

Eurohealth

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Volume 16 Number 2, 2010

Measuring the quality of long-term care



Public reporting of
long-term care quality:
the US experience

Different routes to quality
improvement in Germany

England: The Quality
Assurance Framework

Long-term care quality initiatives: Austria, Finland, Hungary and the Netherlands
Estonia's health system: improving performance during a financial crisis • Health financing reform in Azerbaijan

COMMENTS

Measuring the quality in long-term care: an international progress report

Evidence from US indicates that at least 70% of the over 65s will require some long-term care (LTC) services during their lives. Projections in England over the twenty year period to 2022, suggest that the total cost of LTC will rise by 110%, reaching £31.4 billion. Given the high costs, coupled with the large numbers of often vulnerable and frail older people who will be future consumers of care services, ensuring the quality of services is of paramount importance. The challenge remains as to how best undertake this. Much can be learnt from experience to date.

This issue of *Eurohealth* is devoted to examining such different experiences in seven countries. In the US, Vincent Mor discusses the advancement of public reporting of provider performance as a means of introducing quality based competition. Similarly, as described by Andreas Büscher, Germany has begun to publish overall quality scores for LTC facilities in a manner intended to be accessible to the general public, while also developing expert standards and quality indicators. Finland, unlike many European countries, has a relatively long track record in using quality measures. Harriet Finne-Soveri and colleagues review nine years experience using the US originated Resident Assessment Instrument benchmarking system.

Much of the focus of LTC quality systems focuses on residential care services. Much less attention is paid to care provided in an individual's own home. In Austria Birgit Trukeschitz describes the introduction, not only of a national quality certificate for care homes, but also a tool to be used in respect of quality of home-based care provided by nursing staff.

Judging the impact of quality measures is far from straightforward. Juliette Malley cautions that because they have long been used in England to help change the behaviour of organisations studied, their usefulness as independent, reliable measures of quality is questionable. She argues that research that explores the validity and reliability of the official measures, and in particular examines their sensitivity to changes in users' outcomes, would be of great interest and value. International progress on the quality of LTC has been made, but clearly there is a long way to go.

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Published by LSE Health and the European Observatory on Health Systems and Policies, with the financial support of Merck & Co and the European Observatory on Health Systems and Policies.

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

The views expressed in *Eurohealth* are those of the authors alone and not necessarily those of LSE Health, Merck & Co. or the European Observatory on Health Systems and Policies.

The European Observatory on Health Systems and Policies is a partnership between the World Health Organization Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

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Design and Production: Westminster European
Printing: Optichrome Ltd

ISSN 1356-1030

LSE Health

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Measuring the quality of long-term care: an introduction

Tiziana Leone

Whether we are looking at competition in the private sector or quality assurance in the public sector, the measurement of the quality of long-term care is increasingly prominent. Thus far the key research on this topic has focused mainly on institutional care. However more methodological efforts are now being targeted towards measuring the quality of home and community based care.

The collection of papers on long-term care published in this issue of Eurohealth follow on from an expert meeting on 'Measuring the Quality of Long Term Care', held at the London School of Economics and Political Science on 21 May 2010. This was organised by the Health Status, Health Care and Long-Term Care Research Network. This is part of the European Observatory on Social and Demographic Conditions that is sponsored by the European Commission's Directorate General for Employment, Social Affairs and Equal Opportunities*. The papers in this issue illustrate how an increasing number of countries are moving towards the 'culture' of quality in long-term care. They also indicate that the challenges to be faced remain considerable, with the public availability of data, homogenisation of measurement and choice of indicators remaining key hurdles.

Successful experience in the US is one encouraging sign of a trend towards the application of quality assurance. In particular it shows how the availability of public data has pushed the development of common indicators. Starting from nursing homes it has developed into a wider quality assurance exercise. Furthermore, countries are beginning to follow up on the US experience. Finland, for example, has implemented the Resident Assessment

Instrument (RAI) benchmarking system following on from the American experience. Nevertheless the RAI system is only one approach and the implementation of benchmarking will depend on national needs. More international examples are needed to help in sharing common practices and charting the way forward.

Key issues and challenges

The key issue in many countries is the availability of data. This is often patchy in nursing homes and completely lacking for home care services. While in all of the countries discussed in this issue quality assurance has been implemented at some level, these data are not always made publicly available. This is often due to the opposition of providers, as in England and Germany. In addition, in many European countries the measurement of long-term care quality still remains an academic exercise rather than actual policy implementation. Only in a few countries, such as the Netherlands, has this academic exercise been transformed into policy implementation led by the Ministry of Health, Welfare and Sport.

There seems to be a generalised 'under construction' or 'further development' tendency in indicators, with the most developed being found in the US, Canada and Finland.

We are still far from being able to refer to a common set of indicators at the European level. Differences in providers' characteristics, data availability and organisation of competencies make homogenisation particularly hard. For example, long-term care responsibilities are retained by the Ministry of Health, Welfare and Sport in the Netherlands, delegated to individual provinces in Austria and largely considered to be social rather than health care services in England.

Furthermore, the term quality, it seems, can assume different meanings in settings where there is no agreement on a common framework. Often quality refers to institutional structures, as in Austria. Quality in terms of process and outcomes is harder to obtain; many of the measures currently available still need to be checked for reliability and validity.

Once the hurdle of trying to measure quality in long-term care is overcome, the next step should be to make data publicly available and, if feasible, potentially adopt uniform, clinically relevant, patient information systems for both nursing homes and home health services. As the papers presented in this issue indicate, there remains a big gap in the literature in respect of the latter, which in most cases has not been assessed.

Another key challenge is joined-up care. How can we measure care which is vertically and horizontally integrated? Who is responsible for monitoring and assuring quality? In order to measure this component of quality, it is critical to recognise the dynamic nature of indicators.

Other future challenges include the harmonisation of indicators for both institutional and community based care. These indicators need to strike the right balance between the needs of providers, service users, academics and policy makers. National regulation will be fundamental to the achievement of such harmonisation.

For more information, including links to presentations from the expert seminar held at the London School of Economics and Political Science in May 2010, please see <http://tinyurl.com/34hbk7g>

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* Contract No. VC/2008/932.

Measuring the quality of long-term care in Hungary

Zoltan Balogh

Summary: Measuring the quality of long-term care should not only entail a survey of patient and carer satisfaction. It should also involve an ongoing assessment of the working environment, employment conditions and skills and capacities of professionals working in the system, as well as the constructive development of guidelines and standards defining professional tasks.

Key words: long-term care, nursing, home care, hospice, quality measurement, Hungary

The 'greying world' represents a global problem and a challenge throughout all of Europe, including Hungary. Its impacts are reflected starkly in all aspects of daily life. It can impact on employment patterns and on family responsibilities, as well as having implications for social welfare and health care systems. Long-term care service providers for older people in Hungary have continued to evolve in response to the changing nature of society and economic circumstances, most notably since the turn of the millennium.

A key catalyst for these developments was the political decision taken in the mid-1990s to radically reduce the number of hospital beds. This was primarily due to reasons of economic necessity as their financing had become unviable. Yet at the same time it was recognised that there remained a challenge to better meeting the needs of those individuals with terminal conditions who required specialist care. For these patients reaching their final days, a long nursing care period, often using modes of care that paid little regard to individual needs and involved being housed in large communal wards, was far from satisfactory.¹

The new hospital financing system established as part of the reform process, created

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incentives for medical institutions to engage in efforts to help individuals who did not require hospital treatment, but nevertheless remained in need of home nursing care, to return to their homes as soon as possible after any critical health care needs had been met. It is therefore also a matter of urgency to develop the means of providing better quality nursing care, not just in hospices but also within the home environment.

In fact preparations for the introduction of home nursing began in the early 1990s; this initiative was then integrated into the health care reform process.² It was necessary to establish home nursing in order to make it feasible to introduce new forms of treatment that only require a brief hospital stay, while at the same time offering a reliable service in the long term. Attempts to shift treatment and nursing care back into the home, as historically had been the main practice, are characteristic of health care reforms in many high income countries. This process is now under way in Hungary.³

Quality assurance measures

In 1997, the Hungarian Parliament passed a Health Care Act, which among other provisions specified that health care institutions, including long-term care and nursing providers, must operate a quality assurance system.⁴ This was a new challenge for these service providers; home nursing places a special emphasis on the partnership between the nurse, the care recipient and his or her family. This means

that it is essential that any quality assurance system continuously monitor the satisfaction, both of care recipients and their families, with the services they receive. This gave rise to a need for the introduction of new quality assurance and quality improvement concepts and techniques. The outcomes of this process can also provide an insight into future challenges that will have to be resolved.

Quality assurance entails the effective operation of regulations and professional supervision systems necessary to monitor the implementation of quality standards. In the fields of both medicine and nursing, professional supervision is performed by the National Public Health and Medical Officer Service (NPHMOS). Professional supervision of nurses is performed by the county and regional head nurse officers of this service, on the basis of predetermined criteria.⁵ The quality of long-term care is also regulated at national level by numerous provisions which serve as the basis for clinical audit, including the decree on the minimum human and material resources required for a given treatment, professional guidelines and standards on nursing tasks and nursing protocols for specific procedures (for example, the treatment of decubitus ulcers).²

The audits performed by the NPHMOS extend to investigation of the provisions of the operating license for each service, employment conditions and staff skills (prescribed specialist training, employment contracts, liability insurance), as well as the

working environment, e.g. access to appropriate equipment. These audits include a retrospective analysis of nursing documentation,⁵ as well as an examination of the extent to which patients' rights are respected (evidence of patient consent, availability of patient information and protection of patients' rights representative).

With regard to the working environment, the audit assesses the storage of medical equipment, as well as the quantity and usability of reserve stocks of sterile instruments. Another aspect of audit and evaluation concerns the handling (collection and removal) of hazardous waste generated in the course of care provision, evidence that physiotherapeutic equipment meets certification standards and the periodic review of network-operated machines.²

Professional standards also exist in the field of hospice care with regard to the role of general practitioners, patient admissions, home palliative care, psychosocial support for families, the circumstances of dying and death, maintaining dignity, after-care for families, the handling of documents and the supervision of service staff.⁶

Standardisation and certification

NPHMOS conducts its professional and quality audits using a standardised audit form, the application of which is regulated in the Health Care Act. This standardised system is beneficial for service providers, as it ensures a clear set of expectations and eliminates subjective elements from the audit methodology and evaluation of professional activities. The National Centre for Health Care Audit and Inspection issues guidelines for elaborating the methodology for professional oversight, in respect of which the Ministry of Health has drawn up a recommendation regarding the method for clinical audits.⁵

Efforts to develop the quality of professional home nursing in Hungary and to facilitate measurement of the quality of care, commenced relatively late in comparison to other health care services. Following the examples of other Hungarian institutions, the ISO 9001:2000 quality assurance system was chosen. This is also accepted by the European Union as the basis for European requirements. The measurement of professional home nursing systems and processes is ensured through a certification audit that follows the pre-audit. Certification of service providers in Hungary was commenced by the British Standards Institution (BSA-MertCert) in

2004.⁷ The introduction and ongoing application of the system has resulted in tangible progress towards the establishment of a 'quality culture' in Hungary. Service providers now internalise working practices that follow a quality-based approach, which in turn improves the satisfaction of patients and their relatives.

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Azerbaijan

Fuad Ibrahimov, Aybaniz Ibrahimova, Jenni Kehler and Erica Richardson

117 pages

Reform of the health system in Azerbaijan has been incremental, so that organisationally it still has many of the key hallmarks of the Soviet model of health care. Relatively low levels of government expenditure on health since independence have meant that levels of out of pocket payments are high (at almost 62% of total health expenditure in 2007), which has serious implications for access to care and financial risk protection for vulnerable households. The private provision of services is an increasingly important part of the health system and some services are provided in parallel by other ministries and state enterprises. Future plans include the strengthening of primary care and the introduction of mandatory health insurance as part of major reforms to the health financing system.

Tajikistan

Ghafur Khodjamurodov and Bernd Rechel

154 pages

The health system in Tajikistan is undergoing a transition to new forms of management, financing and health care provision. Following independence and the civil war, informal out-of-pocket payments became the main source of revenue. With the aim of ensuring equitable access to health care, the Ministry of Health has now developed a basic benefits package for people in need and formal co-payments for other groups of the population. One of the main challenges for the future will be to reorient the health system towards primary care and public health rather than hospital-based secondary and tertiary care.

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Public reporting, expert standards and indicators

Different routes to improve the quality of German long-term care

Andreas Büscher

Summary: To ensure the quality of long-term care services has been one of the key elements of German long-term care insurance since its implementation in 1995. A joint agreement between insurers and service providers served as the baseline for quality assurance. Monitoring and control of quality in institutional and home based long-term care was performed by the insurers' Medical Board. As a result of problems in some long-term care facilities reported in the media the Long-term Care System Reform Act of 2008 contained several provisions to ensure and improve the quality of services. The obligatory use of expert standards for the performance of particular nursing interventions and the establishment of a system of public reporting were the first measures implemented. The development of quality indicators has also been initiated. These routes to quality, their anticipated effects and remaining challenges will be addressed in this article.

Key words: Long-term care insurance, quality evaluation, expert standards, public reporting, Germany

The quality of long-term care (LTC) in Germany is determined by regulations within the 1995 LTC Insurance Act that constitutes the fifth pillar of the German mandatory social insurance scheme. It complements the existing pillars of sickness, unemployment, pension and accident insurance. Given that the implementation of the LTC act established a market for care, allowing different types of service providers to offer services, quality assurance has played a key role in the system since its inception. While the Act was seen as a way to ensure a sufficient supply of LTC services across the country, concerns were raised on how to monitor service quality. Before the principles for LTC quality are outlined, a very brief overview of the German LTC system is provided.

LTC in Germany is funded by insurance contributions equivalent to 1.95% (2.2%

for adults without children) of employee gross monthly income. This contribution is shared almost equally between the employee and the employers. Eligibility for LTC benefits is determined by an assessment of the need for assistance in performing the regular activities of daily living (related to personal hygiene, nutrition, mobility and domestic care) as a result of physical or mental illness/disability. This eligibility assessment is the responsibility of the Medical Boards of the sickness and LTC insurers (Medizinischer Dienst der Krankenversicherung – MDKs) (see www.mdk.de), an independent consultancy jointly financed by the sickness insurance funds and organised at Länder (state) level. In addition to undertaking eligibility assessment, each MDK also plays a key role in the control and evaluation of the quality of professional services.

Eligibility assessment is undertaken by doctors and/or nursing staff employed by the MDK and takes place in the applicant's home or in a nursing home. There are three levels of need which are dependant on the time required to perform activities of daily living. Benefits are graded in accordance with these levels of need (Level 1 = lowest

level of need) and may be used for institutional care, cash payments or for care-in-kind services at home. In addition, benefits for respite care, as well as for assistive devices and home adaptations are available. However, discussions and concerns over the quality of care focus mainly on the delivery of professional care in nursing homes or by home care services. An overview of beneficiaries and providers in the LTC system is provided in Table 1.

Joint agreement on principles and measures for quality assurance

The LTC Act asked providers and purchasers of LTC services to negotiate and agree on general principles and measures for quality assurance and quality control. This self-regulatory approach was already established in various areas of German health care policy. It reflects the general principle that all stakeholders share responsibility for the availability and quality of LTC services and implies that a range of measures and procedures are established by means of self-regulation between providers and purchasers. The role of national legislation in this respect is to set the framework and terms of ref-

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Table 1: Key data on the German long-term care system

2.25 million people are in need of care and eligible for benefits from LTC insurance		
1.54 million (68%) are cared for in their own homes		709,000 (32%) are cared for in nursing homes
1.03 million people rely on family/informal care only.	504,000 people use a professional home care service:	
61.8% on Level I	52.5% on Level I	35.7% on Level I
29.9% on Level II	35.4% on Level II	42.3% on Level II
8.3% on Level III	12.1% on Level III	20.5% on Level III
	11,500 home care services with 236,000 employees	11,000 nursing homes with 574,000 employees

Source: ¹

erence. Further political action is only taken when no agreement is achieved within a given period of time. This procedure requires all stakeholders to compromise, but tries to embrace their different perspectives. The challenge that the different stakeholders had to face when negotiating the first LTC agreement was to define solely the quality of nursing care, without any reference to medical services.

The joint agreement that was finally signed by stakeholders set the rules for ensuring quality and committed service providers to open their doors to external control performed by the MDK.² In addition to these external measures for quality inspection, the joint agreement also contained guidelines for internal quality development, which were stated to be the preferred method for ensuring service quality. Guidelines were specified for home care services, nursing homes, short-term care and day-/night-care facilities, with quality of care being defined according to three criteria.

- Structural criteria related to the technical and educational competences of the chief nurse and other nursing staff, as well as to basic criteria for running different types of LTC facilities.
- Process criteria related to the services' self-description, the application of the nursing process, documentation of services provided and collaboration with service user family members, as well as with other professions or institutions.
- Outcome criteria related to service users' satisfaction with services received and the evaluation of care according to objectives stated in their care plans.

Thus, the guidelines not only contained aspects of external quality assurance, but also addressed internal measures for improving quality. The function of the

guidelines in terms of internal quality was to offer and introduce a range of different means that service providers could use for improving the quality of their services, as well as to benchmark their services against other competitors in the market. Suggestions for internal measures of quality development and improvement included: advancement of existing standards of care; employment of quality managers; establishment of quality circles; and attendance at quality conferences. In addition, a distinction between voluntary and involuntary approaches to external measures was made. While involuntary measures were related to external control by the MDKs, internal measures were related to voluntary inspection by other institutions or consultancies that offered certificates or other types of formalised seals of quality.

As noted, the monitoring and control of the quality of institutional and home-based LTC is performed by the MDKs that operate according to standardised obligatory guidelines applying across Germany. It is the responsibility of each MDK to perform quality tests through inspection visits to nursing homes and home care services. The guidelines used for this purpose include an outline and detailed description of the joint agreement.

The results of MDK tests have been published by the umbrella organisation of the MDK, the Medizinischen Dienstes des Spitzenverbandes Bund der Krankenkassen (MDS). The latest report in 2007³ was based on almost 8,000 inspection visits. It revealed some improvements compared to the 2004 report, particularly in respect of the organisation of services. Problems were still reported with regard to direct care provision. In home care and nursing homes respectively, deficits in

pressure sore prevention have been found in 42.4% and 35.5% of all cases inspected. Problems with food and fluid intake have been reported in 29.6% and 34.4% of cases, and similarly in respect of incontinence care, 21.5% and 15.5%, and psychogeriatric care in 26.1% and 30.3% of all cases in home care and nursing homes respectively.

Reform of LTC system

These figures indicate that, despite the efforts that have already been made, the quality of LTC services was still in need of improvement. In addition, concerns about the accuracy and appropriateness of quality tests were raised. While the public (represented by some individuals and the media) were concerned that tests were too laissez-faire and not suitable for detecting the real problems experienced by LTC users, service providers raised doubts about testing methodology. There was also criticism that the results of the tests were not understandable to potential service users and their relatives. Therefore the most recent LTC reform addressed the issue of LTC quality by introducing three different measures to ensure and improve it: the obligatory implementation of the use of expert standards, the mandatory performance of unplanned quality tests by the MDK and the establishment of a public reporting system on the quality of care.

Expert standards

As an important instrument to promote internal quality development within LTC facilities the mandatory development and implementation of expert standards was established. These standards are considered as a means of reflecting the state of the best available evidence with regard to particular nursing interventions. The methodology and procedure for the development of

Table 2: Transparency criteria

Nursing homes	Home care
Nursing and medical care (35 items)	Nursing care (17 items)
Care of residents with dementia (10 items)	Activities prescribed by a physician (10 items)
Social and everyday life support (10 items)	Quality of organisation and grade of service (10 items)
Housing, meals, housekeeping and personal hygiene (9 items)	

these national expert standards in nursing has been developed by the German Network for Quality Development in Nursing (DNQP). This process began almost a decade ago in cooperation with the German Nursing Council. The standards define the quality level of professional care that users of both health and LTC services can expect when being cared for by nurses.

The development of these standards follows a clear methodological approach.⁴ Following the selection of a subject on which an expert standard is to be developed, an expert group is convened that analyses the relevant literature for the best available evidence. The group then agrees on the draft of an expert standard containing aspects of structure, process and outcome quality. This draft is then discussed in a public 'Consensus' Conference, before the final version of the standard is published and evaluated by several health and LTC institutions. The results of implementation are also discussed in a public event. Modifications to the expert standard will also be determined through a consensus process if required after the evaluation. Finally, all expert standards are regularly updated. To date expert standards have been developed for:

- Pressure sore prevention in nursing care
- Discharge management in nursing care
- Pain management in nursing care
- Fall prevention in nursing care
- Promotion of urinary continence in nursing care
- Nursing care for people with chronic wounds
- Nutrition management for ensuring and promoting oral nutrition in nursing care

The methodology developed by the DNQP has now become the official procedure for developing expert standards that

LTC facilities have to implement. Stakeholders have to agree on topics and the final versions of standards. The development is paid for by the LTC insurance.

External quality control

The existing regulations on external quality control were expanded through reform in 2008. The MDKs – still on the basis of a national guideline – now have to perform quality evaluations in each LTC facility on an annual basis, placing a strong emphasis on the quality of outcomes. The MDKs must now take account of the results of any evidence provided on voluntary quality improvement activities initiated by LTC providers within their evaluation. However, the assessment is now performed without prior notice to LTC facilities. This policy was introduced in response to criticism that prior notification gave facilities the opportunity to hide any quality problems.

During the inspection visit members of the MDKs are allowed to interview care recipients and their relatives, as well as nursing staff. The MDS is still responsible for compiling and publishing the results of the external quality control by the MDKs every three years. In the case of concerns about the quality of care, the MDK would provide advice to the LTC facility on quality improvement measures and specify a time frame during which these improvements should be made. Should no measures be taken, the insurance funds have the option to reduce reimbursement for services or, in very severe cases, cancel contracts with providers. The latter implies that the facility is no longer allowed to offer services within the LTC system.

Public reporting of quality

Because of the ongoing criticism of the quality of care, particularly in nursing homes, the LTC reform act introduced the principle of transparency in service quality.

This means that the results of the new quality evaluation procedures not only have to be published, but published with a focus on outcomes and quality of life and in a way that is understandable and accessible to the public. The principles and form of publication were discussed and agreed upon by the relevant stakeholders and began to be published from the end of 2008.

These 'Agreements on transparency of nursing care' are based on a selection of items and questions taken from the general guideline for quality tests, which contains 82 (institutional) and 49 (home care) items that must be completed. Table 2 provides an overview of the areas and numbers of items relating to home and institutional care. Answers to questions are summarised to produce a grade, derived from the German school grading system from 1 (very good) to 5 (poor). This system was chosen because the grades are familiar to the whole population, helping to meet the requirement for comprehensibility. These grades are published in a single scheme summarising results for relevant criteria.

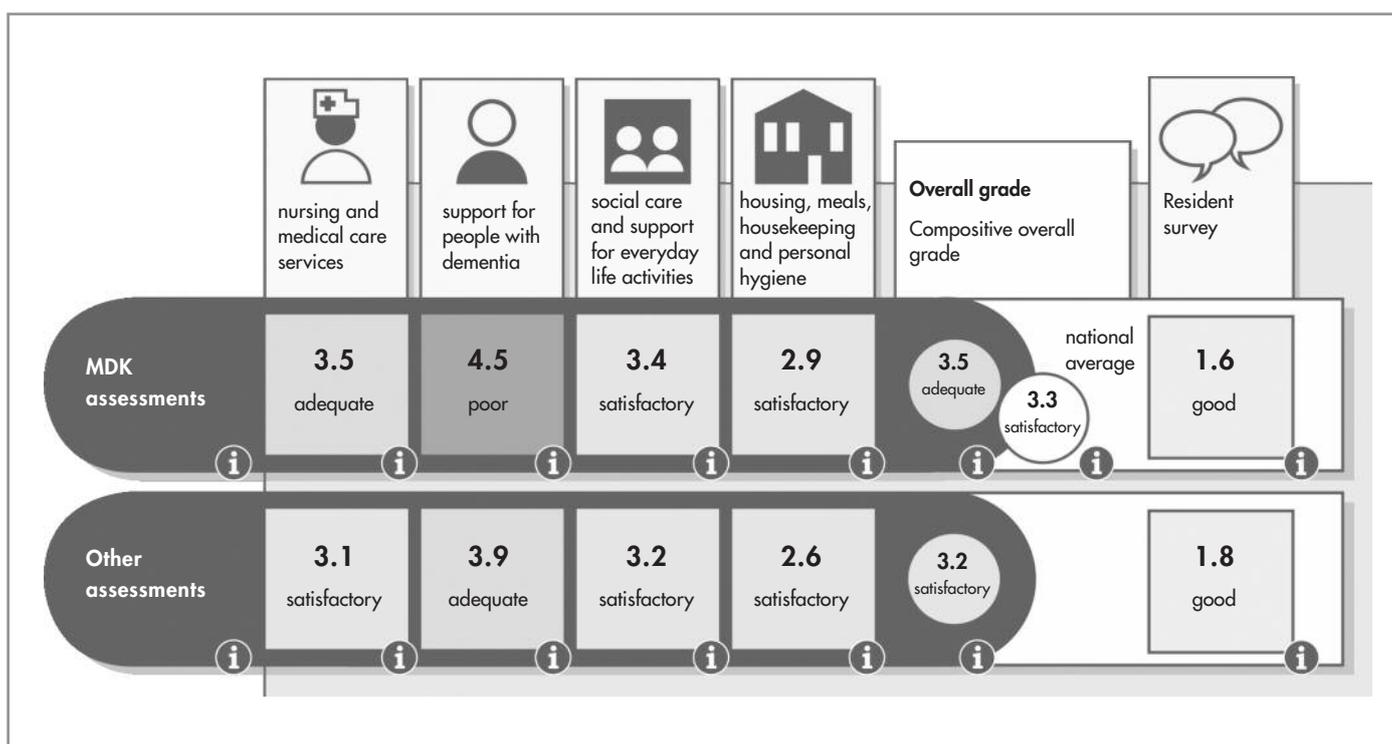
In addition, a user survey is part of the criteria, covering 18 items in institutional care and 12 items in home care. While results from the user survey are reported publicly, they are not included in the overall grading score, because satisfaction rates among users are often quite high.

Figure 1 provides an example of the grading scheme for a nursing home. In addition to the overall grade (*Gesamtergebnis*), both MDK gradings for the four transparency criteria set out in Table 2, and gradings arising from other evaluations, where available, are presented. In addition results from the user survey are reported separately.

As of May 2010, more than 7,000 LTC facilities had been evaluated and 4,715 reports published. Overall and transparency criteria specific results can be compared at both a national and provincial level. To date, the overall score for home care providers is 2.2, compared with 2.0 for nursing homes.⁵

Despite agreement on establishing this system, these initial results have still raised concerns about the robustness of the methodology used. Unsurprisingly, it was largely facilities awarded poor grades that tried to prevent the publication of their results through actions in the social welfare courts. In some cases the courts allowed publication, in others it was prohibited. Ultimately it is to be anticipated that final

Figure 1: Illustration of grading scheme for a nursing home



decisions in these cases will need to be made by the Federal Social Security Court.

Parallel to the implementation of the transparency agreement, the Ministry of Health in cooperation with the Ministry of Family Affairs, Senior Citizens, Women and Youth commissioned a research project for the development of quality indicators on the outcomes of institutional LTC. This project is due to be completed by the end of 2010. The results are likely to further influence debate on quality and transparency procedures, given that several court judgements referred to this project, arguing that there was a lack of an accurate methodological basis to determinations of quality in the existing procedures.

A final measure implemented by the LTC reform Act was the establishment of an arbitration board that can be called upon by providers and purchasers in the case of major disputes on particular aspects of quality assurance and development. Board membership includes equal representation of providers and purchasers, as well as three independent members (a lawyer and two academics, each with their own deputy).

Conclusions

This paper has briefly summarised the various efforts to develop and improve the quality of LTC services in Germany. The current situation is the result of fifteen years of experience with the long-term care

system and in many respects is still a work in progress. Meanwhile, it has become an issue that also involves practitioners, providers, purchasers, academics and decision-makers. Future challenges include the further development of relevant outcome indicators for both institutional and community based LTC, as well as the refinement of the public reporting system.

It remains the case that no attention has been given to the largest group of LTC beneficiaries – the recipients of cash payments who try to manage their situation without professional support. Despite now having the legal obligation to request regular counselling visits by a professional nursing service, not much is known about their current situation or appropriate ways to develop and ensure quality in their setting. To date, there is only limited evidence on the counselling approaches used in terms of their helpfulness and appropriateness. Indeed, recently serious doubts were raised as to whether this procedure is helpful at all.⁶ Thus, this area is another key challenge that remains to be faced in the future.

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Measuring the quality of long-term institutional care in Finland

Harriet Finne-Soveri, Teija Hammar and Anja Noro

Summary: Benchmarking care outcomes may revolutionise both the efficiency and quality of long-term institutional care. Experience over nine years in Finland demonstrates a remarkable decrease in the use of different types of psychotropic medications and various improvements in nursing care patterns. The prerequisite information requirements to these findings are the collection of comparable standardised data, combined with regular performance feed-back mechanisms and skilful leadership.

Key words: Quality indicators, older people, long-term care, nursing homes, Finland

Long-term care for older people in Finland is delivered either at home, in sheltered housing, residential care homes (nursing homes), or within health centre inpatient wards (chronic care hospitals). The latter two forms of care and housing have traditionally been seen as institutional care, mainly due to the payment source rather than due to the needs of the older individual or type of housing. In 2008, more than 10% of those aged 75 years and older received 24-hour care in locations other than in their original homes, while 6% lived in institutions.

According to legislation, local authorities are responsible for organising institutional care. They meet the costs of care whenever the care recipient has insufficient economic resources. The National Supervisory Authority for Welfare and Health (Valvira) is responsible for producing guidance and providing supervision so as to ensure that sufficient care services are available.

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However, care professionals are free to choose their own quality assurance methods. According to an ongoing European Union 7th Research Framework funded project, *Interlinks*,¹ few organisations had by the beginning of 2010 systematically adopted any approach to quality assurance, apart from the Resident Assessment Instrument (RAI) benchmarking system, described in this article.

Practices in long-term institutional care facilities for older people have repeatedly been criticised in the media since the 1990s. Among issues that have been discussed are: relevant staffing ratios; the use of physical and chemical restraints; lack of rehabilitation nursing care; use of incontinence pads and nappies instead of taking the person to toilet; and malnutrition. The lack of any knowledge regarding these topics was obvious at the end of the century and led to the creation of the *RAI benchmarking project for long-term institutional care* in 2000 in order to determine what really was going on in long-term care institutions.

National benchmarking project for quality of long-term institutional care

In 2000, three towns – Helsinki, Kokkola and Porvoo – agreed to adopt the RAI instrument to improve quality of care in their long-term care institutions. The RAI instrument originates from the United States, where it has been nationally mandated for quality, research, and payment purposes since 1990. It includes a 400 item

plus observational questionnaire that is filled out by care staff, a user manual and guidelines for individual care plans. Several well validated scales, sets of performance measures and algorithms for payment systems can be derived from the questionnaire.²

To ensure the quality of the documentation, and consequently the scales derived from these data, an ongoing education programme for nurses was created. A commercial software programme to enhance the use of the scales and indicators embedded in the RAI system was also developed. In this context, the National Research and Development Centre for Welfare and Health (STAKES), an institute also responsible for national health and welfare registers, and functioning directly under the Ministry of Social Welfare and Health, conducted a benchmarking project (2000–2005) to compare outcomes of care.

Since 2000, the number of residents assessed twice a year in the institutions has more than quadrupled, being approximately 10,000 in 2009. The number of benchmarking facilities has increased from 29 (16 residential homes, 13 health centres) to 95 (62 residential homes 35 health centres), despite a reduction in the number of institutional beds. In 2010, the RAI-benchmarking exercise covers most of the major cities, including public and private sector organisations. This amounts to approximately one third of all the long-term institutional care in the country.

The benchmarking activities have evolved from a single project to ongoing multiple activities. In 2003, a project to help in the transfer of knowledge using MDS 2.0 for home care was launched. Moreover, projects for mental health (2007), acute care (2009) and intellectual disabilities (2010) have been conducted by the new National Institute for Health and Welfare – THL (formerly STAKES).

The basic RAI benchmarking activity consists of the following steps:

1. Staff members in participating institutions receive RAI education at the start of the benchmarking process; this also is provided as a result of staff turnover.
 2. Staff members in benchmarking institutions perform RAI assessments for each resident at admission, every subsequent six months and whenever there is a significant change in their status.
 3. Copies of the RAI assessments are sent electronically every six months to the National Institute for Health and Welfare.
 4. A unit-level feedback report in Excel form is delivered to each of the participating units within six weeks of data collection. The figures in the feedback report comprise information (percentages, averages) about functional capacity including cognition, social activities, clinical issues such as mood, behavioural problems, pain, diagnoses, medications, procedures like skin care, and nursing rehabilitation.
- In addition, performance measures to monitor quality of care are presented. These indicators to evaluate performance were created by Zimmermann et al.³ They comprise 26 performance indicators, of which five are risk adjusted, nineteen are concerned with prevalence and five with incidence covering the following domains: accidents and injuries, mood and behaviour, clinical care, cognition, continence, infection control, nutrition, functional capacity, psychotropic medications, quality of life and skin care.
5. Staff members compare each of the measures of their own unit to similar peers and the national average. Wherever performance is poorer than that of their peers, care plans should be rechecked and programmes to improve care initiated.
 6. Twice-yearly seminars are held to

present differences in performance measures between care providers. Attendance rates are increasing, with up to 1,000 professionals including nurses, physiotherapists and administrators participating every year

7. The impacts of any quality improvement project that the participants may have experienced are discussed. Clinical themes such as nutrition, nursing rehabilitation, or use of psychotropic medications and physical restraints are repeatedly chosen. Leadership and management issues linking these themes are discussed.
8. A benchmarking feedback data set has been built online for participants to use and it is updated twice a year.
9. Research is also conducted by participating organisations or by the National Institute for Health and Welfare. Numerous reports and peer reviewed articles have been published, including eight doctoral theses.

Developments and impact of benchmarking 2001–2009

Of the 26 quality indicators, only one has had negative developments of any substantial degree; namely that the use of multiple medications has tended to increase. That said, it is also the case that despite care received levels of incontinence and cognitive impairment have tended to increase. Nutritional performance measures have not improved: the number of fallers or those with fractures remains roughly unchanged, while the prevalence of grade 1–4 pressure ulcers has stabilised at approximately 8%. Reducing physical restraints has shown only modest improvement (from 20% to 16%).⁴

On the other hand, some aspects of quality have improved remarkably among all participating units. The overall level of psychotropic use is substantially lower today compared with the beginning of the new millennium. Several institutions are practically free from regular use of hypnotics without any increase in sleeping disorders. The overall use of hypnotic medications has dropped among benchmarking participants by more than 50% (from 43% to 21%). Moreover, a decrease in antipsychotic medications (from 36% to 26%) and sedatives (from 58% to 39%) has occurred without an increase in behaviour problems (from 34% to 35%). Nursing patterns and care practices have

moved more towards rehabilitative care: the lack of nursing rehabilitation has modestly declined (from 29% to 26%) and the lack of toileting a little more (from 65% to 46%). The organisations that initiated benchmarking activities in 2000 have acted as beacons showing the way to others. Their progress, compared to the baseline is illustrated in Figure 1.

Discussion

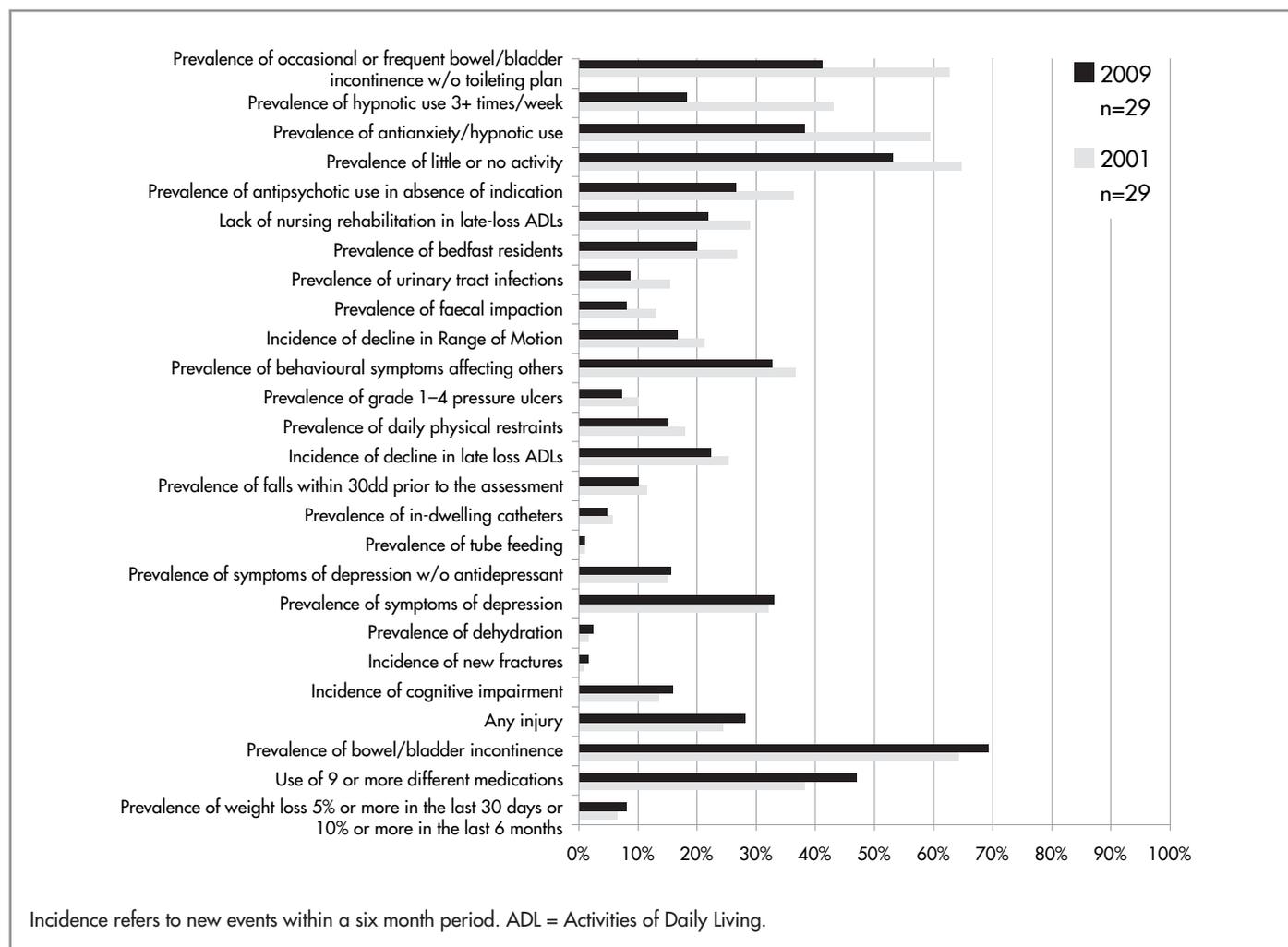
The introduction of a benchmarking approach has had a particularly significant impact on utilisation rates of various psychotropic medications that as recently as 2001–2003 were among highest rates in the world.³ The change in medication patterns is an example of simultaneous improvements in financial efficiency and care quality. Potentially harmful medications can be removed, money is saved and the risks for patient safety diminished. Changes in nursing patterns can also be seen with a tendency to move out of restorative care towards an active approach with a focus on nursing rehabilitation and social activities, including activities to support the frailest and sickest.

Without standardised documentation benchmarking is not possible. This required repeated meetings and discussions without which the change may not have happened. Without benchmarking, the revolutionary change in the use of medications among participating units may not have been observed. Without international links,⁵ both targets to achieve and messages set may not have been as clear. However there remains room for improvement: Finland still has a way to go.

Why was it that not all quality areas improved? One reason might be the observational, rather than leading, role of the National Institute for Health and Welfare. It was up to the long-term care institutions to grasp quality issues and make change happen. Sometimes change may not have been prioritised in the middle of everyday concerns over issues such as sick leave and staff turnover. The project has taught us all the importance of skilful nursing leaders. In the absence of good leadership and a just approach, unwanted nursing patterns, such as too much reliance on psychotropic medications or physical restraints, are easily adopted.⁴ Some changes may also be more difficult to push through than others. Moreover, the role and impact of selection on quality and performance is unclear.

Of importance is the long-term care institutions' willingness to commit to benchmarking. In the absence of national rules, small care providers are more or less

Figure 1: Performance measures in 29 long-term care institutions, 2001 and 2009



on their own. The Finnish health and social care system has been named as one of the most decentralised in the world by Valtonen,⁶ with relatively high levels of independence for local municipalities. This is not, however, without its downsides: few things are comparable, true improvements are difficult to show. Nonetheless, in the European Union, variations in nursing patterns and governance may be vast. Benchmarking offers an opportunity to learn from others with regard to both quality and efficiency. Results from Finland over a nine year period may encourage others to take this option seriously.

Conclusions

The use of a standardised data collection protocol, including documentation instruments, such as RAI, is a useful method of gathering comparable information from different care providers in the long term care sector, particularly in cases where municipalities have substantial autonomy.

When data gathering is further used for quality improvement purposes, benchmarking might thoroughly change care delivered to older people.

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ACKNOWLEDGEMENTS

The authors express their gratitude for interRAI, the not-for-profit research organisation and copyright holder of the RAI instruments for allowing the use of their instruments.

Quality of care assurance in long-term care in the Netherlands

Dinnus H M Frijters

Summary: This article summarises the status and history of quality of care assurance in long-term care in the Netherlands. To achieve this end, an inventory of stakeholders, documents, websites, databases, analysis methods and the scope of quality of care assurance in the Netherlands were analysed. The quality of care assurance system in 2010 is reported on from the perspective of an individual involved in its development and implementation and links are made with quality assurance systems in other European and North American countries. Overall, the Netherlands has developed an elaborate, well structured quality of care assurance system; however, the collection of data and its content can be improved on.

Key words: quality of care assurance, long-term care, quality of care indicators, Consumer Quality Index, Netherlands

Quality indicator collection, analysis and publication

From 2001 to 2003, the Organisation of Care Entrepreneurs in the Netherlands (ACTIZ, formerly ARCARES), initiated a Benchmark for Nursing Homes, Residential Homes and Home Care (Benchmark VV&T). The benchmark served as a research tool to compare similar health care facilities with each other and provide health care facility management staff with data on quality and efficiency of care. It was financially supported by the Ministry of Health. About 400 facilities participated in this benchmark during the initial three-year period. All participants received reports about their own facilities and a summary report on the whole benchmark. The results were only available for ACTIZ members.

The benchmark consisted of five modules which assessed: (i) efficiency; (ii) consumer satisfaction; (iii) staff satisfaction; (iv) quality of care indicators;¹ and (v) facility management. In 2004, ACTIZ adopted the Benchmark VV&T as a permanent

research tool exclusively for its member facilities. The Ministry of Health, however, decided that public, not proprietary, information on quality of care and consumer satisfaction was required and therefore started a new initiative.

The Quality Framework Responsible Care programme

To gain access to information on quality of care in health care facilities the Dutch parliament voted for implementation of a Quality Framework Responsible Care programme. This fell under the responsibility of the Ministry of Health, Welfare and Sports and started in 2005. The programme's report marked the beginning of the mandatory collection of data on quality of care and consumer experiences in all health care facilities in the Netherlands. It is available on a dedicated website, with the final report available in English.²

Since 2005, the Quality Framework Responsible Care programme has contracted major research organisations to develop tools and databases for different sectors of health care that are covered by the Health Insurance Act for Special Medical Costs (AWBZ). These organisations: NIVEL – Netherlands Institute for Health Research, Plexus, the Institute of Health Policy and Management (iBMG) at Erasmus University, RIVM – the National

Institute for Public Health and the Environment, and Kiwa Prismant – publish information on their websites regarding their involvement in specific activities.

Furthermore, the Quality Framework Responsible Care programme set up a new independent institute, the Dutch Centre for Consumer Experience in Health Care (Centrum Klantervaring Zorg, CKZ). CKZ's aim is to ensure that the collection and publication of consumer experiences with health care is systematic and scientifically reliable. In its short existence its impact on the measurement of consumer quality in the Netherlands has been considerable. It makes research on consumer quality operational^{3,4} and supports fundamental research. An example of the latter is a recent thesis 'Public reporting about health care users' experiences: the Consumer Quality Index'.⁵ The thesis answers three research questions: (i) which case-mix adjustment strategy should be applied to ensure fair comparisons between health care plans or providers?; (ii) how are different types of comparative health care information presented on the Internet?; and (iii) which presentation formats of comparative health care information support health care users?

To disseminate the results of the mandatory quality indicator (QI) collection, the Ministry of Health established

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a website (www.kiesbeter.nl), where the results of annual assessments on QIs in every health care facility in the Netherlands are published. To apply this information in care practice, the Ministry of Health has set up yet another website (www.zorgvoorbeter.nl) in cooperation with umbrella organisations in health care. Its main aim is to stimulate improvements in care.

Quality indicators: the InterRAI approach versus the Dutch approach

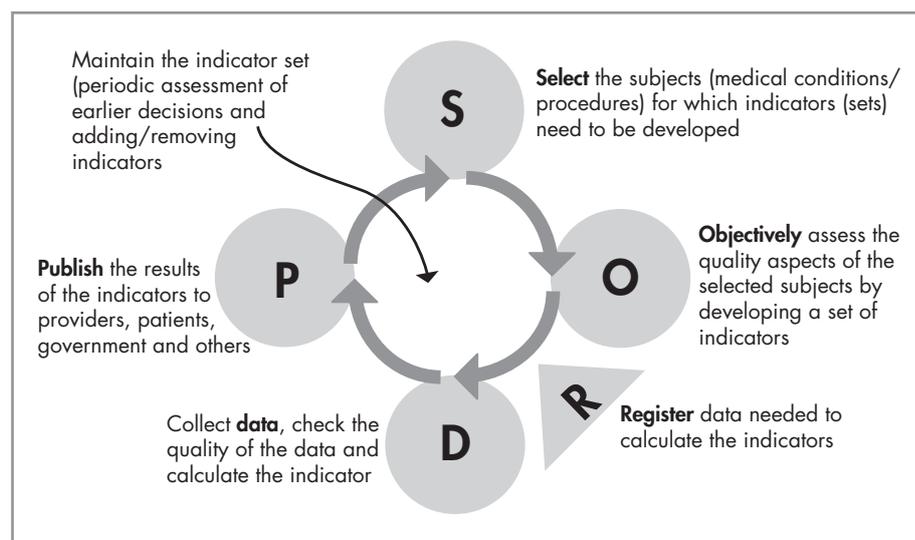
QIs for monitoring quality of care in nursing homes have been developed using assessment data from the widely implemented Resident Assessment Instrument (RAI) for nursing homes.^{6,7} Routine monitoring of these QIs led to QI reports being used for best practice comparisons between nursing homes.⁸ A study commissioned by the US Centers for Medicare and Medicaid Services (CMS) demonstrated that the items from routine use of the RAI in US nursing homes are reliable and that they can be used for the stimulation of improvement of care and reporting to the general public.^{9,10} For most of the QIs some indicator specific risk adjustment is necessary to allow useful comparison of QIs between facilities. Although the relationship between outcomes and good and bad care practices are not equally strong for all available QIs, ten QIs have a good relationship between identifiable proactive and responsive care practices. Those are the QIs that have been selected by CMS for periodically public reporting on a facility level.

InterRAI, an international group of researchers that includes the original developers of the RAI for nursing homes, developed a Home Care instrument, with the same design and structure as the RAI, for assessment and care planning for people living in their own homes.¹¹ InterRAI also developed QIs for the evaluation of the quality of formal care services provided to individuals in their own homes.^{12,13}

A four step approach was used in the development and validation of QIs for nursing homes and for home care.

1. *Selecting indicators of quality of care.* Using large datasets gathered from routine practice, focus groups discuss which assessment items or combination of items may indicate dimensions of quality of care (face validity). QIs are then defined together with the method for calculating numerator and denominator values (con-

Figure 1



struct validity). To be meaningful the indicators must show enough variance between facilities/agencies, have high enough prevalence and show sensitivity to change when care practices change.

2. *Correlating indicators with quality of care.* Experts must agree that high (or low) scores on the indicators in a facility or agency correspond to good (or bad) quality of care. This is formalised by research that identifies care practices that correlate well with indicator scores pro-actively (i.e., prevent problems) or responsively (i.e., remedy problems).

3. *Identifying person level risk factors.* Factors that legitimately increase or reduce the likelihood of an individual scoring on the indicators are identified by regression analysis of client characteristics. Once these risk factors are established over a large enough database, for example, from a large number of care providers across countries, they are incorporated into the calculation of the QIs.

4. *Identifying service level bias.* Service level bias (ascertainment bias) manifests itself in two related forms: service/facility admission practice, as well as staff competence in observation and recording. Home care services or nursing homes that admit a relatively large number of clients with specific indicator problems often continue to score high on these indicators at follow-up, despite risk adjustment. When experts examine the practice of these services/facilities, the quality of care in these indicators areas is not necessarily poor. To resolve this matter a Facility Admission Profile (FAP) covariate was developed for nursing homes⁹ and the Agency Intake Profile (AIP) for Home Care.¹²

In the Netherlands, the Quality Framework Responsible Care programme followed, to some extent, a similar approach. It focused more on the organisation and the required conditions to assure the continued existence of a quality of care indicator system. It compared different approaches in nine countries: Australia, Canada, Denmark, France, Germany, Sweden, Switzerland, the UK and the US. It compared the implementation in these countries of six process steps and drew conclusions about what would be best for the Netherlands, see Figure 1 above.¹⁴

An 'indicator team' was put in charge of the choice of QIs to be adopted for nursing homes, residential homes and home care. The team consisted of representatives of the following stakeholders:

ACTIZ: Organisation of Care Entrepreneurs

V&VN: Nurses and Caregivers Association in the Netherlands

LOC: National Organisation of Clients' Councils

NVVA: Professional Association of Nursing Home Physicians

STING: National Professional Care Association

IGZ: Health Inspectorate

VWS: Ministry of Health, Welfare and Sports

ZN: Dutch Care Insurers Organisation

The indicator team was assisted by experts and used the RAND modified Delphi method to reach consensus. It produced ten 'themes for responsible care', see Table.

Themes for responsible care	
1	Care (treatment)/life plan
2	Communication and information
3	Physical well-being
4	Safety care content
5	Domestic and living conditions
6	Participation
7	Mental well-being
8	Safety living/residence
9	Sufficient and capable staff
10	Coherence in care

Source:²

For each theme, one or a number of indicators of three types were distinguished:

1. Client-bound indicators that are measured by consulting clients (CQ-index), performed by an independent agency;
2. Indicators assessing the content of care at an organisational level, collected by the organisation itself; and
3. Indicators measuring the content of care at the clients' level, assessed by the organisation itself.

For each care theme at least one indicator type was assessed. Only the third type of indicator is comparable to the InterRAI QIs described earlier. Most of the indicators that measure the personal content of care are explicitly borrowed from the QI sets of the InterRAI Long Term Care and Home Care instruments (for example, falls, depression, behaviour symptoms, weight loss, time spent lying down, psychotropic use).

Because the Dutch government chose not to make the use of InterRAI instruments mandatory, many items have been simplified, for instance with fewer response categories. While RAI data are continuously collected for care planning purposes, data to measure content of care in the Netherlands according to the 'Dutch approach' are collected once a year in a 'measurement week'. These concessions in the Dutch approach decrease the quality and reliability of collected data. When the benchmarking method to assess quality of care started, items from RAI were used in

the ACTIZ Benchmark to risk adjust individual indicators.¹ Later on, these items were substituted by items from the Care Dependency Scale¹⁵ for a one-suits-all 'case-mix adjustment'.

Conclusions

In a relatively short time the Ministry of Health, Welfare and Sports in the Netherlands has developed an elaborate, highly structured quality of care assurance system for most health care services, beginning with long-term care and home care. It has defined what is to be collected (customer experience data, content of facility care delivery and persons' care characteristics), mandated its use and developed structures, supported by websites, to ensure that data are collected, properly uploaded to databases, carefully analysed and published for the general public and others to make use of. Together with umbrella organisations, it has set out to stimulate the improvement of care based on the results of the quality of care measurement.

The collection of data and the content of information on the quality of personal care in the Netherlands are still not ideal when compared with how this is done using the interRAI instruments, for example in Canada and the US and in other parts of Europe (for example, Finland). The process to develop the content of care QIs has been achieved through the building of consensus rather than being scientifically based.

Secondly, data collection is not part of the routine collection of data for management information and quality improvement projects, but instead singled out within a 'measurement week'. It may be easier to organise data collection this way, but it carries the danger of upcoding, i.e., scoring to obtain false but better results.

Thirdly, instead of having QI specific risk adjustment, the choice has been made for a general case-mix risk adjustment which is, at least for some of the QIs, inappropriate.

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Public reporting of long-term care quality: the US experience

Vincent Mor

Summary: Efforts to improve the quality of long-term care services traditionally focus on regulatory and enforcement systems, however, increasingly provider quality improvement efforts stimulated by public reporting of provider performance has been emphasised in the US in both institutional and community based long-term care. Over the past decade, in the US publicly reporting provider performance has been advanced as a means of introducing competition on the basis of quality into the long-term care sector, providing benchmarks against which providers can compare themselves and be compared. This paper briefly summarises the US experience over the last decade in these efforts and proceeds to discuss and document research regarding the advantages and pitfalls of quality measurement and the effects that public reporting has had. Since provider comparisons in the acute care sector are already underway in many European countries, it is likely that these efforts will be expanded in those countries that have a uniform data system in place which can be used for measurement.

Key words: Quality, long-term care, USA, public reporting, measurement, policy, Medicare, Medicaid

Most industrialised and industrialising countries are facing a crisis in the provision of health and social care for their rapidly ageing populations. Over the last half century formal care systems have emerged to meet the care needs of frail older people who no longer have the ability to manage independently and whose families are unable to provide the support necessary to enable them to live at home. Different countries have adopted very different strategies in developing services for the frail elderly, with some investing far more in residential care while others also have encouraged the establishment of home care services.¹ While some countries have invested in the provision of home and community based services, according to the Organisation for Economic Cooperation and Development (OECD), only 30% of all public expenditures were devoted to home care; the bulk going to institutional services.² Amongst OECD countries the number of long-term care

beds per 1,000 people 65+ ranges from 88 in Sweden and 71 in Switzerland to under 20 in Italy, with the US, Australia and Japan around the OECD average of 41.³

Given the historical emphasis on institutions, when policy makers seek to improve the quality of long-term care services, they tend to focus on institutional care which is widely believed not to live up to people's expectations. Documented quality problems range from inadequate staffing to high rates of pressure ulcers, restraints and psychotropic drug use.^{4,5} Ultimately, there is a limit to how much long-term care can be shifted to home-based support and services, since the rapidly ageing populations of industrialised and industrialising countries has been accompanied by smaller family sizes, greater geographic mobility and increased female labour force participation, all of which undermine the ability of families to care for older members at home.⁶

Efforts to improve the quality of long-term care services generally focus on improved regulatory and enforcement systems, internal quality improvement efforts and public reporting of provider performance in a manner designed to stimulate market

forces. In the US, while most of the focus has been on institutional long-term care, efforts to assure quality of care in nursing homes and home health care through the use of publicly reported measures of quality based upon common data have been underway for over a decade and some research regarding the efficacy of these efforts has begun to appear.

The purpose of this paper is to summarise the US experience with public reporting as a means of improving the quality of long-term care services. Since public reporting requires that quality be measured, this article begins with a brief discussion of the conceptual and technical considerations in measuring quality and the clinical assessment systems, which are at the core of the quality measures used in these industries in the US.

Measuring quality in long-term care

In the US, federal subsidy of long-term care began once Medicare reimbursed for post-hospital nursing home and home care and once Medicaid began paying for nursing homes. The long-term care service sector represents a diverse group of institutional and community based providers

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but only Medicare/Medicaid certified nursing homes and home health agencies (HHA) are subject to uniform data reporting requirements, even though in some states assisted living facilities, state and privately funded home care agencies, serve many frail older people.

Shortly after Medicare and Medicaid nursing home benefits were instituted, scandals about nursing home quality arose frequently, instigating investigations and commissions. In 1984, the Institute of Medicine recommended various changes, most of which were translated into a law passed in 1987, including a mandate to comprehensively assess all nursing home residents.⁷ Systematic assessment serves to structure the clinical information necessary for care planning and provides the basis for a common lexicon.⁸ A resident assessment was nationally implemented in 1991, updated in 1997 and universally computerised in 1998.

Following considerable testing, the Minimum Data Set (MDS) for nursing home resident assessment (RAI) was found to be reliable and generally valid in population based research^{7,9-12} and the resulting data were found to be correlated with research quality instruments for cognition, depression and physical function.¹³ The RAI was soon used for policy applications such as case-mix reimbursement which pays facilities differentially for serving more impaired and sicker patients.¹⁴ Creating quality indicators to monitor provider performance both to guide quality improvement efforts in a single nursing home¹⁵ and to generate and publicly report nursing home quality indicators also became possible with the universal availability of the MDS.^{8,16} In 2002, the Centers for Medicare and Medicaid Services (CMS) began posting quality measures onto their 'Nursing Home Compare' website at www.medicare.gov/NHCompare/home.asp.

Throughout the 1990s, researchers at the University of Colorado worked with home health agencies to develop a system for monitoring the quality of care provided to HHA patients. Based upon the Outcome and Assessment Information Set (OASIS), the Outcome-Based Quality Improvement (OBQI) was constructed as a means of tracking patients' and agencies' outcomes. The OASIS data characterise patients' diagnoses, medical conditions and treatment, as well as their functional and cognitive status. In 1999, CMS mandated the OASIS as a means of uniformly

capturing patient level information on all home health beneficiaries. With the adoption of OASIS, the entire Medicare-certified home health care industry began to provide data to CMS required for the new Medicare home health Prospective Payment System (PPS) implemented in October 2000, as well as data for quality monitoring and improvement made available on the CMS website 'Home Health Compare' at www.medicare.gov/HHCompare/Home.asp.^{17,18}

Researchers, sponsored by CMS, began developing quality measures for nursing homes and home health agencies about the same time that the data collection instruments were developed. Indeed, while the nursing home MDS was developed as an assessment tool to improve the manner in which staff assessed patients' clinical needs, the developers built in both cross-sectional process quality measures as well as indicators of changes in residents' conditions. Considerable research had been done documenting the reliability and the validity of the MDS data, although variation in data quality from facility to facility continued to be an issue.^{7,11,12} As noted, the OASIS was explicitly designed to allow staff to document changes in patients' conditions over the course of their home health care episode.¹⁹ While used in many agencies for some time, the OASIS has not been subjected to as much reliability and validity testing as has the MDS.^{20,21}

For both the MDS and the OASIS, however, it was a big step to switch from using the data to describe a change in a patient's condition to aggregating the data to characterise the quality experience for the average patient served. This is what is necessary to construct provider (facility, agency or hospital) level measures of quality that summarise the proportion of patients with the positive (for example, improved in function) or negative (for example, acquired a pressure ulcer) quality indicator of interest.²² In constructing the measures now in use on the CMS 'Compare' sites, researchers and policy makers had several important conceptual and technical issues which designers of any indicator have to address. These issues are reviewed below, contrasting how the designers of the MDS and OASIS based measures chose to deal with them.

Conceptual and technical challenges in designing quality measures

Selecting what aspects of quality should be measured and incorporated into quality

measurement metrics is perhaps the most important issue. In long-term care, there are clinical, functional, treatment-related, psychosocial and quality of life related aspects of quality, some of which are more readily measured than others. It is often the case that those aspects of quality that are most valued are most difficult to measure either because we do not trust the patients' voice or because we do not know how to capture that voice. Inherent in selecting a quality measure for a particular health care field is a shared understanding of the importance of the particular aspect of quality.

Any comparison of one provider with another assumes that the providers are otherwise similar, serving similar patients, so that it is something about the way in which care is provided that results in the observed difference. That is, such comparisons lead us to 'attribute' the observed differences in quality to differences in care processes. Since process quality measures summarise differences in what providers do rather than the outcomes patients' experience, it is easier to assume that they are the direct result of provider choices. Thus, differences in the use of physical restraints among nursing home residents may reflect a style of care; however, even in this instance, the mix of residents treated may matter since, on average severely demented residents are more likely to manifest behaviours that call for restraints, although not all facilities apply physical restraints to these types of patients. A more precise definition of the population in the denominator, such as the percentage of cognitively impaired persons who are restrained, might obviate any possible concern about comparing homes with different rates of restraint use. In general, process measures are more likely to be under the control of the provider, whereas 'outcomes' or changes in patients' experience are much more dependent upon the mix of residents being measured.

Having ascertained the importance of a quality measure, there are a host of technical issues that must be addressed before it can be applied in an unbiased manner. First, whether measuring a process or an outcome, the mix of patients served can influence the measure without necessarily reflecting the quality of care. The original quality indicators based upon the MDS and which pre-dated the CMS nursing home quality measures, were largely unadjusted and when an adjustment was applied it was only minimally stratified.¹⁵ Research

suggests that even the CMS measures are inadequately risk adjusted.²³ In contrast, the Home Health quality measures were extensively risk adjusted and this approach has been replicated in research studies.²⁴

Second, the minimum number of observations used in constructing a quality measure has to be considered since comparing providers is a statistical issue not readily understood by the public but very sensitive to sample size. The number of observations necessary to have a high degree of confidence is far greater than most facilities have and statistical modelling efforts often end up shrinking the size of observed differences.²²

Third, both 'Nursing Home' and 'Home Health Compare' sites update reported quality measures on a quarterly basis. This is done to allow for measures to be sensitive to changes in staffing and practices, etc., but can sometime result in a high degree of volatility, particularly in measures looking at changes over time. Much of the volatility comes from the small sample size discussed above, but the mix of patients that long-term care providers admit each quarter can differ in important ways, meaning that the lack of case mix adjustment could exacerbate this volatility. In particular, measures like hospitalisation of home health patients and the proportion of residents declining in Activities of Daily Living (ADL) in nursing homes are variable.

Fourth, it is often the case that providers' quality measures are converted from rates to ranks, facilitating labelling of providers as the 'best', or as in the top or bottom ten percent. If, however, the underlying quality measure is very tightly bunched (for example, most providers only have a 5% decline in ADL), ranks create variation where there was little in the first place, giving consumers the false impression that there is a real difference between the median facility and the facility at the 60th percentile.²² This can be an issue regardless of how well designed and structured the quality measure.

Finally, it is often the case that consumers and policy makers would like to be able to clearly state which provider is the best and not qualify this by stating best in terms of one measure or another. This requires a composite score, one which integrates the information contained in all, or a subset, of specific measures. While desirable, to the extent that the components are not correlated, the composite will be very

insensitive, since adding together unrelated elements means that providers with similar overall scores could be a mixture of very different quality profiles. Research reveals that most of the individual quality measures reported in both 'Nursing Home' and 'Home Health Compare' are minimally correlated, suggesting that the composite now in use in 'Nursing Home Compare' could be misleading.²²

Effectiveness of public reporting

Like most policy innovations, publicly reporting long-term care providers' response has been examined by multiple researchers using very different strategies. Unfortunately, almost all the published literature and policy focus has been on nursing homes and not home health agencies.

With respect to nursing homes, several researchers have surveyed administrators, initially concluding that facilities were largely ignoring public reporting, but later finding that the administrators were clearly aware of their own publicly reported performance as well as that of their competitors, even though they did not believe that consumers sought out this information on the web.^{25,26} Results suggest that in the early years of the publicly reported nursing home measures, improvement in average scores was greater in more competitive markets. More recent analyses undertaken by investigators seeking to understand whether quality improved on both reported and unreported measures found that, adjusting for the changing mix of residents in US nursing home before and following the introduction of 'Nursing Home Compare', general improvement in quality was observed for both reported and unreported measures, although not across all measures.²⁷ As importantly, researchers also have shown that both long stay and short stay rehabilitation nursing home patients appear to benefit from quality improvement efforts designed to improve quality.

Conclusions

In spite of known technical limitations of the measures, publicly reported data are now promulgated widely.²⁶⁻²⁹ Indeed, a pay for performance demonstration project that rewards facilities based upon their quality performance on the indicators, as well as reductions in acute hospitalisations, is now underway. Thus, the assessment instruments that underpin multiple policy applications designed to

improve quality, including providing targets for quality improvement efforts and generating publicly reported indicators of quality performance which consumers and their advocates can use in selecting providers, have done their job. What began as a clinical assessment tool in nursing homes and as an outcome measurement tool in home care has converged precisely because of its universality. Uniform clinical data that is useful to clinicians can be useful for policy makers at all levels. While there are still numerous difficulties and complications that need to be ironed out, the US experience has overall been positive and other countries that are replicating it in various ways may be having similarly positive experiences.

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Safeguarding good quality in long-term care: the Austrian approach

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Summary: This paper provides an overview of quality regulation and initiatives to improve the quality of long-term care in Austria. It starts off describing the regulations public authorities have issued to assure good quality in long-term care. While most of these regulations focus on structure (and process) related aspects of quality, there are also initiatives to measure the quality of long-term care outcomes. Two of these promising approaches will be discussed in further detail. The first example deals with the Austrian national quality certificate for care homes (NQZ) that has recently been developed. The second example looks at a tool that aims to assure the quality of outcomes for informal and professional care provision for dependent people living at home.

Keywords: quality assurance, quality indicators, Austria, long-term care, outcomes

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Approaches to improving quality of long-term care services

People depending on long-term care belong to the most vulnerable group in society. Some will need help, assistance and support for the rest of their lives. Yet, little is known and much has been conjectured about the extent to which long-term care (services) actually meet the needs of

dependent people and support a self-determined life. The quality of long-term care is discussed primarily in the context of professional long-term care service provision. Although the majority of care work is provided by family members, informal care is often excluded from measurements of care quality.

There are many ways of ensuring good

quality in long-term care provision. Regulation plays a key role. It may specify standards for the vocational training of nurses, requirements for market access, or service characteristics and reporting requirements. Monitoring of service provision on a regular basis seeks to ensure that providers conform to legal standards. Additional measures improve access to information on services and providers, thus supporting and empowering clients in the market. Lastly, financial incentives (for example, reimbursement mechanisms) also play an important role.

Regulation and monitoring of long-term care services or financial incentives by public authorities can be regarded as a top-down approach. In addition, bottom up approaches may exist, like agreements by professional care service providers on how their services are provided. These agreements aim at improving and signalling the quality of long-term care services. These initiatives are not legally binding but include self-binding agreements and quality certification on a voluntary basis. In Austria, the five primary welfare organisations providing long-term care services have agreed on quality indicators for long-term care services.

This article gives an overview of measures taken and initiatives set to safeguard good quality of care in Austria. It sketches out the Austrian regulatory framework and takes a closer look at two recent approaches to measuring the outcomes quality of long-term care: the National Quality Certificate for care homes (NQZ), and the visit and counselling programme to improve the quality of care for dependent people living in private households.

Quality regulation as part of the legal framework for long-term care

The Austrian regulatory framework for the quality of long-term care services (mobile, semi-institutional, institutional care and 24-hour stand-by-care) consists of four levels.

At the top level two agreements between the Federal State and its provinces (Länder), based on the Austrian Constitutional Act, relate to long-term care.¹ Both agreements explicitly address quality aspects of long-term care service provision. The first agreement, issued in 1993, defines long-term care service regulation as a responsibility of the nine Austrian provinces. It binds the provinces to assuring minimum standards for long-term care service provision and to issue

regulations for the supervision of care service provision.

Quality criteria for domiciliary care laid down in this agreement include (i) freedom of choice between long-term care services; (ii) access to basic care services on Sundays and public holidays if required and (iii) coordination of different types of service, particularly between institutional and domiciliary care. Quality criteria for residential care services apply mainly to new buildings or the extension of existing-buildings and address: (i) capacity of care homes, (ii) fixtures and fittings in rooms (with an emphasis on en-suite single rooms, and their expandability to apartments), (iii) provision of supplementary infrastructure (rooms for therapies, day guests) and a variety of additional services (for example, hairdressers), (iv) the location of homes (integration into the community), (v) unrestricted rights of residents to be visited, (vi) maintaining the health of service users and freedom of choice regarding medical practitioners, (vii) an adequate number of qualified and unqualified staff. This last aspect – staff qualifications – is addressed in more detail as initial and further training possibilities are explicitly mentioned in this agreement.

The second agreement between the Federal state and the nine Austrian provinces has been in force since 2008 and regulates public funding for ‘24-hour care’, a specific type of support where staff live in the dependent’s home and are employed as private household staff, or work on a freelance basis.^{1,2} In terms of quality assurance the agreement stipulates that staff providing 24-hour care must be adequately trained.

Level two of the regulatory framework on the quality of long-term care services consists of laws, mainly issued by the nine provincial authorities. Federal laws that regulate aspects of quality assurance are, for example, the Federal Long-Term Care Allowance Act (*Bundespflegegeldgesetz*), the Act on Care of People in Private Households (*Hausbetreuungsgesetz*) and the Home Resident Act (*Heimaufenthaltsgesetz*). The latter seeks to protect the personal freedom of residents in care homes and homes for people with learning disabilities. At the provincial level, laws on social assistance or their equivalents regulate long-term care service provision. In addition, some provinces have issued additional laws that concern specific types of long-term care services, especially institutional care. To date, just one province has

issued a comprehensive law on all types of long-term care services provided within its territory.

Interestingly, quality assurance of long-term care service provision is not always explicitly addressed in these provincial laws but is implicit to rules pertaining to recognition proceedings and to provider supervision. These rules focus mainly on the suitability of equipment and personnel, for instance addressing provisions to maintain and improve skills and the competence of care staff. In some instances, the laws also touch on aspects of the quality of the process, such as the reliability of service provision or the degree of coordination in service provision between different types of providers.

Levels three and four of the regulatory framework on the quality of long-term care consist of ordinances and guidelines that substantiate and interpret the laws. At these two lower levels of the regulatory framework quality criteria become more specific, particularly in the case of care home services. Minimum standards address the characteristics of staff (for example, qualification requirements for specific tasks, resident/staff ratios) and standards for the infrastructure (for example, maximum size of homes, minimum size of rooms, facilities required). Some provincial authorities mandate providers to conduct quality management activities.

To sum up, regulation of the quality of long-term care services can be found at different levels of the Austrian legal framework. As a result, regulation and methods for quality assurance vary significantly between the nine Austrian provinces. The legal framework – as far as agreements, laws and ordinances are concerned – is very well documented and easily accessible. However, access to information on guidelines and inspection processes is often restricted. Contrary to countries like England, to date, inspection reports on service quality of care homes or of domiciliary care providers are not publicly available in Austria.

The legal framework mainly seeks to influence quality of structure and, to a lesser extent, the process quality of long-term care service provision. The legal documents, relate to outcomes of care in more general terms, specifying goals for long-term care provision such as the ‘protection of human dignity’ and supporting clients in ‘leading a decent life’, ‘a self-

Box: Dimensions of the NQZ**Signalling good quality in care home services**

The National Quality Certificate (NQZ) is awarded to care homes that obtain 50% or more of all available points; minimum thresholds for the two main fields 'quality of structure/process' and 'outcomes' also apply. If a care home passes the certification process but shows shortcomings in at least one of the areas evaluated, the certificate will be awarded for a single year only (instead of the standard three years). After one year, results of a (limited) follow-up evaluation are used to decide whether a home is eligible to receive the certificate for the remaining two years. In 2009, four out of fourteen care homes were awarded the NQZ for just one year.⁵

Focus on quality of processes and quality of outcomes

At the national level this is the first time that quality criteria for outcomes of care homes have been specified. Quality criteria refer to five areas: residents (e.g. biography & lifestyle, autonomy, communication, (health) care), staff (e.g. participation, communication, and teamwork), management (e.g. company policy, process management), other stakeholders (e.g. relatives and visitors, partners and public authorities) and the organisation as a learning environment (e.g. training).

Continuity of quality improvements

Care homes that organise their quality management in line with one of the established quality assurance systems – E-Qalin®, QAP or International Organisation for Standardisation – are eligible for the NQZ.

Transparency in care home service provision

A selection from the reports of the NQZ inspectors will be published both on the website of the care home and the National Quality Certificate homepage. Provincial authorities, as well as (prospective) home residents and their relatives, will then be able to learn more about the care homes' services and their evaluation.

determined and need-oriented life', or 'maintaining and improving their abilities, mobility and independence'.

Initiatives to measure the quality of outcomes from long-term care (services) are rare in Austria. Two examples on steps towards outcome measurement are described in further detail in the next section.

Two initiatives to measure and improve outcome quality*The NQZ*

The National Quality Certificate (NQZ) was created as the sole government-backed quality certificate for Austrian care homes.^{3,4} The NQZ recognises care homes that successfully undergo a uniform nationwide quality evaluation. It can be interpreted as an answer to both the desire of care homes to signal their service quality and to the confusing variety of different quality certificates that are issued in other European countries. Certification is optional for providers. The NQZ aims at (i) signalling good quality in residential and nursing home services, (ii) focusing on quality of processes and outcomes, (iii) setting incentives for continuous improve-

ments of quality in residential care and (iv) increasing transparency in care home service provision (See Box). In 2009, the first NQZs were awarded to 14 residential and nursing homes.

Overall, the NQZ aims to link self-assessment of homes according to a recognised quality assurance system with a nationwide standardised third-party assessment procedure that comes with the NQZ certification process. In other words, the third party assessment procedure for the NQZ is the same for all care homes, irrespective of their quality assurance system.

The combination of both types of assessments aims at initiating a process in care homes that will lead to continual improvements in quality. The NQZ needs to be renewed every three years. Within a three-year period each care home also has the opportunity to improve the quality of both service provision and of organisational structures according to the recommendations of inspectors. Furthermore, it is expected that a care home conducts and learns from the results of self-assessment in line with one of the quality assurance systems before the next NQZ evaluation is due.

The focus of the NQZ on transparency will be a substantial improvement on the lack of information previously reported.⁵ Furthermore, it is hoped that the NQZ will initiate competition on the basis of quality between Austria's care homes. The next steps aim to improve the evaluation process and publishing 'good-practice' cases to prompt further improvements of care home services. Finally, the NQZ will be anchored in legislation and an organization to conduct the NQZ-evaluation will be launched.

Quality assurance for long-term care for people living at home

Some authorities at the provincial level pay for graduate nurses to visit people in need of care at home. These visits serve the purpose of providing information, as well as providing counselling on request to dependent people and their relatives. In one province, Burgenland, individuals who recently have become dependent on care have been entitled to these information and advice services since 1999. Since 2008 people in need of care who are solely cared for by their families can make use of such counselling visits twice a year.³

A similar approach to providing information and advice has been taken by authorities at the federal level. This federal home visit and counselling programme is rooted in the Federal Act governing federal long-term care cash benefits and in the guidelines on 24-hour care. Starting off with a pilot of 950 visits to dependent people in 2001, the number of visits increased to more than 15,000 per year in 2009.

Three main differences distinguish these visits from those paid for by the provinces: First, visits of registered nurses are not made upon request of the care recipients or their families. Graduate nurses visit a selected sample of long-term care allowance recipients who live at home. However, dependent people may refuse to be visited without bearing any consequences. Secondly, only recipients of the federal long-term care allowance are visited. The latter are characterised as being in receipt of a pension or pension-related benefit and needing more than 50 hours care per month for a period of at least six months.^{1,2} Third, an explicit goal of these home visits is to collect data on the situation of the person in need of care, their main informal carer and care arrangements.

The home visits of graduate nurses to recipients of a federal care allowance are

explicitly labelled as instruments of 'quality assurance' and address all three dimensions of quality. The quality of structure of long-term care at home relates to both the knowledge of all people involved in the care process and the characteristics of the infrastructure. Information and advice increase the household's understanding and knowledge about the background, requirements and challenges of the care situation. Graduate nurses may suggest alternatives to the current care arrangement or adaptations in the home of the care recipient (for instance simple adjustments to prevent falls, such as removing carpets).

The quality of processes in long-term care provision may be improved, as graduate nurses are trained to give substantial advice to informal carers on how to provide care properly. Many long-term care responsibilities will be new to most informal caregivers, such as how to move a bedridden adult around whilst in bed, or how to get this individual in and out of bed without jeopardising the health of either party.

The quality of outcomes has been central to the interest of visits from the very beginning. Until 2010, three outcome indicators were measured: cleanliness of the home, the condition of an individual's skin and personal hygiene. Two indicators captured physical and cognitive skills (mobility and three kinds of (dis)orientation). Additionally, an overall indicator expresses how care quality was perceived by the nurse. However, these outcome quality indicators have been evaluated as fragmentary and problematic with regard to measurement scales. Thus in 2009, the Research Institute for Economics of Aging, Vienna University of Economics and Business, was commissioned by the Federal Ministry of Labour, Social Affairs and Consumer Protection to develop new quality indicators for long-term care of people living at home.

Concluding remarks

The term 'quality' is used in many contexts and triggers many associations. The field of long-term care is far from being unaffected by this pluralism in meaning. The Austrian legal framework for the provision of long-term care services varies across provinces and quality assurance mainly refers to aspects of quality of structure. Although there is a general awareness in Austria that quality of processes and quality of outcomes are important, only a

few initiatives actually aim at measuring outcomes in long-term care. Two of these initiatives have been described in this paper: 'NQZ – a National Quality Certificate' for care homes and the home visit programme to assure quality of long-term care for people living at home.

An important aspect of the NQZ is the focus on the resident's quality of life. The initiators (the Austrian Ministry of Social Affairs and the umbrella organisation of Austrian care homes) were able to get the ball rolling and have paved the way for a discussion of, and an agreement on, quality indicators. Bringing together representatives of all nine Austrian provinces to pull together in the same direction can, in particular, be regarded as a major achievement for the country's federalist system.

It has to be mentioned however, that the NQZ evaluation process is only accessible for a minority of Austrian nursing homes. Use of an established quality management system – which is a precondition for participating in the NQZ programme – has only been implemented by 15–20% of the 800 care homes in Austria. To date, provincial authorities nominate care homes for an evaluation for the NQZ. In other words, it is not up to a care home manager's initiative alone to be awarded such a certificate. Moreover, due to lack of capacity it is currently only feasible to evaluate 16–20 care homes in 2010 and 2011. It will thus take some time before all eligible care homes will have gone through this evaluation process. In the meantime the remaining care homes rely solely on supervision by the provincial authorities. Moreover, to date, information on quality indicators relevant for the NQZ is not easy to obtain and sometimes not publicly accessible at all.

The second Austrian example of an initiative that emphasises quality of outcomes concerns home care. Graduate nurses who visit people in need of care at home help to assure good quality of care. These information and advice services address all aspects of quality of care. Data collection in this home visit and counselling programme has always focused on quality of outcomes. These outcome quality indicators are currently under revision.

Measuring outcome-related quality of long-term care still remains a challenge for social policy, care providers and researchers. In Austria, the first steps in focusing the efforts of long-term care services on meeting the needs of dependent

people have been taken. A process has been initiated where meeting the needs of dependent people is now the foremost priority.

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Birgit Trukeschitz's work on quality of care is funded by the Austrian Federal Ministry of Science and Research from 2008–2011.

Measuring the quality of long-term care in England

Juliette Malley

Summary: Improving the quality of long-term care has been central to the agenda of successive UK Governments since the late 1980s and a number of mechanisms have been introduced to achieve this end. The quality assurance framework that exists in England is comprehensive and supported by legislation. It is also supported by a number of national quality measures, including performance indicators from administrative systems to user surveys and composite measures of quality. There is close interaction between the quality assurance system and the collection of data for quality measures; additionally, the measures are used to support quality assurance activities. This relationship has consequences for the accuracy and validity of the measures.

Key Words: Quality assurance; long-term care; quality indicators; England

Improving the quality of public services, and long-term care (LTC) more specifically, has been central to the agenda of successive UK Governments since the late 1980s. This article focuses on the situation in England, where a variety of mechanisms have been implemented to achieve this end, including the introduction of quasi-markets, an independent inspectorate, national standards for care providers, a national performance management regime and a variety of other regulatory and guiding bodies for the workforce and practitioners. Given the investment in quality improvement, it is important to ask how high is the quality of LTC in England? To provide some background to this question, the first part of this article explores who the key players are, what measures are used and how these measures fit within the quality assurance (QA) framework. Then, the evidence about the quality of LTC for adults in England is critically reviewed. LTC for children is not considered – this is the responsibility of Children's trusts, which are subject to different policies and are accountable to the Department for Education. Furthermore, the article does not look at the situation in the other three

countries in the UK, where, since 1999, responsibility for long term care has been the responsibility of the devolved national administrations.

The quality assurance framework in England

Local authorities (LAs) and care providers are the focus of QA inquiry in England, not the National Health Service (NHS). This is because the majority of LTC, including residential and nursing care homes, domiciliary care and day centres, is defined as 'social care'. The dual focus on LAs and care providers arises for two reasons. First social care, unlike health care, is means tested. Therefore in addition to public provision there is a private market for care. Adult social services departments (ASSDs), within the LAs, are responsible for ensuring that people with little means receive services. LAs are primarily commissioners of care; only a small proportion of publicly-funded care is commissioned from in-house services; the vast majority is purchased from the independent sector.¹ However, the emergence of consumer-directed support means increasing amounts of publicly-funded care are purchased by service users themselves from the market.

There are two government departments with a role in measuring and assessing the quality of LTC. The Department of Health (DH) has primary responsibility for social

care (and NHS) policy. However, since ASSDs are part of local government, the department with responsibility for local government policy, currently the Communities and Local Government department (CLG), also has a role in social care policy. The influence of the CLG over social care policy is particularly important in the area of quality, as the CLG sets the broad regulatory and performance framework for local government. The DH works within the framework set by CLG applying it to social care, for example, by specifying performance indicators and quality objectives for care providers and LAs.

The regulator for social care also has an important role in measuring the quality of LTC. Currently, the Care Quality Commission (CQC) regulates health and social care. Under the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2009* certain services are subject to regulations and must register with CQC. These services include nursing and residential care homes and those domiciliary care agencies and day centres that provide personal care*.

Approaches to quality assurance

The QA system in England is national and is supported by legislation. It is also fairly comprehensive as CQC is required to inspect all registered providers and assess the quality of their provision. Only non-personal care services such as home help,

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sitting services and day centres, which provide companionship or domestic services, are not subject to regulations. However, where these are commissioned by the LA, their contribution to the well-being of their users will be assessed. This is because through its role in improving social care, CQC also inspects LAs and formally assesses their performance, focusing specifically on how they discharge their duties with respect to social care. There is also a sizeable amount of care purchased privately on the grey market, which is not regulated.

QA follows a ‘business approach’: quality is systematically defined, evaluated, maintained and improved through the process of performance assessment.^{2,3} In addition to the regulations outlined, LAs are legally required to develop performance plans, known as ‘Local Area Agreements’ (LAAs), in consultation with local partners. These plans have objectives and targets, which are agreed in negotiation with central government, and include some targets relevant to LTC.⁴⁻⁶ LAs are required to monitor their own progress against these plans. CQC applies external evaluation and pressure to improve. Following performance assessment, CQC maintains contact with LAs and providers throughout the year to ensure they make progress against recommendations. The business approach is supported by inspections, which are targeted, focusing on those providers and LAs that have not had a recent inspection or are performing poorly.

Quality measures

There are two types of measures of quality: performance indicators (PIs), which are based on administrative data and social care user experience surveys (UES) and apply only to LAs, and composite measures of quality, measured on a four-point scale from poor through adequate and good to excellent. The latter are awarded by CQC. When they are given to LAs they are known as performance judgements; for providers, they are known as quality ratings. These measures are described in Box 1.

Box 1 Quality measures in England

Performance Indicators (PIs)

PIs are collected for LAs and derive mainly from LA administrative systems, although in recent years some have come from user experience surveys (see below). The Performance Assessment Framework (PAF) data collection consisted of fifty PIs for social care, of which roughly ten were specific quality indicators. These focused on aspects, such as the timeliness of care, the state of the infrastructure and adherence to procedures. Examples include: the percentage of older clients for whom time from completion of assessment to provision of all services in care package was less than or equal to four weeks; percentage of items of equipment and adaptations delivered within seven working days; percentage of people going into care homes allocated single rooms; and percentage of adult and older clients receiving a review of services. In the new National Indicator Set (NIS), which replaced the PAF in 2009, the number of PIs has been substantially reduced to roughly eight social care PIs.⁹

Social Care User Experience Survey

User experience surveys (UESs) are mandatory annual surveys of publicly-funded social care clients conducted by LAs to collect information on users’ views of their care. The survey has covered a number of different client groups and service types but only two surveys have been repeated. The UESs have questions about aspects of the care process, such as the timeliness and flexibility of care, the characteristics and behaviour of care workers, and satisfaction with care. Examples include the percentage of respondents to OPHCS claiming their care workers ‘always’ do things that they want done; the percentage of respondents to a survey of adults with physical disabilities and sensory impairments asked ‘I can always contact Social Services easily if I need to’ who answered ‘Strongly agree’ or ‘Agree’; and the percentage of respondents to the OPHCS reporting they are ‘extremely’ or ‘very’ satisfied with their care. A new survey is currently being developed to cover all client groups and measure outcomes.^{10,11}

Performance judgements (previously ‘star ratings’)

LA performance assessments result in a performance judgement, which is awarded annually. The measure is calculated by combining information from various sources, including PIs, and qualitative sources of information, such as inspections (if these are available for that year), self declarations and information from ongoing monitoring and meetings. The data are organised into outcome domains, scored at this level then combined with rules to a single score.

Quality ratings

Ratings are only given following a key inspection, which is a major evaluation of care providers. During the inspection, quantitative and qualitative data are gathered as evidence from self-assessment forms and fieldwork. The latter can include data from interviews with service users and a small survey. These data are assessed against National Minimum Standards, organised into outcome domains and scored. Rules are used to combine scores across domains into one figure.

In the past, quality measures have focused on ‘process’ and ‘structural’ quality,⁷ but in recent years the government has refocused quality around improving outcomes for people.⁶ CQC uses the ‘Outcomes Framework’, to define quality for LAs, which captures the domains of improved health and emotional well-being, improved quality of life, making a positive contribution, increased choice and control, freedom from discrimination or

harassment, economic well-being, and maintaining personal dignity and respect,⁵ plus two others for commissioning and use of resources. For providers, quality is defined in service-specific National Minimum Standards (NMS), which are also organised into outcome domains. CQC evaluates the performance of LAs and providers against these definitions, ensuring that these definitions influence the composite measures. Currently the PIs still measure structure and process quality, although new PIs are in development which will be more outcomes-focused**.

* Personal care activities are defined in law as “physical assistance given to a person in connection with (a): (i) eating or drinking (including the administration of parenteral nutrition), (ii) toileting (including in relation to the process of menstruation), (iii) washing or bathing, (iv) dressing, (v) oral care, or (vi) the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist); or (b) the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision.”

** Interestingly, the focus of these PIs is not around clinical outcomes, such as pressure ulcers, as is common in LTC instruments elsewhere,⁸ but on the outcomes listed for the ‘Outcomes Framework’.

How high is the quality of LTC in England?

The general picture from official measures is that the quality of LTC in England is good and improving.¹ CQC finds that more than 77% of adult social care providers were providing an excellent or good service in 2009, an increase of 11% from the previous year. There has been consistent improvement over time, with the number of providers meeting NMS increasing for six consecutive years to 2008. In 2003, about 60% of care homes met or exceeded the NMS, but by 2008 over 80% of care homes hit this target. The picture is similar for domiciliary care providers, where about 65% met the standard in 2005 (the first year data were available) compared to over 80% in 2008.¹¹

For LAs the picture is also one of good performance and continued improvement. CQC found that in 2009 95% of LAs were performing well or excellently and that three-quarters of all places purchased by LAs were in good or excellent care homes. The number of LAs rated as performing well or excellently has increased year-on-year since 2005.¹² Prior to 2005, when a slightly different metric was used, performance also improved in successive years.¹³

In general, scores on PIs have also improved year-on-year;¹³ only the PIs based on the UES have not shown improvement. Data from the 2001 and 2002 survey of newly assessed clients showed a 1% decline in the likelihood of getting help quickly between 2001 and 2002. The older people's home care survey reported an increase in the numbers 'extremely' or 'very' satisfied with their services between 2003 and 2006 of 1.5%, followed by a decrease of 1% between 2006 and 2009. The same survey also reported a 4.5% decline in the likelihood that care workers always came at suitable times over the period from 2003 to 2009. The decline in user-assessed quality is not large but it does raise questions, including: what explains the vast improvement in composite scores and how can this be squared with the lack of evidence of improvement in user-assessed quality? Unfortunately, no studies have addressed this question directly. Therefore, the remainder of this article discusses potential explanations.

What explains changes in quality?

Perhaps the most important factor explaining the vast improvements in the

composite quality score is that they are not neutral measures: a lot is at stake for those perceived to be failing. The worst performing LAs are subject to increased monitoring and intervention;¹⁴ poor ratings have led to negative media attention and changes to senior management teams. Similarly, providers with poor ratings are subject to increased intervention and monitoring and CQC has powers to enforce them to improve. CQC can (and has in the past) close providers that persistently fail to meet standards. For good organisations there are benefits, so LAs with good ratings have various 'freedoms and flexibilities', including a less burdensome inspection regime. Equally good providers have less frequent key inspections: while poor and adequate providers are inspected at least annually, good and excellent providers are inspected biennially or triennially respectively. Intensive intervention alongside 'carrots' and 'sticks' is likely to have a significant effect on the behaviour of organisations, although the effect has not been demonstrated in the LTC sector.

Freedom from regulatory burden for the best performers is laudable from the perspective of targeting resources but it does affect the interpretation of improvement. For example, providers are only awarded quality ratings following a key inspection. Since these are not updated annually for good and excellent providers, unless those at the bottom make no improvement, over time the proportion achieving good and excellent performance can only increase. In intervening years, when inspections are not available the regulator relies on other evidence including self assessments and reporting of untoward events to monitor performance. The success of this system rests on having open and stable organisations. High staff turnover in the sector and the experience from other areas regarding the stability of performance and the tendency to game the system suggests that neither of these factors should be taken for granted.¹⁵ These problems suggest that composite measures are unlikely to be reliable measures of quality, particularly for the best performers, where there are fewer checks and more incentives to game the system.

Another issue that affects the accuracy of composite measures is how data from various sources are combined into a single score. Commentators have criticised these measures for not demonstrating consistency in inspector judgements, using different data sources to form judgements

for the same organisation in different years and different organisations in the same year,^{13,16} and being very sensitive to the rules applied to arrive at an overall rating.¹⁷ All of these problems affect the interpretation of the measure and comparisons both between organisations and over time. This suggests that it is probably better to regard composite measures as quality standards rather than sensitive quality measures, where 'poor' ratings indicate the standard is missed and ratings of adequate and above indicate the standard is met. Evidence of differences in users' outcomes between organisations would of course help to determine how much weight should be placed on differences in ratings.

The focus of measures is probably a key factor explaining the difference in the picture painted by the UES data and the composite measures. The UES data focus on specific services and client groups (a survey of newly assessed clients and a survey of older people receiving domiciliary care); LA composite measures are broader, covering all client groups and services; provider composite measures are specific to certain services like the UES, but they are not client group specific and anyway include privately-funded clients who are excluded from the UES. Although a straight comparison is difficult because of the differences in focus, a more detailed examination of differences between the UES data and the provider quality ratings is possible and would be of value: provider quality ratings are intended to improve market efficiency and correct information asymmetries, by providing LAs and prospective users of services with straightforward information about the quality of care providers so they can make informed commissioning decisions,¹⁸ and if the ratings do not reflect what matters to users they will not be useful for this purpose.

In general, there is a need for more detailed research into the reliability of provider quality ratings and their usefulness. At present, there is limited evidence about how useful LAs and prospective users find this information. Research conducted for CQC found that LAs and prospective users were generally positive about the ratings. There was evidence of LAs using the information and of people using the ratings to inform their decisions about choice of provider, although this is more the case for care homes rather than domiciliary care providers. A very small proportion of users did report that they found the ratings to be unreliable and there

were also questions over the appropriateness of what is measured.¹⁹ With the growing importance of personalisation and the expansion of consumer-directed support, it will clearly be important to see how use of this information changes over time in order to make sure it is relevant and useful.

Conclusion

The QA system in England is well-developed and comprehensive. It is supported by an array of quality measures, which provide data on an annual basis. It is clear that there have been improvements in the quality of LTC during the period under the previous Labour government, but it is hard to say whether improvement has led to more organisations achieving excellence or just fewer failing organisations. Because the quality measures are used to change the behaviour of the organisations they study, their usefulness as independent, reliable measures of quality is questionable. Research that explores the validity and reliability of the official measures, and in particular examines their sensitivity to changes in users' outcomes, would be of great interest and value.

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Implementing Health Financing Reform

Lessons from countries in transition

Edited by
Joseph Kutzin
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Copenhagen: World Health Organization, 2010 on behalf of the European Observatory on Health Systems and Policies

ISBN 978 92 890 4211 6

224 pages

Freely available online at:

http://www.euro.who.int/__data/assets/pdf_file/0014/120164/E94240.pdf

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Health financing in Azerbaijan: Political barriers on the road to reform

Fuad Ibrahimov, Aybaniz Ibrahimova and Erica Richardson

Azerbaijan is a country in the South Caucasus which gained independence from the Soviet Union in 1991 and which has significant oil and gas reserves. The health care system in Azerbaijan still largely resembles the old Soviet Semashko model with highly centralised planning of resources and personnel, primarily public ownership of health facilities, input-based allocation of funds and no clear provider-purchaser split.¹ What has changed, however, are the dominant sources of funds with private sources now accounting for more than half of total health expenditure.² Azerbaijan is characterised by a very large share of out-of-pocket payments made at the time of service provision which significantly affect the population's access to care and expose poor households to the risk of catastrophic health care costs. Reforms to improve equity and efficiency in health care financing have been discussed many times since independence, but thus far implementation has stalled; most recently in 2008 when renewed interest in establishing mandatory health insurance (MHI) based on the legal framework established in 1999 ended in stalemate. This snapshot aims to shed light upon the reasons for this stalemate and discusses potential directions for health financing reform in Azerbaijan.

Health financing system in brief

Government health expenditure as a share of gross domestic product (GDP) was only around 4% in 2007² which is low relative to other countries in the WHO European region. The main sources of funding for health care in Azerbaijan are out of pocket payments (61.5% in 2007) and general

government expenditure (31.5% in 2007); the role of voluntary health insurance and donor funding is small.² In 2008, the share of budgetary allocations for health controlled by the Ministry of Health represented around 63% of all expenditure. The remaining 37% went to the 65 local government administrations which fund primary and secondary state facilities within their district boundaries.¹ As there is no mechanism for the redistribution of funds between district health departments, the funds allocated for local government administrations can be viewed as 65 separate pools. The fragmentation of pooling is an issue in terms of efficiency, but also equity as funding for services is not linked to health needs of the population. Shortfalls in state funding for services have also meant a steady growth in out-of-pocket payments (both formal and informal) which hinder equity and access for poorer households.^{3,4}

The Azerbaijani health care system is characterised by an integrated model where the providers are owned by the payers. The public health providers, as state institutions, have very limited financial and managerial autonomy and there is a tendency for the autonomy of actors to be more limited further down the hierarchy of the system. Public health care facilities receive input-based payments based on the number of beds or staff through prospective fixed line-item budgets typical of the Semashko model of health care. Consequently, a hospital will get paid regardless of whether it has no patients or is fully occupied. Moreover, under-spending is penalised through reductions in allocations for the next year because the budgeting process is based on historic expenditures. The payment mechanism does not provide any incentives for hospital administrators to reduce costs to improve efficiency and there is no mechanism under current payment arrangements to reward better performing facilities.

Main directions for health financing reform

Unlike many post-Soviet countries that introduced significant changes in the way their health care systems are financed, Azerbaijan has been slow to reform for several reasons. The first years of independence were marked by the military conflict with Armenia and economic turmoil due to the collapse of the Soviet Union. Government efforts were focused on ensuring access to basic health care services and public health interventions rather than health system reforms. In addition, the overall political environment was not conducive to radical changes. The Ministry of Health pursued a more conservative approach by preserving those features of the existing system which proved functional. Discussions about reform only began in earnest once the socioeconomic situation in the country began to stabilise towards the end of the 1990s.

These first serious discussions about systemic health reforms commenced in 1998 when the President of Azerbaijan established the State Commission on Health Reforms led by the Ministry of Health. In 1999, the Commission developed the first conceptual document defining the main directions for health reform including the development of new financing mechanisms and the formal introduction of medical insurance. The Milli Mejlis (Parliament) then enacted the Law on Medical Insurance (1999) that created a legal framework for MHI. This law, however, did not detail the implementation mechanisms for MHI, instead it was suggested that the government develop the necessary regulatory documents setting out how the scheme would operate. This regulatory framework was never developed, which was a reflection of scepticism in government circles about the timeliness of introducing MHI under the prevailing economic circumstances. It was felt that the introduction of MHI required a significant increase in budget allocations for health care to cover

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those sections of the population who were not able to pay for themselves, such as children, pensioners, students and the unemployed. Moreover, considering the significant scale of the informal sector in the economy, the taxation base was considered too small to introduce a viable MHI system. As such, the government decided to wait until the economic situation improved and the budget capacity was sufficiently high to allow the successful introduction of MHI.

A change of leadership at the Ministry of Health in 2005, as well as significant increase in country's oil revenues, renewed the government's interest in health financing reforms. The Ministry of Health became a very active lobbyist for such changes and drafted *The Concept for Health Financing Reform and Introduction of Mandatory Health Insurance* which was approved by Presidential Decree in December 2007. The Ministry of Health considered itself the most capable agency within the government to lead reforms in the health financing sector. Its vision was to pool all budget resources allocated to health in a single body that would be under the Ministry of Health. By 2007, the Ministry already managed a majority of public health funds, including those for all tertiary institutions in the country, as well as all primary and secondary health facilities located in Baku (the capital city). It also managed the budget for all targeted state health programmes, which represented a quarter of all public health expenditures in the country in 2008.¹ The majority of these programmes target specific health conditions aiming to cover the cost of equipment and pharmaceuticals through centralised procurement. The remaining public funds for health are managed by local administrations which fund primary and secondary state facilities within district boundaries.

The pooling of all health funds in one body that would act as a single public payer in the health sector would mean that, with the introduction of MHI, the funds currently controlled by local administrations would move to that body. If the vision of the Ministry of Health had been accepted by the government it would have controlled all public health allocations in the country. However, this vision was not shared by the President who signed a Decree establishing the State Agency for MHI (SAMHI) under the Cabinet of Ministers in January 2008. Effectively this decision meant that not only would the Ministry of Health not control all budget allocations for health but

also those funds currently managed by the Ministry would move to SAMHI.

Due to the non-transparent nature of political decision making in Azerbaijan, it was difficult to say what forces advocated establishing an independent body for MHI. This decision may seem technically correct in order to ensure a real provider-purchaser split in the health care sector where the vast majority of health facilities are still state-owned. However, in practical terms this decision led to a loss of interest by the Ministry of Health, a major stakeholder in health sector, in the implementation of health financing reforms.

Although the Cabinet of Ministers approved an action plan for the implementation of the Concept for Health Financing Reform and Introduction of Mandatory Health Insurance in August 2008, the Ministry practically withdrew itself from any policy discussions and activities in this field delegating this responsibility to the Project Implementation Unit (PIU) of the Health Sector Reform Project – a US\$86 million project co-funded by the World Bank and the Government of the Republic of Azerbaijan expected to end in 2012.

Consequently, a technically sound decision to establish a separate payer agency for health care under the Cabinet of Ministers led to a political impasse in that there are now no major forces to lead the implementation of proposed health financing reforms. The Ministry of Health was not able to bring persuasive arguments to the Government to justify the establishment of the single payer agency under its supervision. The Presidential Decree of 2008 requiring the Cabinet of Ministers to prepare a statute of SAMHI has never been implemented and despite the fact that in both 2008 and 2009 the state budget included a separate line-item for SAMHI, its statute has not been approved and the agency has never functioned. Again, due to the non-transparent nature of policy making in the country it is not possible to provide conclusive answers as to why it happened, but the Ministry of Health, alone or with other interested parties, has been successful at least in blocking any further advancement of the implementation of the Presidential Decree of January 2008.

Conclusion

There was no consensus in Azerbaijan that establishing an independent single payer was the best option given the country's circumstances and past experience with health

reforms. Consequently, by losing its major advocate and driving force (i.e. the Ministry of Health), the reforms in health financing have come to a stalemate. In addition, the Ministry of Health has historically always been a major player in health care and there is a lack of expertise outside the Ministry of Health to lead such challenging health financing reforms. As such, the deadlock may continue indefinitely, as happened with the Law on Health Insurance of 1999, some important provisions of which, including those on the introduction of MHI, have never come into force. There is no guarantee that the health financing reforms would be successful were they led by the Ministry, but an inter-sectoral approach would at least garner the necessary political momentum to push reform forward. Moreover, health financing reforms could be started, at least, in order to allow the accumulation of very valuable national experience based on which more advanced and complex steps could be taken in the future on a more solid footing. Azerbaijan is in an enviable position – even in the face of global economic recession, the country has considerable resources, more of which could be directed to health care. What is needed now is greater coalition building to drive forward health sector reforms in order to break the deadlock.⁵ Only then can the system be made more efficient and effective and the Azerbaijani population be better protected from financial risk.

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The institutionalisation of Health Technology Assessment in Slovenia

Eva Turk, Tit Albreht and Valentina Prevolnik Rupel

In the transition process Slovenia focused on systems for delivering health care. Health technology assessment (HTA) was only conducted at a rudimentary level. Today Slovenia has to contend with similar issues facing its health care system to those being experienced in long standing member states of the European Union. The development of medical and pharmaceutical technologies, better education and a growing influence of mass-media continue to increase public demand for new medical diagnostics, rehabilitation techniques and therapies.

All of this requires financial means, which are limited. Hence, a critical continuous assessment of the introduction of new methods of medical treatment is urgently required.¹ To date, most HTAs have been driven largely by the pharmaceutical industry, who have commissioned the assessments from private providers. Currently there is no independent body to assess the findings of such work and to evaluate it against internationally accepted standards.²

The current decision making process

The process of introducing new health technologies into the health system is performed in several ways, namely through the Health Council, Medicines Council and a Commission for the Classification of Medicines at the Slovenian Health Insurance Institute. We now describe in turn the role of each of these bodies.

The Health Council is the highest coordinating and principal advisory body to the Ministry of Health, which ultimately determines which programmes will be financed from public resources (either

compulsory health insurance or from the national budget). To aid in these decisions, the Health Council examines the scope and content of different options for health programmes in terms of their feasibility, affordability and the balanced development of all disciplines.^{3,4} Any decision to introduce new technologies into the health system must comply with the principles of evidence-based medicine, cost-effectiveness and a fair selection in those patients who will benefit.

The second tier in introducing and/or reimbursing new technologies into the system is via the Health Insurance Institute. Its special interdisciplinary Commission is responsible for the classification of prescription medicines, which are covered through obligatory health insurance, on positive and intermediate reimbursement lists. In addition to the classification of medicines, the functions of the Commission include monitoring the status of market authorisations, prices and the status of repayment for medicines, the use of medicines and any adverse effects and their pharmacoeconomics.¹

The Medicines Council was established as a new advisory body to the Ministry of Health in 2009. Its main task is to unify the decision making process for (new) medicines. It coordinates the work of various institutions operating in the field of pharmacotherapy or treatment with pharmaceuticals and cooperates with the Commission at the Health Insurance Institute.

A Slovene Network for HTA (MreHTAS)

The transition to a formalised and systematic HTA programme requires a high level of support and commitment from

government institutions and a motivated team that will take up the preparation of a plan for HTA in the country.⁵ International studies have demonstrated that the establishment of a national HTA agency is a time-consuming process that requires the participation of all stakeholders; this may not always be the best approach. This is particularly the case in countries with limited human resources, where a structured network for HTA that connects and integrates existing national institutions may meet with more success. Such networks typically coordinate and manage a Board, Council or Committee for HTA.⁶

Slovenia is such a country with very limited human resource capacity for conducting HTA studies; thus the establishment of a Network for HTA in Slovenia (MreHTAS) may be a plausible way forward. MreHTAS will consist of representatives of the different disciplines involved in HTA. Its main tasks, in addition to the preparation and review of national studies, will be to review and adapt the results of international studies to the Slovenian context. This adaptation will be conducted in accordance with Slovenian HTA guidelines, which include the European Network for HTA (EUnetHTA) adaptation toolkit.⁷ MreHTAS will be coordinated by the HTA Council. The functions of the HTA Council will include the coordination and identification of potential members of MreHTAS, the selection of contractors to undertake HTA studies, updating HTA guidelines and collaboration at an international level.

This latter function will be of great significance, given that Slovenia is probably too small to have the capacity to set up its own independent HTA programme. Collaboration and coordination with other countries within EUnetHTA is the best way forward. Thus far the institutionalisation of HTA in the country is a promising approach. It can contribute to a transparent decision-making process within the health care system, providing a

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method to balance the needs of patients and the potential for innovation on the one hand and the reality of scarce resources on the other.

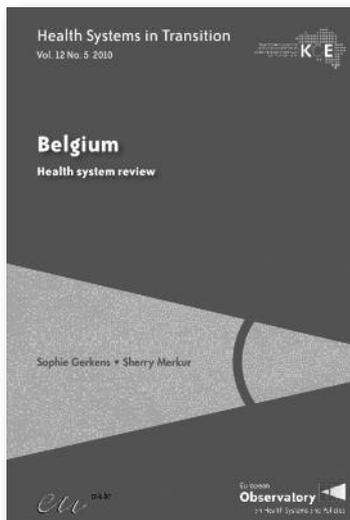
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New Belgian HiT

Improving the performance of the Belgian health system: increased focus on access, quality of care and sustainability

This HiT, produced to coincide with the Belgian Presidency of the EU Council, looks at evolution in the health system since 2007 and includes detailed information on new policies.



Sophie Gerkens and Sherry Merkur

Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2010

266 pages

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The Belgian population generally enjoys good health and high life expectancy, with good access to health services of high quality. The health system is based on progressive solidarity-based finance in combination with mainly private health care delivery. Patients benefit from a high degree of choice and relatively unbridled access to health services. Nearly the whole population is covered under a very broad benefit package.

Private and public health spending reached 10.2% of GDP in 2007 – among the highest in Europe. Although a yearly growth norm for the statutory health insurance budget of 4.5% has been applied since 2004, patients pay a high share out-of-pocket, either through official co-payments or diverse supplements. To prevent patients from foregoing essential care due to these high out-of-pocket costs, existing protection mechanisms have been extended to new categories of beneficiaries and co-payments. In addition, special measures were taken for chronically ill patients, and supplementary fees charged to hospital patients were prohibited for some categories of patients. The economic downturn and resulting soaring budget deficit may put pressure on the 4.5% growth norm.

In addition to addressing these financial challenges, reforms also aim to further improve overall quality and efficiency of the health system. Quality of care and patient safety is increasingly monitored through the establishment of information systems, with providers stimulated through feedback and peer review mechanisms. Financial incentives are also used

to tackle significant differences in clinical practice (including prescription patterns). Other important issues include strengthening primary care, as well as better integration of different levels of care. The use of the general medical file held by the general practitioner (GP) is consolidated as a way to strengthen the position of the GP. Through the creation of patient pathways and the establishment of care programmes and networks, a more structured and coordinated health care delivery system is being put in place.

The need for a coordinated approach also extends to prevention and population-based interventions, as well as long-term care. This inevitably requires coordination between different levels of policy-making, as health policy in Belgium is a combined responsibility of the state, regions and communities. To facilitate cooperation inter-ministerial conferences are held regularly, and result in protocol agreements on specific policy areas (for example, long-term and geriatric care, vaccination programmes, and cancer screening). A good example of this broad integrative approach is the Cancer Plan 2008–2010, which combines actions on prevention and screening, care, treatment and support for patients, with research, technological innovation and assessment.

Despite a traditionally abundant supply of health care providers, Belgium increasingly suffers from a shortage of health care professionals. The quota for medical graduates accepted for further training has been increased for 2015–2018. Financial incentives were also introduced to set up new GP practices and in 2008 the government adopted a plan to increase the attractiveness of the nursing profession by: reducing work load; strengthening qualifications; improving salaries; and providing better social recognition.

Estonia's health system in 2010:

Improving performance while recovering from a financial crisis

Jarno Habicht and Ewout van Ginneken

Summary: Estonia was struck by the worst financial crisis since regaining independence in 1991. High unemployment rates combined with shrinking revenues in both the public and private sector have had an impact on the available funding for Estonia's health system. Several austerity measures were taken. These include changes in value added tax and excise taxes, as well as health sector specific measures such as changes in the benefit basket and a reduction of prices. However, the crisis has also provided opportunities. It enabled implementing necessary but unpopular reforms and significant stimulus money was directed to health infrastructure.

Key words: health care reform, public health, financing, delivery of health care, Estonia

Much has happened since the launch of the Estonia Health System in Transition review at the WHO European Ministerial Conference on Health Systems on 25 June 2008 in Estonia's capital Tallinn. At this conference, Estonia recognised that a healthier population is a key asset in achieving economic growth. It therefore expressed the commitment to invest in further improving the performance of Estonia's health system in line with the adopted WHO Tallinn Charter: Health Systems for Health and Wealth. This commitment has since been put to the test, as the country has been struck by the worst financial crisis since regaining independence in 1991. Estonia's vulnerable, small and open economy, already plagued by a large, persistent current account deficit and a rapidly expanding gross external debt, declined by 3.6% in 2008 and 14.1% in 2009 as a result of the crisis. The unemployment rate, which was hov-

ering around 4% as late as the second quarter of 2008, rose in the fourth quarter of 2009 to over 15%, the highest level since 1991, and only surpassed by Latvia, Spain and Lithuania.¹

At the same time, Estonia's prudent and balanced fiscal policy of recent years will result in the joining of the Euro in 2011 but it has also led to a shrinking public sector. The shrinking revenues both in the public and private sectors reduced the availability of funding for public health and investments in population health, albeit to a lesser degree than other publicly funded sectors. Furthermore, the situation in the labour market has had important repercussions for the funding of health care, where earmarked social payroll tax is the main source of funding. Ironically, perhaps, the financial crisis has also provided opportunities for the health system, for example in terms of implementing necessary but unpopular reforms and in the form of significant amounts of stimulus money directed to health infrastructure. In this review, we assess the Estonian health system in light of the financial crisis. Based on the health system review we made in 2008, we will examine the various components of the Estonian health system and their specific recent reforms, as well as progress achieved, before concluding with an outlook for the future.

Background

Estonia, the northernmost of the Baltic States, with a population of 1.32 million, is a democratic parliamentary republic and has belonged to the North Atlantic Treaty Organisation (NATO) and the European Union (EU) since 2004, and the Organisation for Economic Cooperation and Development since 2010. Since regaining independence, the political environment has been stable enough to implement various economic and social sector reforms which aim to further ensure stability in the country. Until the financial crisis hit in 2008, Estonia had enjoyed a level of continuous above EU average annual economic growth. Since the late 1990s, an increasing birth rate has been observed, yet this is around 4% lower than current death rates. Life expectancy has been steadily increasing since the mid-1990s and in 2008 for women and men respectively was 79.6 and 68.7 years, being one of the largest gender differences in Europe.²

The main challenge in terms of disease burden is premature mortality caused by external causes as well as lifestyle-related risk factors. The working-age population bears more than half the current burden of disease that to a large extent could be avoided.³ The main risk factors leading to ill health are related to tobacco use, alcohol consumption, low levels of physical

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activity and unhealthy nutrition. Some positive trends are visible regarding decreasing tobacco use among adults; moreover since 2008 there has also been a decrease in alcohol consumption. This can be seen as the result of the financial crisis and a new emphasis on indirect taxation and other measures. Excise taxes have been gradually increased for both tobacco and alcohol products since 2008 and are likely to be increased further. In addition, the overall increase in value added tax (VAT) has contributed to price increases in health-damaging products (but controversially also made healthy products more expensive).

Despite this, the rising alcohol consumption and drug use among adolescents remains a worrying trend. Other positive trends since the early 2000s include high vaccination rates and decreasing incidence rates of communicable diseases. One of the most serious public health challenges facing the Estonian health system is the continuing high HIV prevalence and incidence (which peaked in 2001).⁴ During the financial crisis investments in prevention and treatment of tuberculosis and HIV/Aids have been sustained and both diseases show declining incidence rates. However, this was done at the expense of the investments in the prevention of non-communicable diseases. The mid- and long-term impact of this measure is unclear.

Organisation and governance

The steward of the health system in Estonia is the Ministry of Social Affairs. The Ministry is supported in its tasks by various public agencies. These include the National Institute for Health Development, the Health Board (which merged several public institutions on health protection and supervision of health care in 2010) and the State Agency of Medicines. Another important actor is the Estonian Health Insurance Fund (EHIF), which is a public independent body responsible for pooling of funds and purchasing health care services (and some disease prevention and health promotion programmes). Health care providers include private primary care units; (mainly publicly owned) hospitals under private regulation; and various nongovernmental organisations (NGOs) and professional associations. Also non-health sectors (for example, transport and economy, agriculture, environment) have started to be more actively involved in health system activities due to the development and

implementation of inter-sectoral public health strategies (for example, tackling HIV/AIDS and cardiovascular diseases strategies).

Fundamental reforms aimed at developing a modern health system took place in the early 1990s. These were followed by a legislative review in the period 2000–2003 that addressed various areas including health financing, service provision and the regulation of relations between different actors (for example, purchaser, provider and patient). The period since 2004 can be characterised by preparing, launching and implementing inter-sectoral public health strategies. To bring the various initiatives under one umbrella and set a clear vision for the future, a long-term overall National Health Plan running until 2020 covering public health and health care, as well as tackling key social determinants of health, was launched a few years ago and finally approved by the Government in July 2008.

Financing

Estonia's health expenditure as a share of GDP is significantly lower than that of other EU Member States. However, government spending on health as share of total social expenditure is similar to the EU-27 average.⁵ Estonian health care is mainly publicly funded through mandatory health insurance contributions in the form of an earmarked social payroll tax, which accounted for two-thirds of total health expenditure in recent years.⁵ The Ministry of Social Affairs is responsible for financing emergency care for uninsured people, as well as for ambulance services and public health programmes. The role of the local municipalities in health financing is relatively small yet diverse. Private expenditure comprises approximately one quarter of all health expenditure. Out-of-pocket payments (OOPs) account for more than 90% of private health spending.⁵ Most OOPs are co-payments for pharmaceuticals and for dental care. This growing out-of-pocket expenditure may hinder access to health care for low-income population groups and as a consequence, health financing has become more regressive over recent years.⁶ From 2009 onwards, this additional financial burden has been shifted to patients. First, small cash benefits for dental checkups for adults were excluded from the benefit package. Second, the VAT on pharmaceuticals was increased from 5% to 9% in early 2009. Third, in 2010, a 15% co-insurance for inpatient nursing care was introduced.

The core purchaser of health care services for insured individuals is the Estonian Health Insurance Fund (EHIF). The health insurance system is mandatory and covers over 95% of the population. In 2007, coverage was extended to cover the registered and job-seeking unemployed, which provided important protection against the crisis. Contributions are related to employment, but the share of non-contributing individuals covered (such as children and pensioners) represents almost half of all the insured. In the longer term this is a threat to the financial sustainability of the health system, as the narrow revenue base is mostly related to wages and the population is ageing. Adding to this already difficult outlook is the sharp rise since 2008 in the number of the unemployed coupled with the decrease in salaries, which together caused a drop in social tax revenues.

Moreover, total health system resources will further decline as the Unemployment Insurance Fund or state contributions on behalf of the unemployed are lower than the average contributions of the employed. Even though over recent years steps have been taken to increase population coverage, as well as the revenue base, the impact of these steps is still marginal. In parallel until 2008, more resources have been allocated to both health care and public health programmes, but the financial crisis reversed this trend. In 2010 the key challenge is to retain the benefits of earlier investments in public health and healthy ageing, while at the same time also providing mid-term solutions for sustainable health care financing. Clearly, broadening the public revenue base is one of the most obvious options, particularly since a recent study shows that efficiency gains alone do not bridge the revenue and expenditure gap in the long term.⁵

The financial crisis provided an opportunity to implement unpopular changes planned for years. More responsibility to cover short term sick leave benefits was shifted from the EHIF to workers and employers in mid 2009. This will likely impact both on the behaviour of employers and the health behaviour of employees. However, the EHIF funds no longer needed for sick leave benefits were reallocated to cover health care. As a result, the reductions in access to care have not been as drastic as might have been anticipated in 2009.

Health services purchasing builds on a contractual relationship with providers, as

well as being linked to financial incentives. Contracts and procedures to involve providers in negotiations have continuously been developed and, similarly, new payment mechanisms have been introduced. For hospitals a diagnosis-related group(s) (DRG) system has been implemented since 2004, complementing the fee-for-service payments and those related to bed-days. Gradually the proportion paid by the DRG system has been increased, culminating in a final increase in 2009, from 50% to 70%. With regard to primary care, age-adjusted capitation, fee-for-service payments for selected areas and basic allowances have been complemented by a quality bonus system, implemented in 2006, which aims to foster disease prevention and management of selected chronic conditions.

Further discussions on how to stimulate the performance of the providers, including quality considerations, have been ongoing in recent years.^{7,8} To respond to the decreasing revenues resulting from the crisis, the prices paid to providers for services covered by the EHIF have been decreased by 6% until the end of 2010. Moreover, the volume of contracted care was reduced by extending waiting times and by reducing treatment cases in specialist care by 5%, while simultaneously shifting more cases to day care and outpatient settings. At the primary care level, contract volumes have remained stable in order to respond to the most urgent needs adequately.

Physical and human resources

Estonia inherited from the Soviet era a large, ineffective hospital network with poor facilities. Various structural and managerial reforms in the 1990s reduced the number of hospitals (and beds) and restructured the providers' network. The reforms aimed to modernise the network and enable the provision of high-quality services, while also ensuring sufficient health services access. As a result, Estonia has developed a well-equipped infrastructure for primary care that builds on family physicians and nurses. However, the process to modernise the facilities is still ongoing and is supported by various resources, including EU structural funds. Part of a stimulus package was aimed at fostering ongoing and new investments in high level hospitals; new high-tech facilities that were opened in Tartu and Tallinn in 2009.

In addition, long-term care infrastructure

investments from EU structural funds have started in the 2010 to upgrade around twenty hospitals with long term care facilities. Interestingly, in parallel to these additional investments, the government stopped the yearly transfers to the EHIF intended for capital investment, even though this is a legal duty. Although there is a net increase in investments in hospital infrastructure, recent analysis shows that it is important that (1) excess hospital capacity is reduced along the lines proposed in the Hospital Master Plan 2015; (2) a better investment strategy is developed, which serves health system objectives rather than individual providers; and (3) a further fragmentation of health care financing is avoided.

Medical training for doctors is provided by one university in Tartu. For other professionals (including nurses) this has been centralised to a few medical schools to ensure a higher quality of training. The curricula for health specialists and other health workers were reviewed in the 1990s and were brought in line with EU law in anticipation of the 2004 accession. Since a general lack of human resources exists in the health care sector, strong emphasis has been laid on long-term planning and increased training for nurses and doctors. EU accession in 2004 led to a temporary migration spike in doctors and nurses migrating to neighbouring EU countries. In recent years until 2009, however, migration has decreased and the main challenges are to retain qualified professionals in the health care sector, along with the ageing of the current workforce.

The period since the mid-1990s can also be characterised by high investments in information and communication technologies. This has led to e-health solutions which aim to achieve better coordination, improved access and transparency. Since 2005, a countrywide e-health approach encompasses four innovative pillars: Electronic Health Records (EHR), Digital Registrations, Digital Imaging and Digital Prescriptions. Although progress has been made on all fronts, implementing this system countrywide has proven more difficult than initially anticipated. As a first concrete step, the digital prescription was launched and has become gradually functional in 2010.

Provision of services

Reforms which started in the early 1990s introduced a purchaser and provider split; strengthened primary care; free choice of

provider; and a high level of provider autonomy in the Estonian health system. As a result, the current health system is built around countrywide primary care centred on family medicine, with specially trained doctors and nurses. The aim is to provide both curative and preventive services by teams led by family physicians. Further primary care is supported by ambulance services with medical teams (including a doctor) available all over Estonia. Recently, individual nurse visits have been introduced and since 2010 midwives are permitted to operate their own private practice. This should broaden the scope of primary care services available and builds on the national primary care strategy adopted in 2009.

Specialised care has increasingly been provided in outpatient settings and care involving high technology has been further centralised in key hospitals. Furthermore, over the years, the availability of and access to pharmaceuticals has improved significantly and more recently promotion of generic substitution has become a priority. Increasing importance of public health services has led to development of services and standards, raised awareness of population needs, as well a more public health approach to health care services.

Heightened concerns of the population are waiting times to access outpatient specialised services and overall access to health care services. Various initiatives have been implemented, including opening a 24-hour primary care call centre in late 2005; widening the scope of services; and introducing financial incentives in primary care. Contrasting these initiatives is the new crisis measure of deliberately increasing waiting times for out-patient specialists' visits in a search for savings, even if this has not affected waiting time for planned inpatient care and surgery (for example, hip replacement, cataract removal, cardio surgery). Possible negative effects should be monitored closely.

Nevertheless, the Estonian population continues to be satisfied with their health system and the highest population satisfaction to this date was observed in the last available (late 2009) annual patient survey. The financial crisis has also increased the public's reliance on the insurance system and the need for security. This can be observed in the trend that an increasing number of citizens prefer a situation in which all services are covered but with longer waiting times to a situation with less services but rapid access.⁹

In addition, more emphasis is now being put on quality of care, which is visible in initiatives such as voluntary accreditation of professionals by their associations, introduction of quality handbooks in hospitals and the development of clinical guidelines for both professionals and patients. In relation to both access and quality, the coordination and approach to tackling chronic conditions are continuous concerns. Several additional topics need further attention, most noticeably patient empowerment, self-care, as well as the development of further home care and long-term care services.

Discussion

Estonia has vigorously and quite successfully reformed its health system over recent decades. Larger scale legislative reforms in the early 1990s and at the beginning of this century were followed by incremental changes during the period 2003–2008. Since then, the dominant theme in Estonian health care was coping with the financial crisis and ensuring financial sustainability in the long term. The current system is built on solidarity-based health financing; a modern provider network based on family medicine-centred primary health care; modern hospital services; and more concentration on public health initiatives. This has resulted in a steadily increasing life expectancy and continuously high rates of population satisfaction with access and quality.

The Estonian health system is in search of a new equilibrium after many reforms have been implemented in the health system since 2008. Although more evidence on the impact of these changes should become available in future years in the form of health surveys and more reliable data on key indicators, some preliminary conclusions can be drawn.

First, non health sector specific measures on excise taxes and VAT have increased the prices of health damaging behaviours (for example, alcohol, tobacco) and led to some positive trends among adults in terms of their smoking and drinking behaviours. It needs to be noted, however, that the increase of VAT also impacts on healthy behaviours as nutrition has become more costly in real and relative terms because unemployment rose while the real income of households decreased.

Second, the changes in tax policy since 2009 have not only increased the input prices for the providers but also the price of pharmaceuticals for patients. This may

have undesired effects on OOP spending, which has already been increasing over time, and also on equity of access, although a reference pricing system should keep pharmaceuticals accessible to all.

Third, measures have been concentrating mostly on the demand side. They include expanding cost-sharing requirements; changing the benefit package and thus access to certain services; using some of the financial reserves that were collected in better times by the EHIF; and reducing the prices for health services.

Fourth, on the supply side the responsibility to achieve cost savings and efficiency has been delegated to providers. The government's plan to swiftly implement the hospital master plan has been slowed down (compared to 2009) and no central steering has been introduced for (expensive) high tech equipment. The additional investments in infrastructure will surely improve buildings and access to the latest technologies. Yet it is not clear if these investments are bringing additional efficiency to service provision and how the new structure will be financed in the long term.

Fifth, during the crisis the emphasis has been on primary health care by maintaining the purchasing budget at pre-crisis levels. In addition, public health was made one of the priorities and the EHIF has continuously supported disease prevention and health promotion activities.

Finally, in the public health sector, priority was given to preventing communicable diseases at the expense of investments in non-communicable diseases. But the launch of various initiatives targeting NCD among the working age population supported from the EU Social Fund in recent years is a promising development, which could mitigate the cuts in the public health budget.

Conclusion

Going forward, a number of challenges remain for the Estonian health system. Many of these are the same as before the financial crisis. They include reducing inequities in health status and health behaviour; improving control of and responding to the consequences of the high rates of HIV and related conditions; improving regulation and governance of providers to ensure better public accountability and performance; having the necessary human resources and competences at all levels; and ensuring sustainable health financing arrangements that facil-

itate timely access to care of high quality.

This last challenge is particularly important firstly in the face of rising patient expectations, accompanied with increased costs and volume of health care services, and secondly in the hostile macroeconomic environment. If solidarity and equity are to be maintained and guaranteed for the future, additional resources need to be found from public sources of revenue and from efficiency gains in the system simultaneously. Only time will tell how well the often praised Estonian health system will succeed in protecting population health in this process.

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Mythbusters

Myth:

Seeing a nurse practitioner instead of a doctor is second-class care

“...patients who saw a nurse practitioner reported higher levels of satisfaction and better quality of care in comparison to the care provided by physicians”

Nurse practitioners are becoming familiar figures on the Canadian health care scene. Now licensed in all provinces and territories, the workforce doubled from 800 in 2004 to 1,626 in 2008.¹ Despite the growth and evolution of the profession, there is some lingering confusion about when and where they are qualified to work and the quality of care they can provide. A perception exists that seeing a nurse practitioner instead of a doctor is second-class care, best suited for times and places where a doctor is unavailable.

Research suggests otherwise. There is a large and growing body of evidence that shows nurse practitioners deliver care as well as their physician counterparts — sometimes more effectively. And while the autonomy of and substantial overlap in scope of practice between the two professions is recognised as an occasional source of tension^{2,3} there are examples of effective collaboration.^{4,5}

Nurse practitioners in Canada

Nurse practitioners first appeared in Canada in the 1960s in response to shortages of primary care physicians in rural and remote areas. They were the subject of renewed interest in the 1990s, as part of efforts to improve access to primary health care in a context of deepening shortages of doctors as well as growing demand for services arising from older Canadians, chronic illnesses and mental health problems.

Nurse practitioners work in settings such as community health centres, home-care agencies, northern health centres, public health units and family practice units or

physician offices and, more recently, in long-term care settings and emergency departments. They are trained and educated to conduct health assessments, perform a variety of medical procedures, prescribe drugs, and diagnose and manage common illnesses and injuries through ordering and interpreting diagnostic tests.⁶ They also have expertise in health promotion and preventive care.

Because they have comprehensive skill sets and may cost the health system less than primary care physicians,^{7,8} nurse practitioners are often a component of primary health care reform strategies.⁹ For example, in order to increase patient access to primary health care, clinics are being developed with physicians functioning primarily in a consulting role to the nurse practitioner.¹⁰ In British Columbia, nurse practitioners have been integrated into traditional fee-for-service practices. In Ontario, 26 clinics led by nurse practitioners are being introduced in communities with physician shortages.

Tried and true

Since a pioneering study of nurse practitioners in Burlington, Ontario, in 1974,¹¹ at least 28 randomised controlled trials have been conducted, predominantly in the United States, the United Kingdom and Canada. These studies have consistently shown that nurse practitioners are effective, safe practitioners and can positively influence patient, provider and health-system outcomes. A 2002 review of scientific studies compared nurse practitioners and physicians providing first-contact care to patients in primary health care settings and found that patient health outcomes were equivalent.¹² Nurse practitioners tended to spend more time with patients and order more tests, but no differences were found in the number of prescriptions, return visits or referrals to specialists.

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.

The full series is available at www.chsrf.ca/mythbusters/index_e.php. This paper was first published in 2010. © CHSRF, 2010.

The evidence that nurse practitioners are making a difference in the Canadian health care system is accumulating. One study found their inclusion in primary health care teams in four different primary health care models in Ontario was associated with high-quality chronic disease management.¹³ In addition to improved patient outcomes, one Canadian study found when nurse practitioners were added to an emergency department, patients were more than twice as likely to be seen within wait-time benchmarks, their length of stay was cut in half and the proportion of patients leaving without being seen was down by one-third.¹⁴

The proof is in the patient

The patient's perspective is critical when it comes to health care. The previously mentioned 2002 review of studies found that patients who saw a nurse practitioner reported higher levels of satisfaction and better quality of care in comparison to the care provided by physicians.¹² Studies also indicate that patients appreciate their communication style and the extra time spent.^{15,16} Patients tend to be more satisfied with the type of advice provided, too.¹⁷ For example, nurse practitioners tend to ask more questions and offer more information and options than physicians.

A growing body of evidence suggests Canadians are highly satisfied with care provided by nurse practitioners. A 2009 Harris/Decima poll of 1,000 Canadians¹⁸ found that:

- one in five has been treated by a nurse practitioner
- a majority would like to see the role expanded
- greater than three in four would be comfortable seeing one in lieu of their family doctor and
- four in five feel that expanding their roles would be an effective way of managing health care costs (although it should be noted that there is a paucity of evidence on their cost-effectiveness relative to physicians in Canada).

Given public calls for increased access to

care, reduced wait times, and more services related to the ageing population, chronic illnesses and mental health problems, nurse practitioners have the potential to contribute significantly to the improved delivery of health care in Canada.

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NEW PUBLICATIONS

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

Policies and incentives for promoting innovation in antibiotic research

Elias Mossialos, Chantal M Morel, Suzanne Edwards, Julia Berenson, Marin Gemmill-Toyama and David Brogan



Copenhagen: World Health Organization, 2010 on behalf of the European Observatory on Health Systems and Policies

ISBN 978 92 890 4213 0

224 pages

Freely available online at:
http://www.euro.who.int/__data/assets/pdf_file/0011/120143/E94241.pdf

High levels of pathogen resistance are rendering current antibiotics obsolete. Coupled with insufficient investment in discovering new treatments, multidrug-resistant infections are an increasingly urgent public health concern.

To curb the growth of antibiotic resistance and prevent major morbidity and mortality from multidrug-resistant bacterial infections, the overuse of antibiotics must be addressed and research and development for antibiotics with novel mechanisms of action actively promoted. This requires appropriately designed incentives for health and regulatory systems, in addition to economic incentives to attract academic interest and industry investment.

This book, commissioned by the Swedish Government from the European Observatory on Health Systems and Policies, analyses many proposed policies and incentive mechanisms and aims to shed light on the key issues that will help policy-makers reach informed, concrete decisions on how to avert this potential public health crisis.

Contents:

Introduction;
Background on antibiotics;
Background on antibiotic resistance (AR);
Causes of AR;
Reasons for limited innovation;
Health system responses to AR;
Analysis of opportunities and incentives to stimulate R & D for antibiotics;
Conclusions.

International variation in the usage of medicines: a review of the literature

Ellen Nolte, Jennifer Newbould and Annalijn Conklin



Rand Europe, 2010

57 pages

Freely available online at:
http://www.rand.org/pubs/technical_reports/2010/RAND_TR830.pdf

The report reviews the published and grey literature on international variation in the use of medicines in six areas (osteoporosis, atypical anti-psychotics, dementia, rheumatoid arthritis, cardiovascular disease/lipid-regulating drugs (statins), and hepatitis C).

Three broad groups of determinants of international variation in medicines use were identified:

(1) Macro- or system level factors: differences in reimbursement policies, and the role of health technology assessment, were highlighted as a likely driving force of international variation in almost all areas of medicines use reviewed.

(2) Service organisation and delivery: differences in access to specialists are a likely driver of international variation in areas such as atypical anti-psychotics, dementia, and rheumatic arthritis, with for example access to and availability of relevant specialists identified as acting as a crucial bottleneck for accessing treatment for dementia and rheumatoid arthritis.

(3) Clinical practice: studies highlighted the role of variation in the use and ascertainment methods for mental disorders; differences in the use of clinical or practice guidelines; differences in prescribing patterns; and reluctance among clinicians in some countries to take up newer medicines. Each of these factors is likely to play a role in explaining international variation in medicines use, but their relative importance will vary depending on the disease area in question and the system context.

Contents:

Background;
Osteoporosis;
Atypical anti-psychotics;
Dementia;
Rheumatoid arthritis;
Cardiovascular disease lipid-regulating drugs/statins;
Hepatitis C;
Summary and conclusions.

European Network Education and Training in Occupational Safety and Health (ENETOSH)

www.enetosh.net

ENETOSH is an EU funded site containing information on health and safety education and training. Examples of good practice at every level of education can be found online, in addition to a toolbox archive for methods, media and documents. From the homepage it is possible to access the news archive, ENETOSH's objectives and past evaluations. Users can browse through hot topics, statistics and a calendar of events. A who's who is available to search for registered members. Some information – such as the ENETOSH leaflet – is available in over twenty-four European languages but the site is hosted in English.

ProMenPol

www.mentalhealthpromotion.net

ProMenPol was a 36-month project undertaken by partners from Germany, Austria, Ireland, Finland, Estonia, Greece and Belgium. The project was a co-ordination action funded by the European Commission under the 6th Research Framework Programme. It set out to identify useful and practical approaches to the promotion and protection of mental health amongst a wide diversity of theories, models and methods, in order to form the basis for a systematic multidimensional approach to promoting personal mental health and manage risk factors that predispose distress and pathology. The website contains a wealth of resources including a database of mental health promotion tools in three different settings: schools, the workplace and older peoples' residences. It also contains four inter-related manuals on how to implement mental health promotion in general, as well as in these specific settings. It is available in English, German, Dutch, Estonian and Finnish.

European Cancer Observatory (ECO)

<http://eu-cancer.iarc.fr>

The ECO was launched in 2009 by the International Agency for Research on Cancer to serve as a source of data on cancer-related statistics. Users can find data on incidence and mortality rates, as well as cancer fact sheets by type of cancer or European country. The analysis section allows for data to be shown graphically whilst a glossary outlines definitions of terms. There are numerous links to other associated sites. The web site is available in French and English.

Eurosafe – European Child Safety Alliance

www.eurosafe.eu.com

Eurosafe is an EU funded initiative focused on improving the lives of children through injury prevention and safety promotion. The homepage lists details recent conferences, news stories, events and policy documents. The comprehensive website outlines current projects, initiatives and good practice guides. Child Safety Report Cards summarise a country's performance with respect to the level of safety provided to children and adolescents based on over one hundred proven effective national level strategies and policies.

European Society of Cardiology (ESC)

www.escardio.org

The ESC's mission is to reduce the burden of cardiovascular disease in Europe. It represents over 59,000 cardiology professionals across the continent. The ESC contributes to clinical practice guidelines, organises educational courses and carries out surveys on specific disease areas. Information is available on membership, associated groups, communities, board members and committees. Users can sign up to ESC news, follow ESC on Twitter and find out more about future congresses. Seven journals are also edited and published by ESC, details of which are available. A search engine and dedicated members only area is also accessible.

Health First Europe (HFE)

www.healthfirsteurope.org

HFE is a non-profit, non-commercial alliance of patients, health care workers, academics and health care experts and the medical technology industry. Users can download quarterly newsletters, past surveys and press releases within the 'newsroom' and 'publications' sections. Case studies of patients' experiences are available for browsing, and an interactive diagram allows users to explore specific diseases and related treatments. There is a dedicated health care workers' safety section for professionals. Contact information, podcasts and further links can be found online. A search box allows for easy navigation of the site.

News

Press releases and other suggested information for future inclusion can be emailed to the editor David McDaid d.mcdaid@lse.ac.uk

NEWS FROM THE INSTITUTIONS

WHO and European Commission adopt joint declaration

On 13 September the World Health Organization (WHO) Regional Office for Europe and the European Commission adopted a joint declaration seeking to strengthen policy dialogue and technical cooperation on public health.

The declaration was made in Moscow, Russian Federation, during the annual meeting of the WHO Regional Committee for Europe, which was attended by John Dalli, European Commissioner for Health and Consumer Policy. The declaration outlines the framework for cooperation for the next five years and envisages the development of joint systems for health surveillance, alert and information, and stronger collaboration on the country level.

“It is crucial for us to work more closely with the European Commission on addressing common public health challenges in the 53 Member States in the WHO European Region. The consequences of the financial crisis and the existing and emerging public health threats can only be tackled through a more streamlined collaborative framework, backed up by a strategic vision,” said Zsuzsanna Jakab, WHO Regional Director for Europe.

John Dalli said: “I welcome and fully support this declaration for future collaboration between the European Commission and the World Health Organization. By working closer together, we can build synergies, avoid duplication and be more effective in achieving our health objectives. I believe that now is the right moment, at the beginning of my mandate and that of Zsuzsanna Jakab, to strengthen and enlarge our partnership.”

Since 2001, the two organisations have cooperated closely in a wide range of areas, including health security, health information, tobacco control, nutrition and

obesity, cancer and other non-communicable diseases, environment and health, and the strengthening of health systems. They will now extend their cooperation to e-health, health research, innovation in health and education. The partners will also develop a closer working relationship between European Commission delegations and WHO country offices in eastern Europe.

The joint declaration calls for a more cohesive effort to improve health security throughout the WHO European Region. It particularly emphasises the need to act against the threats of antimicrobial resistance, especially multidrug resistance. The WHO Regional Office for Europe and the European Commission will join forces to help improve public health surveillance and strengthen alert and response systems to allow quicker and more efficient responses to disease outbreaks and pandemics across the 53 countries in the WHO European Region.

The two partners will take joint action to facilitate the establishment of a single integrated information system covering the WHO European Region. They will also collaborate to help countries address the consequences of the financial and economic crisis and maximise the health returns of health and non-health investments.

The declaration also highlights the need for closer monitoring of health inequalities across the European Region and for exploring ways to combat them. It underscores the importance of formal education in building healthy lifestyles. A coordinated effort will be made to facilitate the development of a new European health policy for the WHO European Region: an integrated framework for tackling existing health challenges on the wider European continent.

Belgian Presidency event: investing in Europe's health workforce of tomorrow

Europe needs to be able to count on a skilled, engaged and healthy

workforce – capable of adjusting to technological change, new patterns of work organisation and the emerging needs of patients. All Member States of the European Union face common challenges in ensuring and maintaining an adequate workforce to meet the changing and growing health needs. The ageing of the population, the growing number of chronic diseases and the shift of hospital care to prevention and primary care all place a heavy burden on the health sector.

The Belgian Presidency of the EU Council thus organised a ministerial conference on 9 and 10 September entitled “Investing in Europe's health workforce of tomorrow: scope for innovation and collaboration”, to further raise the awareness of the problem and to support the European Commission's efforts in developing a coordinated approach in supporting national and regional policies in this area.

The conference brought together 250 participants, not only including Ministers and senior health officials of all European Member States, Candidate and European Economic Area countries, but also high level representatives of various international organisations such as the WHO, the Organisation for Economic Cooperation and Development (OECD) and professional stakeholder organisations.

For two days they focused on key issues such as assessing the future needs of the health workforce, both in numbers and in types of skills, well-distributed across the country and across care settings, changing needs in competence profiles, training and lifelong learning, recruitment and retention of health workers.

The conference also looked at the role that the health workforce plays in improving quality and safety of health care. The formulation of policies and the use of instruments for quality and safety improvement vary widely between the Member States of the

European Union. Thus there is plenty of scope for learning between countries.

Conclusions from the conference will enable the development of a European action plan, that will allow health authorities and relevant stakeholders to jointly prepare for mid and long term needs. Mrs Onkelinx, Deputy Prime Minister and Health Minister of Belgium said that “the health sector is changing rapidly like any other sector in society. It is our responsibility, together with all stakeholders, to identify today the needs of tomorrow and the best way to meet them not only at national but also at European level”.

John Dalli, European Commissioner for Health and Consumer Policy, said “I welcome this conference on a European Health Workforce by the Belgian Presidency. I believe we must do everything we can to ensure that Europe has an adequate health workforce that is able to meet the growing health care demands of our ageing population. This is essential to ensure that European citizens receive safe and good quality health care.”

More information at <http://www.health.belgium.be/eportal/Aboutus/eutrio/health/europehealthworkforce/>

Environment and health issues under the Belgian Presidency

Several high-level events are being organised by the partners of the Joint-Interministerial Conference on Environment and Health (JICEH) under the Belgian Presidency of the European Union. This very diverse programme of environment and health issues mirrors the growing social and political interest in the challenges and opportunities in looking more closely at the interaction between health and the environment. At least six key conferences and no less than twelve other events will be organised.

The conclusions and results of the Belgian Presidency events shall be used as a foundation to support European Council decisions regarding the preparation and development of a second European Environment and Health Action Plan (EHAP).

A first step in this direction has been taken by the Belgian Federal Minister for Environment by commissioning a reflection document: *The EU Environment and Health Action Plan (EHAP) – Assessment and Outlook for Future Action*. This document sets out the policy and research background for many environment and health themes such as nanomaterials,

indoor air quality (IAQ), human biomonitoring (HBM) and better protection of vulnerable sections of the population.

The JICEH has also underlined its commitment to develop a more coherent environment and health policy at the European level. Such a clear framework it states will serve, firstly, as a strong back-up for policy makers on national and regional levels. Secondly, a framework will highlight the EU’s leadership role in environment and health to other policy makers concerned worldwide. The ‘fine-tuning’ of the policy sectors of environment and health (and in a future phase: mobility, industry, spatial planning, the economy, etc.) is indispensable to improving the environment and the well-being of populations.

More information at www.nehap.be

Universities spark debate on Innovative Medicine’s Initiative

The League of European Research Universities (LERU), a group representing 22 major universities in Europe have written an open letter to the board of the European Commission’s Innovative Medicine’s Initiative raising concerns over ‘deficiencies’ in the programme in respect of financial issues and intellectual property rights.

While LERU noted that they are ‘very much in favour of the spirit and scientific merit of the Innovative Medicines Initiative (IMI) and consider it a valuable mechanism to overcome the research bottlenecks in the drug development process’ they claim that academics are placed at a disadvantage in the current system.

They argue that current funding arrangements under the EC Seventh Framework Research Programme (FP7) mean that only 90% of direct costs are covered, in contrast to other more generous funding mechanisms available under different FP7 schemes. They called for the IMI programme to be brought into line with financial rules governing other FP7 schemes.

LERU also state that the terms of the IMI’s intellectual property policy is ‘vague’ and favours European Federation of Pharmaceutical Industries and Associations [EFPIA] partners. They state that ‘the EC and EFPIA should not expect their ‘partners’ to accept rules, by which they basically give away all their intellectual property for free and do not even receive full funding for their research activities.’

In July, a joint statement expressing similar concerns was issued by a group of 12 leading university and research organisations, all IMI stakeholders. Responding in a letter published in Nature on August 26, Kim De Rijck, External Relations Manager and Michel Goldman, Executive Director of the IMI, said that criticism of the Initiative’s intellectual policies “partly reflects a misunderstanding about how knowledge-sharing is handled in collaborations between academia and industry.”

De Ricjck and Goldman also argued that “these rules have proved workable for academics, for small- and medium-sized enterprises, and for many major pharmaceutical companies – in which sensitivities about commercialisation and competition run high. So far, 24 small- and medium-sized enterprises and 155 universities are participating in 15 ongoing IMI projects.”

According to the IMI website 134 proposals were submitted in response to the first call under the IMI scheme, of which 15 have been successful receiving €281 million in funding. The second call also produced 124 expressions of interest.

The letter from LERU can be accessed at http://www.leru.org/files/general/LERU_Letter%20on%20IMI_2010%2009%2002.pdf

More information on the Innovative Medicines Initiative at <http://www.imi.europa.eu/>

Commission addresses issues in nuclear medicine, radiology and radiotherapy

All over the world, the number of X-ray examinations is around four billion per year. In Europe, around nine million patients are treated each year with radioisotopes. Today, the most widely used diagnostic radioisotope, Technetium-99m, is short in supply because it relies on an unsustainably low number of production reactors. Thus on 6 August the European Commission adopted a Communication to the European Parliament and to the European Council on the medical applications of ionising radiation. (Ionising radiation comprises particles and high energy electromagnetic radiation that are capable of disrupting the structure of atoms or molecules and change the structure of the living cells).

The Communication has proposed a way forward to resolve the urgent issue of the shortage in supply of radioisotopes for nuclear medicine. It also identifies key issues to improve radiation protection for

patients and medical staff, to avoid a rise in population exposure associated with the technological advances in X-ray computed tomography imaging (CT) and an increase of accidental or unintended exposures in radiotherapy. This Communication has been jointly proposed by Günther Oettinger, Commissioner responsible for Energy, and by John Dalli, Commissioner responsible for Health and Consumer Policy.

The Communication proposes a long-term perspective on the medical application of ionizing radiation in the Union to stimulate discussions on the necessary actions, resources and distribution of responsibilities. Among the actions proposed are steps to strengthen the existing regulatory framework. The current legislation (Directive 97/43/Euratom) will be upgraded to enhance regulatory supervision to ensure that the legal requirements are respected. This will be part of an overall consolidation of radiation protection legislation in 2011.

In addition, it is important to raise awareness and promote a safety culture. The medical profession, the Communication states, must receive adequate training and regular updates on good practice, and above all, made sensitive to its responsibility in ensuring both good medical care and adequate radiation protection. Awareness also needs to be raised among patients and among the general population.

There is a need to foster radiation protection and a sustainable supply and use of radioisotopes through research via Euratom, the EU Framework Programmes and in the framework of the Sustainable Nuclear Energy Technology Platform (SNETP). The importance of work on different financing mechanisms to ensure a sustainable supply of radioisotopes, better integration of policies, on public health, research, trade and industry, as well as radiation protection, and improved international cooperation are also included.

Speaking of the Communication, Energy Commissioner Günther Oettinger said “nuclear medicine is essential for diagnosis and treatment of serious diseases like cancer, cardiovascular and brain diseases. At the same time, the overall population exposure to ionising radiation due to medical procedures overwhelms any other man-made exposure.” Commissioner for Health and Consumer Policy John Dalli added that “the shortage of radio-isotopes

needed for medical procedures, as well as the need to improve patient and health professionals protection against accidental or unintended exposures in radio therapy, are important objectives of public health policy”.

More information at http://ec.europa.eu/energy/nuclear/radiation_protection/radiation_protection_en.htm

Protecting patients: EU to upgrade medicine safety monitoring

Patients will be better informed on how to use medicines, and enabled to report their adverse effects directly to national authorities, as a result of updates of EU laws agreed with the European Council and endorsed by the European Parliament on 22 September. The EU and Member States will set up pharmacovigilance web sites and medicines that need special monitoring after being placed on the market will be marked with a black symbol.

UK MEP Linda McAvan, who steered the draft legislation through Parliament, said during the debate that “it is very clear that we need to work together. With a pool of 500 million people, it is much easier and quicker to pick up an adverse reaction than when working alone at national level”.

European Commissioner for Health and Consumer Policy John Dalli said the vote would ensure greater patient safety and cut red tape by sharing data. “Once implemented, the new legislation will strengthen and modernise the current system for monitoring medicinal products for human use in the EU, making it more robust and transparent”.

EFPIA, the voice of the research-based pharmaceutical industry in Europe, welcomed the vote. Brian Ager, Director General of EFPIA, said that the “EFPIA has consistently been supportive of these efforts to strengthen and rationalise EU’s pharmacovigilance system. Whilst some of the provisions raise concerns, and will require carefully considered implementing measures be adopted in order to deliver the stated objectives of the legislation, on balance it is a positive move. EFPIA is fully committed to helping implement the new legislation.”

Pharmaceutical web portals and reporting by patients

MEPs amended the EU pharmacovigilance regulation and medicines code directive to require that EU and national web portals be set up to give information on medicinal

products and their proven side effects. National web portals, to be linked to the EU one, will include assessment reports, summaries of product characteristics and patient information leaflets. The portals and patient information leaflets will also tell patients how to report any suspected adverse reactions, using national web portals or other means.

Additional monitoring of new medicines

Some medicinal products (for example, those with a new active substance) will be authorised subject to additional monitoring after they are placed on the market. These will be identified by a black symbol with the statement “This medicinal product is subject to additional monitoring”, together with an explanatory sentence. They will also be listed on the EU web site and national web portals.

EU single point of receipt for all pharmacovigilance information

The EU Eudravigilance database will be the single point of receipt for all pharmacovigilance information from marketing authorisation holders and national authorities. It will be fully accessible to the Member States, the European Medicines Agency and the Commission, and also accessible, “to an appropriate extent”, to marketing authorisation holders, health care professionals and the public. Personal data protection will be guaranteed.

Possible review of patient information leaflet and environmental impact

Furthermore, amendments to the EU pharmacovigilance regulation and medicines code directive require the European Commission to report back within two years on how to improve the summary of product characteristics and the package leaflet. If appropriate, the Commission may also present proposals to improve the readability, layout and content of these documents.

The Commission is also asked to report back on the environmental effects of medicinal products, such as pollution of soil or water by pharmaceutical residues, and to assess whether amendments to EU legislation are needed to remedy them.

The new EU pharmacovigilance legislation must be put into effect within 18 months of its publication in the *EU Official Journal*.

Further information at <http://tinyurl.com/38f9eyc>

European Medicines Agency workshop on clinical trials

On 6–7 September 2010 the European Medicines Agency (EMA) held an international workshop with a broad cross section of stakeholders from around the world to discuss a way forward for a global framework of clinical trials that has at its heart the protection of the rights, safety and wellbeing of patients participating in clinical trials anywhere in the world.

The workshop was part of the consultation process on the Agency's 'Reflection Paper on ethical and Good Clinical Practice (GCP) aspects of clinical trials of medicinal products for human use conducted in third countries and submitted in marketing authorisation applications to the EMA'.

Some 170 participants from around fifty countries from the Americas, Asia, Africa and Europe came to the meeting at the Agency in London to provide their feedback on the draft Reflection Paper and discuss international cooperation in this context. They represented patient organisations, health-related non-governmental organisations, clinical trial sponsors, pharmaceutical industry, ethics committees, regulatory authorities from all continents and intergovernmental organisations.

The Reflection Paper responds to the challenges arising from the increasing globalisation of clinical research. In marketing authorisation applications submitted to the Agency between 2005 and 2009, only 38.8% of patients enrolled in pivotal clinical trials received their treatments at clinical trial sites within the European Economic Area. These trials involved more than 44,000 clinical trial sites in 89 countries. The data generated was used to support 347 marketing authorisation applications, as well as some applications for a variation or a line extension of the existing marketing authorisation.

"Wherever in the world we stand, the majority of clinical trials are being conducted somewhere else in the world, under a different regulatory framework and in different cultural settings. However, we all rely on the same trials to make decisions: as regulators, to allow or disallow marketing authorisations, and, as patients and healthcare providers, to use or not to use a medicine", said Fergus Sweeney, Head of Inspections at the European Medicines Agency.

A number of practical proposals and recommendations are set out by the

Reflection Paper. It was considered that EU regulators should only expect or require studies in support of an EU marketing authorisation application that would also be ethically acceptable in the EU. There should not be a different standard applied to trials conducted in the EU compared to those conducted elsewhere.

The discussions over the course of the two-day conference highlighted three main points:

- The need for cooperation and networking between regulatory authorities and also ethics committees involved in the supervision of clinical trials, including capacity building activities.
- The need for greater transparency of clinical trials, including clinical trials registers and the provision of information about ethical and GCP aspects in the European Public Assessment Report (EPAR).
- The need to involve patients early on in the design of protocols to ensure the adequate protection of clinical trials subjects.

Thanking the workshop participants for their contributions, the Agency's Executive Director, Thomas Lönngren, said: "What is needed is a robust framework for the oversight and conduct of clinical trials, no matter where in the world the clinical investigator's sites are located and patients recruited. The Agency is committed to build and extend its relationship with regulators in all parts of the world and with international organisations to work to standards agreed and recognised by all."

A conference report is due to be published in October 2010 at <http://www.ema.europa.eu/>

COUNTRY NEWS

UK: Health minister promises to reopen discussions on opt-out clause for EWTD

Health Secretary, Andrew Lansley, has promised to reopen discussions on the opt-out clause of the European Working Time Directive (EWTD), following concerns that, one year on, the quality of medical training and patient care is being undermined.

The 48-hour week was implemented in August 2009, but has been heavily criticised for compromising patients' continuity of care and junior doctor training.

Conservative Member of Parliament and general practitioner, Dr Sarah Wollaston, asked Mr Lansley about the issue in a Parliamentary question on 7 September stating that "one year on from the implementation of the European Working Time Directive, there is evidence that patient care is suffering. Handovers have been inadequate in some cases, and junior doctors' training time has been reduced. Will [the Minister] reassure me that he will take action to allow some acute specialities to opt out of the European Working Time Directive?"

In reply the health minister said that he was very clear that "we need to take the European Working Time Directive back to the European Union. We need to discuss it again. We need to go to the European Union with the intention of maintaining the opt-out and of giving ourselves, not least in the health context, the flexibility that we lack, so that junior doctors, in particular, have the capacity to undertake the training that they need.

"It is not that we want to go back to the past, when there were excessive hours – 100-hour weeks and so on – but we want junior doctors to be confident that they will get the training that they require in the period allocated for training."

The move follows widespread publicity given to preliminary figures presented to the Medical Training Board in July, showing an apparently high drop-out rate among junior doctors, and which have been largely attributed to the impact of the EWTD.

But the figures, which first became publicly available in mid-August, suggest that the picture is more complex, with 244 of the 4,611 successful applicants rejecting offers of specialty training posts this year and 1,300 of the total 6,000 applicants not being offered any post at all.

Meantime, the British Medical Association has published the fourth in a series of reports drawn from its Cohort Study, which tracks the career progression of 430 medical graduates who qualified in 2006. It shows that junior doctors now spend more time on administration than they do in formal training. The trainees said that most of their time was spent on clinical duties (66%), but 14% of their time was spent carrying out administrative tasks which was greater than the time they spent in formal training in a clinical setting (13%). The study also revealed that three in 20 (15%) doctors felt that they had been asked to undertake tasks that were beyond

their capabilities, with this proportion rising to over one third (36%) for doctors on general practice placements.

Finland: experts meet to finalise new European-wide health survey

On 22 September sixty European health monitoring experts gathered at the National Institute for Health and Welfare (THL) in Helsinki to debate and finalise uniform methods for conducting the European Health Examination Survey, EHES, being piloted in 14 European countries this year and next. Standardised methods are worthy of a common rehearsal as they are vital to guaranteeing the quality and comparability of the results obtained from different countries.

The survey consists of measurements of height, weight, blood pressure, waist circumference and blood sample analysis, as well as a questionnaire on health behaviour. In its piloting phase EHES will be administered only to a limited group of citizens in each country. In the near future a full-scale EHES will be conducted on large randomly selected population samples, giving regular information on the health status and functional capacity of European populations, as well as on the risk levels for common national diseases. The information is vital to the development of health services and for focusing health promotion, political actions and research.

Today only a few European countries conduct national health examination surveys on a regular basis and the comparability of health information between EU countries, regions or socioeconomic groups is poor. EHES is coordinated by THL, Istituto Superiore di Sanità from Italy and Statistics Norway, and is co-funded by European Commission DG Health and Consumers.

More information at www.ehes.info

Report highlights training and safety issues in cosmetic surgery in the UK

A number of concerns in respect of training and safety of cosmetic surgery in the UK have been highlighted in a report published by the National Confidential Enquiry into Patient Outcome and Death. The study cites a 'have a go' attitude in some surgery teams that are prepared to undertake procedures that they rarely perform. Furthermore, while more than 250 clinics offered the ten most common cosmetic procedures, many performed relatively few of these procedures every year. 79% of clinics that carry out common

breast reduction procedures performed fewer than 20 operations in any one year. While some consultants are also working in the public sector and thus performing more procedures, there do not appear to be controls in place to ensure that consultants maintain the skills needed for these procedures.

The report also states that 56% of cosmetic surgery providers do not have all the equipment needed to deliver surgery safely and that 18% do not have a policy to readmit patients who have complications after surgery. The report also raises concerns on the level of training of cosmetic surgeons. Training is only available in sixteen sites.

Another overall concern was the low response rate to the survey questionnaire sent out by the study authors. Only 361 (48%) of all practices took part. In response to the report the Royal College of Surgeons for England said it was "alarming" that so many units had failed to take part in the audit. It said that units that do not contribute to audits to prove their safety should not be practising. In a foreword to the report by the chair of the NCEPOD, Bertie Leigh states that it is 'dispiriting' that the majority of facilities did not include a psychological assessment as part of routine consultation, despite the fact that some individuals seeking cosmetic surgery 'may have unrealistic aspirations and deep-seated problems.' At only 4% of sites is it normal for a patient to see a clinical psychologist

Among the report's conclusions are that regulatory bodies such as the Care Quality Commission should monitor more closely how well sites that offer cosmetic surgery adhere to national requirements for audit and scrutiny. It argues that cosmetic surgery should be subject to the same level of regulation as other branches of surgery and that professional cosmetic surgery bodies should issue practice guidelines on training and experience for cosmetic surgeons and that surgeons should have a certificate of competence to practise in specified procedures. A two stage consent process and routine psychological assessment should be also be standard practice. Regulations should also be introduced to prevent the use of financial inducements to influence the process of informed consent.

The report can be accessed at http://www.ncepod.org.uk/2010report2/downloads/CS_report.pdf

Norway publishes its WHO strategy

Norway has a seat on the Executive Board of the World Health Organization from May 2010 to May 2013. In connection with this, the Norwegian Government has developed a WHO strategy.

"Our membership of the WHO Executive Board gives us the opportunity to exert an influence and to take our share of responsibility for strengthening WHO and helping it to achieve its objectives. We intend to use our board membership to promote WHO's role as the leading normative organization for global health," said Minister of Health and Care Services Anne-Grete Strøm-Erichsen.

Norway's efforts in WHO are to be based on important principles such as respect for human rights, democracy and gender equality. The fight against poverty is a key factor in this respect. The strategy sets out overall objectives and priorities for Norway's engagement and provides the basis for a clear, coherent Norwegian WHO policy. The overall objectives of Norway's efforts will be to:

- fight poverty by helping to achieve the UN Millennium Development Goals
- support and promote the right to health services
- help to reduce the great social inequalities in the world
- help to reduce the burden of disease
- promote women's rights and gender equality

"A strong WHO with a clear mandate and the necessary authority and legitimacy to fulfil it is in the interests of all the member states," said Foreign Minister Jonas Gahr Støre.

During its term of office Norway will seek in particular to:

- improve WHO's budget and management
- promote global health research as the basis for knowledge-based policy
- strengthen health systems, including access to health personnel
- intensify efforts to combat non-communicable diseases
- intensify efforts to combat communicable diseases and improve health security

"We know that poor health is just as much a cause of poverty as a consequence of poverty, and we are aware of the links

between access to health services, good health and prosperity. We can achieve equity and good health for all, but in order to do so we will have to focus on improving health systems and primary health care services," said Minister of the Environment and International Development Erik Solheim.

The strategy is available at

http://www.regjeringen.no/upload/HOD/Dokumenter%20ADA/Norwegian_WHO_Strategy_2010-2013_engelsk.pdf

Ireland: All-island study on Traveller health published

The Department of Health and Children (DOHC) in the Republic of Ireland, together with the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland launched the All Ireland Traveller Health Study report on 2 September in Dublin.

Irish Travellers are a small indigenous minority group that has been part of Irish society for centuries. The population in Ireland has been estimated at 40,129 in 2008: 36,224 in the Republic of Ireland and 3,905 in Northern Ireland. They have a value system, language, customs and traditions, which make them an identifiable group both to themselves and to others. Their distinctive lifestyle and culture, based on a nomadic tradition, sets them apart from the general population. Traveller separateness, partly by choice, enables them to retain their identity as an ethnic group, often in the face of opposition and pressure to conform to general societal norms. Their experience of low social status and exclusion, which can prevent them from participating as equals in society, is often aggravated by hostility and misconceptions of people towards them. There are many positive aspects to Traveller life, not generally appreciated by the wider population, including the positive health benefits of social supports and networks, family ties and kinship, community participation and cross-generational respect.

The study, carried out by the School of Public Health, Physiotherapy and Population Science, University College Dublin under a team led by Professor Cecily Kelleher, expands on research conducted by the Health Research Board in 1987: *Travellers Health Status Study – Vital Statistics of the Travelling People*. The new study examined the health status and health needs of all Travellers living in both Northern Ireland and the Republic of Ireland (ROI). Members of the Traveller

community were trained by UCD to undertake the fieldwork within the Traveller community. This use of peer researchers within the traveller community was a very significant aspect of the study and makes it unique in that the study is for, by and with Travellers. In Northern Ireland, the study was assisted by a traveller support group, An Munia Tober.

Among the many findings of the comprehensive multi-volume report is that Travellers of all ages continue to have much higher mortality rates, with Traveller men now living on average 15 years less than men in the general population and Traveller women living on average 11.5 years less than women in the general population. This is equivalent to the life expectancy of the general population in the 1940s. Deaths from respiratory diseases, cardiovascular diseases and suicides were more markedly increased in Travellers compared to the general population. Traveller infant mortality is estimated at 14.1 per 1,000 live births. This is a small decrease from an estimated rate of 18.1 per 1,000 live births in 1987. Over the same time period the general population infant mortality rate has reduced from 7.4 to 3.9 per 1,000 live births.

There have been improvements in Traveller women's health, notably (1) a narrowing the gap in life expectancy between Traveller and non-Traveller women of 0.4 years, (2) reduction in fertility rates to 2.7 per 1,000 population and (3) uptake of cervical screening at rates higher than the general ROI population and uptake of breast screening at rates similar to the general ROI population. Access to health services is good, with Travellers stating that their access is at least as good as that of the rest of the population. However, the research reports that the health care experience is not as good, with communication cited as a major issue by both Travellers and service providers.

Welcoming the findings of the report, Mary Harney, ROI Minister for Health and Children stated that "Traveller health continues to be a priority and considerable work has already been undertaken in this area. This commitment is reflected in the significant resources allocated to the commissioning of this study. The findings will provide a framework for policy development and practice in relation to Traveller health."

Deputy Chief Medical Officer for Northern Ireland, Dr Liz Mitchell,

speaking at the launch also said, "the publication of this report is a milestone. The challenge now for policy makers will be to examine the findings and the key points highlighted in the study. Along with our partners, in particular the Public Health Agency, we will identify actions to take forward the work needed to address the issues raised. The Traveller community has been recognised as a disadvantaged group and the findings of this study provide a framework to work upon to ensure that Travellers have good access to healthcare services to meet their needs."

The summary of findings highlights a number of key points which the DHSSPS and DOHC will consider and take forward appropriately in conjunction with health and social care bodies and other government departments. Some of the key points include the need for a strategic action plan; a focus on adequate accommodation; a specific focus on men's health; all aspects of mother and child services; and a concerted need to address cause-specific issues for respiratory and cardiovascular disease.

The study can be accessed at

http://www.dohc.ie/publications/traveller_health_study.html

Wales: Major campaign aims to save millions by reducing wasted medicines

More than 250 tons of out of date, surplus and redundant medicines are returned each year to pharmacies and dispensing general practitioner (GP) surgeries across Wales at an estimated cost of £50 million to the National Health Services (NHS). This is in addition to medicines that are probably disposed of incorrectly through household waste.

The new campaign to tackle the issue includes radio adverts and leaflets distributed by GP surgeries and pharmacies. Patients receiving prescription medicines will be handed advice such as ensuring they order the right amounts of medicines and do not stockpile drugs.

The Chief Medical Officer for Wales, Dr Tony Jewell, and the NHS Chief Executive, Paul Williams will also be writing to health professionals to highlight the campaign and remind them of the importance to prescribe only what is necessary to help patients manage their condition to avoid wasted medicines.

Unwanted medicines cannot be reused or recycled and all have to be destroyed in an incinerator. The campaign features the case

of one patient who returned £2,000 worth of unwanted medicines.

Targeting GPs, pharmacists and patients, the campaign gives clear advice on how to:

- prescribe more effectively;
- efficiently order repeat prescriptions;
- understand the side effects and benefits of each medicine; and,
- safely discard old and unused medicines.

A Welsh Assembly Government report published earlier this year, showed that the abolition of prescription charges in Wales in April 2007 has not resulted in a rise in the number of medicines prescribed. This was backed by an independent report by Cardiff University, Bangor University and University of Glamorgan.

Speaking on the launch of the campaign, Health Minister Edwina Hart commented that “millions of pounds worth of waste medicines are being burnt every year. This is money that could be better spent elsewhere in the NHS. Not only is there a significant cost associated with wasted medicines, if people have out-of-date medicines, they are risking their health. If we all adhere to the clear and simple guidelines in this campaign and patients only order what they need, and GPs prescribe effectively, the safety and benefits of such medicine management will be felt directly by all in Wales. We all have a duty to play our part in reducing the amount of unnecessary prescribing of medicines. This will ensure that the NHS is able to spend its money in the most effective way.”

More information at
<http://tinyurl.com/2g49bh3>

New tobacco act aims “to put an end to smoking in Finland”

Finland is the first country to lay down the aim of putting an end to smoking in legislation. The key objective of the Tobacco Act is to put an end to the use of tobacco products in Finland, through restricting the marketing and supply of tobacco products especially in the everyday life of children.

Not only shops but also private individuals will not be allowed to sell or supply tobacco products to anyone under eighteen. According to the Act, even selling one cigarette or fetching a packet of cigarettes from a shop on behalf of a minor should be interpreted as a tobacco selling violation, for which the person can be fined

or sentenced to prison for a maximum of six months. It is also forbidden to offer tobacco without payment to those under eighteen, although this is not punishable.

People under 18 are forbidden from importing and possessing tobacco products. A fine can be imposed on importation of tobacco products, but possession is not punishable under the law. In the future, also sellers of tobacco products must be aged at least 18 years.

There will be a total ban on the sale of snuff in Finland, as the ban on import and sale will be extended to also apply to private persons. Ordering snuff, for example, via the Internet will also be forbidden. A maximum of 30 packets, each containing 50 grams snuff, may however be imported for one’s own use. It will be forbidden to import snuff as a gift.

The prohibitions against smoking will be extended, for example, in facilities used by children and young people, the joint facilities of apartment house companies, events organised outdoors and hotel rooms.

In the future, tobacco products or their trademarks may not be displayed in retail sale facilities. Customers can at their request be shown a catalogue or be given a printed list of the prices of the tobacco products on sale. Furthermore, the sale of tobacco products from vending machines will be forbidden. The Medicines Act is amended to the effect that nicotine preparations can be sold in restaurants as well as in shops, kiosks and gas stations.

The Act enters into force on 1 October 2010. The prohibition on the display of tobacco products, as well as the restrictions on smoking in hotel rooms, will not enter into force until the start of 2012. Vending machines for tobacco products will be prohibited from the beginning of 2015.

More information at
http://www.stm.fi/en/welfare/substance_abuse/tobacco

Romanian health care “on verge of collapse”

Romania spends less on health care than any other country in the European Union, and because of the worst recession on record, it is planning to spend even less. This chronic underfunding and a brain-drain of medical staff could be putting patients at risk. Moreover conditions for International Monetary Fund support for the country include a 25% reduction in the salaries of doctors. Since 2007, almost 5,000

doctors – one in ten – have left Romania for Western Europe, where they can earn 10 times more. These are some of the conclusions of a BBC Radio 4 investigation for the *Crossing Continents* programme.

The programme notes that earlier this year the university hospital in Bucharest stated that it had just €4 in the bank, although it has recovered since. Across the country doctors are complaining of a lack of X-ray film and surgical thread. Operations are postponed indefinitely. Patients are being asked to pay for their own bandages and hospital infections are spreading at alarming rates.

Oana Lungescu, the BBC European Affairs Correspondent, returned to her homeland to find out how ordinary citizens are coping with the situation. She highlighted the case of Cristian Grigore, a nine year old boy who died in hospital in Slatina four days after breaking his arm in May, apparently because of a severe infection he caught in the hospital. Subsequently the management of the hospital and the doctors who treated Cristian were sacked. Doctor Romeo Stanculescu, the new medical director, of the hospital told the BBC that he thinks “this child was a victim of the system. But we are the system and all our failings are reflected in such cases.”

Speaking to the programme Health Minister Atila Cseke said he “wouldn’t describe [the current financial problems] as a collapse, but as a very difficult moment, a crossroads in 2010, we must find the right turning point that will lead us out of these problems.”

In July, Minister Cseke transferred control of most hospitals over to local councils, in the hope that it will improve management and inject more cash into hospitals like the one in Slatina.

The programme also highlights wider public health concerns, given that Romania has the highest rate of tuberculosis infection in the European Union. Doctor Adrian Mocanu, manager of the new UN Global Fund supported Institute of Lung Disease said that “we can do what we can do with our specialists, but we must cooperate with all the countries in the EU,” he said. “Since Romania became a part of the EU, tuberculosis is not only our problem, it is a European problem”, he added.

More information and access to the programme at <http://www.bbc.co.uk/news/world-europe-10914678>

News in Brief

Trends in quality of life 2003–2009

The European Foundation for the Improvement of Living and Working Conditions has published a summary of changes in quality of life between 2003 and 2009. Policies to boost well-being are increasingly important in EU debate. It is acknowledged that while economic indicators such as Gross Domestic Product (GDP) are important in assessing the level of well-being in a country, they are not sufficient. More and more, it is argued that public policy should be assessed in terms of how it directly promotes citizens' welfare, taking in considerations of social and environmental, as well as economic, conditions.

The summary can be accessed at <http://www.eurofound.europa.eu/publications/htmlfiles/ef1047.htm>

Netherlands: quit smoking programmes' covered under standard package of insured treatment

The Dutch Minister of Health, Welfare and Sports, Ab Klink, has agreed that from January 2011 the costs of programmes that help people to quit smoking will be covered by the Dutch health insurance system. Research has shown that by providing compensation for such programmes, people are more willing to make use of them and thus to ask for support and help. It also results in higher success rates to quit smoking and it has proven to be highly cost-effective in the long term. This decision may also help to tackle existing health inequalities between different socio-economic groups.

More information in Dutch at http://nphf.nl/footer/fm/File/20100728_persbericht_vergoeding_smr.pdf

New guidelines on weight management before, during and after pregnancy

Women should be encouraged to achieve a healthy weight before they become pregnant and advised that there is no need to 'eat for two' when pregnant. These are just two of the recommendations included in new public health guidance published by the National Institute for Health and Clinical Excellence (NICE) in England on dietary and physical activity interventions for

weight management before, during and after pregnancy.

Health professionals can help women to understand the health risks of being overweight or obese during pregnancy and the importance of achieving a healthy weight prior to pregnancy, but also advise them not to try to lose weight while they are pregnant.

The new guidance is aimed at primary care doctors, obstetricians, midwives, health visitors, dieticians, community pharmacists and all those working in antenatal and postnatal services and children's centres. The recommendations cover four key areas: preparing for pregnancy; pregnant women and women who may become pregnant – particularly those with a Body Mass Index over 30kg/m²; and supporting women following childbirth.

The guidance is available at <http://guidance.nice.org.uk/PH27>

Open Health Forum 2010 Conference – documents now available

Documents from the Open Health Forum 2010, held in Brussels from 29 to 30 June, have now been made available online. These include workshop abstracts, workshop programmes, workshop recommendations and the conference final resolution, the opening speech of Commissioner Dalli, presentations and outcomes from conference workshops and the conference video files.

More information at http://ec.europa.eu/health/interest_groups/en_health_forum/open_forum/2010/

Funding arrangements for EU level voluntary and not-for-profit public health activities

The voluntary sector has an important role to play in public health care sectors across Europe, but public funding can be scarce, particularly for cross-border activities. Therefore a feasibility study was undertaken by the Danish COWI group on behalf of DG Health and Consumers to explore options to establish one or more pan-European trusts to receive donations for public health activities.

The analysis found that there is no legislation at EU level relating to the regulation and governance of voluntary

and non-profit organisations. Three options for a voluntary and not for profit public health blind trust were set out: a blind trust fully under the control of the European Commission (EC); a blind trust fully independent of the EC; a blind trust with satellite offices in EU Member States which can be partly independent and under the direction of the EC.

The feasibility study is available at http://ec.europa.eu/health/interest_groups/docs/blindtrust_frep_en.pdf

WHO and the IOC team up to improve healthy lifestyles

Physical inactivity is ranked as the fourth leading risk factor for all deaths globally, contributing to 1.9 million deaths each year. Thus the World Health Organization and the International Olympic Committee signed a memorandum of understanding on 21 July in Lausanne to promote healthy lifestyle choices, including physical activity, sports for all, Tobacco Free Olympic Games and the prevention of childhood obesity.

They will work together at both the international and country level to promote activities and policy choices to help people reduce their risk of non-communicable diseases such as cardiovascular disease, cancers, and diabetes. The two organisations agreed to establish a follow-up group that will meet at least annually. One focus will be on joint action between WHO country offices and the 205 National Olympic Committees.

Past initiatives have included the implementation of a tobacco-free policy at Olympic Games venues and health promotion campaigns targeting the local population of the Olympic host cities.

More information at <http://www.olympic.org/en/content/Media/?articleId=94731>

Additional materials supplied by

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

European
Observatory 
on Health Systems and Policies

LSE Health

ISSN 1356-1030