

eurohealth

The Madrid Framework



Can the new EU members catch up in cancer care?

Consumer choice in German health care

Mental health reform in Lithuania

What role for NGOs in improving health care systems?

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C O M M E N T

Questioning values, debunking myths

A myriad of factors influence the direction of health policy. Many such as resource constraints, political priorities and technological developments can pull policy in different directions. In his discussion of the 'Madrid Framework', Marshall Marinker recognises the need to 'develop an analytical and non-adversarial discussion about what is to be done, the reasons why, and how health policy is to be implemented.' The Framework, itself evolving from an initial meeting in Madrid, and subsequently going through several iterations, outlines some interlocking dimensions of health policy and governance. It attempts to make explicit some of the values and beliefs that shape policy. It is only, as Marinker notes, by making these values transparent that they can be examined and questioned. The future planned critique of the Framework will thus be awaited with great interest.

Following on from the previous issue of *Eurohealth*, which included a special section on south eastern Europe brought together by section editors, Bernd Rechel and Nina Schwalbe, there is once again an eastern European flavour to contributions. Here Grujica Žarković and Walter Satzinger provide a nice insight into the challenges for a non governmental organisation in Bosnia and Herzegovina, seeking to act as a catalyst for health system change. The importance of effective lines of communication with key policy stakeholders, as well as a good measure of diplomatic skills, political awareness, and patience are well illustrated. Both barriers and progress for change are also evident in the state of cancer care in central and eastern Europe, as well as in respect of mental health system development in Lithuania.

The issue also sees the launch of the Mythbusters series. This will feature a series of short essays prepared by the Canadian Health Services Research Foundation looking at the evidence behind health care debates. Not only must we question and if necessary challenge our own values, but also debunk some of the longstanding myths that can also influence policy.

David McDaid
Editor

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The Madrid Framework

Marshall Marinker

Those with responsibility for health policy and governance are pulled in a number of directions - by the evidence we gather about health and need; by the ethos of public service; by the limits of public resources; by the promise of technical innovation; by a market-driven consumerism; by politics.

All of these concerns are potentially in conflict with one another. How are we to arrive at the best, the most civilised, the most successful policies for health? Behind these questions there are other, prior and deeper, questions? What are our values; how do we express them; how do we validate them; how do we prioritise them; what, of one set of values, can be sacrificed in pursuit of another?

The story of the Madrid Framework begins in 1997 when a small group of academics from a variety of health-related disciplines was invited by Merck Sharp & Dohme (MSD) to act as an Academic Advisory Board to advise on a Europe-wide health targets grants programme. Over the course of the following eight years we were enabled to support a number of innovative health target projects throughout Europe, and a number of brainstorming workshops and international conferences. These all contributed to the development of our ideas about the nature and role of values in shaping local, regional, national and international health policies.

Following the publication in 2002 of a book of essays *Health Targets in Europe: Polity, Progress and Promise*¹ a group of experts, including the book essayists, met in Madrid, in May 2003, to take part in a 'Conference on Values and Principles'. What were these precepts, embedded both in what we believed we were trying to do in health policy, and in how we set about doing it? In particular we were concerned to ask whether there are characteristically European values, around which we could build a consensus.

Armed with the thoughts of the many leading thinkers who took part in this workshop, the transcripts of the papers presented, and the reports from the many discussion groups, I was given the task of drafting some sort of document which would encompass the ideas that had been raised and examined. This is the genesis of

The Madrid Framework.

In the course of our group discussions at the conference, I had become aware of the temptation to debate what was a value, what a virtue and what a principle. This seemed to me to be a potentially sterile line of enquiry. Instead, I suggested identifying a set of 'dimensions' of policy and governance. The terms 'considerations', or 'things to be considered', also suggested themselves as appropriate, but 'dimensions' had the attraction of describing a virtual space for both discourse and action.

The need is to develop an analytical and non-adversarial discussion about what is to be done, the reasons why, and how policy is to be implemented. This discussion is something that Ilona Kickbusch describes as 'constructive conversation'. The Madrid Framework defines the multi-dimensional space in which such constructive conversation can occur.

The Framework

The Framework is composed of 11 'dimensions' of health policy and governance. The word 'dimension' was intended to suggest a *force field* in which each dimension would pull in its own direction, so that policy and governance must perpetually adjust in order to find a moral equilibrium. This dynamic imagery was meant sharply to contrast with the static and rigid imagery characterised by the current fashion for creating 'standards', 'guidelines' and 'protocols'.

What I attempted to do was to achieve maximum coherence within each dimension, putting together a collection of qualities, values, principles and concerns which seemed to belong together. At the same time they were designed to achieve a maximum separation between the ideas contained in each, while acknowledging that there must be an irreducible degree of overlap.

The version which follows is different from those presented at previous meetings. At each meeting the 'constructive conversation' that is provoked, results in better understanding of the issues, and the need for detailed redrafting. The order in which these dimensions are presented is dictated by coherence, not priority; they are not of

"The Framework is composed of eleven 'dimensions' of health policy and governance"

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equal complexity or range; and their contents are indicative, not definitive. The first three are concerned with targets and goals – the changes we are trying to achieve. Dimensions 4–9 are instrumental, concerned with the means of achieving our ends. The final two, concerned with interdependencies and the handling of complexity, are what I call ‘sensibilities’ which pervade every aspect of the work. Prioritising these dimensions, choosing between their conflicting or competing goods, will most often require trade offs and hard political choices. Our values are present in all of the dimensions – and to some degree they are all in conflict.

The Dimensions

1. Health

In the spirit of the WHO definition, the concept of health embraces the widest range of physical, social, mental and spiritual well-being. Ill-health curtails our capacity for life. The health status of a society has been described as the most sensitive indicator of its wealth and freedom. The protection and improvement of health is the *raison d’être* of health policy and governance whose ultimate goal is to enhance the capacities of citizens for a full life.

Policies may address the determinants of ill health, risk factors, and the quality of, and access to, health services. For all policies, although quantifiable and measurable outcomes may be most appropriate, these will often be embedded in important higher-level, open-ended, and longer term, goals where change occurs gradually over time, and short-term linear relationships can not readily be demonstrated.

2. Equity and Justice

In pursuit of social justice, the goal of greater equity in health and care lies at the heart of almost all European health policies. Inequalities in health may refer to levels of general health and well-being, to the probabilities of disease, and to the availability and quality of health services. These closely mirror inequalities in socioeconomic status, but may also be related to gender, age, ethnicity and locality. These inequalities challenge our sense of social justice and solidarity.

3. Choice

While most health policies are directed to large populations, sometimes to whole nations, the individual citizens in whose name these policies are made have their own personal beliefs, priorities and sense of

entitlement. What is deemed best for the group will only randomly be best for, and desired by, the individual. Therefore trade-offs have to be negotiated between the collective interest, and the priorities and desire for choice of individual citizens, and special interest groups. Choice can never be open ended. It can only refer to a limited menu of options. The basis for determining this menu should be made transparent, so that citizens have an explanation of what is included and what excluded, and on what basis.

4. Democracy

Health policy will play an increasingly central role in the overall social and political agenda. If citizens are to have confidence in public health systems, our priorities will need to reflect societal values. For this to happen all stakeholders, and especially citizens and patients, need to be actively engaged. A prerequisite of such engaged citizenship is open access to valid health-related information from a wide range of reliable sources. Another is transparency in the processes of policy making and implementation. At local level, a variety of methods may be required to assure that those whose lives are to be affected by policy changes have a full sense of ‘ownership’.

Although democracies are good at paying attention to the desires of majorities, most people with specific health deficits belong to ‘health minorities’, and their voices need to be heard. Public involvement is best served when there is a high-level of health literacy. Although most often this is assumed to refer to the individual’s grasp of the concepts and findings of the health sciences, a growing body of research has revealed the importance of the individual’s, and the community’s, beliefs and attitudes, preferences and priorities, in determining health related behaviour.

5. Stewardship

Traditionally national governments were deemed to have three key responsibilities: ‘the defence of the realm’, ‘law and order’, and ‘the stability of the currency’. In the 21st century, a fourth responsibility, ‘stewardship for health’, emerges as arguably of similar importance. Successful targeting demands that governments recognise that health is a vital national resource, and make the appropriate commitment of financial, human and intellectual resources, in order to ensure that aspirations become goals that can be effectively implemented. This will include long term investment in the policies themselves, and in the health related

“Choice can never be open ended”

sciences and technologies which underpin them. Such responsible stewardship will invariably require a longer period of time for planning and funding than that of the life-span of any democratic government.

6. Evidence

Successful governance requires reliable data that are comparable over time and across national boundaries. Such information makes it feasible to track health and social trends that unfold over long periods of time. However, health targets are inevitably moving targets. Foresight will inevitably require more than reliable data about past trends; it may require a public health 'intuitive judgement' analogous to the physicians 'clinical acumen'.

Lessons can be learned from experiences in other countries. However reliance on such external evidence is only safe if account is taken of contextual differences: the different physical, cultural, social and political environments of the comparator populations. All data are socially constructed, all perceived 'needs' are also 'wants'. Therefore behind all evidence, there are moral and political, as well as numerical, values. The validity of these may need to be recognised and questioned no less carefully than we question the statistics.

7. Efficiency

Governments have a dual accountability: to protect and improve health; and to ensure the optimal use of the public resources entrusted to it. Macro-efficiency is concerned both with the effectiveness of interventions, and the priority that is given to them. Micro-efficiency is concerned with the optimal uses of resources to obtain the maximum benefit at the operational level. Although this latter is argued in terms of value for money and the avoidance of waste, efficiency calculated in too narrow a way can result in loss of flexibility and diminish the ability of systems to cope with natural fluctuations and surprises. Complexity theory suggests that without some degree of redundancy, organisational and biological systems can seize up. An over rigid regime of efficiency can prove inefficient.

8. Synergy

Policy and governance requires collaboration and cooperation between many relevant actors – government agencies, the private sector, patients and citizens rights organisations, and other elements of civil society. This inter-sectoral governance requires not only an open and stable

relationship between agencies and individuals, but, even more crucially, a willingness of organisations to learn from the experience of working with one another which may challenge them to expand their traditional assumptions about ways of operating, remits and boundaries, to grow in ways that are appropriate and sensitive to the task. At its best such co-production of health can achieve something that is more than the sum of its parts.

9. Sustainability

In most long term enterprises there can be a falling off of commitment and energy. Since most health policies are long-term exercises, provisions must be made to sustain political and organisational motivations over the course of time, and probably of successive governments.

However, sustainability may not always be a priority. Some specific targets may require only short-term alliances of a particular type, and a pre-occupation with creating a sustainable system may inadvertently result in rigidities of thought and action, and the creation of institutional orthodoxies that become resistant to change.

10. Interdependency

In our globalised world, no country, region or locality is an island. At every level there are biological and political inter-dependencies. Health and health services are influenced by global concerns such as workforce mobility, air quality, international agreements and other factors that transcend national boundaries. Local and national health policies can have unintended effects beyond their own borders. The number of international agreements is growing. Increasingly such agreements recognise the links between health and other policies.

11. Creativity

Health policy and governance are not securely predictable and linear exercises: many of the contextual factors may change over time – sometimes quite rapidly and unexpectedly. Tightly specified ends are not necessarily achieved by tightly specified means, and public health challenges may not be solved by current and conventional approaches. Successful implementation requires imagination, experimentation, innovation and flexibility on the part of stakeholders and institutions.

Trade-offs

A further book is now planned for launch in summer 2006. As editor, I shall be inviting a number of international thinkers to

“behind all evidence, there are moral and political, as well as numerical, values”

“our values do have their origin in a long and distinguished history of European thought”

consider and critique the Madrid Framework, to contribute essays on the dimensions, to write about the nature of ‘constructive conversation’, and about the politics and ethics of the trade offs that we have to make.

In particular I will be asking these authors to pay attention to the tensions and conflicts that can occur both *within* each dimension, and also, between them. In what we may call the ‘*internal domain*’ of each dimension, although its elements are conceived as being coherent, the bundle of ‘goods’ described may well contain mutual contradictions.

The term ‘trade off’ is given in the Oxford English Dictionary as “A balance achieved between two desirable but incompatible features; a sacrifice made in one area to obtain benefits in another; a bargain, a compromise.” Even a superficial consideration of what has gone before will suggest that in what we may call the ‘*external domain*’ of the dimensions, each dimension can come into conflict with any of the others.

As an example, take the ‘*internal domain*’ of ‘Equity and Fairness’. The words ‘equity’ and ‘fairness’ are not synonyms. They express quite distinct meanings. However both ‘equity’ and ‘fairness’ imply the need to judge *between* groups or individuals who may be identified by such qualities as socioeconomic status, ethnicity, age, gender, and so on. How are these different aspects of inequality or difference to be prioritised, weighted, balanced, in the name of equity? There is an assumption of social ‘solidarity’ in the values embedded in this dimension, but the boundaries of this solidarity are uncertain. How strong a sense of social solidarity do we have - with our fellow citizens; with our fellow Europeans; with the global population; with the generations yet unborn?

In the Framework’s ‘*external domain*’ an obvious conflict is that between the public good of ‘Equity and Fairness’, and the private good of ‘Choice’. Yet ‘Equity and Fairness’ may as easily be in competition with ‘Evidence’ or ‘Local Empowerment’. The Madrid Framework is composed to allow transparency about such competition, to illuminate the paradoxes created by these internal and external conflicts that have to be reconciled and managed.

European Values

The Madrid Framework was invented to make our values explicit, values that colour our aspirations and shape our judgments;

values that define our relationships; explain the organisations that we create, and how we behave in them; values that determine the goals we set ourselves; that explain how we judge ourselves, and the behaviour of others. We wish to make these values as clear and visible as possible so that we can examine and question them.

A pragmatic definition of values is given by the Oxford English Dictionary: ‘the principles or standards of a person or society, the personal or societal judgement of what is valuable and important in life’. It is worth recalling that values in relation to health targeting, for example, equity, excellence, efficiency, and so on, reflect our *judgements* of what is valuable.

Those of us who have so far been party to this project have made much of the European nature of our values in respect of policies for health. For many the term ‘European’ has become a code word for ‘Not the USA’. On reflection, this is a manifestly unfair use of the term, because the values which we describe as essentially European are in fact globally recognised and owned, and not least by very many colleagues and citizens in the USA.

But our values do have their origin in a long and distinguished history of European thought, and a great European tradition of public health. They are characterised by an emphasis on equity and fairness and on the need to sensitively, and democratically, mediate between this social fairness and the wish for individual freedom of choice. They are also values informed by a recognition that the public health is of crucial importance to the quality of everyone’s *individual* health, and that while solidarity in health may well be a political aspiration, it is also a biological and an epidemiological imperative.

It is because these fine sentiments can so easily be degraded into a coarse sentimentality, that we need constantly to re-examine our values with some rigour, so that they can be used as tools for human progress, and not just as weapons in the battle of competing political ideologies and parties. The Madrid Framework is incomplete. It is designed to remain incomplete, so that in the hands and hearts of all who consider it and attempt to apply it to their planning and their performance, it can be critiqued, modified, improved, and in every location, and in relation to every challenge of health policy and governance, it can continue to evolve in the light of *your* experience, and prove fit for *your* purposes.

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Can the new EU members catch up in cancer care?

*Nick Bosanquet,
Jim Attridge and
Karol Sikora*

“Compared with old Europe there is a higher rate of mortality from cancer”

The new EU members are already getting positive economic results, but could membership also increase momentum towards health gain? The main focus so far has been on funding and staffing of health systems.¹ Often this produces a somewhat dismal picture of financing shortfalls and bureaucratic quagmires. Could there be an alternative approach through bottom up development in specific disease areas?

Our recent review of cancer services took in the Czech Republic, Hungary and Poland. As well as carrying out a literature search we interviewed key leaders among clinicians, funders and patient groups. As well as the obvious urgent requirement for better outcomes and services there is potential for achieving these quickly within a three to five year period. There can be a real chance of “catching up.”

Current situation

Compared with old Europe the main features are firstly that there is a higher rate of incidence and mortality from cancer. In 2000 age standardised mortality rates in Poland were 17% higher, Czech Republic 33% and Hungary 50% higher than in the old EU-15. Secondly there have been rapid

increases in incidence over the 1990s, particularly for breast, prostate and colon cancer. Table 1 shows rates of cancer for women in the Czech republic. There is also a high level of lung cancer although recently with some switch in genders with male cancers declining and lung cancer increasing among females. Cancer of the cervix continues to be high, with an incidence rate of 21 cases per 1,000 people that has remained unchanged since the early 1980s and is more than twice that found in the UK and Scandinavia.

Many of these cancer deaths are in younger age groups. Our estimates are that at least 30% of premature life years lost in the new member states are due to cancer and this weight is likely to rise as prevention and improved treatment reduce mortality from coronary heart disease. There are also significant costs from disability and reduced quality of life in survivors. Outcome figures are based on Eurocare 3, which covers patients diagnosed in 1990–94 and measures survival over the five years to 1999.² For all cancers affecting female patients five-year survival rates were 43.4% in the Czech Republic and 35.3% in Poland compared to 51.2% across Europe and 64.3% in the USA. For breast cancer Poland and the Czech Republic were achieving a 63% survival rate compare to 76% overall in Europe. The high levels of lung cancer in males led to a wider survival gap for men.

Given the low level of resources available in 1990–94 the Eurocare comparisons represent a significant achievement. Health professionals were achieving rates two thirds as good as the Euro rates with less than one tenth of the resources. The results reflect skills in diagnosis and access to surgery, as there has been very limited access to new drug therapies or radiotherapy. So far from these survival rates reflecting discredit on health services they in fact are indicative of great achievement in very difficult circumstances.

These results were achieved with very low levels of spending on cancer services. Spending in the USA on cancer care is 5–6% of total health care spending;³ it is unlikely that the proportion is any higher

Table 1 CANCER INCIDENCE PER 100,000. (FEMALES) CZECH REPUBLIC (APC= Annual Percentage Change)

	1990	2001	APC	US APC
Breast	65.1	93.5	+4.0	+0.6
Colon	28.2	36.1	+2.6	
Rectum	19.0	23.0	+1.9	-0.5
Lung	15.8	25.5	+5.6	-0.2
Uterus	24.2	30.8	+2.5	
Ovary	20.4	22.6	+1.0	-1.0

Source: Eurocare

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Table 2 HEALTH CARE EXPENDITURES, 2002 (US \$ PPP bn/m.)

	Population	Total Expenditure	Cancer Expenditure
Czech Republic	10.24	11.3	0.565
Hungary	9.92	9.02	0.451
Poland	38.62	24.2	1.21

Source: OECD

among the new EU member states. At least for Hungary expenditure figures from the National Insurance Fund of \$191 million for cancer care in 2002 show that spending is likely to be even lower. Table 2 presents some estimates for spending on cancer care.

The achievements in the past with these limited resources have been great but now there are new challenges of patient expectations and a rising incidence. The pattern of spending and organisation seems to reflect historical patterns with little fit between need/workload, while the old strengths of

high quality skills are likely to fail due to growing migration.

A number of our respondents spoke of the system as “fragmented” and “diffused”. Money did not follow the patient and incentives to increase workload were few. In some units we visited there was little sense of intense workload pressure. In fact we were told of the under-use of costly new equipment in diagnostics and radiotherapy. Some specific comments both positive and negative are shown in Box 1.

Towards a new model of cancer care

The new Member States have had a great strength in the past in the extraordinary commitment of doctors and other health professionals to give good care even with limited resources. At present however investment has a focus on big-ticket items, such as scanners and linear accelerators, which tend to pull expenditure into a few large centres. There is little investment in networking and communication, which could raise total capability in the system. This model of cancer care investment in terms of big-ticket projects needs to be replaced by a model promoting integration from prevention through to palliative care.

The aim of the model would be to ensure that scarce professional resources are used more effectively in a changing health environment. This should be regarded as essential for international competitiveness and accreditation. An integrated programme would cover initiatives in the following six areas and for each we define first steps, which could produce real results within three years.

Prevention: The essential element here is to strengthen programmes for tobacco control.⁴ The WHO programme sets the framework but any general reductions in smoking will take time both to happen and to have an impact on health status. Given the urgency of the problem there may well be a case for special measures to reach high risk groups such as men over thirty who have been smokers for ten years or more, pregnant women, and patients with diabetes or coronary heart disease who are already receiving treatment.

Screening and early detection: A good start has been made here in the two key areas of mammography and screening for cancer of the cervix. Case studies in Hungary show that such programmes are cost effective.⁵ It is essential to move forward to ensure population coverage on a three-year basis, without this many resources will be wasted

Box 1 COMMENTS ON CANCER CARE

“Poor follow up after initial treatment”	<i>Patient group Czech Republic</i>
“There is a big problem of fragmentation between centres, with a weakness in follow up and adjuvant therapy.”	<i>Leading specialist Prague</i>
“We often meet very advanced cancer.”	<i>Specialist in regional centre in older industrial area Czech Republic</i>
“In last 10 years there has been good progress, patients are being recognised earlier: but diagnosis is frequently left too late.”	<i>Specialist Silesia</i>
“Life expectancy here is worse than North Africa”	<i>Specialist Hungary</i>
“Only 25 percent of breast cancer patients get the most modern follow up treatment.”	<i>Specialist Hungary</i>
“The system faces very divergent pressures from producers. Money does not follow the patient especially in oncology. It is divided among many hospitals”	<i>Health fund manager Czech Republic</i>
“Of 200 hospitals in the Czech Republic some 80 treat cancer.”	<i>Health fund manager Czech Republic</i>
“The situation of a patient in the last stages of cancer is quite terrible. There is no system of home care and we only have 2 hospices and 120 terminal care beds rather than the 200 needed.”	<i>Health fund manager Czech Republic</i>

On a more positive note:

“We act as a virtual centre for South Moravia. We are the only comprehensive cancer centre in the Czech Republic.”	<i>Specialist Brno</i>
“In 1997 there was a new law on patients rights. This changed a culture of belief that it was better to lie. The new move requires cooperation between physician and patient.”	<i>Patient association Hungary</i>
“The Soros Foundation has been active in funding palliative care and a specialist nursing service.”	<i>Specialist Hungary</i>

on opportunistic screening. Screening for colorectal cancer could begin through pilot schemes in high-risk areas.

Diagnostics and Assessment: Clearer standards need to be set for speed of treatment and information increased on options. The key challenge will be to improve staging so that more patients will be treated quickly at earlier stages.

Treatment and care: There will be a move towards more complex choices with differing sequences and options for surgery, chemotherapy and radiotherapy. Therapy will be longer and more intense, with greater urgency about monitoring patient experience and fatigue.

Follow up and continuing treatment: It will be vital to improve medical records to ensure that patients at risk are recalled. This will be particularly important with longer-term prophylaxis for breast cancer

Palliative care: There has been some progress towards improving the service in Hungary through an initiative by the Soros Foundation but much more needs to be done.

Investment during transition

We recommend a one-off investment programme to assist with the transition. It is unrealistic to expect that national insurance funds will be able to find the investment required when they are under greater pressure to maintain funding for immediate care. One consequence of short-term financial deficits is the starvation of investment and innovation, increasing problems of quality and staff retention. Key steps would include international/charitable sponsorship for National Fight Cancer Funds (\$50 million each for Hungary and the Czech Republic and \$100 million for Poland). A strategy group with representatives from national Ministries, Health Funds, oncologists and patient groups could also be set up. This would set directions to which a full-time Fight Cancer Fund manager would report.

The national social insurance funds face a massive challenge in formulating long-term strategies for allocating limited funds to a range of services. Many face uncertain futures, in terms of income streams, which are heavily dependent upon national economic performance. There are many other competing priorities besides cancer and, above all, the need to push through funding and organisational reforms on a grand scale. Somehow within this context, the concept of a national cancer investment

Box 2 KEY ELEMENTS IN A NATIONAL CANCER STRATEGY

- **Stronger management capability in key local centres especially in areas of systems design and utilisation**
- **Expansion of screening programmes and management to ensure population coverage**
- **Funding survey research on the patient experience**
- **Design new informatics or quality measurement and for networking among professionals**
- **Training of doctors and health professionals in new skills**
- **Design of protocols and care pathways building on some of the excellent work, which is being done in Brno, Warsaw and Budapest**
- **Investing in new management and upgrading of diagnostic /treatment systems so as to ensure most effective use**
- **Developing international links and increasing research/clinical trial participation. Activity in clinical trials has shown rapid increases and had positive effects on funding and quality.**
- **Organising workshops and conferences to increase cooperation between new member states in improving cancer services.**

plan, supported by the relevant professional bodies, needs to be established with a clearer set of investment and funding priorities, which are compatible with the wider reform programme. We suggest a set of initiatives that should be key elements in the strategy (Box 2)

New developments

The aim of these new initiatives would be to create a momentum for quality and development.⁶ We would hope that new developments would see the Fight Cancer Funds having increased confidence in change and a momentum for service improvement. They would be essential to ensuring that the health professions in new member states can play their full role. In the interwar period cancer services were beginning to develop strongly, for example through the Marie Curie Institute in Warsaw and the Masaryk Institute in Brno. EU membership provides an opportunity for a move towards international collaboration and even leadership in reducing the social and human costs of cancer.

The programme would also contribute to a more innovation and development orientated approach to health care. At present most of the focus in external research has been on the health system as a whole. For example the recent comprehensive study by McKee et al¹ defined the agenda for health systems and for public health but had little on how models of prevention and care could be developed for specific disease

“One consequence of short-term financial deficits is the starvation of investment and innovation”

“Without modernisation the strong commitment from dedicated clinicians is likely to be eroded”

areas. Unless such strategies are brought forward health system change is indeed going to present a somewhat dismal picture of unending conflict over deficits.

An innovation focus may in fact help in opening up opportunities for potential savings through redeployment of resources. For example it is possible to finance improvements in chemotherapy by moving away from in patient hospital treatment to ambulatory care.⁷

Development orientation can also help with retention of younger staff as well as attracting back some who have already left. If health care is seen as an exciting area to work in, matching progress with other areas of society and the economy more generally, then there is likely to be a greater rate of retention of key staff. Internal migration across occupations as able people leave to work in other roles is as much a threat to health services as external migration within medicine.

Developments in the cancer field can also help with the development of specialist nursing skills, as well as in systems for screening and prevention. The links between health development and social gain require specific action and initiatives in key areas.

Conclusions

The new member states in the EU face challenges in reducing a disease burden from cancer that is already much higher than in the old EU, and set to rise further without effective action. Levels of expenditure for cancer services, mainly treatments are low ranging between 3% and 5% of total health expenditure. Yet survival outcomes achieved in the 1990s were about two thirds of those in Western Europe. This was a remarkable achievement given the low level of resources available for treating patients diagnosed in 1990–94. Without modernisation the core strength of commitment from dedicated clinicians, is likely to be eroded as some younger professionals migrate. There will also be problems in meeting new challenging standards for clinical governance.

There can be a new model of cancer care, which leads towards balanced and coordinated investment in prevention, screening, and treatment and follow up care. The model also supplies many opportunities for international partnership, and already greater participation in clinical trials can serve as a good start. Use of this model is essential to achieving reductions in cancer

incidence and mortality. We are impressed by the potential for services in the new member states to catch up, but the opportunities must be taken soon.

Recommendations

Another key recommendation would be to develop and attract funding sources for the Fight Cancer Funds, which will provide an impetus to the strategies. The new model of cancer care requires a one-time investment in care programmes, staffing and intensive care. It is hardly realistic to expect that the investment required can be found from existing health funds during a time of great pressure on public sector budgets. Possible contributors to the Funds would be the EU, World Bank, philanthropists such as the Soros Foundation and corporate donors.

National training and staffing programmes are needed to secure the range of new skills required for the implementation of resource plans. These would develop skills for both for newer recruits and experienced staff working in the service. A key leaders programme for staff in their thirties including short-term international placements and opportunities for leadership training might also be developed.

The creation of national initiatives in quality assurance, collaborating with major centres in developing networks and protocols would be crucial for using the full potential and commitment of staff in the services. Roles and opportunities could also be developed for specialist nurses who can make a crucial contribution to screening, treatment and follow up care. Finally it is also important to develop further national initiatives in palliative and terminal care. Many patients are suffering from a great deal of pain as well as distress from other symptoms. The goals of privacy, dignity and control in the last stages of life are vital and achievable.

EU Accession is already having unexpected and positive effects in economic terms. It could also be the opportunity for new social initiatives. The World Cancer Report was an excellent start but did not deal with the way forward for this region in any detail.⁸ We present here a programme of investment, which could allow the region to catch up in terms both of process quality and outcomes. There can be new partnerships to reduce disease burden and to add substantially to life expectancy for the citizens of the new member states.

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Current reform proposals in social health insurance countries

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*“incremental reform
has begun to put at risk
the core commitment to
the central social value
of solidarity”*

Social health insurance (SHI) countries in western Europe have a long history of making incremental rather than fundamental change.¹ Recent changes typically have involved relatively minor adjustments to existing financial mechanisms. On the rare occasions when more major, structural reforms have been attempted, those, too, have been implemented in a careful step-by-step manner.

As pressures for major reform have mounted, a growing number of SHI countries find themselves confronting a predictable dilemma. The combined impact of incremental reform has begun to put at risk their core commitment to the central social value of solidarity. While each reform alone has only a minor effect, the overall impact in some systems has begun to threaten the long time strategic balance between equity and efficiency. To forestall undesirable consequences, it has been suggested that national policymakers should consider introducing a process of what can be termed ‘strategic incrementalism’, that is, assessing each individual change in terms of its likely impact on the totality of health system activity.¹ Such an approach would enable decision-makers to take on board the full implications of specific incremental reforms, and perhaps make adjustments in light of those implications, before they are adopted.

The present debate in SHI countries contains a variety of different reform proposals. Where proposed changes are similar, they sometimes are being discussed and/or introduced to achieve rather different health system objectives. This article first reviews current proposed and/or introduced reforms across seven SHI countries in western Europe (Austria, Belgium, France, Germany, Luxembourg, Netherlands, and Switzerland). It then analyses these reforms in terms of the types of change being proposed and their possible implications for these systems’ overall character.

Proposals made or under discussion

Austria: purchasing agencies; additional cost-sharing

The Austrian government is promoting the creation of purchasing agencies

(Gesundheitsplattformen, or Health Platforms), flanked by a Federal Health Agency (Bundesgesundheitsagentur), at the regional and federal level. The main task of these public agencies would be to purchase services according to predefined quality standards and prices. Full implementation of the proposals would result in a loss of autonomy in contractual powers for sickness funds and in a purchaser-provider split in hospitals and institutions owned by sickness funds. In addition, doctors worry that Health Platforms might gain monopoly power in purchasing their services. In 2004, Health Platforms with limited powers were introduced. The Federation of Austrian Social Security Institutions and the Austrian Medical Association succeeded in negotiating a vote within the health platforms, with sickness funds having a veto right in matters concerning ambulatory care and the government in matters of inpatient care (the Medical Association has no veto rights). At the end of 2005, when the federal and the regional governments are expected to come to agreement about integrated regional health service planning, the role of Health Platforms is likely to be strengthened.²

In addition, the Austrian debate currently focuses on increasing and extending cost-sharing. Co-insurance of 20% has been proposed for certain medical examinations. Increases of existing cost-sharing arrangements have occurred and additional measures are being discussed.

Belgium: activity-based hospital financing; changed drug reimbursement

To date, only marginal changes have been adopted, such as minor adjustments in the benefit package. Proposed and discussed changes include an activity-based hospital payment system for certain treatments, and enhanced financial incentives to reduce pharmaceutical costs.

France: gate-keeping; doctor’s visit co-payment; activity-based hospital payment system; union of sickness funds

The 13 August 2004 Health Insurance Law introduced two important changes. First, France is establishing a mandatory GP gate-keeping system. Before 1 July 2005,

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“In Germany two different reforms of the SHI system have been proposed”

every insured individual (16 years and older) must choose a GP or specialist to be his/her *médecin traitant*, in agreement with the doctor. When patients visit a doctor without being referred by their *médecin traitant*, or if the patient doesn't have a *médecin traitant*, he/she can be faced with an increase of the *ticket modérateur* (co-payment) due to two reasons: a diminution of the reimbursement and possibly an increase of the doctor's fee. An exception is made for emergencies and certain specialties and medical situations. This new system will replace the voluntary GP gate-keeping (*médecin référent*) system that was introduced in 1998. Currently, no new patients and GPs can be included in the *médecin référent* system and it will be fully abolished at the end of 2005.

Second, a mandatory co-payment for all physician visits (*participation forfaitaire*) was created. Since 1 January 2005, all patients pay a €1 fee for every doctor-visit, both to GPs and specialists. While the existing (relatively high) proportional user charges have been neutralised by supplemental insurances, this fixed payment is not reimbursable. This €1 co-payment also applies to a number of specific groups who are otherwise entitled to full reimbursement. Only the very poor (and illegal immigrants) who receive health insurance from the government, pregnant women (after six months) and children under 18 are excluded from this co-payment. The €1 fee is small (and capped at €50 per year), but as seen in other countries, once such a measure is in place, the amount can be raised relatively easily.

Additionally, an activity-based hospital payment system will be introduced in France, replacing global budgets for public hospitals and the per diem payments for private clinics. Lastly, a union was established of the three major French sickness funds (covering about 95% of the French population), which now negotiates medical contracts, fixes reimbursement rates and modifies the list of reimbursable medical services.³

Germany: citizen insurance and/or flat-rate premiums

In Germany two different reforms of the SHI system have been proposed, one by the sitting Social Democratic (SPD) government (and major trade unions), the second by the Conservative opposition. Neither reform plan is expected to be implemented until after the next Parliamentary elections in autumn 2006.

The SPD plan would end the current exemption from the statutory system for Germans who earn more than €46,800 a year. This proposed *Bürgerversicherung* (citizen insurance) would require all citizens to buy a standard SHI package, purchased from either a statutory or a commercial sickness fund. By expanding the statutory system to incorporate higher income earners, the statutory system would become more economically sustainable (by bringing in new revenues) and less regressive (higher income earners would directly cross-subsidise lower income earners).

Quite differently, the Conservative opposition CDU/CSU have proposed to restructure the existing system on a flat-rate premium (*Gesundheitsprämie*). This income-independent premium would be €109 for adults, plus €60 for their employers. The contribution is capped at 7% of the insured's total income and will only apply to those currently insured by the statutory system. People with earnings above the income limit will still be able to opt-out from the statutory scheme. The sickness fund contribution for children, as well as for the unemployed and low-income households, would be financed directly from taxation.⁴

Luxembourg: cost sharing

On 9 November 2004, the Sickness Fund Union implemented several incremental changes to deal with its increasing deficit. It limited reimbursement of laboratory analyses, increased hospital cost-sharing, introduced cost-sharing for certain benefits, and increased premiums. There are also proposals to increase the role for generic drugs. Hospital payment continues to be based on budgets, introduced by a 1992 law and operational since 1995.

Netherlands: activity-based provider payment system; no-claim bonus; private standard insurance

Since 1 January 2005, the Netherlands has utilised a DTC (Diagnosis Treatment Combinations) system to pay hospitals and independent care centres. The DTC system is somewhat broader than DRGs (Diagnostic Related Groups) because it also includes remuneration of medical specialists and outpatient care. Moreover, in the case of DRGs, a clinical administrator is responsible for classifying each case, while with DTCs this is in the hands of the doctors themselves. Lastly, while DRGs are often coded at the beginning of a treatment, DTCs are coded after discharge. About 10% of DTCs are subject to negotiation

between sickness funds and providers, while the government fixes the tariff for the remaining 90%.

Further, an annual €255 no-claim bonus has been introduced as of 1 January 2005. If an insured individual does not utilise any services during the year, €255 will be rebated. The cost of any services used will be deducted from this refund, except for GP services, care for children under 18 years old, maternity care and midwifery. This rebate is financed through an increase in the flat-rate premium paid by those insured by the sickness fund. The average flat-rate premium (weighted for the number of insured) increased by 25.4% from €306.86 in 2004 to €384.72 in 2005.⁵

The most important reform, however, is the proposal by the Dutch Ministry of Healthcare, Welfare and Sports to expand the statutory health insurance system to all Dutch citizens, beginning 1 January 2006. It has been approved by the Second Chamber of Parliament and is scheduled to be voted upon by the First Chamber in June 2005. Currently, Dutch citizens with an annual salary above €33,000 are excluded from SHI and rely on private insurance packages that often differ from the statutory social insurance package. The Ministry's new approach would create one standard (curative care) benefit package for all citizens, regardless of income. At a later stage, this package is also likely to incorporate long-term care benefits currently provided under the Exceptional Medical Expenses Act. The proposed, mandatory, standard insurance would be along the lines of current health insurance and could be purchased from both non-profit and for-profit private health insurers.⁶

Switzerland: activity-based hospital payment system; selective contracting

Two SHI reform packages are being discussed in Switzerland (see Box). In 2004, both Swiss chambers of Parliament (National Council and Council of States) approved reform proposal 1A. In March 2005 both chambers also approved proposal 1C, which will be implemented 1 January 2007. Proposal 1D has been approved by the Council of States, while the National Council is still debating about it. Proposals 1B and 2B have still not been considered by either council. Lastly, proposal 2A is likely to be changed, as the Council of States is expected to propose a new system to replace the fixed dual financing system by some form of single source financing of which the details have

not yet been released.

Since 2002, all Cantonal governments have had to pay at least 50% of the hospital bills for the basic mandatory insurance package, for multi-patient wards in both public and private hospitals admitted to the Cantonal hospital list and also for private rooms in public hospitals. In practice, Cantons generally choose to pay more than 50%. Cantons also pay the investment costs of public hospitals. Before 2002, Cantonal governments did not subsidise or plan private institutions. After 2002, in return for paying their expenses, Cantons could plan, for the institutions admitted to the list, the number of both public beds in private hospitals and all beds in public hospitals. If the reform is implemented, there will be a fixed percentage that all cantons have to pay for hospital bills, for whatever type of bed, including investment costs. Sickness fund premiums in Switzerland are relatively regressive, so the political left prefers that the Cantons pay for the major part of hospital costs out of taxation. As the Cantonal subsidy would also apply to for-profit organisations admitted to the Cantonal list, government planning capacities would thus expand to this type of organisation.

Within three years after the new financing arrangement has been implemented, the Federal Council is to put forward its vision for a new system, in which Cantonal governments will transfer to the sickness funds the money that Cantons now pay to hospitals, and the sickness funds will then sign contracts with hospitals. This will make

“The ‘citizens’ and ‘standard’ insurance proposals in Germany and the Netherlands, would have far-reaching organisational effects”

BOX

First package:

1A – The risk adjustment fund will be maintained for at least five more years; the financing law will be extended until a new law (in the second package) is approved; the nursing tariff is frozen until a new tariff is implemented latest at the end of 2006; and a legal framework for an electronic insurance card will be created.

1B – Sickness funds will no longer be required to offer a free choice of provider within their Canton. While the Canton defines the minimum number of providers the insured should have access to, sickness funds are free to negotiate and choose the particular service providers they want to contract with.

1C – Health insurance premiums will be reduced by at least 50% for children and young low and middle income students. Cantons have considerable latitude in defining these groups more precisely. Cantons must spend a minimum amount of money on this type of premium relief in order to be eligible for a federal subsidy.

1D – General cost-sharing (currently 10% of all incurred health care costs) will be increased to 20%. The annual total will still be capped at 700 Swiss Francs per adult (350 Swiss Francs per child under 18).

Second package:

2A – Hospitals will no longer be financed by objectives (currently also often on the basis of per-diems), but by services delivered.

2B – Managed care, while already widely applied, will be formalised in the health insurance law.

“what appears to be nearly the same reform may be intended to produce quite different results”

sickness funds the only payers for hospital services, combining both tax and premium revenues. Capital costs will remain financed mostly by the Cantons. This reform is planned for implementation in 2007–2008, but as there might be a referendum, the process could be delayed.” In other words: take out last sentence, change ‘will’ into ‘might’ and ‘might’ into ‘could’.

Assessing the patterns

Several clusters of activity can be discerned among this rather disparate catalogue of recent reforms, expected future measures, and proposals under discussion. While all of these reforms have some degree of financial implication for the overall cost of running these health systems, they reflect different approaches not just to financial questions but also to the logic of health sector reform generally.

There would appear to be three distinct categories. The first can be termed short-term financial fixes, typically seeking to raise additional revenue and/or to restrict the demand for services. These include increased patient charges, deductibles, co-payments, no-claims bonuses, and other similar devices. A special category here is the growth of flat-rate premiums rather than income-tied contributions, as exist in the Netherlands and have been proposed by the CDU/CSU in Germany. This emphasis on individual incentive mechanisms has been growing over the past ten to fifteen years,⁷ and is an example of isolated incremental measures that, taken together, can lead to the erosion of solidarity.

The second category involves organisational or structural changes that are essentially institutionalised versions of short-term financial fixes. That is, they focus almost entirely on cost issues, however they utilise a new office or organisational entity to do so. The example here seems to be purchasing. While purchasing has become quite sophisticated in tax-funded health systems over the past fifteen years,⁸ it is a relatively undeveloped activity in SHI countries. Austria’s ‘health platforms,’ and Switzerland’s proposal 1B to allow selective contracting by sickness funds, represent two efforts to develop purchasing further.

The third category consists of more major institutional changes. Here there are several good examples. One – activity-based hospital payment (Belgium, Germany, The Netherlands, possibly France and Switzerland) – could, if properly regulated, encourage hospitals to increase their operating efficiency. A second, using public tax

money to pay for insurance premiums for children (Switzerland, CDU/CSU in Germany), is an equity-oriented measure that would expand publicly financed coverage beyond the unemployed and indigent. While both measures represent a major change, neither alters the fundamental social and organisational landscape.

Two other institutional reforms, however, represent major change in the national organisation of SHI systems: mandatory gate-keeping (France) and a universal ‘citizens’ or ‘standard’ insurance (Germany, Netherlands). The introduction of gate-keeping in France is intended not only to reduce unnecessary demand and thus expenditures, but it is directed also at improving continuity of care. The change thus addresses a longstanding criticism of SHI systems, which argues that they lack clinical coordination (Netherlands has gate keeping and thus is an exception). Among other advantages, gatekeeping in France is expected to improve regular medical contact with older people, thereby reducing avoidable deaths such as those during the 2003 heat wave.

The ‘citizens’ and ‘standard’ insurance proposals in Germany and the Netherlands, respectively, would have far-reaching organisational effects. In each case, the reform would end the long-standing opt-out (voluntary in Germany, mandatory in the Netherlands) of high-income earners from the statutory SHI system, creating what would be a universal statutory system. However, the purpose in doing so is quite different between the German and Dutch government approaches. In Germany, the centre-left SPD government has previously sought to incorporate a greater number of citizens into the statutory system. For example, the earnings ceiling below which membership is mandatory has risen 16.9 % in Germany between 2001 and 2005 (from €40,034 to €46,800). In the Netherlands, conversely, the centre-right government has avoided expanding eligibility for the statutory system, raising its much lower ceiling only by 2.3% during the same period (from €32,251.73 to €33,000).

For Germany, induction of higher income citizens into the statutory system would be a way to raise SHI revenues by increasing subsidies from wealthier citizens, with the intent of stabilising and reinforcing the existing system. For the Dutch government, a universal statutory system would be an important stepping stone to market-oriented competition among sickness

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funds, in effect attempting yet again to fulfill the vision of the 1987 Dekker Committee, thus changing the core structure of the existing SHI system fundamentally. It is a commentary on the importance of national culture and policymakers' values that, in this instance, what appears to be nearly the same reform measure can in practice be intended to produce quite different results.

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Exploring possibilities for consumer choice in the German health care system

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This article reports on the results of a project conducted to explore feasible reform options in the German health care system*. More specifically, the project examined policy instruments to address the inherent problems of the Statutory Health Insurance system (*Krankenkassen*), where more than 90% of the population is currently insured. These instruments include demand- and supply-side measures such as the extension of patients' cost sharing, a modification of the benefits catalogue and organisational changes such as gatekeeper systems and selective contracting.

Traditionally, three principles are fundamental to the German system, and may be used to test the reform options.

The first is the solidarity principle, which has two components: one of which implies a 'sharing of health risks' in the sense individuals may demand health services on the basis of need (*Bedarfsprinzip*), and one that ensures contributions are based on ability to pay irrespective of costs incurred to the health system (*Leistungsfähigkeitsprinzip*).¹

The second principle is that the German health insurance system is funded through employer and employee contributions based upon wages, as opposed to general taxation, risk-based health insurance, or contributions based on total income.

The third principle is that of subsidiarity, meaning that the state delegates the organisation of the health care system to the respective organisations of health care insurance bodies and medical specialty societies.²

The factors contributing to Germany's current health system problems fall into three categories: revenue, expenditure and system structure. Revenue problems are caused by a weak financing base, transfers to other sectors of the social system, and a sinking wage/GDP ratio. Expenditure

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“Consumer choice is not synonymous with individual responsibility”

issues are concerned with demand and supply side effects such as supplier-induced demand and a problematic demographic structure, particularly with an increase in elderly people. The system structure is also suffering from under-provision, over-provision and mis-provision of specific services to the general population, something attributed in 2001 by the Advisory Council for Concerted Action in Health Care to the general lack of transparency and providers' autonomy within the German health care system.

Approach

Following an extensive international literature review that provided available evidence regarding the effects of 'consumer choice in health care', we designed and carried out a series of three runs of a seminar game to stimulate debate among the major stakeholders of the German health care system. Each run of the game used a different scenario:

Back to the Future featured managed care and a number of cost-control measures such as co-payments and deductibles.

As You Like It that featured different packages of benefits available to the insured at different prices.

Renaissance of a Single Payer System in which a quasi-governmental body was the single insurer, and used its monopoly power to control expenditures.

Each of these scenarios was presented to a different set of stakeholder representatives, who visited the Bertelsmann Stiftung for a whole day of participation. The stakeholder representatives were divided into four teams, representing providers, insurers, government and social partners.

Each stakeholder team did a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) of the scenario, based on its perspective. The SWOT analysis led to recommendations for adjusting the reforms given in the scenario, which were subsequently discussed in a plenary session. At the end, participants were asked to assess the favourability of the scenarios (before modification in the morning and after

modification in the afternoon) compared to the present situation.

Consumer Choice and Responsibility

Theoretical foundations.

Our literature review³ systematically examined 184 separate publications, of which the majority were published in international peer-reviewed journals. It focused on the effects of various degrees of consumer choice on health service utilisation, health status, satisfaction, equity and macro-economic effects. The current economic paradigm of consumer choice assumes that consumers behave rationally and maximise the utility they receive from consumption, over a set of preferences. In health care these preferences may include any attributes of the medical care consumed (for example, provider, treatment, time, cost, quality etc.). Because considerable uncertainty exists about future illness, and because people tend to be risk-averse, consumers often choose to insure themselves against the risk of having future health care costs.

This insurance is usually regulated, (and sometimes provided) by the government. In cases where consumers can choose between different benefit packages, insurance companies, or health plans, a second level of choice alternatives is introduced. In some cases choices on this second level may set restrictions to the choice set on the first level, which is for example the case if an insurance firm only contracts with a limited set of providers or offers a limited benefit package.

Economic markets function best when consumers know what their preferences are and can find a product with the combination of qualities and cost that is best for them. However, because of existing information asymmetries between consumers, insurers and providers alike, it is difficult for consumers to define their preferences; patients often have to rely on the judgment and advice of the doctors who treat them. Therefore, the concept of consumer choice is closely connected to the presence of information in the market.

When choosing an insurance company, benefits package or level of co-payment, consumers might receive incentives to consume an appropriate (instead of a too limited or excessive) amount of medical care. These incentives can help to minimise the welfare loss to society as a result of imperfections in the health insurance market (for example, moral hazard*). In this sense, the concept of consumer choice is

* The existence of moral hazard is not only confined to health care or the insurance market, moral hazard describes the chance that a contract will change the risk-taking behaviour of one or both of the involved parties. Moral hazard can be present in almost any situation involving two parties coming into agreement with one another. In a contract, each party may have the opportunity to gain from acting contrary to the principles implied by the agreement.

also connected to cost containment and shared responsibilities over the consumption of medical care by consumers, providers and insurers. Solving these market imperfections by giving consumers more choice can lead to more efficient outcomes but might also have an effect on the distribution of medical care. It is important to keep in mind that consumer choice is not synonymous with individual responsibility. They may reinforce each other, but one can also exist without the other, or neither may exist.

Empirical evidence

To remedy the existing gaps and improve individual and market outcomes, there have been some attempts to provide consumers with more information, especially in the US. The current literature is not clear about the extent to which more information actually influences consumer choice, there is even empirical evidence from some studies that people prefer less complexity in information.^{4,5} Delivering more information might be helpful but will certainly not reduce the inherent asymmetry in the provision of health care services.

Aggregate consumer preferences differ across groups and within groups across time. Much of the literature assumes that the choices of consumers are mainly driven by financial incentives. However, a number of studies address the fact that there exists a whole range of other issues on which consumers want choice, for example quality, coverage, waiting time or travelling distance. Consumer choice in health care can deal with more than just financial incentives, in principle leading to better matching on many dimensions of care.⁶

Regarding models of consumer choice and instruments of cost reduction, there is much evidence on the effects within the health care system, but little evidence on larger effects on the economy or society in general. The literature on instruments (such as deductibles, co-payments, bonuses) is convergent, they reduce utilisation, while the literature on organisational delivery is mixed. The way these instruments are put into practice can vary enormously and this can influence their effects in practice. We can therefore conclude that the debate on picking a model for more consumer choice should consider both the instruments (serving as ‘building blocks’) and the way they are implemented in a health care system. This conclusion has been particularly relevant when applied to the scenario development.

Results of the seminar game

There were three themes that arose from the debate on future reform options that took place during the runs of the seminar game.

Ensure quality of care

Participants’ opinions converged in their need never to sacrifice quality of care for efficiency savings. To ensure quality, participants asked for incentives that guarantee the provision of high quality care throughout the insurance system. Some of the policy measures mentioned concerned regulation:

- leading to explicitly defined quality of care criteria, aligned with state-of-the-art internationally available evidence, also to guarantee consistent quality throughout all regions, and
- ensuring the use of health technology assessment (HTA); and ‘pathways’ for (chronic) care as a useful policy instrument.

“What seems most striking is the attempt to maintain and actively increase quality control in the system”

The patient representative group in particular foresaw an increase in the quality of care in our ‘managed care’ model scenario, i.e. when providers would have to prove both their ability to work efficiently and deliver high quality of care. Physicians and pharmacists however, were concerned that price controls would override quality control measures and called for constant improvement efforts in defining quality of care. The insurers stressed the need to define clear evaluation criteria in measuring quality. Whilst the government would be concerned over doctors’ practice in general, insurers saw great merit in quality control measures sanctioned by a democratically elected independent committee. Insurers expressed scepticism about the possibility of creating a truly independent and scientific HTA committee.

Transfer responsibility to individuals in a sensible way

Participants’ opinions converged in the belief that increased *Eigenverantwortung*, (the concept of personal responsibility and choice, internally translated as ‘individual responsibility’) could lead to a reduction of health care expenditure spent on less necessary care through supplementary health care insurance by insurers’ choice. However, a common concern was that a high degree of individual responsibility could lead to less efficiency, because a greater amount of necessary health care expenditure would be funded through private incomes and supplementary

“measurement of quality must be incorporated into potential reform”

insurance packages.

Participants did not reach consensus over the un/desirability of *Eigenverantwortung* when this would restrict basic health care coverage. The insurers expressed this view, arguing that a limited catalogue of health care services would cause many of the insured to seek supplementary insurance. Moreover, the insurers stressed the importance of advocacy committees to represent patients' interests. They also argued that co-payments are more acceptable than bonuses when introducing demand-side policy measures to the system. In terms of stakeholder participation, the government recommended the institutionalisation of a democratically elected advisory committee for health.

Other aspects of individual responsibility were discussed as well. For example, the group representing the government clearly wanted to emphasise prevention by considering it as part of risk sharing (*Risikostrukturausgleich**) in order to provide incentives for insurers to invest more in prevention efforts. At the same time, the cause of patients' health would be supported by public health initiatives and greater emphasis on information sharing that would then enhance the performance of health care systems in terms of efficiency.

Debate values

Participants discussed the structure of Germany's system in the light of a multitude of inherent values in the system. For instance, insurers preferred some form of tax based financing system that would increase the financing basis for health care to the current wage-dependent financing model. They believed it would tackle the problems of demographics, employer's contribution and related anti-competitive effects in the German economy.

The government group, as well as providers of care, viewed introducing competition as desirable if it encouraged selective contracting. Of great interest was the plea to have some form of income-based premia reform. Both the provider group in the Managed Care scenario, as well as the insurers and government groups argued in favour of some greater income basis through means of either tax-based supplementary insurance (providers and government), inclusion of higher income groups (patient represen-

tative groups), or some income reform that would separate wages and freeze employers contribution.

Discussion

Taking different components from different health care systems and designing future scenarios provides us with different thinking models for reform. 'Playing' with ideas that arise from these models and thinking about future reform options for Germany's health care system gives a focus to the debate around consumer choice and responsibility. For the purposes of informing policymakers about possible reform options, seminar gaming allowed us to explore different ideas and identify barriers to reform.

Inherent values such as justice, transparency, solidarity and satisfaction take on different meanings in the light of current changes, changing roles and engagement of stakeholders in such discussions about possible futures. Other countries are currently debating reform options for their health care systems with a similar agenda that focuses around consumer choice with an emphasis on consensus: France, in particular, states explicitly that any political decision-making concerning changes to their health care system should be guided by stakeholders' consensus.⁷ The English are actively engaged in defining consumer choice but find that "almost half of the general public does not know what patient choice is".⁸ The 2004 Policy Agenda of the Dutch Ministry of Health, Welfare and Sport also contains one chapter exclusively devoted to "more individual responsibility for citizens".⁹

The attempt to reform Germany's health care system requires an ongoing and extensive exchange of ideas and recognition of prevailing interests of different stakeholders involved. Exploring the feasibility of reform through compromise and trade-offs between stakeholders presents one way of discussing the viability of future reform options for Germany. Our observations showed that stakeholders are willing to engage and discuss a set of what may seem at times radical reform options in the light of concepts such as choice and responsibility for consumers. What seems most striking is the attempt to maintain and actively increase quality control in the system.

* The German risk structure compensation scheme takes characteristics like age, gender, status and the various health situations of the insured persons (for example, chronic disease) into account. By 2007, new morbidity-based indicators will be introduced as well.

Conclusions to inform policy

Based on the review of the literature, the scenarios, and our analysis of the interaction among participants during the seminar games, we outline a set of conclusions that might provide useful information for future reforms of the German health care system, which has value for other countries faced with reform as well.

Quality assurance needs to be part of any system. This may mean increased oversight of care providers and the use of quality indicators to assess whether performance is adequate.

Personal responsibility in the form of taking charge of one's own health is viewed favourably. This can be a vehicle for differential contributions to health insurance and/or 'sin taxes' that are earmarked for the health care system. However, there is no consensus on how to define appropriate individual behaviours to differentially ration health care services.

Personal responsibility in the form of greater co-payment and deductibles/bonuses are generally acceptable, with a range from favourable to 'necessary evil', as long as there is a safety net to preserve solidarity. There is a general agreement that these mechanisms will reduce utilisation. Whether it also reduces costs depends on the relationship of cost to utilisation.

There is merit in supplementary general tax financing to balance future health care expenditure. A need was identified to decouple insurance contribution from wages, and freeze employers' contributions. A general tax financed system would ensure solidarity is maintained, and stabilise the general economic climate.

The emphasis on assurance of quality of care as a necessary element of any reform cannot be ignored. It is tempting, in times of economic headwinds, ageing populations and expensive technological advances, to give weight to other values such as efficien-

cy, cost containment and the power of the market. This raises the question of knowing whether or not quality care is being delivered; while money can be used as a yardstick for measurement of costs, a currency for quality is not as readily available.

If maintenance of quality is to be essential, it makes sense to incorporate the measurement of that quality into any potential reform to the health care system. Although for a long time, the operationalisation and measurement of process and outcomes of medical care were considered infeasible, recent studies have shown that results in this area are promising and sometimes quite spectacular. For example, a recent major study showed that Americans get only about half of recommended care.¹⁰

At this point we could express the hope that Germany fares better in future than it does at present and will not decline further if there is an increased movement towards *Eigenverantwortung* and efficiency. However, the truth of the matter is that we simply do not know. Even estimating the current German situation, much less the future, is impossible given the present quality measurement methods and availability of data.

The views expressed in this article in no way represent those of the European Commission

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* A full description of the project can be found in the (German language) report *Eigenverantwortung – Ein gesundheitspolitisches Experiment*, Bertelsmann Stiftung (Hrsg.). 2004. www.bertelsmann-stiftung.de/de/4435_4437.jsp [accessed on 3 May 2004]. This article focuses on the contributions of RAND Europe to this effort – namely the international literature review, the design and conduct of a seminar gaming exercise to test possible options, and the analysis of the results of the exercise.

Mental health care reform in Lithuania: *Development and challenges*

Vaida Bankauskaite
and
Nijole Gostautaitė
Midttun

*“Mental health has
been deteriorating
during the last decade”*

Introduction

During the last decade, post communist countries in Central and East Europe have been experiencing dramatic changes in their health systems, including the mental health sector. The need to reform mental health services was obvious since these countries have inherited mental health services dominated by specialised psychiatric institutions, neglect of mental health issues, indifference to human rights and sometimes outright political abuse.¹ Post communist countries have been facing similar challenges in reforming their mental health service, but these processes are not well documented. The aim of this paper is to discuss the development, achievements and challenges of mental health reform in Lithuania and therefore, provide the insight into the implementation of these reforms in post communist countries.

Lithuania regained its political independence in 1991 and together with two other Baltic countries joined European Union in 2004. In Lithuania, health care reform started in 1992 and mental health reform in 1994. Official documents indicate that mental health is a priority issue of health policy in Lithuania.^{2,3,4} Other legal acts determine the general principles for mental health reform and regulate the rights of mental patients.^{5,6} The main objectives of the national programme of prevention of mental illnesses adopted in 1999 include improving access to mental health services, increasing outpatient mental health services, reducing the number of beds in psychiatric hospitals and strengthening prevention measures.⁵

The need for mental health services

Mental health in Lithuania has been deteriorating during the last decade. The morbid-

ity of mental illness has increased from 3,929 per 100,000 people in 1990 to 4,289 in 2000 and 4,627 in 2003.⁷ Lithuania has one of the highest suicide rates in Europe, which was 43.7 per 100,000 inhabitants in 2001, compared with an average in the EU in 2000 of 10.2.⁸ Disability due to mental illness has climbed from 23,000 cases in 1990 up to 27,167 in 2000, and to 28,697 by 2003. In Lithuania, the National Commission of Medical and Social Expertise decides the level of an individual's disability based on their temporary or permanent loss of working capabilities due to illness. At least two reasons can explain these trends. Firstly, improved access to mental health services, including the establishment of Mental Health Centres, has led to the improved diagnosis of mental illness. Secondly, widespread poverty in the country has created an increased need for disability pensions.

The most frequent users of mental health services in Lithuania are people with schizophrenia, which implies that this group receives the largest share of financial resources. In 2000 morbidity from schizophrenia was 626.4 per 100,000, compared with 581.2 for learning disabilities, 273.2 for neurotic, stress, personality and behaviour disorders 273.2 and 428.5 per 100 000 for affective disorders.⁷ The treatment situation is paradoxical since people with learning disabilities receive many inpatient services based on a traditional biomedical model, which is not appropriate. Specialised social and educational programmes would be a more effective way of reducing disability and promoting integration into society.

One of the existing obstacles to the development of mental health care reform in Lithuania and probably in other post communist countries is the lack of epidemiological data. Effective planning of mental health services requires an analysis of epidemiological indicators and data on needs assessment. The current indicator of the number of patients served by inpatient and outpatient services does not reflect real need for mental health services, which in

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turn does not allow efficient planning of mental health service reform, including the restructuring of health care institutions. There has though been one major attempt to assess community needs for mental health services in the Kaunas region municipality focussing on quality of life.⁹

Provision and financing of primary mental health services

Municipal mental health centres (MHC) and general practitioners (GPs) provide primary mental health services in Lithuania. MHCs are a municipally owned institutions that have been providing primary health care services since 1994. There were 64 MHCs in 2004 in Lithuania, two of them privately owned.⁷ The concept of the MHC entails contradictions, because primary mental health services are provided by specialists, such as child and adult psychiatrists, psychotherapists, narcologists (who specialise in addiction) and mental health nurses. The number of personnel working in these centres has been steadily increasing: there were 126 adult psychiatrists, 40 child and adolescent psychiatrists, 167 nurses, 111 social workers and 71 psychologist in all MHCs in 2003.⁷ Existing regulation prevents MHCs from providing services not related to primary mental health care, which results in the duplication of services by GPs.

The responsibilities of GPs in terms of mental health in many countries, including Lithuania, consist of diagnosing and treating mental disorders. The World Health Organization has stressed the role of the GP in diagnosing mental illnesses. Nevertheless, 65% of patients with mental disorders have somatic and not mental problems, making it difficult for GPs to diagnose these disorders. Additionally, Lithuania and other post-communist countries have introduced the GP institution relatively recently. As a result, GPs may lack experience in providing mental health services and thus, may try to avoid 'complex' patients. Currently in Lithuania GPs do not perform their gatekeeper function for patients with specialised care needs, since patients have direct access to MHCs.

There are differences and similarities between the two primary mental care providers in Lithuania. MHCs and GPs differ in care provision patterns and the authorisation to prescribe subsidised pharmaceuticals. Therefore, the clients of GPs and MHCs are very different: GP clients are a mostly healthy general population, while most clients of MHCs have severe

mental illnesses. Even though MHCs are providing specialised care (adult psychiatry, child and adolescent, dependency psychiatrists and psychotherapists), both MHCs and GPs receive per capita financing and MHCs are not funded for specialised services and secondary level outpatient services. This situation results in competition for the same per capita financing and duplication of their functions.

Provision and financing of secondary mental health services

Mental health services at the secondary level are mostly inpatient and are provided in nine psychiatric hospitals (3,718 beds) and 13 psychosomatic and psychiatric departments in general hospitals (342 beds). The number of inpatient beds for people with mental disorders has decreased by nearly 40% between 1985–98.¹⁰ There were 3,816 beds in 2002 in Lithuania, making 11 beds per 10,000 population, which is very close to the recommended number of beds. Recently, the number of specialised psychiatric hospitals has been the same, while number of psychiatric departments in general hospitals has decreased. Three institutions in two main cities in Lithuania provide tertiary mental health care services. A new trend has been to establish specialised clinical and research centres devoted to specific disorders, such as a centre for eating disorders opened recently under the auspices of Vilnius University Psychiatry Clinic.

The financing of the Lithuanian health system is complicated, as is the case in other post communist countries, and undergoes constant reform. The State Sickness Fund (SSF) provides 70–80 % of health care budget. Municipal budgets and government investment programmes provide the balance of funds, which mainly covers the costs of equipment, but is not intended to pay for services. Mental health services are financed based on a needs assessment, which includes the current scope of care rendered, limited information on epidemiological trends, and morbidity and mortality data on registered psychiatric patients. Based on this information the SSF signs a contract indicating the limited number of services they will pay for each year, based on fixed rates. Total health expenditure in Lithuania reached 5.7% of GDP in 2001.⁸

The financing of inpatient services in Lithuania has changed many times. The current principles of financing inpatient care services date from April 2002. There are four categories of inpatient services

“GPs may lack experience in providing mental health services”

Table 1
Regulation of the financing of inpatient services in Lithuania from April 2002

Category	Type of service	Financing provided by the State Sickness Fund
IA	Precisely stipulated inpatient services, with full regulation of their scope by providers	Complete reimbursement of these services
IB	Precisely stipulated inpatient services, with limited influence by providers on the scope of these services	Completely reimbursement of these services, but there are limitations on reimbursement
II problematic services	Complex services: there is a lack of stipulation of indications and criteria for these services	Complete reimbursement for services included in quotas, and 15% of reimbursement for services not included in quotas
III	Outpatient services, which could be provided as inpatient services if needed	50% reimbursement of services included in quotas, and 15% reimbursement of those not included in quotas

“between 15% and 40% of residents could live in community if they received adequate outreach services”

with different systems of financing (see Table 1). The objective of this regulation was to strengthen cost containment and the development of outpatient services, to reduce the deficit of SSF and the number of inpatients treated. The problem is that practically all psychiatric services belong to groups II and III, which require further specification of mental inpatient services and due to the absence of such a specification the provision and financing of inpatient mental health services in Lithuania is limited. The total expenditure for mental health services in 2001 was 118.5 million Litas (€1 is equal approximately to 3.5 Litas, Lithuanian currency) or 8.25% of total expenditure for health care services, of which 36% were allocated to social care institutions, 34% to inpatient services, 19% for subsidised medicines and 2% for disability and rehabilitation programmes.¹¹

Provision and financing of services provided through social welfare

A large share of services for people with mental disorders are provided through the social welfare system and regional institutions (over 5,500 beds). They are social care services, yet follow a medical care service model, for example, all residents have their medical records and receive pharmaceuticals covered from the institutions’ fixed budget. Approximately 40% of residents have schizophrenia, 40% learning disabilities and 20% with other mental health and neurological disorders including dementia, epilepsy, addiction, or personality disorders. The main reason for receiving residential services are medical criteria (diagnosis, mental status), and not social function-

ing, therefore the level of disability of the residents does not always require these intensive and expensive services. Estimates by the staff of these institutions suggest that between 15% to 40 % of the residents could live in the community with high degree of autonomy, if they received adequate outreach services.¹²

The majority of specialised residential care homes for the mentally disabled operate under the auspices of regional authorities that are funded from the social services budget. This situation misrepresents a large number of residents with mental disorders and distorts calculations of costs of mental illness, as well as number of long-term beds. Therefore, a unified mental health budget could improve the balance between more and less intensive, in and out patient services, in response to population needs. In 2001, the Social Welfare and Labour Ministry published a catalogue of social services, where, for example, services for those with developmental disabilities are specified, but not for those with severe and persistent mental illnesses. Municipal payment contracts with primary service agencies for social services might also provide additional funding, improve quality and continuity of care while expanding the functions of the MHC network.

Achievements and challenges of mental health reform in Lithuania

Mental health reform in Lithuania is relatively new therefore it is difficult to evaluate its development. It is possible to conclude that there have been some positive results as well as many remaining challenges for this reform effort. The main achievements include establishing a network of municipal mental health centres, improving access to mental health services, developing a strong legal basis for mental health care and introducing positive changes in the training of mental health specialists. In addition, new services, such as rehabilitation, counselling, and social services, have been established during the last decade. Structural changes in inpatient institutions include a reduction in the number of beds and decreased average stay and number of re-hospitalisations. In addition, and significantly, the current health minister has repeatedly and publicly declared mental health a priority for Lithuania and has taken steps to incorporate the recent WHO/EU Helsinki Declaration and Action plan. Recently, there have been positive changes in user involvement in mental health services (user run survey on patients’

rights in major psychiatric institutions and participation in hospital administrative boards), diminishing the stigma towards mental illness, through joint activities of users and professional organisations (for example, Club 13 and Co, Lithuanian Psychiatric Association, etc.)¹³ It is important to mention that Lithuanian Open Society Fund (Soros Fund) has been instrumental in funding the development of new models of services, system analysis of programmes and the establishment of a number of NGOs operating in mental health care.

Nevertheless, there are still institutional, legal, financial and human resource issues to be addressed in the formulation of mental health reforms in Lithuania. One of the major challenges is determining the future role of GPs in the provision of mental health services. It would be feasible to delegate primary mental health care to GPs, leaving MHCs to deal with secondary level service provision. Under this scheme, these agencies could also monitor public mental health indicators in close cooperation with GPs. Then the MHCs could provide more varied as well as specialised mental health services (crisis intervention, day centres, rehabilitation, case management, etc.), which are currently lacking. Other institutional challenges include the lack of integration of mental health services, for example, in and outpatient mental health care systems are not related financially or administratively, making it difficult to implement WHO recommendations.

These institutional problems are interlinked with those of financing. For example, the majority of MHCs are an integral part of the organisational structure of primary health care centres (PHC). This type of integration with primary health care institutions should be beneficial for the continuity of care and improve somatic health, but it actually reduces the budget earmarked for psychiatric services. An additional problem occurs because of the excessive financing of inpatient mental health services, which in turn increases the overall inefficiency of the system. As mentioned earlier, the largest share of expenses for mental health services goes to inpatient services and inpatient nursing services (34% and 36% respectively), while outpatient and rehabilitation services receive approximately 9% and 1% of the budget (see Figure 1). Future mental health care strategies in Lithuania should reconsider the balance of types of services provided (inpatient vs. outpatient, social and psy-

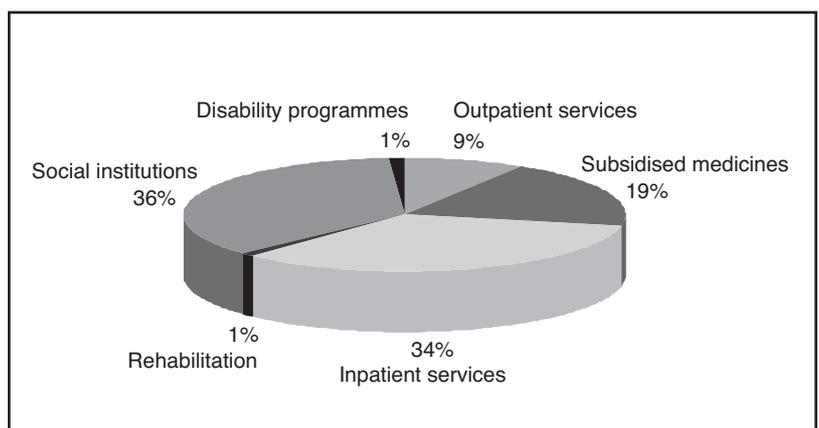
chotherapy services) and their financing.

Challenges in adopting legislation pertaining to mental health issues persist at a national as well as institutional level. For example, at the national level a clear strategy for the restructuring of mental health institutions is lacking. At the institutional level, there is a lack of practical instructions on how to implement laws on patients' rights, such as compulsory treatment, right to information, and the right to file complaints among others. In addition, more attention should be paid to the implementation of legislation. For example, the objectives of Lithuanian Health Programme adopted in 1998 included stabilising the prevalence of mental illness and creating a quality of life monitoring system by 2005 and reducing the suicide rate to the EU average by 2010.⁴ However, these objectives were not achieved due to the lack of appropriate finance and political support.

There are at least three other pressing issues for professionals working in the mental health system. First, deficiencies in clinical work include not following treatment recommendations, and an overemphasis on high dosages and drug combinations. Second, the strong influence of pharmaceutical companies, the weak activities of professional associations and the number of physicians working abroad are additional problems. The third issue is the very low level of salaries for physicians and nurses, which may at least partly explain the prevalence of some of the problems outlined. The salaries of medical staff are lower than the average salaries in the country. This does not contribute to motivating health workers and impedes the implementation of health care reform.

“mental health care strategies should reconsider the balance of services provided....”

Figure 1
Structure of state expenditure for mental health services in Lithuania in 2001



Source: Murauskiene L, 2003.

Concluding remarks

The development of mental health reform in Lithuania illustrates that there have been significant achievements in a relatively short time. Nevertheless, numerous challenges remain and require political commitment in order to address them. The WHO European Ministerial Conference on Mental Health 'Facing the Challenges, Building Solutions' in Helsinki (Finland) 12–15 January 2005 has outlined the milestones for the European countries for the coming five years.^{14,15} These documents can be especially useful for countries dealing with post communist problems where decision makers should develop clear priorities and implementation plans in a complex social, political and economic environment.

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- Octavi Quintana Trias, Director, Health Research, DG Research European Commission

No role for NGOs in improving the performance of health care systems?

A case study from Bosnia and Herzegovina

Grujica Žarković

and

Walter Satzinger

“ideals of equity and solidarity were tacitly abandoned”

Background: After the destruction of socialist health care systems in Eastern Europe – what next?

Before 1990, the National Health Care Systems (NHCS) of most socialist countries had been, to many western visitors and scientists, a subject of admiration or benign criticism.¹ Their common features were summarised by Roemer² as follows: Everyone was entitled to receive comprehensive health services free-of-charge as his social right; the provision of health services was the responsibility of the government at its various levels; the delivery of preventive and therapeutic services was principally well integrated, with an emphasis placed on prevention; health resources and services were centrally planned as part of the entirely planned economic and social order.

All components of the health system were integrated under the direction of one major authority, the Ministry of Health and its subdivisions. Although local groups of citizens had the possibility of contributing to health policy formulation, final decisions on core system structures and functions were made by central political authorities. In the case of resource shortages, the health care of industrial workers and children were given priority. Private medical practice (and related activities) was not prohibited but subject to strict regulations. All health interventions were based on principles of scientific medicine; non-scientific and alternative medicine were not permitted.

After the collapse of communism, NHCS disintegrated quickly, both in terms of their structure and strategic base. In almost all Former Socialist Countries (FSC), citizens lost their entitlement to free medical care paid from tax-generated funds. Governments introduced health insurance schemes that were financed predominantly by employee contributions, but became insolvent in a time of ailing economies and staggering unemployment. Consequently, large sections of the population were left

without access to health care. The socialist ideals of equity, solidarity and the priority of vulnerable groups were tacitly abandoned. Particularly in three FSC (USSR, Yugoslavia and Czechoslovakia) dissolved into 25 independent countries, health planning became very difficult or even impossible, as each had specific health problems, political structures, ideologies, and many more interest groups and decision-makers.

After a few years this became evident. The increased costs of medical services, reduced access to quality medical care and a blatant lack of programmes for health promotion led to a dramatic deterioration in the health status of the FSC.^{3,4} This outcome amazed those who expected the transition to a market economy to contribute to an improvement rather than deterioration in health service performance. Among the explanations for this development and strategies for reversal, three different positions can be distinguished:

- The *pessimistic* view which interprets the collapse of socialist NHCS as the effect of neo-liberal policy of international financial organisations, particularly of the International Monetary Fund and the World Bank, and does not expect – in foreseeable time – any serious improvement of the health sector.
- The *pragmatic* view that neither expects great advances to come soon, but believes that some progress can be made with ‘reforms’ consisting of small incremental changes.
- The *optimistic* view that interprets the deteriorating performance of health care (in those FSC which previously already educated an oversupply of health workers, and had a high capacity in health facilities) primarily as the effect of poor management and mistakes which could and should have been avoided, if the new decision-makers had known what to do and had been willing to do so.

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“Without the support of relevant interest groups, even the best proposals are doomed to failure”

The first position is expressed by Afford⁴: “The international community, its financial institutions, the IMF, World Bank and investors, must all bear considerable responsibility for advocating an approach to economic transformation which exposed the people of Central Eastern Europe to such extremes of dislocation.” The presumption underpinning the economic policy of these institutions was that price liberation would create market conditions, tighten fiscal policy, depress demand and public spending, and, supported by privatisation, force enterprises to pursue efficiency. This sequence of reforms, however, proved inappropriate. Price liberation led to spiralling inflation and indebtedness of enterprises and was followed by a collapse in production and labour markets. Pressured to reduce budget deficits and to cope with dwindling tax revenues, governments responded by cutting public expenditure and investment in the social infrastructure. In Afford’s opinion, improvement in the performance of the NHCS in FSC will predominantly depend on swift and thorough economic recovery. But as the growth rate in FSC economies remains slow, their population may wait half a century or more to receive the health care that it enjoyed fifty years ago.

The second position is shared by most health authorities and foreign advisers in FSC. It also associates improvements in health care with economic growth, but believes that small reforms in the meantime might produce some relief in the situation. The third position, advocated by only a few authors, interprets the paralysis of health policy in FSC as an a consequence of poor macro-management during the transition from a socialist to ‘capitalist’ health care system (if anything of the kind exists), and also due to the lack of qualified managers capable of properly advising health policy-makers and appropriately managing health care systems. Accordingly, all FSC could have saved what was good, and eliminated what was deficient in their NHCS. This position, first proposed in 1994,⁵ further developed with specific strategies and managerial methods until 1998,³ and then, with the help of local co-authors, disseminated in Russia, Romania, Serbia and Montenegro and Bosnia and Herzegovina, was neither accepted nor rejected by the relevant national health policy makers to whom it was submitted, it was just ignored.

Optimists believe that most FSC already have at their disposal most ingredients needed to improve health sector perfor-

mance, and that the present paralysis in health policy could be overcome if long delayed changes were introduced by enlightened decision-makers well advised by properly educated and dedicated health managers. Unfortunately, in most FSC, bold progressive decisions are blocked because their resulting profound alterations to the system would inevitably change the power and position of various interest groups.^{6,7} Those gaining from these changes might eventually, but not necessarily, support reform, while those losing would certainly oppose it. However, in order to change a health system, first, one must be able to formulate and propose a clear vision of the goals, strategies and targets of reform, second, obtain support of relevant interest groups, and third, manage consensus-building between these relevant interest groups. Without the support of relevant interest groups, even the best proposals are doomed to failure.

Focus

This paper describes the attempts of a group of dedicated optimists to cure the health policy paralysis in Bosnia and Herzegovina (B&H) between 1999 and 2004 and explains why they failed. The subject is the Health Care Committee (HCC) of the Department of Medical Sciences of the Academy of Sciences and Arts of B&H, and the focus is on aims pursued and methods applied by the HCC when it tried to mediate between relevant interest groups while discussing a common health policy for the country.

The HCC was founded in 1980 by the Council of Academies of Sciences and Arts of Yugoslavia. It is a non-governmental organisation (NGO) without any power or financial means, but with some prestige due to its former activities and the authority of its members. Before the collapse of Yugoslavia, the HCC advocated changes to improve the performance of the ‘self-managing’ health system and avidly supported the health policy based on the *Targets for Health for All* of the World Health Organization Regional Office for Europe. Three years after the end of war in B&H, the HCC co-opted a number of health professionals from both entities of B&H and decided to tackle the crucial issue of health policy.

Health care in Bosnia and Herzegovina

The health care system in B&H, its historical background, organisational structure

and delivery management, resources and expenses, as well as some proposals for reform, are extensively described in a publication of the European Observatory on Health Systems and Policies.⁸ This report was cautious in its analysis of performance; yet it emphasised, *inter alia*, that:

B&H “inherited a particularly formal and rigid health facility and human resource planning method...” (p.31). “The pre-war health institutions unready for change, remain functioning as in the pre-war environment, while newly created facilities lack the capacity to operate efficiently” (p.22). “...there is no serious prevention programme in place” (p.32). “...legislated entitlements for the receipt of publicly-financed health care in both entities are far above available resources that can be collected at present. This results in implicit rationing...” (p.44). “The health care sector became and continues to be burdened with specialists. So far, much of the primary care in B&H is in the hands of specialists due to the underdevelopment of community-based primary care” (p.61). “Despite a number of reform proposals, a plethora of working groups, laws and draft laws, health care delivery remains essentially unchanged” (p. 20). Finally: “Western donors have contributed large amounts of funding to rebuilding system...This support, however, has not been free of contentious side effects...western aid seems to have triggered a ‘rent-seeking’ donor culture and a foreign aid dependency among politicians and professionals” (p.88).

A World Bank Group for B&H, in its report of 2000 to the president of IDA, found the health system in B&H to be complicated, expensive, ineffective and inefficient, due to an administration reflecting the poor state of public administration in B&H as a whole. “Weak new institutions and political environment fragmented by ethnic divisions leaves space for corruption and rent-seeking”.⁹ According to a document of the United Nations High Commissioner for Refugees,¹⁰ the key problems of health system access and efficiency are a combination of complicated non-portable insurance schemes, a lack of adequately equipped facilities and the general lack of funds to properly run the health system. An earlier survey of the World Bank¹¹ found out that “rural residents complain about the ...lack of access to health facilities” (basic health care is available to only 28% of the rural population surveyed), that, in general, “most sorely needed are ...the local health care

services...” and over 73% of households perceive that fundamental change is required to improve the health sector.

The reform strategy of the Health Care Committee

In addition to these critical reports, the HCC made its own evaluation of the current system and identified, as its main and most disturbing features, an enormous inequity in the financing of and access to health care, a lack of public health programmes for the prevention and control of non-communicable diseases, and poor performance of medical and prophylactic services at all levels of health care, especially in primary care.

Some causes of the misery of health care in B&H are beyond the reach of domestic health politicians (such as the division of the country into two entities and many cantons, the fact that political parties are based on ethnic and religious differences, the influence of foreign powers and mandates of international organisations). The following deficiencies, however, could be alleviated or eliminated by domestic decision-makers alone:

- Inadequate organisation of the health care and insurance system;
- Inappropriate economic relations within the health system;
- Decentralised sickness insurance funds obliged to pay for equal rights to medical care from unequal (per capita) funds;
- Indifferent attitude of the authorities towards health research and development;
- An absence of qualified managers in ministries of health, institutes of public health and insurance funds;
- Poor postgraduate education in public health, and
- A complete lack of postgraduate education and training in health care management.

The trouble with health policy-makers and their would-be health managers in B&H is that they do not share the desire of 73% of the population for fundamental change. Therefore, the HCC decided to try to mediate between the two groups. In 2000, it published its first set of recommendations for changing the principles and methods of health care services in B&H. The most important proposals and postulations included:

“there is enormous inequity in access to health care”

“it is up to NGOs to try and stimulate improved performance in the health care system”

- Equity in the financing and delivery of essential health services for everyone.
- Establishment of public health programmes capable of improving the health status of the whole population.
- Freedom of choice of providers of medical services, particularly in primary health care, and their payment on a per capita basis.

This document was supplemented by a programmatic address to the political parties. In 2001, the HCC published yet another document containing similar, but differently worded, proposals. Both documents were distributed to distinct target groups within registered political parties, governments, ministries of health, health care institutions and insurance funds, the media and international organisations. Additional methods used to disseminate messages included conferences for large audiences addressed by invited speakers, small conferences and working groups, visits to key stakeholders, and individual contacts.

Unfortunately, due to a lack of funding, the HCC had to restrain most campaign activities to the towns of Tuzla and Sarajevo and was unable to stimulate major media support throughout the country. All the more, it relied on strategies, laid out by the WHO Regional Office for Europe in a 1999 document entitled *Health 21*, to advise “policies and mechanisms for managing the change”, and tried to realise these recommendations: mobilise partners for health (governments, professionals, non-governmental organisations, individual citizens) and bring them together for action; provide a clear map of the way forward, create awareness, set targets, search for consensus, achieve transparency, evaluate progress. The four years of HCC activity was guided by this ‘line’: informing stakeholders in the health care system and mobilising them to public pressure on the political authorities to go ahead with reform while, at the same time, supporting ministries and agencies of health in formulating “a clear map of the way forward”.

The failure of the HCC-strategy

The attempt of the HCC to make health care reform a major policy issue failed in many respects:

- The HCC initiative did not succeed in drawing the attention of the state administration to the issues at stake. Both governments never sent their members or observers to HCC meet-

ings, and never discussed the HCC proposals.

- The HCC did not win the interest of the ruling political parties for its project. All received HCC documentation but only six of 32 registered political parties in B&H accepted the HCC’s invitation to support them in formulating their health programmes and to discuss health care issues in their organisations.
- The HCC failed to obtain any strong support from the B&H media. When invited, reporters attended the HCC meetings, but never commented on issues discussed. No editors were prepared to report regularly on health policy issues and advocate changes to health system management.
- Although a high proportion of health professionals approved the HCC proposals and attended meetings, hardly any actively promoted and publicised HCC policy recommendations.

Of course, the HCC is only a panel of distinguished and committed health care experts, working as a NGO and neither financially nor logistically in a position to solely run a nationwide campaign (no international organisation in B&H was asked to support it, apart from attending the HCC public meetings). Why its initiative to provoke the political authorities into action failed so miserably, is not totally clear. Did its proposals run too heavily against the vested interests of those responsible for health policies, or is it sheer ignorance towards the importance (and existing impotence!) of the health care system that forms the attitudes of decision makers?

There are some indications of the latter. First, the draft of *Strategy and plan for the reform of the health care system and the health insurance in FB&H*, prepared by the two ministries of health in 2002 and meant to guide health policy until 2012, is a document great in words but small in verifiable targets. It is rich only in non-obligatory declarations on “global development goals” and the “introduction of a modern, rational and efficient system of the allocation of financial resources ... in favour of the improvement of the health status of the population”. It does not take account of the actual deficiencies in the present care system nor of potential means to overcome them, neither does it practically commit the government to resolute reforms. No wonder that the draft of this document is still waiting to be discussed and approved by the FB&H parliament!

A second example of that ignorance: In February 2004, a team of both ministries, responsible for the management of a large World Bank credit for the *Basic Health Project*, received certificates for having successfully attended seminars on the teaching of health care management. The seminars' organisers, when asked which teaching material they used with their students, spoke of some modules developed by a foreign consultant, since, this was their reasoning, no dependable textbook about health care management existed anywhere in the world. Obviously, they had no knowledge of the many books that are highly specific to the topic, all available in Bosnian libraries and partly even written in Bosnian language!¹²

Third, in June 2003, the HCC sent a well developed proposal on the financing of public health programmes to the health ministries and, later on, also to 46 top B&H political personalities. More than half a year later, the President of the B&H Federation forwarded the answer of his health minister which read as follows: "...We do not wish to argue about the proposals of the Academy. Instead we wish to mention what the Ministry has so far done, what it is currently doing and what will be done to consolidate the health system without major breakages." This was said in spite of the deplorable situation of the country's health care system, and reflects the helplessness, if not inertia, characterising the politically responsible bodies of a country "which barely functions as a state".¹³ This episode ended the efforts of the HCC to break the paralysis of health policy in B&H and to persuade decision-makers that, with the proposed changes, substantial improvements in the performance of the health system could be achieved in terms of the equity, effectiveness and efficiency of health care for all three ethnic groups in this country.

Any conclusions?

Wherever (like in B&H) the improvement in performance of a health care system is inhibited by a paralysis in decision making in health policy strategies, it is up to NGOs to try and stimulate the necessary changes. To succeed in this mission, we think, these organisations will foremost need: (a) a clear vision not only of the goals of the intended changes but also of their outcomes and possible side-effects; (b) a dedicated and optimistic leadership, guided by sound scientific advice; (c) close and good relations with most stakeholder groups in health care; (d) some financial support; (e) diplo-

matic skills, a lot of patience and, above all, a sense of humour to endure defeats!

In our case, we might have well fulfilled these first two criteria, the third one at least partially, the fourth one unfortunately not. What of the fifth? After the HCC experience, we should recognise that diplomacy, patience and endurance are perhaps the most important, and difficult, properties of NGO actors to attain and uphold.

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Mythbusters

Myth: User fees would stop waste and ensure better use of the healthcare system

There's an old idea that frequently sparks debate: that patients rampantly abuse the healthcare system. They indulge in unnecessary, expensive medical procedures all because they can get them for free. So why not teach Canadians to be more responsible by making them pay a charge for every health service used?

Because the idea just doesn't hold water. Research has long proven that user fees won't eliminate inappropriate care nor do much to reduce costs, and even the claim that patients waste healthcare resources is faulty.

Patients abusing health services? The true story

Robert Evans, a health economist at the University of British Columbia, explains: medical procedures are not hotcakes. People aren't going to line up eagerly demanding heart transplants just because someone else is paying.

What's more, patients can't really waste healthcare resources. Institutional and hospital care, physician visits, prescription drugs, and other medical services, make up most of total Canadian health spending.¹ But most of that spending is beyond a patient's control: many visits to doctors, all hospital care and prescription drugs, can only be given on a doctor's order.²

That means patient-initiated abuse happens mostly during physician visits – which made up about 13.5 per cent of total health spending in 2000. But roughly half of physician services are referrals, or call-back visits to the same doctor, says Evans. So 'first visits' initiated by patients probably made up about six to seven per cent of all spending. Since most of these visits are reasonable, Evans estimates patient-initiated

abuse is probably about one to two per cent of total spending – hardly rampant.

Tried, tested and quite untrue

In any case, user fees are unlikely to reduce costs. Researchers found that user charges – implemented in Saskatchewan in 1968 and abolished seven years later – reduced the annual use of physician services by about six per cent. But this happened mainly because the elderly and the poor saw about 18 per cent less of their doctors.³ What's more, Saskatchewan's overall healthcare costs didn't shrink – thanks to physician fee increases and people with higher incomes, who saw their doctors more often.² The fees also didn't affect the cost of hospital services, the most expensive form of care.

Another famous study on user fees is the US Rand Health Insurance Experiment, which assigned individuals to insurance plans with different rates of user fees.⁴ Researchers found people got less medical care in those plans with heavier charges. But the proportion of inappropriate antibiotic use, hospital stays and admissions was the same^{5,6} – with or without user fees – proving that the fees don't solve such problems.

What changed was the way high-risk and low-income patients used medical services. Everyone used fewer medical services, but the decline was greater among poorer people. Sick people were also more likely to die when user charges were installed.⁷

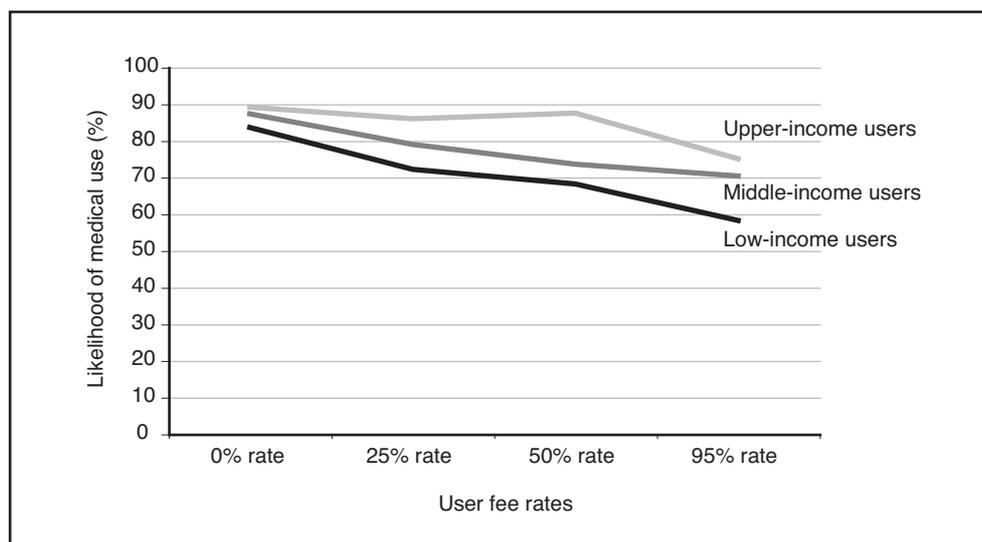
However, Rand investigators found healthcare costs for people who paid user fees were lower than people with total health coverage. This seems to prove user charges at least lowered costs. But that disputes the findings in Saskatchewan, where costs didn't decrease. Why?

While the Saskatchewan experience affected all patients, Rand involved a dispersed group of 5,800 people, so each doctor only had a few patients enrolled in the study. That's not enough to provide evidence on

Mythbusters are prepared by Knowledge Transfer and Exchange staff at the Canadian Health Services Research Foundation and published only after review by a researcher expert on the topic.

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EFFECT OF USER FEES ON MEDICAL USE, RAND HEALTH INSURANCE EXPERIMENT



People do reduce their use of health services when user fees increase – but the poor, often the ones who need medical care most – are the hardest hit.

In the Rand experiment, low-income users cut their likelihood of medical use from 82.8 per cent when they didn't have to pay, to 61.7 per cent when user charges were highest.

Data from Manning WG et al. 1987. Health insurance and the demand for medical care: Evidence from a randomized experiment. *American Economic Review* 1987;77(3):251–77.

the effect of user fees on the system. Therefore the Rand experiment, unlike the Saskatchewan experience, does not address the question of *overall* costs. We just can't conclude from Rand that healthcare costs would drop across the system; the evidence simply isn't there.⁸

Penny wise, pound foolish?

But both studies confirm it is mostly the poor who use less medical care when forced to pay extra charges. In the long run that would probably cost more, because the old and poor are less healthy than other groups.

In Quebec, for instance, when the elderly and people on welfare had to pay user fees for prescription drugs, they took less medicine. But that resulted in sicker patients and more visits to hospital emergency departments.⁹ These findings echo earlier research, which showed that user fees helped reduce costs in the short term, but eventually led to more spending because more people would neglect to get early treatment.

Despite the rhetoric, user fees don't lead to a more affordable health system. Research has shown time after time that user fees inevitably create advantages for the rich and healthy while making matters worse for the sick and poor.

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Evaluating Health Promotion: Practice and Methods

Edited by Margaret Thorogood and Yolanda Coomes.

Review by Walter Holland, Emeritus Professor of Public Health, LSE Health and Social Care, London School of Economics and Political Science

This is the second edition of a book first published in 2000, which suggests the demand for this book was good. There are good descriptions of methods of evaluation, how evaluation has been used in a variety of situations and how it can be disseminated and used in practice.

The introductory chapters include a brief overview of the book and a very potted history of health promotion. It is unfortunate that the historical perspective has not been informed by practitioners but is the view of an eminent public health historian (also, of course, of some others). For example, the term “new public health” is used without critical analysis of whether actually there is anything new. It is even suggested that “old public health” “struggled” to tackle health hazards – this diminishes the achievements of Chadwick, Simon, Potts and many others, who succeeded in both improving sanitary conditions for all of us and played a major role in the diminution of occupational hazards. In contrast, the “new public health” may have been successful in reducing cigarette smoking but finds it difficult to reduce the environmental hazards such as air pollution, climate change, violence or transport.

It is long forgotten that health promotion was equally important in the past as it is now – our forebears were far better at recognising and influencing the public health needs of sanitary behaviour, for example, washing required both a change in individual behaviour as well as the provision of a clean water supply – in contrast though we may be good at devising anti-smoking propaganda or urging people to take exercise, but are poor at reducing poverty or the provision of playgrounds.

Although the book is intended for students and practitioners of health promotion, it is necessary to provide a ‘health warning’. Most of the authors are academic social scientists. Although some very good examples are given of the application of the evaluative methods to encourage health promotion activities, such as impregnated bed nets to prevent malaria or the introduction of a Healthy Living Centre in Scotland, others are less felicitous. The most glaring example being the apparent ignorance of the “herd immunity” (p.52), a side effect of immunisation. The apparent absence of a policy-maker amongst the authors to emphasise what information is actually used in informing policy, rather than what the academics consider should or could be used is illustrated by the example on fluoridation quoted on p.67. The benefits of fluoride in drinking water have been illustrated in innumerable examples since the late 1930s, both by controlled trials, before and after statistics, as well as ecological comparisons. The strength of the example quoted in Cheshire was, I am sure, was as a local study – and thus the local decision makers were far more likely to accept it than one done in the United States, or even North East England! No reference to the importance of local studies was made.

Thus, although this may be useful as an introduction to how health promotion activities can, and should, be evaluated, it is important that practitioners developing methods of health promotion consult more dedicated texts, both on the methodological aspects of evaluation, information needs of those responsible for policy formulation and implementation, and above all how to define the objectives of a programme, which requires knowledge of the social, psychological, biological and environmental factors that need to be remedied.

Contents

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RAND Europe, part of the worldwide RAND corporation, is an independent think tank that aims to serve the public interest by improving policymaking and finding public-private solutions to shared problems. Research projects are undertaken across a number of areas including health and policy audit and governance. Research in the health field includes looking at how to define and measure the quality of care, setting priorities for health care and health care research, examining the impact of how the organisation and financing of care affect costs, quality and access, and how to integrate informed patient choice into the health decision making process.

Information is available on the website on current projects, and research areas together with news and organisation structure. Most publications are available to download. A quarterly newsletter *REview*, was also published summarising key research and publications. The entire RAND website can also be searched and there are links to other divisions within the RAND corporation.

TNO

www.tno.nl/tno/index.xml

TNO based at a number of locations across the Netherlands is a knowledge organisation for companies, government bodies and public organisations. The daily work of some 5,000 employees is to develop and apply knowledge. The group provides contract research and specialist consultancy. One area of research is 'Quality of Life' which includes research in the areas of work and employment, prevention and healthcare, pharma and food and nutrition. This includes work on absenteeism and disability in the labour force. A newsletter is published three times a year. Information is also provided on TNO publications, together with summaries and ordering instructions. The website is available in both English and Dutch.

Health Service Executive – Ireland

www.hse.ie

The Health Service Executive (HSE) is a new Irish national body that aims to improve the patient/client journey and to provide a better working environment for staff in the Irish healthcare system. The HSE took over full operational responsibility for running the country's health and personal social services on January 1, 2005. Information is provided on the latest news, publications, events and links to other health agencies. A newsletter is also published. The website is available in both English and Gaelic.

DIMDI, German Institute of Medical Documentation and Information

www.dimdi.de

DIMDI was founded in 1969 and is an institute under the auspices of the German Federal Ministry of Health and Social Security. Its main task is to provide the public with quick and easy access to the latest information in all fields of life sciences. The website provides access to approximately 80 databases with a total of over 100 million records. DIMDI is also responsible for maintaining and updating the official German language versions of medical and surgical procedures and nomenclature for medical devices. In addition, DIMDI is establishing database-supported information systems for medical devices health technology assessment (HTA) and evidence-based medicine. The focus of the HTA information system is national and international HTA results in prevention, diagnostics, and therapies as well as developments in HTA methodology.

DIMDI commissions HTA reports on the efficacy, risks, costs as well as effects of procedures and technologies in health care and their effectiveness in everyday conditions. It has a particular focus on those procedures and technologies of key importance to health policy. All 108 HTA reports may be freely downloaded. All the HTA reports as well as reports of the self-administration bodies of the German healthcare system and of international HTA agencies are searchable in the database. The site is available in both German and English.

The Heads of Agencies

<http://heads.medagencies.org>

This is the common website for the medicines authorities in the European Union and Norway, Iceland, Liechtenstein. It also provides links to the authorities' own websites. Information is provided on the activities of the Heads of Agencies as well as those of the Mutual Recognition Facilitation group. The Heads of these Member States Competent Authorities meet regularly to provide a focus for leadership within the Community System of Medicines Regulation, and to provide a forum for the exchange of views on issues of Community interest. The website contains a product index which includes medicines approved in the EU Member States according to the procedure for Mutual Recognition. Information on fee structures for licensing of medicines by various national agencies is provided. Press releases and access to publications such as the recent Action Plan to further progress on the European Risk Management Strategy are also available.

UK Parliamentary Report on the Influence of the Pharmaceutical Industry

The Health Select Committee of the lower house of the UK Parliament, the House of Commons, has published the findings of a wide ranging investigation into the influence of the pharmaceutical industry, its first inquiry into the industry since 1914. Areas of examination included the conduct of medical research, government policy, the use of journals, company promotional activities, information for patients, regulation including evaluation and cost effectiveness, post marketing surveillance and the patient voice.

The report acknowledges the enormous contribution that medications have made to both saving and improving quality of life. The UK pharmaceutical industry accounts for 10% of global research and development (R&D) expenditure and 65% of all health related R&D in the UK. It also recognises the growing cost of pharmaceuticals to the NHS, with more than £7 billion spent annually, 80% of which is for patented drugs.

The Committee concluded that individuals are being prescribed too many drugs, before the full consequences of adverse effects are known. The adverse reactions are responsible for approximately 5% of all hospital admissions in the UK. More research is required on adverse drug impacts and there is a call for government funded research into the costs of drug induced illness.

The Committee felt that the 'medicalisation' of society, the belief that every problem requires medical treatment, can be attributed in part to the activities of the pharmaceutical industry. They noted that regulation of the pharmaceutical industry is too light and that there is a lack of transparency. The regulator, the Medicines and Healthcare products Regulatory Agency (MHRA), the

committee concluded had failed to adequately scrutinise licensing data and furthermore that its post marketing surveillance was insufficient.

The report states that MHRA "has been too close to the industry, a closeness underpinned by common policy objectives, agreed processes, frequent contact, consultation and interchange of staff. We are concerned that a rather lax regime is exacerbated by the MHRA's need to compete with other European regulators for licence application business."

The report calls for greater transparency. A fundamental review of the MHRA is recommended. In addition it calls for greater public access to materials considered by the MHRA prior to licensing, with clinical trials focusing on outcomes that are of real benefit to patients. Better communication is required between companies and the MHRA during the early stages of drug development. A systematic system of appraisal should be part of the post-licensing surveillance process.

The report also calls for strengthened guidelines for the declaration of links between industry and patient groups, and individual prescribers, in particular doctors, should be required to declare hospitality or gifts received from industry. These should be maintained in a register by professional bodies.

More can also be done by government to support the industry in its research efforts, acknowledging the problems of confusing ethical procedures and a lack of trained health service researchers. The Committee were of the view however any sponsorship of industry should be moved from the Department of Health to the Department of Trade and Industry, as the Department of Health needs to be seen to prioritise the interests of patients and public health.

Speaking on the publication of the report Committee Chairman David Hinchliffe said "The pharmaceutical industry is extremely powerful and influences healthcare at every level. The lives of millions of people have been improved by the medicines the industry has produced. However, we have developed an over-reliance on medicines. They have been over-prescribed and patients have suffered as a result.

"Like any industry, drug companies need effective discipline and regulation, and these have been lacking. The industry, the regulator, doctors and other prescribers must take their share of the blame. Our recommendations reflect the need for tighter controls over drug company activities, improved medicines regulation and more effective monitoring of drug safety and efficacy. Above all, greater transparency is required. Both the pharmaceutical industry and the regulator have already taken steps in this direction. Further change is needed to ensure that the best medicines reach patients."

The report is available at: www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/42/4202.htm

Health and Consumer Protection Programme 2007-2013

The European Commission adopted a Health and Consumer Protection Strategy and a proposal for a European Parliament and Council Decision creating the Community Programme for Health and Consumer Protection 2007-2013 in April. The strategy and programme proposal bring together and extend the current EU Public Health Programme and the current Consumer programme in support of EU consumer policy.

It is hoped that by bringing the two programmes together the synergies between health and consumer protection can be exploited, improving

policy coherence, economies of scale, and the visibility of procedures.

The Communication proposes the following common objectives:

- Protect citizens from risks and threats which are beyond the control of individuals and that cannot be effectively tackled by individual Member States;
- Increase the ability of citizens to take better decisions about their health and consumer interests;
- Mainstream health and consumer policy objectives across all Community policies.

Specific health objectives are to:

- Protect citizens against health threats;
- Promote policies that lead to a healthier way of life;
- Contribute to reducing the incidence of major diseases in the EU;
- Contribute to the development of more effective and efficient health systems
- Support the objectives above by providing health information and analysis.

For further information:

http://europa.eu.int/comm/health/ph_overview/pgm2007_2013_en.htm

ECJ Ruling on the costs of urgent medical treatment in a non-member country

The European Court of Justice has ruled that the costs of medical treatment for an individual with forms E111 and E112, who for urgent medical reasons must be admitted to a hospital in a non-member country, must be borne in accordance with its social security institution rules by the member state of stay on behalf of the institution of the member state of affiliation.

The judgement arose in Case C-145/03, the heirs of Annette Keller v Instituto Nacional de la Seguridad Social (INSS) and Instituto Nacional de Gestión Sanitaria (Ingesa), formerly Instituto Nacional de Salud (Insalud).

Ms Annette Keller, of German

nationality and resident in Spain, asked the competent Spanish institution (Insalud) for a Form E 111 for a period of one month, in order to travel to Germany. During her stay in Germany, she was diagnosed as having a malignant tumour liable to cause death at any time. She asked Insalud to issue a Form E 112, so as to be able to continue receiving treatment in Germany. The validity of that form was extended on several occasions.

The German doctors treating Ms Keller transferred her to Zurich University Clinic in Switzerland, the only facility they felt where an operation could be performed with any chance of success. Ms Keller paid €56,000 in costs herself and subsequently requested a reimbursement from Insalud which was refused. As a part of ensuring court proceedings the national court asked the Court of Justice of the European Communities for an interpretation of the 1971 regulation on the application of social security schemes to migrant workers, concerning the possibility of reimbursement of the costs of hospital treatment received in a non-member country.

The Court stated that the doctors in the member state of stay are best placed to assess the treatment needed by the patient, and that the institution of the member state of affiliation, during the period of validity of the form, places its confidence in the institution of the member state and the doctors authorised by it, as providing the same guarantees of professional competence as doctors within the country. Consequently, the institution of the member state of affiliation is bound by the findings relating to the need for urgent vital treatment made by the doctors authorised by the institution of the member state of stay, and by the decision of those doctors to transfer the patient to another state to be given the urgent treatment which the doctors of the member state of stay are unable to provide.

The Court ruled that whether this state is within the EU is of no importance, nor can the member state of affiliation require an individual to return home for medical assessment or indeed be subject to

medical examination in the member state of stay.

The Court also confirmed that the costs of treatment should initially have been borne by the host country Germany, who then would subsequently be reimbursed by their Spanish counterparts. As in this instance Ms Keller had paid for the treatment herself the Court ruled that the Spanish social security institution must reimburse these costs directly to Ms Keller's heirs.

The full text of the judgement is available at:

http://europa.eu.int/smartapi/cgi/sga_doc?smartapi!celexplus!prod!CELEXnumdoc&lg=en&numdoc=62003J0145

EU prepares new Research Framework Programme for 2007–2013

On 6 April the European Commission adopted a proposal for the next EU Programme for Research, calling for a doubling of the EU research budget over the period of 2007 to 2013 to €67.8 billion of which more than €7 billion is allocated to health. This will however still represent less than 10% of total public expenditure on research in the EU.

The new programme places a greater emphasis than that seen previously on research relevant to the needs of European industry with the aim of helping it compete internationally and promote economic growth. The programme will establish a European Research Council to identify and support the best research endeavours being carried out throughout Europe.

There is though a strong element of continuity with the past in the proposed Seventh Framework Programme. An important element of the new programme will be a continued focus on supporting the careers of scientists and researchers to strengthen research capacity. Projects undertaken by consortia of European partners will remain at the core of the programme, and the themes for these projects will remain more or less as now.

The programme will continue to develop the concept of a European

Research Area. Funds will be used to develop and increase those elements of previous programmes that worked well: Marie Curie, SME actions, collaborative projects, Networks of Excellence. The aim of continuity will be strengthened through a programme that lasts seven years (with the possibility of a mid-term review).

There are also several new elements. One key feature of FP7 will be a significant simplification of its operation. Measures are being considered, in line with the future revision of the Financial Regulation, to make the programme as straightforward as possible for potential participants.

The European Commission has established a sounding board composed of representatives of small companies and research teams, groups which seem to face the biggest difficulties in participating in the programme. This sounding board will advise on whether measures proposed to make the programme simpler will in fact have the required effect.

The proposed programme will now be debated by the Member States (Council) and European Parliament, before a final Decision is adopted.

More information at:

www.europa.eu.int/comm/research/future/index_en.cfm

Safety of Medicines: The European Risk Management Strategy

On 11 May two documents on the European Risk Management Strategy were published as a result of collaboration between the Heads of the National Medicines Agencies across the EU and the European Medicines Agency (EMA). The two documents set out what has been delivered to date and what the priorities will be for the collaborative European Union (EU) system of monitoring the safety of medicines in the future.

The impact of this collaborative work is set out in the 'Progress report of the ad hoc working group on the implementation of the European Risk Management Strategy'. This includes implementa-

tion of measures designed to strengthen the safety monitoring of medicines in the EU. The collaborators argue that strong regulation, based on robust scientific decision-making should clearly assess the balance of benefits against the known risks. The two reports acknowledge that medicines regulation cannot protect the public from every risk; the Strategy aims at putting in place a coherent approach to the detection, assessment, minimisation and communication of risks in Europe.

The next steps of the Strategy are set out in an 'Action plan to further progress the European Risk Management Strategy'. This builds on the progress made and takes into account the need to respond to public concerns over the safety of medicines. The action plan focuses on three priority areas: the implementation of new EU pharmaceutical legislation; supporting initiatives to put in place an intensive drug-monitoring system focused on risk detection, assessment, minimisation and communication; further strengthening of the EU pharmacovigilance system.

The action plan is available at:

http://heads.medagencies.org/heads/docs/ERMS_actionplan_20050504.pdf

and the progress report at:

http://heads.medagencies.org/heads/docs/HMA_2ndreport_20050511.pdf

Commission on the Social Determinants of Health launched

On 18 March the President of the Republic of Chile, Ricardo Lagos Escobar and World Health Organization Director-General, Dr LEE Jong-wook launched the Commission on Social Determinants of Health, a new body to spearhead action on the social causes behind ill-health.

The new Commission, which will operate for three years, includes leading global experts on health, education, housing and economics. Commissioners will work to recommend the best ways to address health's social determinants and safeguard the health of poor and marginalised populations, and to

break the 'poverty equals ill-health' cycle.

Speaking at the launch Dr Lee said that "this commission will assist countries, no matter how rich or poor, to implement strategies that will help people who are poor and marginalised live longer, healthier lives. This effectively places the needs of the disadvantaged first on the health agenda in the 21st century."

The Commission aims to identify, evaluate, adapt and distribute effective strategies to address social determinants, with the aim of supporting governments to scale-up interventions. Commission Chair Michael Marmot said that "A great share of health problems is attributable to social conditions, and this is why the poor carry the greatest burden of ill-health. On a global scale, we must ensure that health policies move beyond exclusively disease-focused solutions and include the social environment,"

The Commission will work with national authorities to determine ways to replicate proven successful approaches in other countries and settings. It will focus the attention of leading experts and researchers on specific social determinants such as urban settings, social exclusion, and employment conditions.

More information on the

Commission and its activities can be found at: www.who.int/social_determinants/en/

What is the evidence for the effectiveness of interventions to reduce hepatitis C infection and the associated morbidity?

A new report written by Nat Wright, Charles Milson and Charlotte Tompkins for the Health Evidence Network shows that interventions among drug users are promising: particularly behavioural interventions; the distribution of bleach disinfectant, and clean needles and syringes; and the provision of supervised injecting centres.

Further information at:

www.who.dk/HEN/Syntheses/hepatitisC/20050412_1

News in Brief

WHO publishes report on chronic diseases

The CINDI programme (Countrywide Integrated Non-communicable Disease Intervention) is a WHO coordinated international collaboration programme on non-communicable diseases. The report presents the CINDI vision for a chronic disease strategy for the WHO European region.

www.euro.who.int/document/e83057.pdf

Economic appraisal of public health interventions

A report prepared for the Health Development Agency in England by Mike Kelly, David McDaid, Anne Ludbrook and Jane Powell analyses the challenges and potential approaches to the economic evaluation of public health interventions. It notes that while economic evaluation in this area has been under developed, this should be a routine and consistent element of evaluation of all public health interventions. The authors argue that while formal cost benefit analysis theoretically is ideal, the complexity of evaluation may mean that cost consequence analysis may be an alternative pragmatic approach to capturing the layered outcomes of public health interventions at a local level.

The report is available via
www.publichealth.nice.org.uk

Smoke free workplaces – one year on

The Office of Tobacco Control has published a report on the initial impact of legislation to ban smoking in workplaces across Ireland. According to the report more than 98% of the public believe that workplaces are healthier since the introduction of the ban in March 2004, and 96% of the population believe that the legislation has been successful.

Smoke-free workplaces in Ireland a one-year review is available at:
www.otc.ie/Uploads/1_Year_Report_FA.pdf

Report on illegal charging for long stay care published

A report by John Travers examines how people in Ireland were illegally charged for residential care over a period of 28 years was published in March. Responding to the report's findings Health Minister and Tainaiste Mary Harney said "Over 300,000 people were charged illegally during 28 years. This was entirely wrong. They were old, they were poor, they suffered from mental illness, they had intellectual disabilities, they were physically disabled. As vulnerable people, they were especially entitled to the protection of the law and to legal clarity about their situation. The charges should never have been made illegally, even though the principle of charging for shelter and maintenance had broad public and political acceptance... It has given rise now to a major financial, legal and administrative problem that was entirely avoidable." The Department of Health and Children has subsequently begun to set up procedures to compensate individuals and their descendants.

The report is available via
www.dohc.ie/news/2005/travers_report.html

Commission Green Paper on demographic change

A recent Commission Green Paper entitled *Confronting demographic change: a new solidarity between the generations*, notes that the European Union has been addressing issues of demographic change for some years within different policy areas and processes, but that a more in-depth debate is now needed for the many issues of common concern. The demographic 'time bomb' has become a political priority in a growing number of Member States. The paper sets out the Commission's views on the principle policy responses needed to address the potential impacts of demographic change.

For further information:
http://europa.eu.int/comm/employment_social/news/2005/mar/demog_gp_en.html

Health Development Agency in England subsumed into NICE

From 1 April 2005, the functions of the Health Development Agency were subsumed into NICE creating for the first time a single excellence-in-practice organisation in England responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. The new NICE, the National Institute for Health and Clinical Excellence has already launched a public consultation on how public health guidance should be produced.

More information at
www.publichealth.nice.org.uk/page.aspx?o=503109

World Asthma Day, 3 May

3 May was World Asthma Day. The prevalence of asthma is growing, particularly among children. The European Federation of Allergy and Airways Diseases Patients' Associations (EFA) has published a new study on the social and economic costs of asthma.

More at
www.efanet.org/default-efa.asp

Economic assessment of health promotion and prevention

Health Promotion Switzerland commissioned the Winterthur Institute for Health Management (WIG) to investigate methods of economic assessment, to document and assess economic evaluations for health promotion and prevention, and draw conclusions regarding the potential for economic assessment.

The report is available in German with summaries in German and French via
www.gesundheitsfoerderung.ch/en/activities/quality/default.asp

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Programme

8th European Health Forum Gastein

5th to 8th October 2005

Partnerships for Health

Healthy nutrition and physical activity

eHealth in Europe

Involved citizens

Health research

Pharmaceutical surveillance

Enabling healthy choices

International Forum Gastein
Tauernplatz 1, 5630 Bad Hofgastein, Austria

Tel: +43 (6432) 3393 270

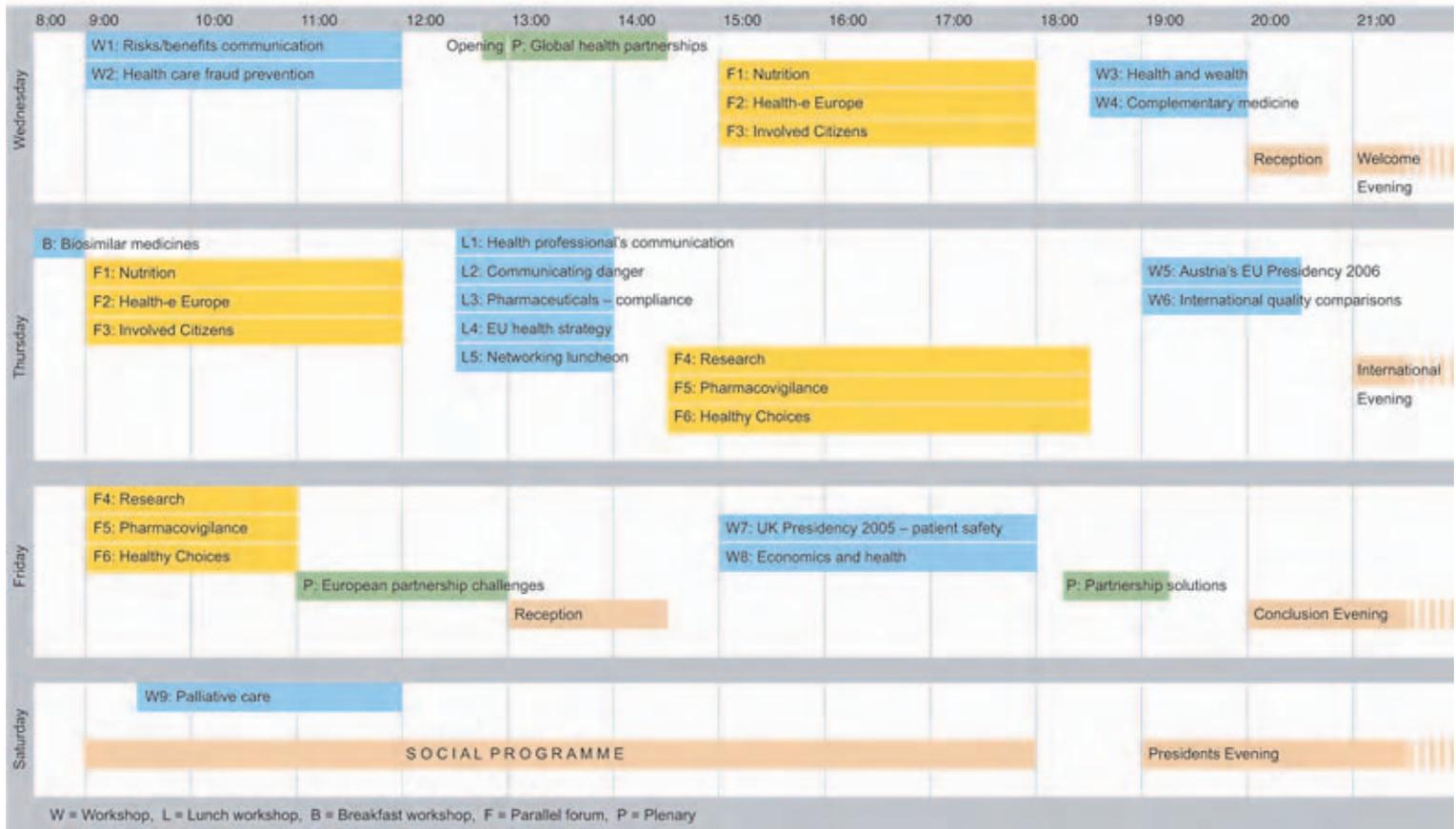
Fax: +43 (6432) 3393 271

Email: info@ehfg.org

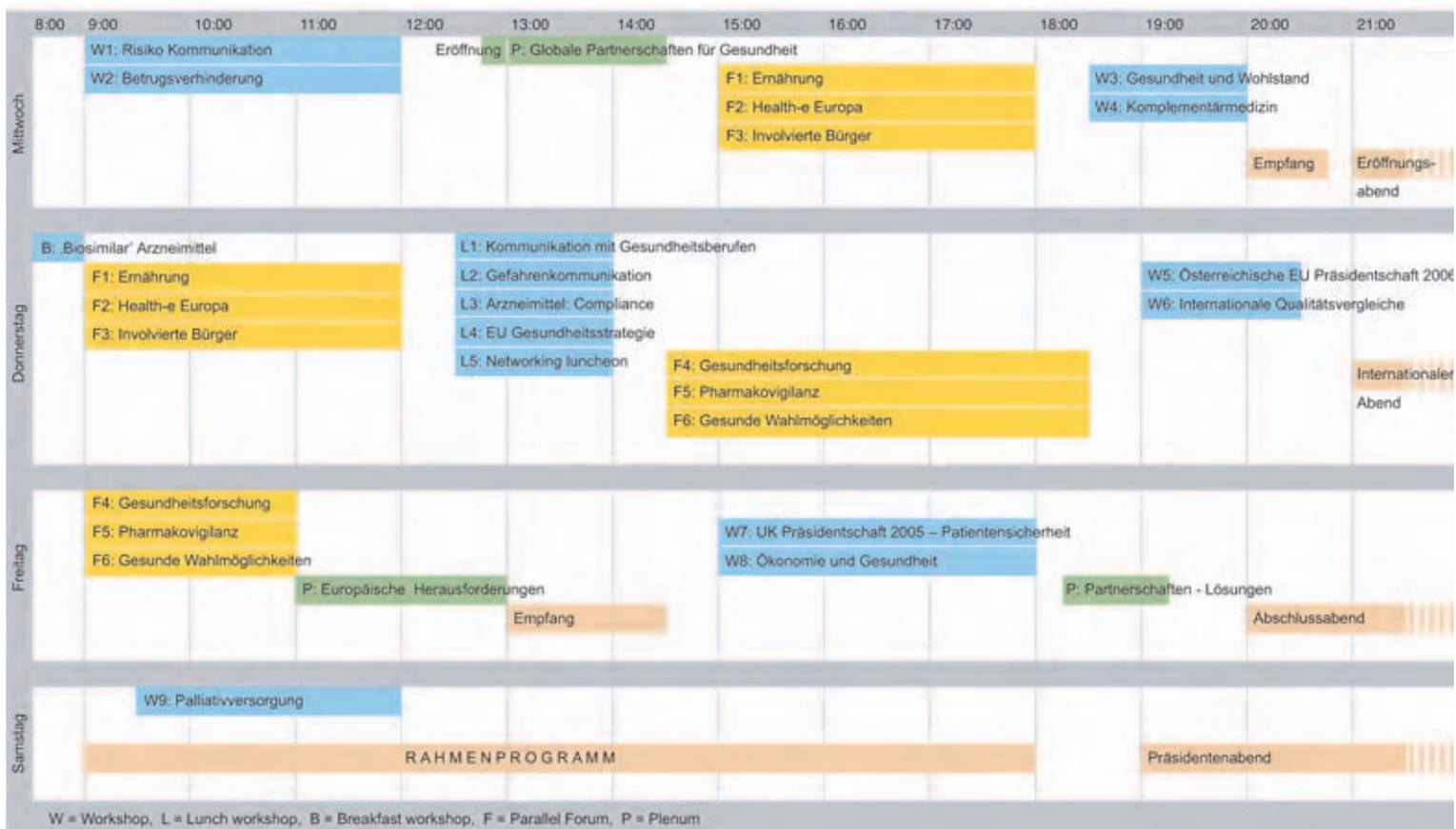
Web: www.ehfg.org



Programme overview



Programmüberblick





The 2005 Gastein Forum will focus on much needed partnerships for progress in health development. In various fields, challenges will be assessed and potential solutions developed in discussion with delegates.

In addition to following the traditional Gastein approach of engaging a broad range of stakeholders, a particular focus will be given to involving and serving citizens in Europe.

Those participating in the event include senior policy and decision-makers representing politics and government at EU, national and regional levels; business and industry; health care funders and service providers; civil society; as well as experts and researchers in health care and public health.

Das Gastein Forum 2005 betrachtet Partnerschaften die für fortschreitende Verbesserungen in der Gesundheit notwendig sind. Die Herausforderungen in verschiedenen Sachbereichen werden beurteilt und potentielle Lösungen in Diskussion mit den Teilnehmern entwickelt.

Zusätzlich zum traditionellen „Gastein“ Ansatz, der Einbindung eines breiten Spektrums von Interessengruppen, wird besonderes Augenmerk auf die Involvierung der Bürger Europas gelegt.

Bei den Teilnehmern handelt es sich um Entscheidungsträger aus den Bereichen, Politik und Verwaltung auf EU, nationaler und regionaler Ebene, Wirtschafts- und Industrievertreter, Zahler und Dienstleistungsanbieter, Zivilgesellschaft sowie Experten und Forscher aus den Bereichen Gesundheitsversorgung und öffentliche Gesundheit.

Plenary sessions

Wednesday 12:30 – 14:30

Official opening

Offizielle Eröffnung

Global health partnerships – bridging the health divide

Partnerships between developed and developing economies, between business and civil society and the implications for global governance.

Globale Partnerschaften im Gesundheitsbereich – die Überbrückung der Gesundheitslücke

Partnerschaften zwischen Industrie- und Entwicklungsländern, Wirtschaft und Zivilgesellschaft und die Auswirkungen für globale governance.

M Rauch-Kallat, Minister of Health, Austria

E Lambo, Hon. Minister of Health, Nigeria

World Bank, tba

M McKee, London School of Hygiene & Tropical Medicine

Friday 11:00 – 13:00

European health and partnership challenges

The widening health divide in Europe. Partnerships between the state and its citizens, health reforms and patient safety.

Europäische Herausforderungen

Die zunehmende Gesundheitslücke in Europa. Partnerschaften zwischen dem Staat und seinen Bürgern, Gesundheitsreformen und Patientensicherheit

Sir L Donaldson, Chief Medical Officer, Department of Health, England

G Burgstaller, Governor of Salzburg

M Kyprianou, European Commissioner for Health and Consumer Protection

Friday 18:15 – 19:30

Partnerships for health: What solutions?

Partnerschaften für Gesundheit: Welche Lösungen?

Moderated panel discussion with rapporteurs of Forum sessions.
Moderierte Podiumsdiskussion mit den Berichterstattern der Foren.

M Danzon, Regional Director, WHO

Simultaneous interpretation in English and German
Simultanübersetzung in Englisch und Deutsch

Social programme

- Fitness and wellness programme
- Sneak-in visit to the mountain health gallery
- Gastein Valley tour
- Stubnerkogel panorama trip
- Excursion to the city of Salzburg
- Historic walk through Bad Gastein
- Großglockner tour (only in good weather conditions)
- Trip to Wagrain with the ‘Silent Night, Holy Night’ memorial place, Jägersee
- Horse coach ride in romantic scenery to the Prossau
- Liechtensteinklamm ravine (only in good weather conditions)
- Visit of Castle Hohenwerfen and birds of prey show
- *Fit- und Wellness Programme*
- *Schnupperfahrt in den Gasteiner-Heilstollen*
- *Gastein-Rundfahrt*
- *Auffahrt auf den Stubnerkogel*
- *Exkursion nach Salzburg*
- *Historischer Rundgang in Bad Gastein*
- *Großglockner Tour (nur bei Schönwetter)*
- *Fahrt nach Wagrain, Stille-Nacht-Heilige-Nacht Gedenkstätte, Jägersee*
- *Kutschenfahrt in die romantische Prossau*
- *Liechtensteinklamm (nur bei Schönwetter)*
- *Besichtigung Burg Hohenwerfen mit Greifvogelschau*

Forum 1

Nutrition

New approaches to promoting healthy nutrition and physical activity

Chair: *R Madelin, Director General, Health and Consumer Protection Directorate General, European Commission (tbc)*

<p>Alarming trends: obesity, nutrition and physical activity in Europe – a review of developments around Europe</p>	<p>The obesity epidemic: an overview</p> <p>Obesity in children and adolescents worldwide: current views and future directions</p> <p>Review of the scientific research evidence on the effects of food promotion to children</p>	<p><i>N Rigby, Director Policy and Public Affairs, International Obesity Task Force</i></p> <p><i>B Koletzko, European Society for Paediatric Gastroenterology, Hepatology, and Nutrition</i></p> <p><i>G Hastings, Institute of Social Marketing, University of Stirling</i></p>
<p>The European Platform for Action on Diet, Physical Activity and Health – a new initiative at European Union level</p>	<p>Rationale, working methods, expected outcomes</p> <p>Consumer perspective</p> <p>Food industry perspective</p>	<p><i>European Commission, tba</i></p> <p><i>S Davies, Principal Policy Adviser, Which? – the UK’s consumer association</i></p> <p><i>N Christiansen, Chairman, Diet Task Force, Confederation of the Food and Drink Industries of the EU (tbc)</i></p>
<p>New partnerships: the role of stakeholders in tackling obesity – what can different industries, health professionals, and the public health community contribute?</p>	<p>An NGO’s view on public-private partnerships in the nutrition/physical activity field</p> <p>Public-private partnership in practice: a retailers’ perspective of the ‘Green Keyhole’ symbol</p> <p>The medical case for a slimmer Europe, and the role of health professionals in obesity prevention</p>	<p><i>S Logstrup, Director, European Heart Network</i></p> <p><i>L Kohls, Vice President VP Corporate Responsibility, ICA Sweden (tbc)</i></p> <p><i>P Kopelman, President, European Association for the Study of Obesity</i></p>
<p>Best practice across Europe – practical examples of initiatives to promote healthy nutrition and physical activity</p>	<p>The Spanish strategy on nutrition, physical activity and obesity prevention (NAOS)</p> <p>The Dutch covenant against overweight</p> <p>The German multi-stakeholder initiative ‘Platform Diet and Physical Activity’</p> <p>The French multi-stakeholder project ‘Together, we can prevent childhood obesity’</p> <p>The WHO Health Evidence Network on interventions to tackle obesity/the 2006 WHO Ministerial Conference on Nutrition and Physical Activity</p>	<p><i>M Neira, President, Spanish Food Safety Agency (tbc)</i></p> <p><i>E Engelsman, Health Attaché, Dutch Permanent Representation to the European Union</i></p> <p><i>E Harms, Chairman (tbc)</i></p> <p><i>S Raffin, National Coordinator, Director ‘Proteines Contact’</i></p> <p><i>C Knai / H Nikogosian, WHO Regional Office for Europe (tbc)</i></p>
<p>Towards a European strategy on nutrition and physical activity – concluding session</p> <p><i>Hosted by the European Commission, Health and Consumer Protection Directorate General</i></p>	<p>Preparing a European strategy on nutrition and physical activity</p> <p>Podium discussion</p>	<p><i>European Commission, tba</i></p> <p><i>Participants:</i> <i>Member States representatives, Commission services, WHO, food industry stakeholder, consumer/health NGO stakeholder</i></p>



Interpretation available (subject to sufficient demand) *Simultanübersetzung wird (bei ausreichendem Bedarf) angeboten*

Forum 2

A Health-e Information Revolution for European Citizens

Eine Health-e Revolution für die Bürger Europas

<p>Session I:</p> <p>eHealth infostructures for tomorrow's health systems – the EU eHealth Action Plan and beyond</p> <p>eHealth Infostrukturen für die Gesundheitssysteme von Morgen – Der eHealth Aktionsplan der EU</p> <p>Session chair: P Brosch, Ministry of Health, Austria</p> <p>Rapporteur: Z Kolitsi, Ministry of Health and Social Solidarity, Greece</p> <p>Round table discussion: Allgemeine Diskussion:</p>	<p>Vision and reality: experience from one and a half year's eHealth Action Plan <i>Vision und Realität: Erfahrungen aus eineinhalb Jahren eHealth Aktionsplan</i></p>	<p>G Comyn, Directorate ICT for Citizens and Businesses, Information Society and Media DG, European Commission</p>
	<p>Can new Member States leap-frog the eHealth revolution? A critical reflection on the Action Plan <i>Können die neuen Mitgliedsstaaten die eHealth Revolution überspringen? Eine kritische Reflektion über den Aktionsplan</i></p>	<p>V Sinicienė, Ministry of Health, Lithuania</p>
	<p>Case study I: NHS Direct Online – citizens first <i>Fallstudie I: NHS (England) Direct Online – Bürger zuerst</i></p> <p>1. The public view <i>1. Die öffentliche Sicht</i></p> <p>2. The benefits <i>2. Die Vorteile</i></p>	<p>B Baldwin, Public Involvement, NHS Direct Online, UK</p> <p>T Jones, eHealth IMPACT study, UK</p>
	<p>Case study II: cross-border cooperation for health care provision in the Euregio Meuse-Rhine <i>Fallstudie II: Grenzüberschreitende Kooperation zur Gesundheitsversorgung in der Maas-Rhein</i></p> <p>1. The professional's view <i>1. Die Sicht des Experten</i></p> <p>2. The assessed benefits <i>2. Die Vorteile</i></p>	<p>J Scheres, University Hospital Maastricht, Netherlands</p> <p>K Stroetmann, eHealth IMPACT study, Germany</p>
	<p>Patient representative <i>Patientenvertreter</i> : A Parent, AGE – European Older People's Platform Hospital association <i>Krankenhausverband</i> : P Berman, European Health Management Association Industry <i>Industrie</i> : C Parisot, Integrating the Healthcare Enterprise Europe initiative</p>	
<p>Session II:</p> <p>Health information strategies for European citizens – the Member State activities</p> <p>Gesundheitstelematik-Strategien für die Bürger Europas – Die Aktivitäten der Mitgliedsstaaten</p> <p>Session chair: G Comyn, European Commission</p> <p>Rapporteur: M Thonnet, Ministère de l'Emploi et de la Solidarité, France</p> <p>Hosted by the European Commission, Information Society and Media Directorate General, organised by V N Stroetmann empirica GmbH, Germany / eHealth ERA project</p>	<p>Roadmaps for eHealth infostructures: needs, priorities and expectations – a view from the Member States <i>Roadmaps für e-Health Infostrukturen: Bedürfnisse, Prioritäten und Erwartungen – eine Sicht aus den Mitgliedsstaaten</i></p>	<p>R Mainz, Working Group 'Health Information and eHealth', EU High-Level Group on Health Services and Medical Care</p>
	<p>Hungary: implementing a regional eHealth infrastructure with support from the EU Structural Fund <i>Ungarn: Implementierung einer regionalen eHealth Infrastruktur mit Unterstützung des Strukturfonds</i></p>	<p>L Balkányi, K Fogarassy, G Nagy, eHealth Programme Office, Ministry of Health, Hungary</p>
	<p>Austria: establishing a high level coordination committee for implementing the eHealth strategy <i>Österreich: Einrichtung eines hochrangigen Koordinationsausschusses zur Umsetzung der eHealth Strategie</i></p>	<p>K-P Pfeiffer, Medizinische Universität Innsbruck, Austria</p>
	<p>Romania: change management and stakeholder involvement – a regional hospital case <i>Rumänien: Management von Veränderung und Einbeziehung von Interessensvertretern – der Fall eines regionalen Krankenhauses</i></p>	<p>G Mihalas, 'Victor Babes' University of Medicine and Pharmacy, Romania</p>
	<p>Spain: YKONOS – Digital Medical Images Network of Castilla La Mancha <i>Spanien: YKONOS – Ein Netzwerk für die digitale Übertragung medizinischer Bilder in Castilla La Mancha</i></p>	<p>J Chacon Fuertes, Health Service of Castilla La Mancha, Spain</p>
<p>New Member States: investing in eHealth infostructures – good practice, project appraisal, lessons learned <i>Neue Mitgliedsstaaten: Investitionen in eHealth Infostrukturen – Praxisbeispiele, Evaluationsergebnisse, Erfahrungsberichte</i></p>	<p>D Haazen, The World Bank, Washington, DC</p>	



Forum 3

Involved citizens: partners for health

Involvierte Bürger: Partner für Gesundheit

Partners for health: empowerment, involvement, information

Partner für Gesundheit: Befähigen, Involvieren, Informieren

Chair:
B Weihrauch, Ministry for Health, Social Affairs, Women and Family, North Rhine Westfalia

Rapporteur:
M Marinker, Kings College, London

Panel discussion:
Podiumsdiskussion:

Panel and plenary discussion:
Podiums- und Plenumsdiskussion:

Programme organiser:
H Stein, European Public Health Centre

Sponsored by Merck, Sharp & Dohme through an unrestricted educational grant

The involved citizen – a partner in health policy
Der involvierte Bürger – ein Partner in der Gesundheitspolitik

J Bowis, Member of European Parliament

Democracy – a key value in health policy
Demokratie – ein Schlüsselwert für die Gesundheitspolitik

G Moro, Active Citizenship Network, Rome

Citizen participation in priority setting and healthcare choices
Bürgerpartizipation bei der Festlegung von Prioritäten und Entscheidungen in der Gesundheitsversorgung

S McMahon, Irish Patients Association

Involved citizens and health system reform
Involvierte Bürger und Gesundheitsreform

J Figueras, European Observatory on Health Systems and Policies, Brussels

Empowerment of citizens – a global challenge
Empowerment von Bürgern – eine globale Herausforderung

I Kickbusch, Senior Advisor on Health Policy, Bundesamt für Gesundheit, Switzerland

What policies are needed to facilitate greater citizen participation in policymaking and health care decision making? How can we balance more democracy with commitment to equity?

Welche Politik kann erhöhte Partizipation von Bürgern bei Entscheidungen in Politik und Gesundheitswesen ermöglichen? Wie kann ein Gleichgewicht zwischen mehr Demokratie und Gerechtigkeit geschaffen werden?

Empowering people to reduce inequalities
Empowerment zur Reduzierung von Ungleichheiten

Sir L Donaldson, Chief Medical Officer, UK

Information – prerequisite for citizens involvement
Information – eine Voraussetzung für die Beteiligung von Bürgern

A Jovell, FBJL, Barcelona

The involved citizen – a stakeholder perspective
Der involvierte Bürger – die Sicht von Betroffenen

R Hess, Gemeinsamer Bundesausschuss, Germany

Health and wealth: what are governments for?
Gesundheit und Wohlstand: welche Aufgaben haben Regierungen?

M McKee, London School of Hygiene & Tropical Medicine

How can stakeholders cooperate toward increasing patient/citizen involvement and reducing inequities in access to health care? How can governments and stakeholders work together to provide the information citizens need to participate and take greater ownership of their health? Is there a role for public-private partnerships?

Wie können Betroffene für erhöhte Patienten- und Bürgerbeteiligung und die Reduzierung von Ungleichheiten beim Zugang zu Gesundheitsversorgung zusammenarbeiten? Wie können Regierungen und Betroffene kooperieren, um Bürger für mehr Partizipation und Teilhabe zu informieren? Gibt es eine Rolle für Public – Private Partnerships?

Summary and conclusions: the way forward
Zusammenfassung und Schlussfolgerungen: Der Weg nach vorne

Simultaneous Interpretation in English and German

Simultanübersetzung in Englisch und Deutsch

Forum 4

Research Serving the Citizens of Europe

The need for targeted research to improve the health of European citizens

Chair:
O Quintana Trias, Director Health Research, European Commission DG Research

Rapporteur:
F Carinci, Health System Research, Italy

Europe has a strong tradition and an excellent record in public health and health services research. The policy oriented strand of the 6th Framework Programme – presented at Gastein in 2002 – is now reality. This session is the occasion to examine how the evidence generated supports health policies in Europe and is put into practice.

The 7th Framework Programme will serve as a backdrop to discussion on how future research will contribute to European policies, enhance Europe's competitiveness and ultimately improve the health of Europe's citizens.

Part I Scientific support to health policies

Setting the scene: research for better health in Europe

Senior policy maker (tba)

Identifying European answers to European problems: an example

R Busse, TU Berlin, EC FP6 Project HealthBasket

The challenges of gathering evidence for policies

M Rosenmöller, IESE Business School, EC FP6 Project Europe for Patients

How to get evidence into policy

M McKee, LSHTM and European Observatory on Health Care Systems

Research interacting with stakeholders in Europe

M McCarthy, University College London, EC FP6 Project SPHERE

Part II The future of European health research

Public health research and the 7th Framework Programme

O Quintana Trias, Director, Health Research, DG Research European Commission

Panel discussion on the future of European research

I de la Mata, Permanent Representation to the EU, Spain
N Azzopardi Muscat, Ministry of Health, Malta
E Barris, Senior Health Specialist, World Bank, Europe & Central Asia Region
C Włodarczyk, Institute of Public Health, Jagiellonian University, Poland
A Coulter, Director, Picker Institute, UK

Part III Bridging the gap – research into practice

Setting the scene: research into practice

Sir L Donaldson, Chief Medical Officer, UK

Developing effective quality improvement programmes in European health care

A Oxman, Director, Norwegian Health Services Research Centre, EC FP5 Project REBQI (tbc)

Methods of assessing response to quality improvement strategies

R Suñol, Director, FAD, Barcelona, EC FP6 Project MARQUIS

Pharmacovigilance research and patient safety policies

J Hasford, Member of the European Society of Pharmacovigilance, Epidemiology and Biostatistics, University of Munich, Germany

Evidence serving practice: a perspective from WHO Regional Office for Europe

A Dumitrescu, Director, Division of Information, Evidence and Communication, WHO Regional Office for Europe

Programme organisers:
Kevin McCarthy, European Commission
Magdalene Rosenmöller, IESE Business School

Hosted by the European Commission, Research Directorate-General



Forum 5

Pharmacovigilance planning and safety issues

Arzneimittelüberwachung, Planung und Sicherheitsfragen

Chair: *P Kielgast, past President, International Pharmaceutical Federation (FIP)*

Co-Chair: *high-level representative of the Ministry of Health, Taiwan*

Rapporteur: *E Nolte, London School of Hygiene and Tropical Medicine*

	Opening <i>Eröffnung</i>	<i>P Kielgast, past President, International Pharmaceutical Federation</i>
Value of reporting and prevention <i>Der Wert von Meldepflicht und Prävention</i>	Adverse drug event <i>Nebenwirkungen von Arzneimitteln</i> New drug watch <i>Die neue Arzneimittelüberwachung</i> Networking of pharmacovigilance and public education on rational medicine <i>Die Vernetzung der Arzneimittelüberwachung und öffentlicher Bildung über rationale Arzneimittelnutzung</i> Health professional perspective <i>Sichtweise der Gesundheitsberufe</i>	<i>tba</i> <i>N Wathion, Head of Unit, EMEA (tbc)</i> <i>HP Wang, Director General, Bureau of Pharmaceutical Affairs, Taiwan</i> <i>World Medical Association (tba)</i>
Current status and challenge of compensation and mitigation <i>Aktueller Stand und Herausforderungen der Kompensation und Wiedergutmachung</i>	Drug relief for adverse reaction <i>Arzneimittelbereitstellung bei Nebenwirkungen</i> Current status of no-fault compensation for adverse reaction in Europe <i>Aktueller Stand der verschuldensunabhängigen Kompensation für Nebenwirkungen in Europa</i> Balancing patient safety and the human factor in health care delivery <i>Gleichgewicht zwischen Patientensicherheit und dem Faktor „Mensch“ in der Gesundheitsversorgung</i> Stakeholder perspectives <i>Sichtweise der Stakeholder</i>	<i>ML Hsiao, Chair, Taiwan Drug Relief Foundation</i> <i>F Giorgio-Gerlach, Secretary General, PGEU</i> <i>A van der Zeijden, Chair, International Alliance of Patients' Organizations</i> <i>Representatives from health insurance and pharmaceutical industry (tba)</i>
Exploring alternative medicine and drug interaction <i>Alternative Arzneimittel und deren Wechselwirkungen</i>	Regulating alternative medicine in Europe <i>Die Vorschriften für alternative Arzneimittel in Europa</i> Drug interaction of herbal and western medicine <i>Wechselwirkungen zwischen pflanzlichen und „westlichen“ Arzneimitteln</i>	<i>H Pittner, Federal Ministry for Health and Women, Austria, (tbc)</i> <i>O Hu, Dean, Department of Research and Development, National Defense Medical Center, Taiwan</i>
Session organizer: <i>Center for Health Policy Research and Development, National Health Research Institutes (NHRI), Taipei, Taiwan</i> Co-organizer: <i>International Pharmaceutical Federation</i>	Panel discussion on policy <i>Podiumsdiskussion zur Politik</i>	

Interpretation available (subject to sufficient demand) *Simultanübersetzung wird (bei ausreichendem Bedarf) angeboten*

Forum 6

Enabling healthy choices in modern health societies

Gesunde Wahlmöglichkeiten in modernen Gesundheitsgesellschaften ermöglichen

The rapidly changing health environment in Europe requires a high level of health literacy. Changing demographics, new lifestyles, increased mobility of people and patients, new knowledge about health risks, changes in health policy and the health care system, new products on the health and wellness market, a new relationship between patients and health professionals require well informed patients, consumers and citizens. An increasing number of choices in everyday life have become choices for or against health. These developments carry great potential for empowerment but they also increase the risk of disorientation and new imbalances and inequities. While in democracies people cannot be instructed to follow a healthy lifestyle there is an increasing expectation that they do. How do patients, consumers and citizens respond to this new environment?

This Forum will outline the key characteristics of the new health environment and its challenges using concrete examples, such as obesity and migrant health. It will describe initiatives undertaken by different actors to support healthy choices. It will attempt to bring forward some innovative proposals related to the interface between the knowledge and skills that people need to navigate health information, health systems and the health market and the policies and environments required to support healthy choices.

Das sich rasch verändernde Gesundheitsumfeld in Europa erfordert ein hohes Niveau von Gesundheitsbildung. Veränderungen in Demographie, Lebensstil, neues Wissen über Gesundheitsrisiken, Veränderungen in Gesundheitspolitik und Gesundheitswesen, neue Produkte auf dem Gesundheits- und Wellnessmarkt, eine neue Beziehung zwischen Patienten und Gesundheitsberufen - all dies verlangt gut informierte Patienten, Konsumenten und Bürger. Eine zunehmende Anzahl an Entscheidungen im täglichen Leben werden zu Entscheidungen für oder gegen die Gesundheit. Diese Entwicklungen beinhalten großes Potential für Empowerment, aber sie erhöhen auch die Gefahr der Desorientierung, neuer Ungleichgewichte und Ungerechtigkeiten. Während Menschen in Demokratien nicht dazu angewiesen werden können, ein gesundes Leben zu führen, besteht eine zunehmende Erwartungshaltung, dass sie es tun. Wie reagieren Patienten, Konsumenten und Bürger auf diese neue Umwelt?

Dieses Forum wird die wesentlichen Charakteristika des neuen Gesundheitsumfelds und seine Herausforderungen anhand von konkreten Beispielen wie Übergewicht und Gesundheit von Migranten darstellen. Es wird Initiativen verschiedener Akteure zur Unterstützung gesunder Wahlmöglichkeiten beschreiben. Es wird versuchen, einige innovative Vorschläge zu erarbeiten, die sich auf die Schnittstelle zwischen Wissen und Fähigkeiten beziehen, und die vonnöten sind, um Gesundheitsinformation, Gesundheitssysteme und den Gesundheitsmarkt zu navigieren. Die Politik und das Umfeld, die für gesunde Wahlmöglichkeiten förderlich sind, sollen ebenfalls behandelt werden.

<p>Facilitator: H Saan, Health Promotion Expert, the Netherlands</p>	<p>Welcome and introduction <i>Eröffnung und Einleitung</i></p>	<p>H Saan, Health Promotion Expert, the Netherlands I Kickbusch, Senior Advisor on Health Policy, Bundesamt für Gesundheit, Switzerland</p>
	<p>Panel discussion: Navigating the health society – balancing equity and choice (with particular focus on obesity) <i>Podiumsdiskussion: Navigieren der Gesundheitsgesellschaft – Gleichgewicht zwischen Gerechtigkeit und Wahlmöglichkeiten (Schwerpunkt Übergewicht)</i></p>	<p>P McGuire, Director, European Institute of Womens' Health, Ireland V Hainer, Vice President, European Association for the Study of Obesity, Czech Republic B DeBuono, Senior Medical Director, Pfizer Inc J Seidell, Free University of Amsterdam</p>
	<p>Panel discussion: Navigating the health system – the role of health literacy (with particular focus on migrant health) <i>Podiumsdiskussion: Navigieren der Gesundheitsgesellschaft – die Rolle von Gesundheitsbildung (Schwerpunkt Migrantengesundheit)</i></p>	<p>J Pelikan, Professor, University of Vienna, Austria I Szilard, Senior Medical Officer, International Office for Migration PG Svensson, Executive Director, International Hospital Federation, UK E Thoss, Executive Director, Pro Familia, Germany</p>
<p>Programme organiser: H Stein, European Public Health Centre</p> <p>Sponsored by an unrestricted educational grant from Pfizer</p>	<p>Panel discussion: Health policies in support of healthy choices – partnerships for health literacy <i>Podiumsdiskussion: Gesundheitspolitik für gesunde Wahlmöglichkeiten – Partnerschaften für Gesundheitsbildung</i></p>	<p>R Rosenbrock, WZB, Germany Tim Lobstein, Director, Food Commission, UK (tbc) B Pettersson, Deputy Director, National Institute of Public Health, Sweden <i>Panels will also include senior representatives from ministries of health and European institutions. Podiumsdiskussionen werden auch von hochrangigen Vertretern europäischer Gesundheitsministerien und EU-Institutionen geführt.</i></p>

Workshops

Workshop 1

Risks/benefits communication

Wednesday
5th October 2005
9:00–12:00

Communicating with patients: risks and benefits of pharmaceuticals

Building on the success of the 2004 pre-conference workshop on Pharmaceutical Policy Issues, the London School of Economics and Merck Sharp & Dohme are pleased to host a workshop on communicating risks and benefits of pharmaceuticals. This workshop will include an expert panel consisting of various stakeholders from government, industry, academia and non-government sectors who will address the policy issues around medicines communication in the European Union.

Co-chairs:
E Mossialos, London School of Economics and J Sturchio, Merck Sharp & Dohme

Speakers to be announced



MSD

Hosted by the London School of Economics and Merck Sharp & Dohme

Workshop 2

Health care fraud prevention

Wednesday
5th October 2005
9:00–12:00

Prevention of corruption and fraud in health care systems

Resources made available for the provision of health care services should not be lost to fraud and corruption.

The workshop aims at raising awareness, showing and discussing ways to pinpoint ‘hot spots’ as well as identifying measures to prevent and reduce fraud and corruption in public and private health care systems.

The workshop will conclude with a panel discussion.

Health care fraud and health care management training: an academic issue?
C Thoma / B Rupp, IMC FH Krems

Awareness raising – an important step towards cultural changes
Austrian Federal Ministry of the Interior (tba)

Measuring the economic burden of health care fraud and corruption
B Schwarz, Austrian Association for Health Economics

Health care corruption: measures taken by the Austrian pharmaceutical industry
JO Huber, PHARMIG

Limits of incentives – practical examples
HVB d. Sozialversicherungsträger (tba)



Organised by MC Fachhochschule Krems (IMC University of Applied Sciences Krems)

Workshop 3

Health and wealth

Wednesday
5th October 2005
18:30–20:00

Do healthy and active ageing generate wealth?

An ageing population and increasing longevity could result in unsustainable expenditure on pensions, health and social care. Recent studies in economics and public health, however, suggest that increased longevity, if coupled with good health and active ageing, may lead to economic growth.

The workshop will explore the issues and opportunities that increased longevity offers and will look at the relationship between economics and population health. It will address new studies linking health and longevity to productivity, the demographic and social changes associated with longevity, the implications of the extended healthy lifespan on retirement and work life.

Chair:
R Bernabei, Chairman of the Alliance for Health and the Future, Italy

From ageing to longevity: facts and policy challenges
J Oliveira, OECD

Does health care save lives? The role of the health care system
E Nolte, London School of Hygiene and Tropical Medicine

Perspectives for extending healthy life expectancy
J-M Robine, INSERM



Organised by the Alliance for Health and the Future

Workshop 4
Complementary medicine

Wednesday
5th October 2005
18:30–20:00



Complementary medicine – an efficient and safe contribution to patient satisfaction?

There is a growing demand across Europe for complementary and alternative medicine and, in particular, for homeopathy and anthroposophic medicine. Politicians and the scientific community, however, treat these traditional therapies with scepticism.

What are the real benefits of complementary medicine? What is the evidence of efficacy that has been demonstrated over the last few years? Could complementary medicine have a positive effect on public health budgets? Are inappropriate regulatory requirements starting to seriously impede a 200-year-old European medicinal tradition?

The workshop will make a critical assessment of the pros and cons and demonstrates different models for good use of complementary medicine.

The role of the World Health Organisation (WHO) in providing standards for quality, safety and efficacy of complementary medicine
U Solimene, Director, WHO Collaborating Centre for Traditional Medicine, University of Milan, Italy

Complementary medicine – an efficient element for sustainable health budgets?
S N Willich, Director, Institute for Social Medicine, Epidemiology & Health Economics, University Hospital Charité, Germany

Complementary medicine – the efficacy profile of homeopathy
P A Fisher, Clinical Director and Director of Research, Royal London Homeopathic Hospital, United Kingdom

Organised by ECHAMP, the European Coalition on Homeopathic and Anthroposophic Medicinal Products

Workshop 5
Austria's EU Presidency 2006

Thursday
6th October 2005
19:00–20:30

FEDERAL MINISTRY OF
HEALTH AND WOMEN



A preview on Austria's activities and expected EU dossiers

In the first half of 2006 Austria has its second EU Presidency. Main topics introduced by the Austrian Minister will be diabetes and women's health.

Continuous work on the current dossiers will concentrate on the council-group and council level chaired by Austrian representatives.

The workshop will give a preview on the Austrian activities and the expected EU dossiers.

Overview, schedule, Council-Group on Public Health
B Magistris, Federal Ministry of Health and Women

Foodstuffs
P Kranner, Federal Ministry of Health and Women

Women's health
T Philippi, Federal Ministry of Health and Women

Diabetes
T Unger, Österreichisches Bundesinstitut für Gesundheitswesen

Organised by the Austrian Ministry of Health and Women

Workshop 6
International quality comparisons

Thursday
6th October 2005
19:00–20:30



International comparisons of health care quality

Health care quality assessment has risen high on national agendas across Europe. Cross-national comparisons and benchmarking can provide additional information of value to policy makers. The OECD's Health Care Quality Indicators Project was developed to respond to the need for improved data at the international level.

This session will focus on core concepts and issues that arise in making cross-national comparisons of the quality of care. Initial results from the ongoing HCQI Project will be presented and lessons for applying findings from cross-national comparisons in domestic quality improvement initiatives will be discussed.

Chair:
tbd

Titles of presentations and speakers to be announced

Organised by the Organisation for Economic Co-operation and Development

Workshop 7

UK Presidency of the European Union 2005 session

Friday
7th October 2005
15:00–18:00

Patient safety: from research to practice

The session will highlight known solutions to identified patient safety issues and explore the processes and research used to develop them, as well as evaluating their impact in terms of improved patient safety.

Case studies of practical safety solutions:
Each case study will (a) identify the issue, (b) work up the solution, and (c) evaluate the impact in terms of improved patient safety as a result.

International agenda:
The development of an international agenda for patient safety research and engagement with the EU will also be discussed.

Chair:
Sir L Donaldson, UK Chief Medical Officer/WHO

Overview of patient safety challenges and solutions
Sir L Donaldson

Case studies from:
The Netherlands
United Kingdom
United States

Developing an international research agenda
WHO World Alliance for Patient Safety

Tackling the patient safety research agenda in Europe
Speaker to be confirmed



Co-organised by the UK Presidency of the European Union 2005 and the WHO World Alliance for Patient Safety

Workshop 8

Economics and health

Friday
7th October 2005
15:00–18:00

Economics and health

The main aim of the joint workshop is to discuss the state of the art in relation to the economic impact of investment in health.

In particular, the report commissioned by DG Health and Consumer Protection on the contribution of health to economic growth and competitiveness as well as latest reports and analysis of the World Bank, WHO and the European Observatory will be considered.

Furthermore, during the panel discussion, activities and progress of work in competent institutes and organisations including the Member States of the EU will be presented and discussed.

Panel discussion on the implications of investment in health for policy making in order to strengthen economic growth and competitiveness

Co-chair:
B Merkel, European Commission
J Figueras, European Observatory
A Fidler, World Bank

Rapporteur:
M Rosenmöller, IESE Business School

Report on the contribution of health to economic growth – implications for EU Member States
M McKee, London School of Hygiene

Report on the macroeconomic consequences of poor health in Russia
M Suhrcke, WHO

Report on fiscal sustainability in the new Member States and Candidate Countries
M Chawla, World Bank

Panel chair:
A Fidler, World Bank

Panel:
N Boyd, Department of Health, UK (tbc)
U Fronaschütz, Ministry of Health, Austria
R Dimitrova, Bulgarian Parliament
B Merkel, European Commission
M McKee, London School of Hygiene
M Suhrcke, WHO
M Chawla, World Bank
A speaker from a new Member State (tbc)



European
Observatory
on Health Systems and Policies



Organised by European Commission – DG Health and Consumer Protection, European Observatory on Health Systems and Policies and the World Bank

Breakfast Workshop

Breakfast Workshop

Biosimilar medicines

Thursday
6th October 2005
08:00–09:00

Biosimilar medicines and patient safety: making an informed decision

As patents of first generation biotech products are expiring in Europe, regulators need to evaluate the safety and efficacy of emerging copy or 'biosimilar' products. In parallel, physicians and patients must understand the safety profile of these new medicines and take decisions on their future prescription and acceptance. This session will provide an overview of biosimilar medicines and the current scientific and regulatory issues surrounding them. It will look how biopharmaceuticals differ from traditional chemical medicines, and explore the considerations for patients and why it matters that biosimilars might differ from the reference product.

Biosimilar medicines, what's all the fuss about?

Speaker tba



Sponsored by Amgen Europe

Lunch Workshops

Lunch Workshop 1

Health professionals' communication

Thursday
6th October 2005
12:30–14:00

The doctor knows best – does he? Improving health communication

This workshop will focus on:

- The crucial role of health professionals in involving patients in their health care and treatment options.
- Ways to improve health professionals' communication with and information to patients as part of this greater involvement.
- A debate on a concrete proposal for a set of guiding principles ('charter') for health professionals' communication and information provision.
- A discussion on practical ways of progressing and developing these guiding principles.

Chair: *S Ratzan, Vice President, Government Affairs, Johnson & Johnson*

The informed patient: the role of the health professional

P Singleton, Cambridge University Health

Developing good practice in health communication

D Human, Immediate Past Secretary of the World Medical Association

What do patients expect from health professionals?

R Mitchell, Chair, European Federation of Crohn's and Ulcerative Colitis Associations



The *Johnson & Johnson* Centre for Advancing Health Information

Sponsored by Johnson & Johnson

Lunch Workshop 2

Communicating danger

Thursday
6th October 2005
12:30–14:00

Can better risk communication contribute to safer health care?

Providing health care always involves a degree of risk; and how best to communicate risks to patients and the public is an issue regularly faced by policy makers at all levels. This workshop will examine, with experts and stakeholders, cases where governments need to communicate potential risks. It will address common risk communication issues, identify challenges and opportunities and make recommendations on best practice. In particular, it will consider how communication, aimed at building partnerships with patients and the public, may improve understanding of safety and risk.

Chair:

Sir L Donaldson, Chief Medical Officer, United Kingdom and Chair, WHO World Alliance for Patient Safety

Panellists confirmed to date:

S Sheridan, Lead, Patients for Patient Safety, World Alliance for Patient Safety

A-T Rodgers, Baxter, and former Corporate Affairs Director, National Institute for Clinical Excellence



Baxter

Organised by the WHO World Alliance for Patient Safety and Baxter

Lunch Workshop 3

Pharmaceuticals

Thursday
6th October 2005
12:30–14:00

Make medicines work better: patients, health professionals and the role of compliance

All over Europe and the world governments are facing the challenge of increasing expenditure on medicines. All governments are striving to find innovative solutions to contain such increases. Very often the measures taken focus primarily on pricing and reimbursement: providing an immediate but often short-lived solution. This session will look at how ensuring more appropriate uses of medicines could contribute to meeting this challenge. Speakers will provide data and give examples of how a collaborative care approach could lead to improved therapeutic outcomes and generate savings.

The potential for a targeted approach to compliance
P Stephens, Vice President Public Health Affairs, IMS Health, European Region

Medicine management: benefits and challenges for the healthcare systems, a case study
A Hämmerlein, Center for drug information and pharmacy practice, ABDA, Germany

Panel discussion:
Patient and health professional representatives



ims

Organised by PGEU and IMS Health

Lunch Workshop 4

The new EU health strategy

Thursday
6th October 2005
12:30–14:00

The Commission will present for discussion its new Health and consumer protection strategy

On 6 April, the Commission adopted a strategy and programme proposal setting out a number of ambitious targets for EU health policy from 2007 until 2013.

The strategy and programme proposal brings EU health and consumer protection policies together under a single framework. This will give more weight and visibility to two policies at the heart of citizens' concerns that share important objectives such as health protection and citizens' information. It will also develop positive synergies in terms of economies of scale and streamlining of administrative procedures.

The aim is to pursue a set of common health and consumer protection objectives: protecting citizens from risks and threats; increasing citizens' ability to take better decisions about their health and consumer interests; and mainstreaming health and consumer policy objectives across all Community policies.

As regards health, the new programme reinforces the three strands of the existing Public Health Programme: to gather and provide information; to monitor threats; and to tackle key health determinants. In addition, the programme creates three new strands: to deliver an efficient response to health threats; to help prevent diseases; and to foster cooperation between health systems. Finally, in line with the Lisbon agenda, bridging health inequalities and addressing ageing will be priority themes.

The Commission proposals are currently under discussion in the European Parliament and Council.



Organised by The European Commission, Health and Consumer Protection Directorate General

1st World Hospice and Palliative Care Day

Workshop 9

Palliative care

Saturday
8th October 2005
09:30–12:00

Hospice and palliative care – key issues for health policy

Every year, millions of people around the world living with a terminal illness experience unnecessary pain and distress, either unaware of or unable to access the care they need. High quality hospice and palliative care which aims to meet the needs of the whole person can and does, provide an answer.

On the occasion of the 1st *World Hospice and Palliative Care Day* the session will provide an overview on international and European hospice and palliative care issues, and discuss different models of care including work undertaken by the Council of Europe.



Organised by Help the Hospices, UK

Markos Kyprianou – EU Commissioner for Health and Consumer Protection



The theme for this year's European Health Forum Gastein – 'Partnerships for Health' – points to the fact that health policy can only be successful if joint approaches are being developed across society, involving stakeholders and different levels of government. This is certainly a very valid principle for EU-level policy actions on health. I am confident that this conference will once again provide a forum of interesting debates among the many different actors involved in health policy and health services across Europe.

Das Motto des diesjährigen European Health Forum Gastein – 'Partnerships for Health' – lässt erkennen, dass Gesundheitspolitik nur dann erfolgreich sein kann, wenn gemeinsame Lösungen aus allen Gesellschaftsbereichen unter Einbeziehung aller Betroffenen und verschiedener staatlicher Instanzen erarbeitet werden. Dieses Prinzip trifft sicherlich auf die Maßnahmen der Gesundheitspolitik auf EU-Ebene zu. Ich bin zuversichtlich, dass diese Konferenz erneut ein Forum interessanter Debatten zwischen den vielen verschiedenen Akteuren der Gesundheitspolitik und der Gesundheitsdienstleistungen aus ganz Europa bieten wird.

Maria Rauch-Kallat – Austrian Minister for Health and Women



Health policy is a multisectoral issue and, in the long run, it can function only through cooperation and coordination with other policy areas and close partnerships with the stakeholders outside the world of politics. Despite the different organisation of their health systems, European countries can continue to learn from each other, and an ever stronger European integration will see the creation of partnerships between them in the health sector as well. International organisations will have a major role to play in this process.

Gesundheitspolitik ist eine Querschnittsmaterie und kann langfristig nur in Kooperation und Abstimmung mit anderen Politikbereichen und engen Partnerschaften mit den Akteur/inn/en außerhalb der Politik funktionieren. Die Europäischen Staaten können trotz der unterschiedlichen Organisation ihrer Gesundheitssysteme kontinuierlich voneinander lernen und werden in einer zukünftig stärkeren europäischen Integration auch im Gesundheitswesen Partnerschaften miteinander eingehen. Der Arbeit der internationalen Organisationen kommt dabei eine wichtige Rolle zu.

Marc Danzon – Regional Director, WHO



I very much welcome the theme of this year's forum. Partnerships are indeed central to health development and are also one of the main components of the policy of the WHO Regional Office for Europe. The complex nature of health requires all key stakeholders to be fully engaged in a common and well coordinated effort in order to address the many determinants that contribute to health development. Partnerships have to concentrate on citizens' needs. They have to seek ways to further empower citizens to make healthy choices and to have more influence in the direction and running of health systems. I look forward to participating in these important discussions with stakeholders represented in this forum, with the hope to further strengthen our common efforts to improve the health of all citizens.

Ich möchte die Wahl des Mottos für das diesjährige Forum sehr begrüßen. Partnerschaften sind tatsächlich für die Gesundheitsentwicklung von zentraler Bedeutung und bilden auch eine der Hauptkomponenten in der Strategie des Regionalbüros für Europa. Die komplexe Natur der Gesundheit verlangt das volle Engagement aller wichtigsten Betroffenen in einer gemeinsamen und gut koordinierten Anstrengung, um die zahlreichen Determinanten der Gesundheitsentwicklung zu berücksichtigen. Partnerschaften müssen ihren Schwerpunkt auf die Bedürfnisse der Bürger legen. Sie müssen die Bürger dazu befähigen, gesunde Entscheidungen zu treffen und mehr Einfluss auf die Zielrichtung und Leitung der Gesundheitssysteme auszuüben. Ich freue mich bereits auf die Teilnahme an diesen wichtigen Diskussionen mit den anwesenden Betroffenen und hoffe, dass wir unsere gemeinsamen Bemühungen zur Verbesserung der Gesundheit aller Bürger weiter vorantreiben werden.

Gabriele Burgstaller – Governor of Salzburg



As the venue of the European Health Forum, this year the Gasteinertal will be hosting one of the most important health conferences in Europe for the 8th consecutive time. This year's event is staged under the motto 'Creating a Better Future for Health in Europe'. The future of health care is rightly regarded as one of the central tasks for the Europe of the future. I wish to express my thanks in advance for the scientific and expert impulses that will once again emerge from the European Health Forum this year.

Durch die Ausrichtung des European Health Forums wird das Gasteinertal bereits zum 8. Mal zum Veranstaltungsort einer der bedeutendsten Gesundheitstagungen in Europa. Heuer heißt das Motto 'Creating a Better Future for Health in Europe'. Die Zukunft der Gesundheitsversorgung wird zu Recht als eine der zentralen Aufgaben für das Europa der Zukunft gesehen. Ich darf mich schon jetzt für die wissenschaftlichen und fachlichen Impulse bedanken, die auch heuer wieder vom European Health Forum ausgehen werden.

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Federal Ministry of Health and Women
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We provide a variety of services to assist you during your stay. Booking the congress and your accommodation through the International Forum Gastein will ensure that you benefit from the following services: direct shuttle service from Salzburg Airport (75 minutes) or Schwarzach-St. Veit/Bad Gastein railway stations; participation in EHFG sessions (restrictions may apply) and social events for all participants and partners including the weekend, if you choose to stay until Saturday or Sunday.

For further information and a registration form please contact the IFG office or visit our homepage at www.ehfg.org. Hotel rates are available upon request. Accompanying persons (non-participants) staying in the same room pay 60% of the regular hotel rates.

All information in this announcement is subject to change.

Buchungsinformationen

Wir bemühen uns, Ihren Besuch so angenehm wie möglich zu gestalten. Wenn Sie den Kongress und Ihr Hotel über das Internationale Forum Gastein buchen, stellen Sie sicher, dass folgende Leistungen inbegriffen sind: Direkter Transferdienst vom Flughafen Salzburg (75 Minuten) oder den Bahnhöfen Schwarzach-St. Veit/Bad Gastein; Teilnahme an EHFG Veranstaltungen (Einschränkungen sind möglich); gesellschaftliche Rahmenveranstaltungen für alle Teilnehmer und Begleitpersonen einschliesslich des Wochenendes, wenn Sie sich entscheiden bis Samstag oder Sonntag zu bleiben.

Für Einzelheiten und ein Anmeldeformular kontaktieren Sie bitte das IFG Büro oder besuchen Sie unsere Homepage unter der Internetadresse www.ehfg.org. Hotelpreise sind auf Anfrage erhältlich. Nicht am Kongress teilnehmende Begleitpersonen im gleichen Zimmer zahlen 60% des regulären Hotelpreises.

Änderungen der Informationen dieser Programmankündigung bleiben vorbehalten.

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Die Stornogebühr beträgt bis 9 September 2005 10% des Gesamtbetrages, danach 50%. Stornierungen gelten nur schriftlich.



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