Juzwishin D. *SWOT Analysis and Priority Setting Identified Actionable Steps to be Used in Implementing Health Technology Assessment (HTA) in Romania.* Oral presentation. 18th Annual Meeting of The International Society of Technology Assessment in Health Care, Berlin, June 2002.

9. Moga C, Corabian P, Enachescu D. *Health Technology Assessment in Romania.* Oral presentation. 19th Annual Meeting of The International Society of Technology

Assessment in Health Care, Canmore, 22-25 June 2003.

10. Gibis B, Justo A, Corabian P, Meiesaar K, Koppel A, Jacobs P, Serrano P, Menon D. Application of strengths, weaknesses, opportunities and threats analysis in the development of a technology assessment program. *Health Policy* 2001; 58: 27–35.

Health Technology Assessment International Annual Meeting 2004

Krakow University of Economics, Krakow, Poland, May 30 – June 2, 2004

This meeting will tackle the key questions of assessing quality, effectiveness, and appropriateness of not only medical devices, equipment, and pharmaceuticals, but all procedures and processes for prevention, treatment and rehabilitation, as well as assessments in the public health context and in regard to systems and organisational issues. Three plenary sessions featuring internationally recognised speakers will deal with:

• Assessments in policy and practice

• Assessing quality and cost-effectiveness of clinical services

• Effective management and organisation of health services

For more information on the conference, on-line registration and an opportunity to submit abstracts (closing date 15th February) is available at www.htai2004.pconcept.com

European Health Forum Gastein 2003:

Health and Wealth

Mike Sedgley

"it would be ironic if longer life expectancy was now only seen as a burden"

Conference Report

A challenge to European health and welfare systems

Fundamental factors are driving change in the nature of health and the delivery of healthcare to European citizens. An unprecedented demographic shift is occurring: the population of Europe is ageing rapidly with dire predictions of a falling population in many countries and of a volte-face in the ratio between the productive and the retired populations during this century. This presents a basic challenge to the health and welfare systems that have been constructed in Europe since the second world war. These systems are further challenged by globalisation: not only is the global economy increasingly competitive but also some of its features present specific challenges to Europe's broadly 'social model' of the market economy. There is a global interaction of tax and welfare systems, with the movement of people and especially capital across borders being more fluid than ever before. An excessive tax burden threatens to drive out business and the rich, while welfare systems have the potential to attract those from poorer countries. Furthermore, the 'information revolution' is underpinning a new 'consumerism', challenging established economic and social relationships, not least in the area of health care.

It seems that the timing is not auspicious. As Europe's economy has faltered and solutions to raise competitiveness and growth are sought, it faces a simultaneous demographic threat. There is at times a pervasive feeling of an aged and sclerotic Europe facing a more dynamic America and a younger, emerging and developing world beyond, as jobs migrate to India,

China and South-East Asia. More than in any other area of policy, health and welfare represent the coming together of these various challenges and enable us to focus 'holistically' on their likely solution.

Within Europe there is a more local development, EU enlargement, that will have important implications over the next few years. The enlargement process has been a difficult and painstaking task, not least for the prospective member states. In the area of health, significant inequalities exist between the current members and the accession states and there are worries about the possibility of a brain drain in this crucial area.

Within this context, the European Health Forum at Gastein sought to address the question of "Health and Wealth: The Economic and Social Dimensions of Health". As Commissioner David Byrne concluded at the conference, "Health is a productive economic factor in terms of employment, innovation and economic growth. …the long term health of the European economy will depend on the health and longevity of its citizens." This, Byrne said, was the conundrum of health policy: it is so often seen as a financial burden and a drain on current expenditure, and not sufficiently trumpeted as a long-term investment in human capital. This article gives an overview of the proceedings and the main areas of debate on two of the principal topics covered at Gastein: Healthy Ageing and Pharmaceutical Policies.

An ageing Europe

The prognosis for Europe's population is stark. Some countries face a particular challenge: Italy and Germany can look forward to significant reductions in their present population while only the UK and France

Mike Sedgley is a health and pharmaceutical policy consultant.
E-mail: m.d.sedgley@lse.ac.uk

appear to have stable or even slightly rising populations over the coming forty years. Smaller populations do not present problems in themselves but the transition implies a period of harsh adjustment in the context of a 'generational contract' for the working populations that fund the retirement of the elderly. With life expectancy rising, the calculations on which present welfare states are constructed simply do not add up.

Pension arrangements throughout Europe are not adequate to fund the rising number of retired people. The retirement age is a key factor in solving this anomaly. Current retirement ages were set when life expectancy was but a few years beyond, and it is now clear that significant rises in the age of retirement and/or pension eligibility will be necessary to both contain pension costs and raise the amount of time that many people spend as productive employees. An increase in the average retirement age is unavoidable. Philip Berman, Director of the European Health Management Association, noted, as rapporteur for the Healthy Ageing forum, that Europe has the lowest number of people over 65 in the workforce, among the developed countries.

Care arrangements

Pension funding in itself is not the only issue facing an ageing Europe. Professor Axel Borsh-Supan, Director of the Mannheim Research Institute for the Economics of Ageing, commented that the nature of living arrangements and social networks was a key issue. As people live longer, it will be more important to examine the social structures of life. Dr Hans Stein, German representative on many EU health committees over the years, noted how the present care of the elderly across Europe is inadequate. Indeed, discussion of the care of the elderly was particularly poignant given the large number of deaths that occurred during the summer heat wave and the continuing stories about sub-standard care of the elderly in many European countries.

The degree of uncertainty in both the extent and nature of the demographic challenge, as well on how to meet it, were emphasised by several participants. Three basic questions were raised: who cares, who pays and who decides? Central to these questions put by Dr Henk Nies, Director of the Netherlands Institute for Care and Welfare, was the interplay of different types of care, which is likely to be a

more salient issue as large numbers of older people require various types and degrees of social and welfare assistance. Informal care is likely to increase in this context, raising questions about the relationship between professionals and informal carers.

There will be a defining political dimension to an ageing society as well: 'grey power', noted Berman, will influence political decision making. Crucially, this is a reason for Europe to face the pension debate as soon as possible because significant policy changes will only become more difficult as growing numbers of people perceive pension reforms to directly affect them in the short term.

Accentuating the positive

In addressing these problems, the Healthy Ageing debate focused not only on the negative and the challenges to be overcome; many also stressed the positive aspects of an older society. Indeed it would be ironic if the longer life expectancies now being experienced in the western world, which mark a great success in public health and health care, were seen only as a burden, as the organiser of the programme, Dr Stein observed. There is some evidence that for health care, an ageing society does not in itself imply exploding costs: research to date indicates that the largest part of an individual's health care burden is expended in the final year or so of his or her life, regardless of age.

Moreover, as the riddle of pension funding is approached, potential solutions present great opportunities. Current approaches to retirement tend to envisage work purely as a negative, embedded in assumptions forged in an industrial society. Raising the pensionable age is not only about making people work longer, but enabling them to do so. It is likely that the stark choice between work and retirement will erode and many people will freely choose to continue some work long after 65 and not because of penury. The negative side of standard retirement was highlighted, as many people suffer from a feeling of uselessness when they retire suddenly. A transition between full time work and full time retirement is likely to emerge for large numbers of people. Improved health and the changing economy mean that the extra years people can expect now to live will be 'young years', not aged ones, shifting the ground rules of the 'generational contract'.

Health as an investment

Quality of life, and its relationship to the

"An uneasy yet potentially fruitful relationship exists between the health and industrial dimensions of pharmaceutical policy"

economy, was a constant theme of the debate. Peggy Maguire, Director General of the European Institute of Women's Health, noted that opening up access to education and training can improve the quality of older people's lives. Dr Patricia Barry, Executive Director of the Merck Institute of Ageing and Health, said that the aim of health care and medicine should be to enable older people to thrive, and that health promotion was a major factor in succeeding to do so. She concurred that a longer life span could be spent in good health.

Across health and welfare policies, there was a perceived need to make health an investment rather than a cost, with demographic changes providing the impetus. There was also a broad consensus that insufficient research has been undertaken to fully understand the nature and extent of the challenges faced by an ageing society.

"advances in treatment imply a greater need for informed patient cooperation"

Pharmaceutical policy

Many of the issues facing Europe impinged on the debate over pharmaceutical policies. Demographic change, the 'information revolution' (the advent of the internet and more informed patients and consumers), and technological advances are placing ever greater pressure on existing pharmaceutical budgets. The conference discussed the issues of legislation, innovation, access to medicines and the doctor-patient relationship in this context.

The interplay of health and the wider performance of the European economy can be seen most starkly in the area of pharmaceuticals. An uneasy yet potentially fruitful relationship exists between the health and industrial dimensions of pharmaceutical policy. A chief concern for Europe is in fact industrial: pharmaceutical investment has declined in European countries while it has ballooned in the United States. This is significant not only because the delivery of innovative medicines is important in itself but because the pharmaceutical industry is one of the most research intensive of all industries, providing high value jobs and contributing greatly to the science base. The fate of the pharmaceutical industry will have implications for some aspects of the 'Lisbon Agenda', the aims of which already look like an insurmountable mountain. Although pharmaceuticals and biotechnology are not, perhaps surprisingly, explicit benchmarking industries for the Lisbon Agenda, they represent some of the most cutting-edge, high-tech and high value added of all industries. Europe can-

not be a modern economy without them.

The complex industrial and health policy concerns of European governments, industry, health professionals and the Commission have been examined in depth by the G10 group under the auspices of Commissioners Byrne and Liikanen. Aside from research and development (R&D) investment and output, a particular concern has been the prospect of enlargement and the greater parallel trade of pharmaceutical goods, where traders take advantage of higher prices in some countries to export from lower priced ones. With pharmaceutical pricing intimately connected to national health systems, this anomaly of the single market has the potential to undermine national health systems.

Innovation

The state of the European pharmaceutical industry focused on the rising investment in R&D in the US and its decline in Europe. Yet the connection between R&D and the delivery to market of innovative medicines produced a debate about how innovative new medicines really are. Dr Kees de Joncheree from the WHO Regional Office for Europe said that surveys indicate only around 15% of new medicines are genuinely innovative. James Copping, responsible for pharmaceutical competitiveness in DG Enterprise, noted that some European countries currently test for the cost effectiveness of medicines and thereby judge relative effectiveness to some degree; other countries do not and there is no EU-wide system for making these assessments. He saw this as one of the big issues for the coming year, along with the debate about patient information, as well as pricing and reimbursement systems organised at the national level. Clearly, better measures, not to mention better clarity of definitions, are needed if the debate is to progress towards politically useful conclusions.

Silvio Garattini from the European Medicines Evaluation Agency (EMEA), outlined a working definition of genuine innovation: increased effectiveness; elimination of treatment-limiting reactions; increased compliance by the patient (through, for example, ease of use); and increased safety. Without some assessment of therapeutic value, he suggested, the current assessments of quality, safety and efficacy would not guarantee improved medicines. Nevertheless, of course, therapeutic value and cost effectiveness are very different; whatever the judgements of the

former, those on the later will always be subjective.

Bernie Merkel, head of the unit for public health policy at DG Health and Consumer Protection, noted that there had been a reduction in Europe in the number of genuinely innovative medicines reaching fruition. Jeff Sturchio of Merck & Co. Inc. noted that innovation of medicines over the past two to three decades has shown definite cyclical tendencies, with peaks and troughs, and that there was nothing fundamental about the reduction in the number of new medicines in recent years. Rather, the advent of biotechnology was creating unprecedented opportunities for treating and curing disease over the coming years. Dominique Limet from GlaxoSmithKline noted that the bottleneck in bringing new drugs to market now was not at the level of drug development but instead related to clinical development, and that the relationship with hospitals was therefore key to improving this situation.

A more important immediate issue, Dr Sturchio argued, was the uneven access to medicines across Europe, with truly innovative medicines not being quickly available to patients who could benefit from them. A recent report by Europe Economics shows a two-year differential between EU countries on the time it takes for new medicines to reach patients. [1]

The role of patients

The role of the patient, both through access to medicines and availability of information, was a central subject and continuing theme of the pharmaceutical forum. Professor Don Detmer of Cambridge University's Judge Institute of Management spoke about their Informed Patient Project and noted that the changes taking place in the relationship between doctors and patients were driven not only by a less deferential public but also by demographic change: an ageing population implies more chronic disease, where doctor-patient interaction is on-going. Furthermore, advances in treatments mean they are more complex, also implying a greater need for informed patient co-operation.

There was a consensus on the need for a less deferential doctor-patient relationship. Dr Sir Alexander Macara, physician and chairman of the UK National Heart Forum, suggested that doctors needed to become "gate openers" rather than gate keepers. He said empowered patients did not imply disempowered doctors. It was a partnership and both could benefit from better informed and more proactive patients. Indeed, compliance with treatments and drug regimens could be improved by having more active patients involved in decisions about treatment. He suggested that the nature of professionalism was in a state of profound change. Albert van der Zeijden, chairman of the International Alliance of Patients' Organisations, said that social class had underpinned the nature of doctor-patient relationships, as doctors were seen as another class.

Information for patients

Information to patients is an ongoing debate within Europe, where advertising by pharmaceutical companies directly to patients is not permitted. The benefits and drawbacks of direct-to-consumer advertising (DCTA) have been discussed in the G10 process. Dr Merkel noted that the European Parliament and Council have rejected the notion of direct information to patients from pharmaceutical companies and that non-legislative solutions now have to be found. Several participants suggested that a distinction between information and advertising was needed if improved information and access to it by patients was to be achieved. Dr Macara proposed that the Commission should take on this task, involving patients, health care professionals and the pharmaceutical industry. Professor Detmer said all information, from whatever source, had a potential bias and that collaboration among different groups and interests was the best way forward. Tamsin Rose, General Secretary of the European Public Health Alliance noted that patients needed to be informed before they get to the stage of visiting a doctor: accessing the health care system requires from the outset skilled and proactive patients.

There was a broad acceptance of the potential for a win-win scenario with more informed patients. Albert van der Zeijden noted that compliance with drug regimens was often lax, with less than half of all medications being used in the way they are prescribed. The potential for gain for all parties from improving this is clearly great. Mr van der Zeijden warned, however, that there is a significant gap between what patients want to know about their condition and what doctors think they want to know.

Certainly it seems that with the widespread use of the internet for health information,

"there is a role for patients, medical professionals and the pharmaceutical industry in creating frameworks for improved communication with the public"

and its availability across jurisdictions, a 'ban' on any type of information risks becoming anachronistic. Pharmaceutical representatives noted how difficult it was to distribute any information about pharmaceutical products in Europe. Professor David Taylor of the London School of Pharmacy, and rapporteur for the forum, questioned what information from industry those who oppose DCTA were afraid of. He also noted that for industry, their relationship with doctors was fundamental and that industry would not wish to pursue a course with which doctors were not content. Lissette Tiddens, Secretary General of the Standing Committee of European Doctors, said that there was a need to offer patients an alternative to some of the information on the internet. Another comment made was that the debate was somewhat back to front: the important issue was that patients have a *right* to information, there can then be a debate about the quality of the information available.

This debate on patient information cannot only be based on abstract principles but must be founded pragmatically on, as Henry Kissenger would say, the situation on the ground. Policy makers risk attempting to hold back the tide if this is not recognised. Information is now clearly widely available across borders and from a plethora of organisations. The use of the internet for health information is widespread and growing. The question, then, is how to ensure that correct and useful information is available to the public and patients. We should also avoid judging this new availability of information on the basis of old assumptions about its usability: the information society itself is likely to improve people's ability to judge and use information of all kinds. Professor Taylor suggested that societies with free-flowing information work better in general. What seems clear is that there is a role for patients, medical professionals and the pharmaceutical industry in creating frameworks for improved communication with the public.

Conclusions

The challenges that Europeans face in health policy are substantial. The debates at Gastein showed that the real common challenge is how to create win-win solutions. An ageing society is first and foremost a great success. Enabling people to live fulfilling lives well beyond retirement age is an important part of the solution to the pension crisis; investing in health is in turn a part of achieving this. In pharmaceutical policy, many of the conundrums identified can again underpin a situation where all parties gain: a balanced doctor-patient relationship not only recognises a changed social attitude to professionalism but can enable greater compliance with treatments and improved health outcomes. Meanwhile, the industrial dimension of pharmaceutical policy can contribute to Europe's Lisbon ambition of becoming the most dynamic knowledge-based economy in the world, while providing the sorts of innovative treatments that an older and active population will require.

Commissioner Byrne summed up the link between health and wealth, and the win-win situation that it is within the power of Europe to bring about: "I believe that the next generation of European citizens should have a new health birthright. Their new European birthright should ensure equal access to a longer, healthier and more productive life." There is also clearly a major role for public health policy here to engage Europe's citizens in their own health: the issues of diet, tobacco and physical activity will all be central to a healthy ageing society and success here will also demand an informed and proactive population. As ragtime pioneer Eubie Blake said on his 100th birthday, "If I'd known I was gonna live this long, I'd have taken better care of myself."

The EUROPEAN HEALTH FORUM GASTEIN (EHFG)
was founded in 1998 as a European health policy conference with the aim of providing a platform for discussion for the various stakeholders in the field of public health and health care.

The EHFG has become an unique annual event, bringing together experts, interest groups, politicians and decision-makers representing politics and administration; patients and consumers; business and industry as well as science and academia to debate key health issues.

Integrating various national, regional and European perspectives the Forum facilitates the exchange of views and experience amongst key actors and experts from the 15 EU countries, but also from the rest of the 51 countries of the WHO European region, in particular the EEA countries and the EU candidate countries.

Website: www.ehfg.org
For information, email: info@ehfg.org"

REFERENCES

1. Europe Economics. *Patient Access to to Major Pharmaceutical Products in EU Member States.* December 1998.

Remote consultation by telemedicine

Viability and organisational consequences

I H Monrad Aas

"The structure of work is changing with the introduction of telemedicine"

Telemedicine may be defined as the use of telecommunications in health care. This new development permits remote consultation. In remote consultation images and sound are transmitted live, and a common application of the technology is for specialist consultation. This may occur, for example, between primary care, home health care, nursing homes, local and university hospitals, as well as with ships at sea. Remote consultations actually involve many disciplines, for instance, dermatology, psychiatry, otolaryngology, surgery (guidance during surgery), gastroenterology (endoscopic examination), ophthalmology, geriatrics, acute medicine, and rehabilitation.

In the last decade telemedicine has been at an early stage of development, but in future the technology will be widespread, either using mobile technology or fixed installations. Furthermore the volume of use may become much higher than today, begging the important question of how well remote consultations then function. In Norway interest in telemedicine has been great and several applications are in use, making analysis possible. The analysis in this article is based upon seven empirical studies of four applications of telemedicine that have previously been published.[1–7] These applications to teledermatology, telepsychiatry, remote frozen-section pathology, and teleotolaryngology provide four very different types of remote consultation.

Cooperation

Cooperation, the process of working with one or more individuals for a common purpose,[7] via telecommunication is a new form of medical cooperation. Whether such cooperation works poorly or well will be important given the increasing use of telemedicine. In these four applications the specialist consulted plays an important role, but personnel elsewhere in the network (for example general practitioners) are also active.[7] Cooperation in general does not necessarily work well and telemedical cooperation often occurs across organisational boundaries, which may cause significant problems.[2] The general impression from the empirical studies is that communication technologies do not seem to present a barrier to cooperation and that in practice cooperation can work well. No severe problems were observed but some factors that may play a role are: personality, personal knowledge of participants, level of preparation and experience.

When two-thirds of the respondents cannot suggest anything that might improve teamwork, this may underline the fact that cooperation works well. Cooperation in telemedicine may work well where the technology allowing procedures and roles can be very similar to those in everyday medical work. Therefore during telemedicine meetings, with several participants, it may be important though to have a chairperson and an ordered list of speakers.

When participants frequently engage in external activity, one question is whether this has a detrimental effect on their relationships and working arrangements with colleagues within their own organisations. However the converse seems to apply, where there is an effect this seems to be of increased cooperation, which may be connected to the notion of providing information to others and the reduced need to travel. Internal relationships also seemed to benefit although this effect was only slight.

I H Monrad Aas is based at the Work Research Institute, Oslo, Norway.
Email: maa@afi-wri.no

"Working by telemedicine results in learning""

Organisational consequences

The potential organisational consequences of telemedicine are frequently mentioned within the scientific community but there are few empirical studies. There are a number of organisational consequences, each of which will be looked at below, most notably:

– Permitting distance working.

– Impacts on other staff.

– Formation of new organisational units.

– Minor staffing changes.

– Revised mechanisms for internal cooperation.

– Changes in working arrangements.

– Limited opposition to telemedicine.

– Impact on the distribution of tasks between different care sectors.

Telemedicine permits practical distance working. One local hospital employed a psychiatrist who lived 2,500km away, and his private practice functioned as a satellite office of the psychiatric outpatient clinic, allowing him to provide support and guidance in clinical matters, undertake remote consultations and participate in administration.

The consequences for other staff not directly involved in telemedicine are similar. They may perform tasks which without colleagues working with telemedicine would have been impossible. It is also true that staff working in telemedicine therefore can share their experience with others.

New organisational units may be established, for instance one hospital, which did employ a dermatologist, was able to set up a more complete dermatology department, following the establishment of a UV treatment unit. The need for patients to travel to receive treatment was also reduced. Elsewhere two psychiatric outpatient clinics could be merged, with one manager for both, and there is a prospect in future of a system of satellite clinics under common management.

Administration can also be more flexible as the scope for videoconferencing increases. Such an organisation does not need to have any geographical boundaries; it is only constrained by the limits of its telecommunication infrastructure. Telemedicine cannot claim to reduce the costs of healthcare through reduced staffing, but equally few new posts are created. Only two of the 13 organisations examined employed additional staff. In one instance for teledermatology it was necessary to employ a nurse

"Health policy needs to take account of remote consultation and telemedicine"

and secretary following the acquisition of UV treatment.

Revised mechanisms for internal coordination may be required, for instance in pathology departments to manage the frozen telepathology section. The simplest way initially of doing this was to allocate responsibility to a few of the department's pathologists. A more encompassing solution was to establish a weekly rotating duty roster, among the department's pathologists. As many people will be involved with this service both in the pathology department and at local hospitals, it can also be prudent to provide written instructions with specific responsibilities and telephone contact numbers.

Changes in work processes were the most common organisational change, with 77% of respondents indicating this. Remote frozen section pathology requires a completely new process of work at local hospitals and external cooperation becomes more important. In respect of telepsychiatry patients may receive follow up within their own localities, and travel to psychiatric facilities is therefore significantly reduced. Multidisciplinary psychiatric team meetings, including social care workers, employment authorities, GPs, local psychiatric nurses and psychiatrists may also be easier to arrange. Clinical teamwork may become independent of location.

The distribution of tasks between different levels and sectors of care also is not heavily affected by the use of telemedicine.[6] However one example where some impact was observed was in telepsychiatry where learning may stimulate GPs to make more diagnoses of patients, and follow them up after discharge.

Changes in the working situation and environment

With the introduction of telemedicine, the structure of work is changed by adding a new task, but little has been known about how this affects the working situation and environment.[4] The studies show that telemedicine has positive aspects such as reduced travel, freeing up of time for other work or establishing new contacts, engendering an increased feeling of safety with easily access to professional support, as well as the satisfaction gained from seeing the people that one is working with. However working with telemedicine is tiring and may also be stressful, as sessions require continuous attention on a screen. Moreover individuals in other organisa-

tions will be dependent on an individual's performance, and the presence of patients reduces autonomy.

The problems may be resolved by limiting telemedicine activity per employee. The maximum volume may be, for example in psychiatry, one day and in dermatology half a day per week. In future, as the use of telemedicine increases, health care managers may have to involve themselves in ensuring that such activities are assigned to several employees. For areas such as dermatology and otolaryngology this raises doubts over the future vision of large telemedicine clinics where many specialists work full time. This may mean that the number of hours per week working with telemedicine for each individual may be too high, and careful planning of the working day will be required ensuring that there are several fixed breaks.

Scope for learning

In the information society learning is an important activity, with talk about learning organisations, a learning society and building up human capital. For the health service dissemination of knowledge may be important for improved patient care, but life long learning is not the product of a health care education.

There is no doubt that working with telemedicine results in learning.[5] Four out of five respondents indicate that they have learnt something new, most frequently improving knowledge of their discipline. They may also learn about other things such as technology and cooperation. This learning applies to many categories of personnel, including GPs, nurses and psychologists. Even specialists may comment that they have reflected on the difference in work settings.

Although learning does not necessarily result in the extension of general work roles, some staff indicated that this was the case. Clinical learning may also lead to more seamless care, for instance when a follow up can be done by telepsychiatry, patients can be discharged to their local community sooner, which may improve their quality of life.

In future many applications of telemedicine may be implemented in the health service, and distance education may play a greater role. The workplace may become an important arena for learning, and a greater focus on this may be needed. Management to promote the intellectual capital of the organisation may include a steering of employee relationships to promote knowledge sharing and to develop a learning organisation culture and infrastructure. Hierarchical organisations in health care may though present a hurdle to the flow of knowledge, one solution may be greater decentralisation.[8]

The process

Remote consultation uniquely allows a simultaneous flow of services between different organisations. It is plausible that further analysis of the way in which remote consultations are conducted may require more organisational change. Initial evaluation has shown that this process works well.[7] No major reorganisation seems to be necessary for the production process of remote consultations. Managers in organisations planning telemedicine activity do not need to brief staff about goal formulation or the contents of remote consultations. For the individual health care worker remote consultation does not require any more preparation than for an ordinary consultation. Proposals for improvements though do include a desire to have a technician readily available, and improved booking systems.

Conclusions

In a series of papers remote consultation by telemedicine have been analysed from different angles and no major problems have been identified. Its use implies no major cooperation problems, the production process works well, negative effects on the working situation can be tackled, and personnel involved can learn much from working with telemedicine. It does though have consequences for the way in which organisations function.

Remote consultation can thus be classified as viable, and there is little reason to refrain from its use. Health policies need to be adapted to take account of remote consultation and telemedicine in general. This includes legislation where responsibility can be clarified without hampering the practice of telemedicine, while financing methods should ensure that all stakeholders are reimbursed. The administrative and organisational structure of health care systems within countries may also need to be adapted towards a more market oriented approach.

REFERENCES

1. Aas I H M. Working with telemedicine: User characteristics and attitudes. *Journal of Telemedicine and Telecare* 2000;6 (Suppl 1):66–76.

2. Aas I H M. Telemedical work and cooperation. *Journal of Telemedicine and Telecare* 2001;7:212–18.

3. Aas I H M. A qualitative study of the organisational consequences of telemedicine. *Journal of Telemedicine and Telecare* 2001;7:18–26.

4. Aas I H M. Changes in the job situation due to telemedicine. *Journal of Telemedicine and Telecare* 2002;8:41–47.

5. Aas I H M. Learning in organisations working with telemedicine. *Journal of Telemedicine and Telecare* 2002;8:107–11.

6. Aas I H M. Telemedicine and changes in the distribution of tasks between levels of care. *Journal of Telemedicine and Telecare* 2002;8(Suppl 2):1–2.

7. Aas I H M. Organising for remote consultations in health care - The production process. *Behaviour & Information Technology* 2003;22:91–100.

8. Aas I H M. Telemedicine and the organisation of the health sector. *Journal of Telemedicine and Telecare* 1999;5(Suppl 1):26–8.

9. Aas I H M. Organisational change: decentralisation in hospitals. *International Journal of Health Planning and Management* 1997;12:103–14.

NEW PUBLICATIONS

Eurohealth aims to provide information on new publications that may be of interest to readers. Contact David McDaid d.mcdaid@lse.ac.uk if you wish to submit a publication for potential inclusion in a future issue.

Equity in Health and Healthcare: Views from Ethics, Economics and Political Science

Edited by Adam Oliver

Nuffield Trust, 2003

ISBN 1-902089-93-6

70 pages.

Freely available online at www.nuffieldtrust.org.uk/ policy_themes/docs/ equityinhealth.pdf

The latest collection of papers from the Health Equity Network examines equity in health or health care from different disciplinary perspectives: ethics; economics; and political science. Primary papers were prepared and then commented on by peers from the other two disciplines. In his introduction to this publication chair of the HEN network, Adam Oliver, notes that whilst the remit was broad many of the papers directly or indirectly consider the notion of patient choice. Choice he notes "in a resource constrained system can have both good and bad implications…for many [in society] allowing more choice may seem less attractive if such a policy ultimately harms those who are [already] worst off." Tom Sorrell argues that while much reasonable patient choice has not been accounted for in the NHS, this does not mean that all patient choices should be met in a resource constrained system. Simon Stevens writing from a policy-making perspective argued that subject to some caveats more choice does not inevitably lead to more inequity, and that there is scope for the NHS both to increase patient choice and improve equity.

Contents: Introduction, Adam Oliver; Health care provision and public morality, Tom Sorrell; A comment on Sorrell's paper from a political science perspective, Stephen Harrison; A comment on Sorrell's paper from an economics perspective, Alan Williams; From pawn to queen: an economics perspective, Julian Le Grand; A comment on Le Grand's paper from an ethics perspective, Alastair Campbell; A comment on Le Grand's paper from a political science perspective, Rudolf Klein; Democratic values, public consultation and health priorities, Albert Weale; A comment on Weale's paper from an ethics perspective, Raanan Gillon; A comment on Weale's paper from an economics perspective, Hugh Gravelle; Equity and choice: can the NHS offer both? A policy perspective, Simon Stevens.

Unhealthy State. Anatomy of a Sick Society

Maev-Ann Wren

New Island, 2003

ISBN 1-902602-88-9

445 pages.

Paperback €17.99

The Irish Government has recently announced a package of reforms intended to increase the fairness and effectiveness of the health care system. This follows the publication of several extensive reports highlighting areas for improvement in the current structure. Such discussions are not new, the health care system has been the subject of constant debate. In 2000 journalist, Maev-Ann Wren, wrote a series of articles for the *Irish Times* entitled 'An Unhealthy State' examining the workings of the Irish system, highlighting limitations and inequities in its operation, and comparing this to approaches adopted internationally. This book builds on that series, providing a detailed discussion of the politics of the health care system in Ireland from the 1940s to the present day. It includes a discussion of why Ireland did not adopt an NHS model after the Second World War, examines the relationship between the medical professions and the State and looks at the important role played by the Catholic Church in shaping the health care system over the last sixty years. It concludes by considering how international experience can be used to aid a process of change in Ireland.

Contents: Health in an unhealthy State; Defeat of the early reformers; Evolution of an unhealthy State; A failed System; Options for reform; A healthier state.

The Future of Health – Health of the Future

Edited by Keith Barnard

Nuffield Trust, 2003

ISBN 1-902089-89-8

195 pages.

Available online at www.euro.who.int/ document/E81516.pdf

The Fourth European Consultation on Future Trends, held in London in December 1999, hosted by the Nuffield Trust and the WHO Regional Office for Europe, considered the prospects for implementing the HEALTH21 policy framework. It explored the future environment of health in Europe and anticipated future problems and opportunities. This event built on previous work under the auspices of the Nuffield Trust looking at "Policy futures for the UK". This volume provides an extensive account of the London meeting, together with a section on the international context: Cristina Puentes-Markides describes the experience in the Americas; and Morton Warner looks at lessons from attempts to improve public health in Wales. The volume also includes a paper by Graham Lister mapping out a possible scenario for health in Europe in 2020 and concludes by flagging up a series of issues for further reflection.

Contents include: Using futures in the policy process; Health 21 – a future orientated policy framework for Europe; Future of Europe in light of geopolitical and economic developments; People, alliance and partnerships; Work and health; Equal opportunity; Preparing for change/implementing Health 21; Lessons from the Americas; Lessons from Wales; Looking forward: combining clinical and public health knowledge; Using research and evidence in moving ahead; A scenario for health and care in the European Union of 2020.

WEBwatch

European Network for Workplace Health Promotion

www.enwhp.org

Set up in 1996 to promote good practice in workplace health promotion, this is an informal network of national occupational health and safety institutes, public health, health promotion and statutory social insurance institutions. It aims through the efforts of all its members and partners to contribute to the improvement of workplace health and well-being and to reducing the impact of work-related ill health. The network has developed good practice criteria for workplace health promotion, and the website includes models of good practice by country and also by type of organisation. It also provides information on the benefits of investing in workplace health promotion from both the perspective of business and that of health care payers.

European Heart Network (EHN)

www.ehnheart.org

Based in Brussels, the EHN is an alliance of 29 member organisations including heart foundations and other non-governmental heart health organisations in Europe. Its mission is to play a leading role through networking, collaboration and advocacy in the prevention and reduction of cardiovascular disease (CVD) so that it will no longer be a major cause of premature death and disability throughout Europe. The site contains publications and information on expert groups related to heart health, nutrition, physical activity, tobacco and psycho-social factors. It also publishes a newsletter Heart Matters, and summary information on CVD statistics.

EU Bone and Joint Decade

www.boneandjoint-decade.org

Launched in January 2000, its goal is to improve the health-related quality of life for people with musculoskeletal disorders throughout the world. These disorders can have severe health consequences causing severe long-term pain and physical disability, affecting hundreds of millions of people. The Decade aims to raise awareness and promote positive actions to combat the suffering and costs to society associated with disorders such as joint diseases, osteoporosis, spinal disorders, severe trauma to the extremities and crippling diseases and deformities in children. Information on activities, and networks together with access to presentations and other resources are available on the website. A detailed site update option is also included providing easy access to the latest publications, news and events.

The Irish Presidency

www.eu2004.ie

News and information on the Irish Presidency of the European Union.

STAKES

www.stakes.fi

STAKES, the Finnish National Research and Development Centre for Welfare and Health, produces information and know-how in the field of welfare and health and forwards them to decision-makers and other actors in the field. The website contains a wide range of information on projects and publications and is available in Finnish, English and Swedish. A journal *Dialogi* published 6 to 8 times a year in Finnish and once a year in English is also freely available on-line.

The Campbell Collaboration

www.campbellcollaboration.org

The international Campbell Collaboration (C2) is a non-profit organisation that aims to help people make well-informed decisions about the effects of interventions in the social, behavioural and educational arenas. Like its sister organisation the Cochrane Collaboration, C2's objectives are to prepare, maintain and disseminate systematic reviews of studies of interventions. Materials are collected and access promoted to information about trials of interventions. C2 builds summaries and electronic brochures of reviews and reports of trials for policy makers, practitioners, researchers and the public. The on-line library contains two databases: the Social, Psychological, Educational, and Criminological Trials Register (SPECTR) and a register of Systematic Reviews of Interventions and Policy Evaluation (RIPE).

The Norwegian Centre for Telemedicine (NST)

www.telemed.no

This is a research and development centre, based at the University Hospital of North Norway in Tromsø, that aims to gather, produce and provide knowledge about telemedicine and e-health. It works to ensure that these services are integrated into health service provision. The University Hospital of North Norway has been involved in a variety of telemedicine activities since the late 1980s, and in 2002, was designated by WHO as its first Collaborating Centre for Telemedicine.. The website provides information on current research activities and publications, and many of the centre's reports are available to download. It has both English and Norwegian pages, and some material such as the centre brochure is also available in Russian.

EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL TO BE BASED IN SWEDEN

At the meeting of the Employment, Social Policy, Health and Consumer Affairs Council in Brussels on 1–2 December a general consensus was reached on the urgent need for the establishment of a European Centre for Disease Prevention and Control (ECDC).

At the Heads of Government summit in Brussels on 12–13 December it was agreed that the Centre would be based in Sweden.

Since 1999, the Commission has managed a Communicable Diseases Network, based on ad hoc cooperation between Member States. The new centre is intended to strengthen this current system and improve the EU's ability to respond to communicable disease outbreaks and other serious health threats affecting EU citizens.

While the remit of the centre is yet to be finalised, principal tasks envisaged include the development of epidemiological surveillance and networking of laboratories, acting as an early warning system, and facilitating the provision of scientific opinions and rapid technical assistance/communication with not only Member States, but also the European Economic Area and candidate countries. It is envisaged that the ECDC will be up and running from 2005.

The full proposal for the ECDC is available at
http://europa.eu.int/eur-lex/en/com/pdf/2003/com2003_0441en01.pdf

WHO EUROPEAN OFFICE FOR INVESTMENT FOR HEALTH AND DEVELOPMENT OPENED IN VENICE

The WHO European Office for Investment for Health and Development, established with the cooperation and support of the Ministry of Health of Italy and the Italian Region of Veneto was officially launched on December 15 in Venice.

Commenting on the launch of the office WHO Regional Director for Europe Dr Marc Danzon said this was "excellent proof of the high level of commitment of the WHO Regional Office and its 52 member states to investing in health promotion and the reduction of health inequalities."

Plans for the establishment of the centre were put in place following the publication of the report of the WHO Commission on Macroeconomics and Health that emphasised the links between health and economic development. The office is also a recognition of the growing inequalities in health and in socioeconomic status across Europe, with differences in absolute life expectancy of more than ten years between high and low income countries in the region, as well as marked variations in health status across socioeconomic groups within all countries. Head of the new office Dr Eric Ziglio stated that "we want to broaden knowledge and know-how about public health, this knowledge is crucial to the protection and promotion of the socioeconomic factors that contribute to people's health all over the WHO European Region."

Further information is available at
www.euro.who.int/eprise/main/WHO/Progs/SED/Home

WORLD HEALTH REPORT 2003: SHAPING THE FUTURE

The World Health Report 2003: Shaping the Future was launched in December. The 130-page book outlines solid strategies for health care and public health to shape a healthier future for all, and links these to United Nations Millennium Development Goals intended to promote sustainable development. Commenting on the publication of the report WHO Regional Director for Europe Dr Marc Danzon stated that "progress in health goes hand in hand with progress in economic development. We should understand that health is a critical factor to everything we call progress, and we should act, keeping this understanding front and centre." While noting that life expectancy globally has increased significantly over the last 30 years, the report heavily emphasises the growing health gap between high income countries and the rest of the world. Life expectancy in a number of countries in Sub-Saharan Africa in particular has fallen significantly over the last decade largely due to the HIV/AIDS epidemic.

Inequalities in health status across the WHO European region are also growing. In the eastern half of Europe, particularly in the former Soviet Union, adult life expectancy fell by 4.2 years for males and 1.6 years for females between 1980 and 2002. Mortality rates now in some eastern European countries are much greater than in low and middle income countries in the Americas, Asia or the Middle East. The main causes are non-communicable diseases, particularly cardiovascular and alcohol-related problems, and injuries including suicide. The WHO European region is experiencing the fastest-growing HIV epidemic in the world, and significant further growth is likely

The World Health Report 2003 can be accessed at www.who.int/whr/en

IRISH PRESIDENCY: EUROPEANS – WORKING TOGETHER

The programme of the Irish Presidency "Europeans – Working Together" identifies four key priorities: successful enlargement; working together for economic growth; developing the Union as an area of freedom, security and justice; and global engagement with the outside world. Within the health area a number of specific priorities have also been outlined.

Cardiovascular Health
A conference will be held in Cork on 24-26 February to discuss primary and secondary prevention of cardiovascular disease. There will also be development of Cardiology Audit and Registration Data Sets, (CARDS) which will be collected in clinical cardiology practice. Work will be done to establish a permanent system of coordination of cardiovascular research.

E-health
An E-health conference will be held in Cork on 5-6 May, which will look at a number of issues affecting the use of E-health in the area of public health including health cards, integrated health care records, health portals and evidence based decision making.

Patient mobility within the EU
Building on the work of the High Level Process of Reflection of the Commission, preliminary work on patient mobility issues will be carried out and presented at a Health Ministers Consultative meeting in Cork on 12 May.

In addition to these priorities the Presidency will work on the current legislative agenda including tobacco control, the pharmaceutical review package, food safety and labelling and public health issues related to the Children's Environment and Health Action Plan to be presented at the WHO Budapest Conference in June 2004. Within the area of social policy and employment emphasis will also be given to promoting opportunities for work, reducing poverty, and maintaining a high level of social protection and social inclusion.

Launching the health priorities within the Irish Presidency programme on 7 January, the Minister for Health and Children Micheál Martin stated that "the Presidency offers a special opportunity to demonstrate our commitment and determination to advancing public health throughout the Union. Irish based Presidency meetings and events will involve an estimated 3,000 plus delegate attendances. I believe that we have developed a very focused Presidency programme which will allow us to give practical expression to this commitment."

General information on the Irish Presidency together with specific details of priorities related to health and social policy can be accessed at www.eu2004.ie

IMPASSE IN BRUSSELS

The Inter-Governmental Conference that took place in Brussels on 12–13 December broke up without any agreement on adopting a new European Constitution, principally due to objections to voting procedures, raised by Spain and Poland. EU enlargement will still occur in May as agreed in the 2000 Nice Treaty, but some countries have suggested that the failure in Brussels may lead to a 'two speed' Europe developing. The text of the Constitution in respect of health, as indeed in most areas had been broadly agreed, and therefore it is difficult to see much change being made in the existing text, although some campaigners may see the current impasse as an opportunity to strengthen further the article on health.

What happens next is difficult to gauge. At the start of the Irish Presidency in an address to the European Parliament on 14 January, the Taoiseach, Bertie Ahern, pledged to do all that was possible to reach agreement and consult widely ahead of the European Council meeting in March. More recently speaking at the World Economic Forum in Davos, Polish President Aleksander Kwasniewski stated that it is still possible to reach agreement during the Irish Presidency but argued that any further delay would not be unduly problematic. Realistically many commentators now believe that substantial progress is unlikely to occur before the Dutch Presidency begins later this year.

PUBLIC HEALTH INTERVENTION RESEARCH: THE EVIDENCE

A recent report Public Health Intervention Research: The Evidence written by Louise Millward, Mike Kelly and Don Nutbeam has been published by the Health Development Agency (HDA) in England. The report found that less than 0.4% of public health research published in the UK relates to interventions for the prevention and reduction of ill-health. Mike Kelly, Director of Research and Information at the HDA said "prevention is better than cure – so a strong research base from which to gather the evidence of what works to reduce ill-health is essential. But there are a number of factors that may be discouraging intervention-oriented research, for example an interest in short term, politically high profile 'quick hits' which could inhibit a focus on longer term health benefits." The report suggests a number of solutions to enhance the capacity for intervention- oriented research, including a research framework to lead development, incentives for universities to engage in this type of work and a National Public Health Database to permit measurement of the impact on policy in the short term.

The report can be accessed at www.hda.nhs.uk/documents/pubhealth_intervention.pdf

MEETING OF THE EMPLOYMENT, SOCIAL POLICY, HEALTH AND CONSUMER AFFAIRS COUNCIL

The Employment, Social Policy, Health and Consumer Affairs Council of the European Union met on 1 and 2 December 2003 in Brussels. In addition to discussing plans for a new European Centre for Disease Prevention and Control (see separate item) a number of other outcomes were reached:

Healthy Lifestyles

Ministers adopted Council conclusions on healthy lifestyles, education, information and communication, in line with the overall Public Health Action Programme for 2003–2008. The Council recognised that healthy lifestyles not only result in better health and in the prevention of disease but also are cost effective.

The Council also called for initiatives intended to improve population health to take into account economic and social inequalities. The importance of education (especially at school), information and communication in promoting healthy lifestyles was also stressed, as well as improving links across areas of Community policy that can impact on health.

Public health and pharmaceuticals

A Resolution was adopted on "Pharmaceutical and Public Health Challenges – Focusing on the Patients". This emphasises that patients should be the focus of pharmaceutical policies; in particular ensuring that they have better access to information to enable them to make rational decisions, and that medicine are affordable and available. It is intended to complement Council Conclusions on "Reinforcing the Competitiveness of the European Based Pharmaceutical Industry" adopted in September.

The resolution also calls on the Commission and Member States to work towards building a system for sharing health data and strengthen the collection and dissemination of information on the cost effectiveness of medicines. It recognises that there is a need to improve the communication of such information to both professionals and patients. The Commission were also invited to set up a European Medicines Information System for patients and health professionals, which may make use of current initiatives such as the European Health Portal.

Medical Devices

The Council adopted Conclusions on medical devices which indicate that a number of current directives (90/385/EEC, 93/42/EEC and 98/79/EC) subject to some amendments, provide an appropriate legal framework for the use of medical devices. They also called for improved implementation of these directives. The Council also invited the Commission and the Member States to set up a European database for medical devices.

Cancer Screening

A recommendation was adopted calling on Member States to implement effective screening programmes for breast, colon and cervical cancer. The Commission will report on implementation of such programmes by 2007.

Nutritional and health claims on food

The Council took note of a progress report on the Commission's proposal for a Regulation on nutrition and health claims on food. This Regulation would specify the circumstances under which health claims could be made, and they would need to be backed up by independent scientific evaluation. The Opinion of the European Parliament is due in February 2004.

Full Council Conclusions are available at http://ue.eu.int/pressData/en/lsa/78152.pdf

---

Turin Round Table on Poverty and Social Exclusion in Europe

This annual event, within the social inclusion strategy, took place in October under the Italian Presidency in Turin, bringing together relevant stakeholders to discuss issues and developments relating to these issues.

During a presentation on progress achieved and challenges ahead regarding the National Action Plans on Social Exclusion, Haroon Saad of the European Social Platform noted that health inequalities are the ultimate inequality. One of the advancements made is that health-related approaches have gained prominence in the efforts to address social exclusion.

Saad also argued that while the overall quality and process of the strategy has improved, the issue of social exclusion in Europe remains politically and organisationally marginalised, and that much still has to be done, not least with respect to greater awareness raising and evaluation of the process.

Conference: Inclusion and Mental Health in the New Europe

The sixth international conference of the European Network for Mental Health Services Evaluation (ENMESH) will take place from 3–5 September 2004 at King's College, London. The conference has four main themes: User/Consumer Involvement; Mental Health Policy in the New Europe; the Mental Health of Vulnerable Groups; and Interventions that Work. Colleagues from Eastern, Central and Western Europe are encouraged to meet and exchange expertise across national and regional boundaries. There will be a limited number of bursaries to enable those, including consumers and carers, in need of some financial support to attend. The deadline for receipt of abstracts is 29th February 2004.

Further information on the conference and the abstract form can be downloaded from the conference web site: www.enmesh2004.org

News in Brief

EU Osteoporosis Action Plan launched

The European Union Osteoporosis Consultation Panel presented a report, Osteoporosis in the European Community: Action Plan, to the European Parliament on November 12. This report outlines three key steps necessary to prevent fragility fractures that result from osteoporosis. These can be summarised as development of evidence based prevention guidelines, access to and reimbursement of diagnosis and therapy, and coordinated collection of fracture data in the EU. *To download the report and access further information see* www.osteofound.org/advocacy_ policy/eu_policy_project.html

Tromsø Telemedicine and eHealth Conference, Norway June 21–23

This conference entitled "Citizen participation in eHealth; Challenges for research, technologies and health care organisations" focuses on individuals using eHealth for their own health purposes. The conference will provide a venue for the exchange of knowledge and debating of strategies between key players in eHealth. The conference is organised by the Norwegian Centre for Telemedicine in cooperation with the National Research and Development Centre for Welfare and Health (STAKES), Finland, the Norwegian Federation of Organisations of Disabled People (FFO) and the Norwegian Cancer Society (DNK). *More information at* www.telemed.no/ttec2004

EuroHealthNet and HDA can be contacted at the following addresses:

EuroHealthNet

EuroHealthNet
6 Philippe Le Bon, Brussels Tel: 00.322.235.0326
Fax: 00.322.235.0339
Email: i.stegeman@enhpa.org

NHS

Health Development Agency

Health Development Agency
Holborn Gate, 330 High
Holborn, London WC1V 7BA
Email: maggie.davies@ hda-online.org.uk

Government policy making in European Countries: A position report

The report summarises the results of a pan-European survey that examined governments' views and perspectives of health impact assessment in 22 countries. The survey was undertaken by The Welsh Assembly Government working in conjunction with the European Commission Public Health Policy Unit, the World Health Organisation and the European Network of Health Promotion Agencies. *The report is available online at* www.hpw.wales.gov.uk/ English/resources/reportsandpapers/hia-govpol(2)-e.pdf

What is the efficacy/ effectiveness of antenatal care?

An increasing number of complex examinations and interventions are becoming part of modern antenatal care. A new report from the Health Evidence Network written by Professor David Banta reviews the evidence on the health benefits of antenatal care, especially in relation to its costs, and outlines considerations for policy-making. *This is available at* www.who.dk/ document/Hen/antenatalcare.pdf

Health impact assessment and 4th European Conference on Promoting Workplace Health

This conference organised jointly by the European Commission, the Department for Health in Children in Ireland, and the European Network for Workplace Health Promotion will take place in Dublin Castle on 14-15 June. It is intended to help facilitate the development and exchange of information between national forums for workplace health promotion. *More information at* www.whpdublin2004.org

---

12th UK Annual Public Health Forum
Combining the World Federation of Public Health Associations
10th International Congress on Public Health

Sustaining public health in a changing world: vision to action

Brighton, UK • 19-22 April 2004

The UKPHA's Annual Public Health Forum is the UK's largest, most exciting multidisciplinary public health event. With 600 abstracts submitted and 50 organisations involved the 2004 Forum – now extended to four days – promises to be the biggest ever. Please mark your diaries now!

The programme mixes world-class keynote speakers, topical debates, concurrent and parallel sessions, poster exhibitions and fun social events. The first day of the Forum will focus on international health. For 2004 the Forum will be organised through three streams: UK and Republic of Ireland, International, and European

Theme areas include:
Socioeconomic inequalities in health: research to action • Community participation and health promotion • Environmental sustainability and population health • Public health law • Healthcare: meeting needs or demands? • Strategies for non-communicable and chronic disease • Violence and injury • Global health security and bio-terrorism • Global health: disease burdens, chronic conditions and new challenges • Health demographics: mapping trends for population health • Understanding the terrain between health care, public health and the wider public health • Health partnerships and ethical responsibility • The public health toolkit • Public health in the enlarged European Union • Public health: regaining leadership • Workforce capacity, skills, and standards • Investment in health

Who is the Forum for? **Anyone who contributes to, or is concerned about, the public's health and well-being, including: key decision makers in the NHS and local government, public health practitioners, people working among vulnerable groups, academics and researchers, the voluntary sector and health and environmental specialists and campaigners, community workers and activists**

For further information please contact
Hampton Medical Conferences
Tel: +44 (0)208 977 0011
Email: publichealth@hamptonmedical.com
Conference website: www.ukpha.org.uk