Eurohealth

RESEARCH • DEBATE • POLICY • NEWS

Volume 16 Number 3, 2010

Measuring and managing performance

Improving performance in the English NHS

The performance paradigm: potential, pitfalls and prospects

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COMMENT

Managing performance: what do we know?

If there was ever a time for putting an emphasis on improving performance management then surely this is it. At a time when economic resources are tight but Europeans continue to demand an ever more personalised approach to health care, it is of critical importance that systems operate as cost-effectively as possible. They also need to maintain high quality standards and be flexible enough to respond to changing population need. Even more fundamentally, health systems need to be held accountable for decisions that are made.

Better performance monitoring mechanisms can potentially help with these issues, but what has happened in practice? What do we know about how well they work? This issue of *Eurohealth* focuses on this issue. It features articles that originate from a seminar hosted by LSE Health and the NHS Confederation and funded by the Higher Education Innovation Fund in April 2010.

The situation is complex. Gwyn Bevan in looking at different motivations to respond to performance assessment measures finds that systems that potentially have an impact on the reputation of service providers, for example by ranking them publicly, are more likely to generate incentives for poorly performing providers to make improvements. A reliance on altruism or market mechanisms is less likely to be effective. Chris Ham looking at experience in England argues that the introduction of targets and national standards has indeed contributed to performance improvement in the English NHS.

Both Mark Exworthy and Niek Klazinga focus on what is measured. Exworthy points out that with all the competing pressures on providers, it is important for regulators, managers and other users of data to agree on what will be measured and how data will be used. He further stresses the importance of knowing what does not get measured and how this affects performance. Klazinga also argues that when utilised improperly data from performance management can result in sub-optimal service delivery.

Clearly no system of performance assessment will ever be perfect, but we need to learn more from systems that have been implemented. What may be lacking to date is sufficient consistency in health policy over time to fully evaluate the impact of different approaches.

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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.

Design and Production: Westminster European
Printing: Optichrome Ltd

ISSN 1356-1030

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Eurohealth
Volume 16 Number 3

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User fees in the Czech Republic:

The continuing story of a divisive tool

Ewout van Ginneken, Alena Ottichova and Matthew Gaskins

Summary: The introduction of user fees and the ongoing discussions on their continuation have caused a great deal of debate in the Czech Parliament, media and general public. Although evidence from the first year after their introduction suggests a decrease in resource utilisation, second-year data already show a slight increase for some important indicators. Measuring the effectiveness of user fees is notoriously difficult, but in the Czech Republic this challenge has been further compounded by efforts in some regions to tap into regional budgets to reimburse patients for user fees, undermining the mechanisms on which the system was based.

Key words: health reform, cost sharing, user fees, Czech Republic

User fees have become a very sensitive political issue in the Czech Republic, sparking debate in Parliament, the media and the general public. Their introduction and the ongoing discussions on their continuation have played a key role during the last three regional and national elections and were widely seen as a major contributor to the collapse of Prime Minister Mirek Topolánek's centre-right coalition in spring 2009.

This seems quite remarkable given that private households' out-of-pocket payment on health as a percentage of total health expenditure in the Czech Republic has been relatively modest from an international perspective. In 2008, this percentage stood at 13.7% (compared to 13.2% in 2007, the year before user fees were introduced), which is slightly lower than the EU15 average of 14.5% and substantially lower than the percentages for Hungary (25.2%), Poland (24.2%) and Slovakia (26.2%) for that year.[1] In the present review, we describe the introduction of user fees, the political controversy surrounding them, and their impact on health care utilisation in the Czech Republic.

Background

Since 1993, the Czech Republic has had a system of social health insurance (SHI) based on compulsory membership in one of a range of health insurance funds. Eligible residents may freely choose among these and among health care providers. SHI contributions are mandatory and calculated as a percentage of wages. Compared to Western Europe, the health system is characterised by relatively low total health care expenditure as a share of gross domestic product (GDP), low out-of-pocket payments and plentiful human resources, albeit with some substantial regional disparities.

The population enjoys virtually universal coverage and a broad range of benefits. Some important health indicators are better than the EU15 and EU27 averages (such as mortality due to respiratory disease and infant mortality rates). On the other hand, the standardised death rates for diseases of the circulatory system and malignant neoplasms are well above the EU27 average. A range of health care utilisation rates, such as outpatient contacts and average length of stay in acute care hospitals, are also above this average. Overall, there is substantial potential in the Czech Republic for efficiency gains and improved health outcomes.[2] This was recognised by the centre-right coalition led by Prime Minister Mirek Topolánek's Civic Democratic Party (ODS) from 2007 to 2009, forming the rationale for the introduction of the user fees in 2008.

Prior to 2008, inpatient and outpatient health services were free of charge at the point of use, with the exception of some co-payments for prescription pharmaceuticals and medical aids. From the perspective of the centre-right coalition, this had in many cases led to high utilisation rates and the inappropriate use of scarce health resources. Indeed, the number of outpatient contacts per person in the Czech Republic (15.0 per year) was

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the highest in the WHO European Region in 2006.[1] Moreover, an estimated CZK4–10 billion (€144–360 million) worth of prescribed pharmaceuticals were being wasted or went unused each year.[2] The chief aim of user fees was to reduce over-consumption and inefficiencies in the health sector by encouraging people to use health services responsibly. The Public Budgets Stabilisation Act, passed in August 2007, introduced small user fees for a variety of health services and changed the system for setting prices and reimbursement rates for pharmaceuticals.

Introducing the user fees

A range of user fees were introduced on 1 January 2008, amounting to flat rates of CZK30 (€1.20) per doctor visit, CZK60 (€2.40) per hospital day, CZK90 (€3.60) per use of ambulatory services outside of standard office hours, and CZK30 (€1.20) for prescription pharmaceuticals.

Some vulnerable groups were exempted from the fees, including people living below the poverty line, neonates, chronically ill children, pregnant women, patients with infectious diseases, organ and tissue donors, and individuals receiving preventive services. Moreover, an annual ceiling of CZK5,000 (€200) per insured individual was established for selected user fees (excluding user fees for hospital stays and the use of ambulatory services outside of standard office hours), as well as for co-payments on prescription pharmaceuticals with a price exceeding the reference price in a particular pharmaceutical group.

As early as March 2008, user fees began to play a major role in the campaigns for the regional and Senate elections planned for October that year. On 28 March 2008, the Chamber of Deputies for the first time rejected the Social Democrats' (ČSSD) proposal to repeal user fees. The ČSSD then pledged to eliminate user fees in regional hospitals and pharmacies if they regained power. Furthermore, on 28 May 2008 the Czech constitutional court rejected the ČSSD's claim that the user fees were unconstitutional.[3]

A large portion of the population opposed the user charges, and the ČSSD could be assured of their backing. Indeed, many people in the Czech Republic were not bothered by the amount they had to pay (that is, €1.20–3.60), but by the principle of having to pay user fees, which went against the idea of free health care delivery – one of the main tenets of the Czech health care system.[4] Furthermore, the sensitive political nature of the subject and negative media coverage may have led to general uncertainty about the new system among insured individuals. This was reflected in a public opinion poll in which a third of respondents stated at the time that they did not know the purpose of the user fees nor feel that they were necessary.[5]

The unrest begins

It thus came as no surprise that the results of the regional and Senate elections in October 2008 were a disaster for the governing centre-right coalition. Thirteen of the fourteen regions were lost to the opposition. The aftermath of the autumn elections was chaotic. In December 2008, members of the ČSSD voted in the Chamber of Deputies in favour of abolishing user fees for health services altogether. This was rejected by the Senate in January 2009, which instead preferred to reduce the burden on the young and the elderly.

The political landscape remained volatile. In March 2009, in the middle of the Czech Presidency of the European Union, the centre-right coalition led by Mirek Topolánek lost a vote of confidence. An independent, Jan Fischer, was selected to become the Prime Minister of a caretaker government in April. His government, nominated by both major parties (the ODS and the ČSSD), was inaugurated on 8 May 2009, and new elections were scheduled for May 2010. Again, the ČSSD pledged to repeal user fees if they regained power in the Chamber of Deputies in the 2010 elections.

Under enormous political pressure, the new caretaker government adjusted the user fee system in April 2009. Although the annual ceiling had been reached by only approximately 0.2% of insured individuals in 2008,[2] the ceiling was lowered. As of 1 April 2009, a new annual ceiling of CZK2,500 (€100) was set for persons under 18 years or over 65 years of age; moreover, those under 18 years were also exempted from user fees for doctor visits. In June 2009, the Czech Senate rejected new efforts by the Chamber of Deputies to abolish user fees.

The regions revolt

In the meantime, the regions, which by February 2009 were all governed by the ČSSD with the exception of Prague, had decided on the 1st of that month to pay the fees from their own budgets on behalf of patients. To achieve this end, the regions implemented their own reimbursement systems, leading to a different system in almost every region. In several regions, patients were automatically reimbursed for user fees, while in other regions patients had to file a written request for reimbursement.

Since January 2009, great uncertainty has prevailed. For example, some public hospital pharmacies have tapped into regional budgets to reimburse patients for the user fees, whereas privately owned pharmacies have not. In some cases, actions likes these have been prohibited by the courts on the grounds of unfair competition after complaints made by the private pharmacies.[6] Furthermore, the Czech Ministry of Health began an administrative proceeding against four regions in January 2010, and nine sickness funds protested openly against regional hospitals and their pharmacies that had not been collecting user fees.[7]

As a countermeasure, the ČSSD launched a 'struggle against fees' campaign and filed two complaints with the Constitutional Court in February 2010.[8] The European Commission voiced the informal view that the current system, in which regional authorities pay the fees, is discriminatory and, if formally investigated, might be deemed as conflicting with European state-aid rules.[9] Another problem is the costs: reimbursing patients for the fees places a great burden on regional budgets. After one year, approximately two thirds of patients in regions governed by the ČSSD took advantage of user-fee reimbursement, leading to a total cost of CZK478 million (€19 million).[10]

Have the user fees worked?

Data from the Czech Institute of Health Information and Statistics show that the number of visits to ambulatory specialists fell by 17% in 2008.[11] The decrease in the use of ambulatory care services outside of standard office hours was even more pronounced at 41%; importantly, this was not accompanied by an increase in the use of emergency services.

Looking at hospitalisations in 2008, the number of hospital days decreased by 4.4% in acute care hospitals and by 3.2% in non-acute care hospitals[11] even though the number of hospitalised patients increased by 3% and 5%, respectively, during the same period.[2] This suggests a reduction in the average length of stay, which is confirmed by Health for All (HFA) data, which show a reduction of 0.6

days (to an average of 7.4 days) between 2006 and 2008 for all hospitals observed.[1] It should be noted, however, that a decrease in the average length of stay was already visible in 2007, the year prior to the introduction of user fees.

Finally, the number of prescribed pharmaceuticals and the number of unit packs of prescribed pharmaceuticals fell by 26.7% and 7.4%, respectively. At the same time, SHI expenditure on prescribed pharmaceuticals rose by 8.3%, indicating a shift in SHI reimbursement from less expensive, everyday pharmaceuticals to more costly pharmaceutical treatments and bigger unit packs.[11]

For 2009, utilisation data for health services show a moderate reversal of the trend seen in 2008. For example, the number of prescribed pharmaceuticals increased by 6%.[12] Although the number of unit packs of prescribed pharmaceuticals fell by 1.8%, expenditure on prescribed pharmaceuticals rose by 9.6%.[13] The average number of hospital bed days increased slightly, by 1.3 days to 255.5 days, while the average length of stay remained at 7.4 days.[14] Also, the number of visits to ambulatory specialists and the use of ambulatory care services outside of standard office hours in 2009 increased by 9.2% and 10.1%, respectively.[13]

The 2009 statistics may reflect the effect of the reimbursement of user fees by the regions, which likely undermines the effectiveness of the system. It should also be noted, however, that measuring both the short- and long-term effects of user fees is notoriously difficult. Even decreasing utilisation rates may give an incomplete picture of the cost-saving potential of user fees, with costs arising elsewhere in the system. For example, patients may forgo necessary treatment or fail to adhere to treatment, which could lead to the need for costlier treatments at a later time. International evidence on the effectiveness of user fees, especially over the long term, is inconclusive.[15,16] More data will be needed in the coming years to make useful interpretations about the effectiveness of the measures taken in the Czech Republic.

Latest developments: the unrest continues

Against all expectations, the ČSSD won the May 2010 elections of the Chamber of Deputies with only 22% of the vote, followed closely by the ODS with 20%, the newly founded TOP 09 party with an unexpected share of 16.7%, the Communists (KSČM) with 11.3% and the newly established Public Affairs party (VV) with 10.9% of the vote. The success of TOP 09 and VV was unparalleled in the political history of the Czech Republic. The elections were a political earthquake in which the established parties suffered heavy losses. As a result, another centre-right coalition was formed, this time with the ODS, TOP 09 and VV.

Opinions about user fees remain divided. It seems unlikely that the new centre-right coalition will abolish or significantly reform the user fee system. On the contrary, the new coalition inherited a health system affected by the financial crisis and with a large deficit (CZK 10 billion in 2009, €400 million) and is currently looking at ways to increase out-of-pocket payments and the responsibility of patients to share in costs.[17] The opposition ČSSD and Communist Party continue to call for the repeal of the user fees. Since June 2010, health facilities in some regions have abolished the reimbursement of user fees to retain more resources and to lessen their administrative burden.[18]

Conclusion

User fees remain a divisive issue in Czech politics. Although out-of-pocket spending is still low from an international perspective, the concept of having to pay for something that had been historically provided for free has led to a great deal of public debate and played a large role in several elections since 2008. The introduction of user fees is widely thought to have contributed to a change in political leadership, which if true shows the ability of this relatively small measure to pack a big punch. Other countries contemplating the introduction or expansion of user fees might want to consider the Czech experience.

Good evidence is essential when deliberating whether to introduce user fees. Although evidence from the first year after the fees were introduced suggests a decrease in resource utilisation, the second year data already show a slight increase for some important indicators. When interpreting these data, however, it is important to keep in mind that the mechanisms on which the system was based were undermined by the regions that chose to reimburse patients for the user fees from the regional budgets. Several more years of data are needed before any definitive conclusions can be drawn on the impact of user fees in the Czech Republic.

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Providing a solid evidence base for policy makers: ECHI initiative

Marieke Verschuuren, Pieter Kramers and Gudrun Kr Gudfinnsdottir and Arpo Aromaa

Summary: With the aim of providing a solid evidence base for policy making, the European Commission initiated a European public health monitoring policy a decade ago. The European Community Health Indicators (ECHI) projects have played a central role in the development of this policy. ECHI currently is in its fourth phase (Joint Action for ECHIM). Twenty-four EU Member States are engaged in an effort to implement the ECHI shortlist (88 indicators). One of the major challenges will be to find sustainable solutions for public health monitoring, both at Member State and at European level.

Key words: evidence-based policy making, public health monitoring, indicators, European Union.

The need for international public health comparisons

The gap between the Netherlands and the European Union (EU) average is widening for rates of female cancer mortality. The Netherlands has higher than average rates of smoking while relatively few mothers breastfeed their babies. The 30-day in-hospital fatality rate for stroke in the Netherlands is high compared to other European countries. On the other hand, injury-related mortality is very low in the Netherlands, and it is among the best scoring countries when looking at health determinants such as levels of physical activity and overweight.

These are some of the main conclusions of the report *Dare to Compare! Benchmarking Dutch health with the European Community Health Indicators (ECHI)*, written by the Dutch Public Health Institute (RIVM) in 2008.[1] The indicator information presented in the report raises questions; why do so many Dutch people smoke? Are the anti-smoke policies in countries with a lower smoking rate different than the policies applied in the Netherlands? Are there other factors, such as cultural differences, which may explain the different smoking rates in the EU countries? The same kind of questions may be asked of the indicators for which the Netherlands is doing relatively well.

These examples illustrate the usefulness and necessity of international public health monitoring by means of indicators for policy making. Through international benchmarks, authorities may be made aware of good practice examples in other countries. Moreover, this international orientation may draw attention to some of the causes of avoidable health inequalities between European citizens, achievable health gains and the efficient use of

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resources. That such an approach is successful is shown by figures from Finland that reflect a remarkable decline in the rates of many cancers, as well as a large reduction in traffic accidents and cardiovascular deaths, which were among the highest in Europe in the 1970s.

The ECHI initiative

Aiming to meet policy makers' need for comparable international public health information, more than a decade ago the European Commission initiated a European public health monitoring policy, starting with the EU Health Monitoring Programme, which ran from 1997 until 2002. Within this Programme, many projects were involved in indicator development. The ECHI-I project acquired a key role, collecting proposals for indicator definitions from all of these projects. These proposals were arranged systematically in the so-called ECHI long list, comprising at that time more than 200 indicators.[2]

It was clearly not feasible to implement all indicators on the ECHI long list at once. Therefore, DG SANCO and the ECHI experts decided to create a shortlist for priority implementation. Further refinement of the indicator selection was coordinated by the ECHI-II project, and carried out in close cooperation with DG SANCO and its working parties and committees under the Health Information Strand. The next phase, under the Public Health Programme 2003–2008, was coordinated by the ECHIM project (M stands for Monitoring). ECHIM identified national health information experts, and started mapping the availability of data in the EU Member States for calculating the shortlist indicators. Indicator metadata (definitions, calculation methods, preferred data sources etc) was documented in a structured way in ECHI Documentation Sheets.[3]

In 2007 the EU Health Strategy White Paper *Together for Health* was adopted, stating as one of its actions the implementation of a European ECHI system.[4] In 2008 the European Commission therefore called for a Joint Action for ECHIM. This new financing mechanism implies a direct invitation from the Commission to the Member States to present a proposal. Public health institutes from five countries took the lead in preparing the proposal, and twenty-four Member States in total gave a declaration of intent to participate in the Joint Action for ECHIM. It started on 1 January 2009 and has a three year duration.[5] (See Box for an overview of the Joint Action for ECHIM partners and participating countries).

Box: Joint Action for ECHIM: participating countries, Core Group members and project partners

Member States

1	Belgium	(Core group member)
2	Bulgaria	
3	Czech Republic	(Core group member)
4	Cyprus	
5	Denmark	
6	Estonia	(Core group member)
7	Finland	(Core group member and project partner)
8	France	
9	Germany	(Core group member and project partner)
10	Greece	(Core group member)
11	Hungary	
12	Ireland	(Core group member)
13	Italy	(Core group member and project partner)
14	Latvia	
15	Lithuania	(Core group member and project partner)
16	Luxembourg	
17	Malta	
18	Netherlands	(Core group member and project partner)
19	Poland	
20	Portugal	
21	Slovenia	(Core group member)
22	Spain	(Core group member)
23	Sweden	(Core group member)
24	United Kingdom	(Core group member)

Other countries

25	Iceland
26	Norway
27	Moldova

Other Core Group Members

DG SANCO
DG EUROSTAT
WHO-Europe

The ECHI shortlist

The following set of criteria was applied for selecting indicators in the ECHI long and subsequent shortlists:

- The list should cover the entire public health field, following the commonly applied structure of the well known Lalonde model; health status, determinants of health, health interventions/health services, and socioeconomic and demographic factors.[6]
- The indicators should serve user needs, meaning that they should support potential policy action, both at EU and Member State level.
- Existing indicator systems, such as the WHO-Health for All (WHO-HFA) and Organisation for Economic Co-operation and Development (OECD) indicators, should be made use of as much as possible, but there is also room for innovation.
- Adopt viewpoint of the general public health official ('cockpit') as a frame of reference.

– Focus on large public health problems, including health inequalities.
– Focus on the greatest potential for effective policy action.

Applying these criteria resulted in a selection of about 80 indicators. This so-called ECHI shortlist was approved in 2005 by the European Commission and the Network of Competent Authorities of the Health Information Strand under the then Public Health Programme. Under the ECHIM project an update of the shortlist was carried out. The most important change was the addition of seven new indicators which represented emerging policy information needs, such as heat wave related mortality and selected communicable diseases. The current version of the shortlist contains 88 indicators.[7]

The shortlist is divided into an implementation section and a development section. The first section holds the indicators for which detailed definitions and calculation methods have been developed, and for which data are either available in existing international databases or in a reasonable number of EU Members States at national level. The development section holds the indicators covering those areas of public health for which there is a need for data, but for which no common indicator methodologies and data collections exist in most EU Member States. The ECHIM experts and the European Commission are dedicated to facilitating further work on the development section being placed on the political agenda.

Added value and specific features ECHI compared with existing indicator systems

What is the added value of the ECHI initiative? After all, there are several international indicator databases containing public health data, such as WHO-HFA, OECD and Eurostat. Furthermore, there are several European Agencies collecting data for their specific areas of practice, for example, the European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA), the European Centre for Disease Prevention and Control (ECDC) and the European Environmental Agency (EEA).

The ECHI shortlist is a practical public health policy tool for general use. A theoretical framework was applied for the selection of indicators, leading to the ECHI shortlist representing in a very focused yet comprehensive way the public health topics which are most relevant for policy makers. This distinguishes the ECHI shortlist from many other existing data collection initiatives, which may either apply a broader or more limited orientation.

The ECHI shortlist represents a carefully considered selection of available public health data, which was supplemented by a number of indicators covering important public health issues currently not (adequately) described by existing data collections. This explicit attention on health information gaps also distinguishes ECHI from other health data initiatives.

The ECHI shortlist was developed through intense cooperation with a large number of European health information projects and Member State experts, which has resulted in the incorporation of innovative results. This holds especially true in those areas for which currently no comparable data are readily and regularly available. Examples are the attack rates of acute myocardial infarction and stroke, perinatal health and health promotion.

ECHI also focuses on obtaining data from the Member States for the shortlist indicators for relevant subgroups, most importantly subgroups defined by socio-economic status. It is widely acknowledged that there is an urgent need for public health data stratified by socio-economic status. Yet, adequate data to a large extent are still lacking. Several initia tives have started in recent years to overcome this lack of information, one of the most important being the social protection and social inclusion indicators which are being developed through the Open Method of Coordination (OMC).[8] ECHI will build on the work already carried out in this field, in particular the OMC work.

A final characteristic of the ECHI initiative is the strong focus on communication aimed at the dissemination of health information to policy makers - as a first target audience - and other user groups. One aspect of this communication within the current Joint Action will be the dissemination of meta-data, explaining in a structured and clarifying way to what extent the data are valid and comparable. For indicator information to be used as an evidence base for decision making, this kind of information is essential.

Synergy with Eurostat and other Commission activities

As the Statistical Office of the European Communities, Eurostat is the main data provider for ECHI.[7] From the onset of the ECHI initiative, Eurostat has been involved in the developmental work. The main result of this ECHI-Eurostat cooperation is the embedding of the ECHI shortlist in the new Regulation on Community statistics on public health and health and safety at work, which states that its aim is to obtain "…data for structural indicators, sustainable development indicators and European Community Health Indicators (ECHI), as well as for the other sets of indicators which it is necessary to develop for the purpose of monitoring Community actions in the fields of public health and health and safety at work".[9]

The above-mentioned Regulation provides a general framework for the development of several detailed implementing acts. One of the first implementing acts to be realised will be on the European Health Interview Survey (EHIS), which contains many topics from the ECHI shortlist. Currently, comparable Health Interview Survey (HIS) data at European level are scarce due to variations in methodology. Some European surveys, such as the Labour Force Survey (LFS) and the Survey on Income and Living Conditions (SILC) do contain several questions on health or on health related topics. A harmonised European Health Interview Survey therefore will be an important step forward for ECHI and thus for European public health monitoring.

Another important development initiated by the Commission is the European Health Examination Survey (EHES), starting with the FEHES project in 2003, which examined the feasibility of carrying out an EHES in the EU Member States.[10] In 2009 the Commission called for a Joint Action for the implementation of a pilot European Health Examination Survey, and 14 countries responded to this call. In future, when EHES will be fully implemented, this survey will be an important data source for ECHI.

Towards implementation of the ECHI shortlist

During the ECHI-I and ECHI-II projects, the focus was on the development and selection of indicators. The ECHIM project prepared for the process of implementation of the ECHI shortlist, by assessing the availability of data for the ECHI shortlist indicators in the Member States and by establishing a network of national health information experts.[3] With

the Joint Action for ECHIM the work now moves into a new phase; the phase of actual implementation at Member State level.

Implementation of the ECHI shortlist indicators entails putting the indicators into practical use in the Member States by:

- introducing the indicators to national (and possibly regional/local) administrators and decision makers
- modifying existing data sources, applying new calculation methods and creating new data sources in order to improve national data availability and quality
- setting up a sustainable data flow from Member States to a central ECHI database
- setting up a presentation system, integrating the ECHI shortlist with existing national health reporting systems (if existing)
- analysing and interpreting the results for health policy and planning

General guidelines for implementation have been developed by the ECHIM experts to support the national contacts in formulating feasible short- and long-term national implementation plans. A central element in the national implementation plans is the formation of national implementation teams, which should consist of representatives of the major stakeholders in health information. At the time of writing of this paper (September 2010), most of the countries represented in the ECHIM Core Group, as well as some non-Core Group countries, have started forming their national implementation teams and drafting their national implementation plans. The remaining countries participating in the Joint Action for ECHIM will do so in the coming months.

Within the Joint Action a system to facilitate data flow from the Member States to a central ECHI database will be tested. This central database will be hosted by the European Commission and is linked to a European level web-based data presentation system.[11] The ECHIM Core Group members, who are experts in the field of public health statistics and monitoring, are working together with the Commission to ensure that the data presentations will meet basic quality standards for presenting international public health comparisons to a policy maker audience. These basic requirements are reflected in a data presentation pilot, which was developed by the ECHIM experts.[7] The results of this pilot serve as an example for other (inter)national ECHI data presentation initiatives.

Challenges ahead

Successful implementation of the ECHI indicators requires close cooperation between the European Commission, the ECHIM experts and Member States. It is also clear that future development of the ECHI system is dependent on policy support and sustainable financing.

Regarding the cooperation between the different stakeholders, the Directorate General Health and Consumers (DG SANCO) of the European Commission organised an 'extended ECHIM core group' meeting in February 2010, in which representatives from all Member States have had the opportunity to participate. This has been an essential step forward for the implementation process. Furthermore, DG SANCO's Expert Group on Health Information (former Health Information Committee, HIC) can play a key role as the principle advisory committee for the European Commission on health information.

DG SANCO mainly funds activities through projects or tenders. A Joint Action is slightly different as a financing mechanism as it involves a more explicit commitment from Member State authorities. However, it too is a temporary construction. Health information systems are not static; they need to be constantly developed in order to reflect current policy needs and advancing scientific insights. It is therefore important that consideration already be given to possible venues for the continuation of work on the ECHI indicators to ensure sustainability of developmental work as well as in implementation.

National health information systems form the basis of the European ECHI monitoring system. The involvement of Member States therefore is a prerequisite to success. As illustrated at the beginning of this paper, national health information systems producing relevant and comparable indicators are of direct use to Member States. The financial burden of the ECHI monitoring system should therefore not be carried by the European Commission alone. National authorities need to recognise the importance of basic health data collection for a well functioning health system. Working towards a long-term commitment to valid and comparable health monitoring is a challenge for Member States, particularly in these days of financial restrictions.

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Private sector providers in England:

The implications of Independent Sector Treatment Centres

Nidhi Vaid

Summary: Over the last few years, private sector providers have begun to have an increasing role in the NHS. This article outlines the advantages and disadvantages of private sector involvement following the introduction of one such initiative, the independent sector treatment centre. It further discusses how we should learn from the mistakes made and apply what we have learnt to the proposed government reforms that have been outlined in the recent White Paper "Equity and Excellence: Liberating the NHS". There are certainly potential benefits to be gained from private sector involvement; however, we must take care not to develop a segregated, two-tier NHS that disregards the principles on which it was originally founded.

Key words: NHS, private, commissioning, reforms, ISTCs

The National Health Service (NHS) is the publicly-funded health care system in the United Kingdom. In 2002, there were already sixteen NHS-run treatment centres. They vary in the scope of care provided but centre mainly on the provision of elective surgery, together with diagnostic and outpatient services. As part of reforms in the first years of the previous Labour government, bids for such services were invited from the private sector. These new Independent Sector Treatment Centres (ISTCs), while privately owned, have contracts to treat NHS patients.

The ISTCs were designed with several objectives in mind. Their main focus was to reduce waiting lists, thus moving towards the 'patient centred' model proposed in the *2000 NHS Plan*. Additional proposed benefits included encouragement of reform within the NHS by providing competition, facilitating innovation and reducing spot purchasing prices*, thus improving value for money.

There have been two phases or 'waves' of ISTCs procured by the Department of Health (DH) throughout England and Scotland, with the first ISTC opening in 2003. This was followed by further procurement with the first of the second wave opened in 2007. The locations for the new ISTCs were identified by local service commissioners. The criteria for an ISTC was either a lack of capacity or long waiting times. In the first wave 25 fixed site and two mobile site ISTCs were opened. The second wave was originally intended to develop 24 schemes but this was subsequently reduced to just ten with the DH stating that the extra capacity was no longer required.[1,2] This article aims to discuss the implication of contracting out clinical services to the private sector, using the introduction of ISTCs in the English health care system as an example.

What are the implications for health care professionals?

During the first wave, ISTCs were unable to employ staff who had worked in the NHS in the preceding six months. This resulted in ISTCs being staffed largely by overseas doctors. This led to questions regarding not only the quality of their training, but also their suitability to be working with potentially unfamiliar NHS techniques and processes. The policy was heavily criticised by the British Medical Association (BMA) and the Royal College of Physicians, with suggestions that the procedures ensuring adequate competence were not rigorous enough.[1,3] It has also been suggested that this policy hindered integration between ISTCs and NHS trusts; in fact staff mobility was key to cooperation between the two providers. The rules were subsequently relaxed during the second wave and NHS staff can now, albeit with some restrictions, work in ISTCs.

Although all doctors employed by an ISTC are required to be registered with the General Medical Council, there is no equivalent to the NHS Advisory Appointments Committees to act as a quality control mechanism. Consequently, ISTCs take on responsibility not only for recruitment, but also professional development and appraisal, an area where the Healthcare Commission in 2007 identified some shortfalls.[4]

With regards to training, concerns have been voiced by senior surgeons that the transfer of 'straightforward' elective procedures, suitable for training junior doctors, from NHS hospitals to ISTCs has impacted negatively on training.[5] The

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* Treatment in the private sector which is purchased by the NHS on an ad hoc basis in order to cut waiting lists.

apparent efficiency of ISTCs may also in part be accounted for by a lack of responsibility for training which, although time consuming, is extremely important. A solution is to place junior doctors in ISTCs where they can be trained in a 'high volume, low risk' arena; subsequently ISTCs in the second wave were obliged to include a training component if requested by postgraduate deans.

Innovative workforce management, such as in the case of Blakelands NHS treatment centre, includes regular staff consultations and multi-tasking, and has led to a four day working week by maximally utilising theatres and clinic rooms, leaving Fridays for administration.[6] Based on case studies of individual ISTCs, it certainly seems that novel workforce management is increasing efficiency and there are lessons to be learned for the NHS where clinical and administrative agendas are not always well integrated.

What are the implications for health care users?

One of the main stated objectives of the introduction of ISTCs was to provide a more patient centred system. The separation of emergency from elective procedures ensures that patient appointments and procedures do not have to be cancelled if an emergency case is admitted. Since ISTCs concentrate on specific procedures, streamlined patient care pathways with efficient pre-operative processes have led to high ratings in patient satisfaction surveys. However, one may also argue that patient satisfaction outcomes have no demonstrable correlation with health outcomes and although clearly important, they should be given less importance than other indicators.

Under new initiatives, patients are able to choose where they have their procedure performed, however, they are not given any information regarding the quality of care provided, thus their choices are not informed, questioning whether it is really patient choice or government waiting list targets that have driven ISTCs. ISTCs have been criticised by clinicians for providing inferior care with a low level of monitoring and governance, for example, the British Orthopaedic Association has stated that more revisions of operations are required when patients are treated at ISTCs.[7] This statement however has not been supported by the National Centre for Health Outcomes Development (NCHOD),[8] and in fact the chief executive of the Healthcare Commission warned that it is difficult to form such conclusions since the data is not directly comparable.[1]

ISTCs were intended to reduce waiting times by both adding capacity and introducing competition, consequently stimulating productivity within NHS facilities. Although in certain specialties ISTCs account for a substantial proportion of activity, nationally, ISTCs account for only 2% of NHS elective activity, indicating that they have not been a significant contributory factor to the reduction in waiting times.[9] Additionally, an analysis by the King's Fund found no difference in the rate at which waiting times were reduced when comparing areas with and without ISTCs.[10]

How are they financed?

Funding for ISTCs is negotiated by the DH in the form of five year contracts and payment is made based on the NHS national tariff, together with a further premium to cover capital costs. During the first wave, ISTCs received a 'take or pay' guarantee meaning that they received the full contracted value from PCTs irrespective of whether or not they reached activity targets, a payment strategy which has been heavily criticised. The DH informed the House of Commons that Wave 1 ISTC providers received, on average, payments that were 11.2% greater than the NHS equivalent cost which incorporates other NHS costs such as pensions [1]. The payment structure was modified in the second wave and although the full contract value is no longer guaranteed, ISTCs still receive guaranteed fixed value payments from the DH.

There have been further criticisms with regards to both under and over-commissioning of services. Poor initial needs analysis and projected demands have resulted in flawed commissioning and under-utilisation of ISTCs. The Ravenscourt Park treatment centre in London was forced to close just four years after opening. It was operating at just 50% capacity and failing to be cost-effective. Improvements in integrating referrals, both vertically and horizontally, from the NHS are certainly required in order to prevent other centres facing a similar demise. Over-commissioning has also been a problem, with more procedures being commissioned than individuals on current NHS waiting lists, with resultant negative financial consequences.

Criticisms even extend to include selection policies, with some ISTCs being allowed to choose less complex cases, leaving the NHS with complex cases together with longer, more expensive inpatient stays. There have been calls by the BMA for the payment structure of selective ISTCs to be altered to reflect this.

Is the data comparable?

ISTCs are required to provide data regarding quality outcome and monitoring to the DH in the form of performance indicators; however, the DH retains the publication rights of these data. Some authors have concluded that the data provided by the ISTCs are of poor quality, and as discussed below, not directly comparable with NHS data. This clearly needs improvement, and following recommendations by the Healthcare Commission in 2007,[4] changes have been made to reporting methods in ISTCs; despite improvements in the last two years, the quality of data is still not equivalent to that collected by NHS providers making comparisons difficult.[11]

Regulation of the ISTCs, as for the NHS, is carried out by the Care Quality Commission. However, whilst NHS providers are required to meet 'core standards' together with 'developmental standards', ISTCs are only required to meet the 'National Minimum Standards'. A new registration system has been introduced in an attempt to standardise regulation but there are now new 'improvement standards' which will still only be applicable to the public sector. Whilst these discrepancies in required standards and data publication remain, quantitative comparisons are impossible. The variation in case-mix between ISTCs and NHS facilities is also marked, making even qualitative comparisons challenging.[12]

Further implications for the health system

Encouraging innovation is certainly the case in some ISTCs, for example, Boston and Gainsborough Treatment Centre implemented a new technique for general anaesthesia which decreased post-operative side effects and enhanced recovery time with subsequent improvements in patient care as well as improved productivity measures for the ISTC.[6] Many prominent surgeons have argued that these, and analogous techniques, have previously been evaluated in the NHS, and they are neither original nor innovative and have no discernible impact on service delivery [1].

There are suggestions that some NHS providers have responded to a new ISTC

in their area by improving service delivery and increasing productivity; a joint report from the Audit Commission and Healthcare Commission found that in some cases, competition introduced by ISTCs provided "a useful tool to engage clinicians and work with them to deliver change".[9] The House of Commons Health Committee concluded that the effects of competition may have been one of the greatest benefits of ISTCs, but criticised the government's lack of systematic evaluation of this effect and recommended that the National Audit Office should conduct an evaluation.[1]

A review of the first Scottish Regional Treatment Centre by Allyson Pollock and Graham Kirkwood in 2009, resulted in a damning report which criticised lack of data, payment methods and wastage of funds. Extrapolating from the Scottish data, they estimated that in England, up to £927 million may have been paid for treatments that were never actually carried out and recommended that there should no further signing or renewal of contracts until a comprehensive evaluation addressing their concerns has been undertaken and published.[13]

New proposals for reform

The economic crisis and its financial implications for all public sector services, including the NHS, has prompted the recent publication of a government White Paper outlining radical NHS reforms.[14] The paper includes plans for phasing out PCTs and SHAs and replacing them with General Practitioner (GP) consortia. With all GPs being part of a local consortium, these new consortia will be responsible for commissioning services for the majority of NHS services, including elective and emergency hospital care. Commissioning will be based on knowledge of local needs, thus theoretically avoiding the previous problems with over-commissioning of services and subsequent financial waste. Importantly, the role of purchasing services for primary care will be the responsibility of the NHS commissioning boards. A crucial flaw in this system appears to be the lack of input to the consortia from secondary and tertiary care providers or public health specialists as well as the lack of competency and experience of GPs to manage commissioning of specialist areas such as mental health.

Economic regulation will come from Monitor, and consortia will be accountable to the NHS commissioning board. The role of Monitor will include licensing providers and regulating prices as well as promotion of competition in health care, a feature which has been viewed negatively by some, including the BMA. Concerns stem from the fact that encouraging competition rather than the quality of health care may adversely impact on patient care. An essential remit of Monitor must therefore be to ensure that no advantage, financial or otherwise, is given to private providers, as has clearly been the case in ISTCs. Also, the use of 'any willing provider' of health care services rather than encouraging NHS providers builds on the ISTC precedent of involving the private sector in NHS care, an approach that has so far not demonstrated a significant or consistent improvement in health care. The involvement of several small providers will require highly skilled integration to avoid providing fragmented health care to patients.

The new plans once again focus on increasing patient choice with regards to choice of provider, diagnostics and maternity services, as well as choice of a named consultant-led team with quality of care being reported by both clinical outcomes and patient reported outcome measures (PROMs). Although patient choice is important, the reforms fail to outline tools for data collection or their validity. As with ISTCs, it can be argued that PROMs do not correlate with health outcomes and PROMs should not be used in isolation to judge good quality care. Moreover, in order to avoid the problems with data reporting that have been experienced with ISTCs, there need to be clear and comparable guidelines and regulations for both commissioners and providers.

In addition, all NHS trusts are set to be granted Foundation Trust status thus encouraging what the government has termed 'employee-led social enterprise'. Currently, Foundation Trusts have a cap on income derived from private rather than NHS services. The White Paper aims to abolish this cap and whilst theoretically beneficially to staff and patients, in reality, removal of restrictions encourages private sector involvement which faces the same hurdles as other private sector initiatives already mentioned in this article.

Conclusion

The introduction of independent providers into the NHS, traditionally thought to be the foundation of public sector services in the UK, has certainly had effects on both health care users and providers as well as the health system as a whole. However, despite a heightened awareness of costs, efficiency and accountability, the changes have been insufficient, and at times ill thought out.[15] The expected outcomes such as 'value for money' have been not been achieved, and in fact there are many cases of financial waste. Despite recognition and remedial action of problems from the first wave, many would argue that the changes do not go far enough, and that the intended benefits are yet to materialise. Even a reduction in waiting times cannot be attributed to the introduction of ISTCs. Theoretically, ISTCs could have achieved much more, but a lack of appropriate needs analysis, flawed procurement and poor integration with existing NHS services has produced disappointing results. Perhaps increased utilisation of existing NHS treatment centres which are already well integrated, or using NHS facilities out of hours, would be a more cost-effective and efficient way of meeting demands.

Furthermore, the recently outlined reforms are likely to come at a significant cost and at a time that the NHS has been required to make efficiency savings in excess of £20 billion, one wonders if this is the most appropriate time to be once again, introducing radical re-structuring programmes.

There are beneficial effects of cooperation with the independent sector, but for ISTCs to succeed and truly encourage NHS reforms there needs to be equal regulation and transparency for all providers. By introducing inequalities in human resources, infrastructure, data provision and financing, we are in danger of creating a two tier system in which the NHS loses. Patients need to make an informed choice and commissioning needs to be based on outputs rather than projected inputs. This, together with appropriate recruitment and training, should help to integrate ISTCs and other private sector providers into the NHS more effectively, thus pushing forward and reaping the benefits of reform, rather than creating an uneconomical system that has promised far more than it has delivered.

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Five barriers to physician workforce development in Uzbekistan

Zukhra Karimova and Gary L. Filerman

Summary: The 1998-2005 health system reform in Uzbekistan aimed to increase efficiency, self-financing mechanisms and develop the private sector. However, the reform process has also had implications for the physician workforce, including the low number of medical school graduates employed as physicians. This article identifies five key barriers that contributed to the poor alignment between the number of medical graduates in the country and the number of working physicians. It presents recommendations for improving the health resource planning process in the country.

Keywords: health care reform, physician supply and demand, education, health workforce planning, Uzbekistan

The Uzbek health system has undergone significant change since the country became independent in 1991. Following independence, health system reforms were introduced with the aim of adapting to the challenges of the new social, political and economic environment. The reforms placed an emphasis on increased efficiency, self-financing mechanisms and private sector development.

The Uzbek health system includes public, private and other non-public entities. The voluntary National Health Insurance Programme provides support for both public and private services. Private practices and clinics have rapidly been set up in an effort to mobilise additional resources, increase efficiency and improve quality. Since 1994 1,075 health care entities, including hospitals, ambulatory clinics and solo practices, have been privatised. In 2004, there were 1,165 hospitals with a bed capacity of 142,900; of these the private sector accounted for 141 hospitals (12.1%) with a bed capacity of 3,000 (2.1%).[1] However, a higher proportion of ambulatory clinics are under private control – 1,220 of 5,536 clinics (22%).[2]

Medical education and graduates

In Uzbekistan, as in many other countries, aligning the development of the physician workforce to match the needs of the emerging health care system is a complex challenge. A substantial portion of medical graduates are not employed in the profession. Even though legislation requires five years of practice in the public sector before a physician can enter private practice, of the 2,571 graduates of medical schools in 2005, only 895 (36%) entered medical practice in the public sector[1] (Figure 1). While a small number of graduates went to work for the pharmaceutical industry, the majority of graduates entered other professions, emigrated or ended up being unemployed. This loss of expensively educated medical professionals is a major issue for human resource development in the country.

The cost to the individual of a medical education is high. The tuition fee for each of the seven years in training is ~US$800–850. An individual entering the general workforce directly from a high school or community college can expect to earn about $1,200 per year. The opportunity cost of a medical education is therefore

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~$14,175 ($5,775 in tuition fees plus foregone income of $8,400 over seven years). This is a conservative calculation and does not include other expenditure that must be incurred by students.

According to the United National Development Programme (UNDP), 69% and 75% of all university students study on a fee paying basis at Bachelor's and Master's level respectively.[3] Here, we assume that the proportion of medical students who must pay tuition fees is similar. Estimates of public expenditure on education vary substantially. According to one UNICEF survey Uzbekistan reportedly spent about 12% of Gross Domestic Product (GDP) on education, which is the highest percentage in the sub-region and region.[4] According to the 2001 Resolution of the Cabinet of Ministers of the Republic of Uzbekistan, any income derived from students' fees should not decrease the amount of financing from the state budget, which still can be used entirely for the needs of the educational institution.[3] To the extent that graduating physicians do not practice in the country, a substantial portion of government investment is being wasted.

Thus, the question is: why do students who have invested on average over $14,000 not work in the health sector? In this article, we identify five factors that contribute to the poor match between the number of medical school graduates and levels of employment in the profession.

1. Lack of financial incentives

The annual incomes of state employees in general, and in the public health sector in particular, are substantially less than the incomes of professionals in the private sector, such as for construction, retail and the service industries. On average, the basic monthly salaries of physicians in the public sector range from US$80 to US$150. In some cases these salaries are lower than the middle class standard of living. These salary levels are based on professional category and calculated by multiplying the size of the official minimal wage by some coefficient (from 2 to 7). Starting from 1 August 2009, the minimum wage was set at 33,645 soums per month[5] (around US$24)*.

Medical degrees are awarded on a graduated basis, with the level of degree increasing over time based on experience and acquisition of additional qualifications.

* In January 2009, the official exchange rate was US$1 = 1,396 soums, but on the black market the rate climbs to 1,700 soums.

Figure 1: Demand and supply of new medical graduates in Uzbekistan

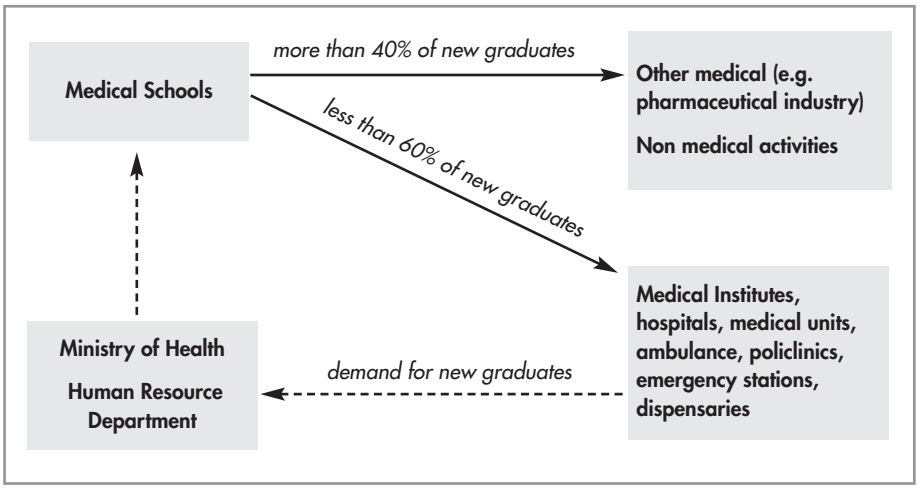
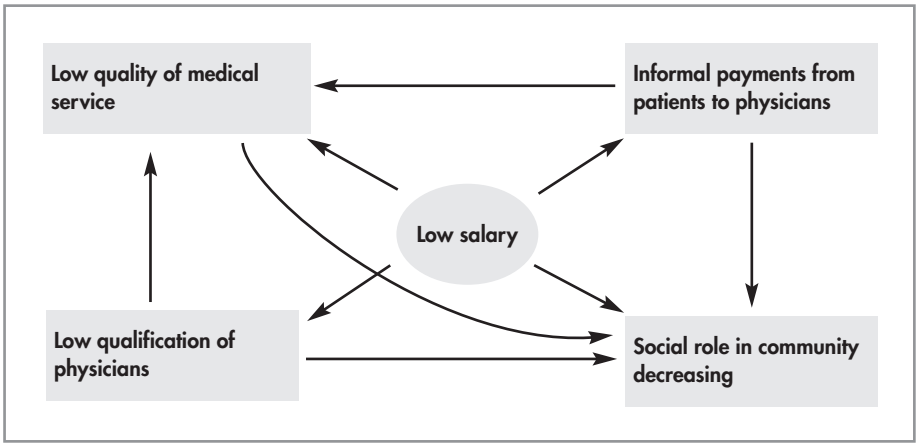


Table 1: Proportion of medical graduates by level of degree obtained in 2005

	Highest Degree	First Degree	Second Degree	Third Degree
Proportion of graduates	17.8%	30.4%	3%	48.8%
Numbers	6,168	10,535	1,040	34,654

Source: [1]

Figure 2: The consequences of low physicians salaries' in the public sector

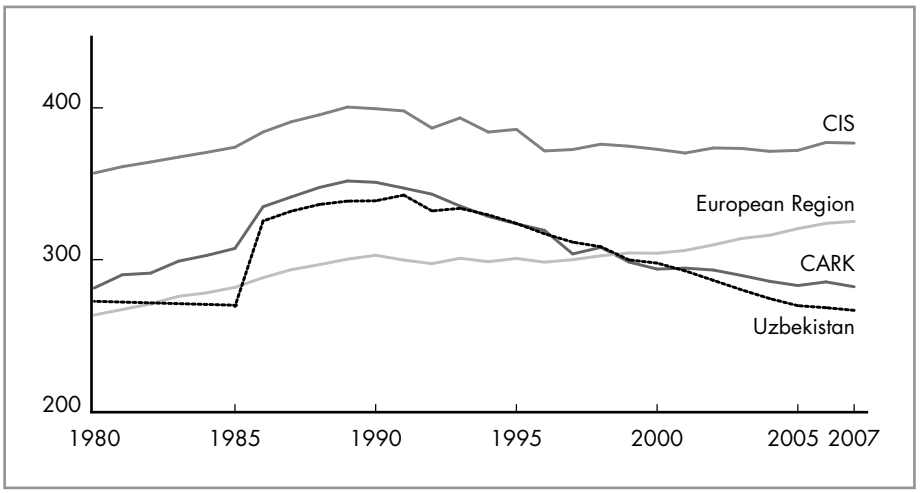


All new graduates are awarded a third level degree. Physicians can then be promoted to a second level degree after completing five years' working in the public sector and successfully passing the National Centre for Licensing and Accreditation Test. Subsequently working for another five years and completing 288 hours of continuing education is required before a physician can apply for a first degree. The highest level of degree (the higher) requires an additional five years' experience and passing an exam in front of an expert panel. The data presented in Table 1 reflect the situation in 2005, before the requirement to apply for advancement every five years became mandatory in 2009.[6]

The financial rewards gained for improved professional status are small, thus they provide little incentive for physicians to increase their knowledge and skills. This clear lack of motivation to gain new knowledge further contributes to the generally low numbers of practising physicians. It is estimated that approximately 27% of physicians had not completed any advanced training after fifteen years of practice.[7]

As Figure 2 shows the low levels of financial remuneration lead to a poor social status for physicians, as well as limited services and other quality issues for patients. There is a dependence on

Figure 3: Number of physicians per 1,000 population 1990–2007



Source: [13]

informal payments that flow from patients directly to physicians and hospitals. There are no data on the magnitude of these payments but they are clearly substantial. These funds are not used for improving working conditions, expanding technology, purchasing equipment or developing facilities. Rather, they set a tone in the relationship between patients and providers that demeans the status of health professionals in the community.

2. High rate of emigration of medical professionals

Most migrants are seeking better living standards, better access to education for their children and higher quality health care. According to the UNDP, Uzbekistan has an emigration rate of 8.5%. Other sources estimate the number of emigrants to vary between 250,000 and 1.5 million in 2008. Russia accounts for 70% of migrants and Kazakhstan perhaps a further 10–15%.[8]

One way of measuring the magnitude of emigration is by the increase in the annual inflow of official remittance. According to the Central Bank of Uzbekistan, over the 2002–2006 period the annual inflow of official remittances to the country increased five-fold, reaching almost US$1.4 billion or 8.2% of GDP in 2006. Unfortunately, the data do not reveal the professions of those sending money to Uzbekistan.

Citizens of Uzbekistan speak Russian and the Uzbek medical diploma is recognised in Russia and Kazakhstan. In an attempt to reduce shortages of medical staff in its own rural regions, Russia encourages the immigration process by providing significant start up financial capital to newcomers. The salaries of medical staff in Russia and Kazakhstan, which are several times greater than those in Uzbekistan, are another attraction.

3. High level of unemployment

New physicians enter a difficult employment market. Job creation in the general labour market has been slow: just 2.1% between 2000–2004 compared with an average annual growth in the working-age population of 3.2%.[9] While the official unemployment rate was just 0.9% in 2009, unofficial sources report that unemployment and underemployment are very high at 8% and 25% respectively,[10] but reliable figures are difficult to obtain, as no recent credible surveying has been done.

4. Inadequate working conditions

According to a recent sociological survey, health workers in Uzbekistan are not content with their working conditions because of the lack of equipment and supplies, lack of proper recognition for their work, and limited opportunities to improve their knowledge.[1] According to statistical reports, in any one year only 14% of mid-level health workers have a chance to improve their skills. This is clearly not enough to give all specialists an opportunity to update their knowledge at least once in five years.[7] Moreover, many health care facilities are in need of renovation, better cold and hot water supplies and telephone lines. The problem is most severe in rural areas. Thus, the majority of health care institutions are in need of technical upgrades.[7]

5. Weak health care workforce planning and management

The Department of Human Resources and Science, Medical Education Institutions and the Ministry of Health are responsible for forecasting the requirements for health personnel and for planning human resources development. Two mechanisms are used to regulate the supply of health professionals: enrolment in universities and professional colleges, and the licensing framework for the private sector.[7] The number of undergraduate and post-graduate medical student positions is established by the Cabinet of Ministers, based on the recommendations of the Ministry of Health. A perceived surplus of physicians in the early years of independence resulted in cutbacks in enrolment in medical schools. The number of graduates of medical schools decreased from a peak of 5,156 in 1996 to 3,020 in 2004.

The total population of Uzbekistan in 2004 was 25.6 million people with population growth of 1.9%. In 2010, the population is 28 million with population growth at a slightly lower level of 1.7%.[11] The ratio of physicians to the population has decreased steadily over the period from 1991 to 2010 (Figure 3). It decreased from 3.7 physicians per 1,000 population in 2001 to 2.9 and 2.66 (2010) per 1,000 population in 2005 and 2010 respectively.[12] This compares unfavourably with ratios elsewhere, including in the Central Asian Republics and Kazakhstan (CARK) and the Commonwealth of Independent States (CIS)[14] (Table 2). If policies are left unchanged, based on these data, economic factors previously discussed and the current level of medical student enrolment, it is estimated that Uzbekistan faces a continuing undersupply of 23,520 physicians compared to the Eurasian average.

Despite the observed shortage of physicians, there is actually a surplus of medical graduates. In 2009, while there was a shortage of 1,635 physicians there were more than 2,500 graduates from medical school.[13] As noted, many new professionals choose not to work in the health sector for financial and career development reasons. A further deterrent is that most medical schools are located in Tashkent and other cities. After graduation, the majority of young doctors do not want to work in rural areas but cannot find a job within their specialty in the cities, thus, they seek employment in other professions (see Table 3).[1] Additionally, based on Table 3, it is evident that the supply of doctors and beds is concentrated in the cities. Other factors that contribute to the problem of effective planning include traditional customs, such as women leaving

Table 2: Number of physicians per 1,000 population

Uzbekistan	2.66
CARK	2.82
European region	3.39
CIS	3.76

Source: [14]

Table 3: Number of population per doctor, nurse and bed in various areas

	Per doctor	Per nurse	Per bed
Nationwide	334	98	182
Djizzak Region	474	111	209
Surkhandarya	451	106	224
Tashkent City	131	77	118

Source: [1]

their jobs after marriage, widespread gender stereotyping issues and the influence of Muslim traditions.

Conclusion

The important factors that contribute to the imbalance between the supply and demand for physicians in Uzbekistan include: the lack of financial incentives; the high emigration rate of medical professionals; the high rate of general unemployment; inadequate working conditions; and inadequate workforce planning and management. Of these, the last is the most important.

Uzbekistan currently has 2.66 physicians per 1,000 population. Although the number of medical graduates is more than the Uzbek population requires, many medical graduates are taking up work in other professions or moving abroad. Therefore, it appears that the health sector is clearly under financed, with a total health care expenditure of only 2.4% of GDP in 2005.

A substantial reform of the health workforce planning process is required, with more realistic links to general economic conditions and the structure of medical practice. It appears that improving remuneration is key to improving retention rates, as well as working conditions. Performance-based remuneration schemes should be considered as well as steps to expand private practice.

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Managing performance:

An introduction

Rachel Irwin

Why manage performance?

The John Radcliffe Hospital in Oxford suspended child heart operations after four children died over the course of a few months in March 2010.[1] The hospital was also investigated by the Healthcare Commission in November 2005 after it was discovered that the number of patients who died between April 2002 and March 2005 after their first coronary artery bypass graft was more than double the national average.[2] Better ongoing performance measurement provides evidence that can be used as a starting point to improve safety and quality of care and thus help reduce the number of such adverse events. In recent decades, the public's expectations have increased and measuring performance is a way to satisfy this: what Nolte and McKee have deemed a "quest for accountability".[3] Cross-country comparisons of performance can also give impetus to governmental reforms.

Measuring performance is not a new concept. It can be dated back to Florence Nightingale's work during the Crimean War and her subsequent epidemiological and statistical studies on surgical mortality in London that lay the groundwork for surgical audit. However, using this information to manage performance has become a new paradigm over the past two decades in an attempt to manage public services, control professional autonomy, contain costs and accommodate rising public expectations. Moreover, even before we found ourselves living in an 'age of austerity', measuring and managing performance was seen as a way to improve cost-effectiveness.

This issue of *Eurohealth* sets out to explore these issues further. It features four articles that originate from a seminar hosted by LSE Health and the NHS Confederation and funded by the Higher Education Innovation Fund in April 2010. Topics covered included how and why we measure performance; how quality indicators and quality systems in health care can be developed; and the impact of performance measures on the English NHS.

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Managing performance

As Gwyn Bevan sets out in his article, there are three main pathways for using performance data to manage performance. Firstly, in the change pathway, where providers may use information to make changes without external pressure. Specifically, if they see that they are performing badly against their peers, then they will act to improve. This is Julian LeGrand's notion of knights: politicians and civil servants do the best job they can to respond to the needs of the population they serve.[4] Secondly, the selection pathway occurs when providers may make changes in response to market pressures in which patients choose good providers over poor ones, typically based on publically available 'report cards'. However, there is simply little evidence that patients switch providers, even when given information on performance.

Finally, Bevan notes that providers may respond to systems that report on performance in a way that may affect their own reputation (the reputation pathway). Perhaps the most famous example was the "targets and terror" regime in the English National Health Service (NHS).[5] This referred to the aggressive policy of targets, together with sanctions for poorly performing managers and the public publication of waiting times data at the hospital level. This gave managers an incentive to see their targets improve and thus secure their jobs.

Mark Exworthy begins his contribution to the issue by noting that managing performance necessitates that we decide what to measure and how to do so. His starting point is that performance is a contested concept. When a situation occurs where the measured indicators are the only ones that are measured, why would a manager concentrate on improving quality in an area which is not reported? Therefore, we must be acutely aware of what does not get measured and how this affects performance as well. With all the competing pressures on providers, it is important for regulators, managers and other users of indicator data to agree on what will be measured and how these data will be used.

Chris Ham points to the contribution that targets and standards have made to performance improvement in the English NHS and cautions against a simple rejection of policies from previous governments without careful consideration of their strengths and weaknesses. In the meantime, Niek Klazinga discusses measuring and managing health systems' performance, arguing that when utilised improperly, performance management can result in sub-optimisation. That is, if one starts to increase management in one area of health care because it is measurable, this does not always lead to overall improvement in the health system. He also discusses some of the hazards of cross-country comparisons and the importance of using the right indicators for the right purposes.

Conclusions

Although these articles cover the gamut of issues surrounding performance management, three main themes emerge. Firstly, consistency over time is important: consistency in vision, regulation and in the use of market incentives. While Gwyn Bevan has argued that the market incentives did not work in England, Peter Smith

of Imperial College London, who chaired the seminar, has argued that the market had never been properly tested because there has been no long-term consistency due to frequent political changes. Ham concurs with this pointing out that the English health system has been the subject of endless new initiatives, in which reform is laid upon reform, and stability is lacking.

Secondly, tensions lie between self-improvement, self-regulation and external pressures. Where the best balance lies between these forms of regulation gives rise to further questions on the role of managers, peer reviews and external regulators. Thirdly, there is concern that the use of targets tends to concentrate activity on the areas measured, whilst neglecting other areas, so that what gets measured gets managed, but questions remain over that which is not measured.

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The performance paradigm in the English NHS:

Potential, pitfalls, and prospects

Mark Exworthy

Summary: Managing the performance of health services has become a dominant paradigm in policy and research in many countries over the past two decades. Attention has been directed to the development and implementation of performance 'products' such as management systems and metrics (for example, indicators). Whilst this approach offers some benefits, the limitations of relying solely on this approach are increasingly apparent. It is not always clear how such `products' generate improved performance and whether unintended consequences are apparent elsewhere in the health system. Understandings about performance could benefit from stronger and more explicit conceptual foundations. This article highlights one example of how research could be broadened to elicit a more rounded perspective on performance; namely, a focus on 'informal' aspects of performance. The article concludes that continued pressure from government, the public and health service users will demand on-going improvements. However, it is likely that, in an era of constrained budgets, new ways of thinking must be sought to meet rising expectations.

Keywords: Performance, health policy, NHS, subjectivity, England.

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Potentials and pitfalls of performance

Over the past two decades, in many countries, the performance paradigm has become firmly established by governments seeking to manage public services, to control professionals, to contain costs and to accommodate rising public expectations.[1,2,3] It is not surprising, therefore, that notions of performance have been central to the way in which health policy has developed. The National Health Service (NHS) in England is no exception; indeed, it has arguably been at the forefront of developments. To examine the potential, pitfalls and prospects of the performance paradigm, this article focuses on the English NHS.

Varying notions of 'performance' have been prevalent and different approaches

have previously been attempted.[4] For example, Smith[5] has defined performance management as a: "set of managerial instruments designed to secure optimal performance of the health care system over time, in line with policy objectives"

Performance has thus become a central pre-occupation of health policy-makers and managers over the past twenty years or so. The performance paradigm has been pivotal to the wave of approaches to managing public services (especially health services) that have been called 'new public management' (NPM).[6,7]

Managers were given specific responsibility for managing the performance of services and staff. Performance was thus not only to be measured but also to be actively 'managed'. Many governments, especially those in the 'Anglo' and northern European countries, often had a revolutionary zeal towards NPM in being able to transform services through a greater focus on managing performance and service improvement. Osbourne and Gaebler[8] were at the forefront of promoting NPM in the form of 'entrepreneurial government.' A new approach to performance was central to their thesis: "Entrepreneurial governments promote competition between service providers… they measure the performance of their agencies, focusing not on inputs but outcomes. They are driven by their goals – their missions – not by their rules and regulations".

A key aspect of the performance paradigm has been the development and introduction of quantitative metrics, comprising performance indicators, targets, benchmarks and comparisons.[9,10] Services and the activities of staff had to be standardised in order to facilitate such measures and aid comparisons. Information from such comparisons was also central to the operation of market-style mechanisms, introduced by the separation of purchasers and providers – another key feature of NPM.[11] It follows that qualitative measures have been less evident.

The performance paradigm has received much negative criticism for its shortcomings.[4,12] Any performance system suffers from incompleteness; it is inevitable that some aspect of service delivery will be omitted from performance measures. The implication is that measured aspects get priority and unmeasured ones are neglected; hence, the adage 'what gets measured gets done'.[13] This can lead to behaviour whereby agents 'game' the performance system as an end in itself. Attribution of decisions to subsequent performance is complicated by the open systems within which health services operate, as well as the robustness of the measures themselves.[14] Patient behaviour, plus the many interactions with different agencies, make assessment of (health) outcomes problematic. Attribution is further hampered by 'performance churn' whereby there is little consistency in performance measures between successive applications.[15] This makes it difficult to gauge whether 'performance' (as measured by those indicators) has improved or not over time. This churn highlights a final factor – the short-term focus of many performance systems. Annual measures may not necessarily capture 'improvements' and yet managers are held accountable over this short time period.

Health services are characterised by generic features which make direct comparisons of performance difficult, including:

- ambiguous goals;
- few reliable measures of effectiveness;
- multiple definitions of 'success' which are likely to compete and conflict;
- complexity of cases (such as individuals with multiple social problems or co-morbidities);
- perverse incentives (including the so-called 'efficiency trap' whereby 'good' organisations were not rewarded);
- limited 'user choice', implying a greater reliance on professional proxies (such as GPs or care managers); and
- professional dominance.

In England, the approach to performance management in the NHS has consisted of guidance, monitoring and response.[5] Over the past decade or so, this English performance paradigm has tended to be centralised.[1,2]

The shifting parameters of performance

The traditional approach to managing performance has been a minimalist one with few (if any) explicit mechanisms to deal with 'poor' performance and promote 'good' performance. This approach is outlined in Table 1.

More recently, the approach to managing health service performance has evolved with three developments being prominent:

1. New 'steering' organisations including regulators, such as the Care Quality Commission (CQC) or the Office of Standards in Education (OFSTED);
2. Extensive use of information technology (in performance management);
3. Greater challenge to professional norms and practices.[17]

These features are consistent with the emergence of post-bureaucratic organisations.[15] The traditional approach has thus undergone transformative change but the 'new' approach remains emergent in different spheres of health policy. Not all performance measures are, for example, directed towards individuals; organisations remain the predominant unit of analysis. Nonetheless, the direction of travel away from the traditional approach is clear (Table 2).

The implications of this approach are becoming increasingly apparent. First, the number of stakeholders involved in performance is increasing and goes well beyond traditional health policy networks. For example, the growth of summative performance has been associated with new regulatory regimes such as the CQC which assess the quality of service and financial management. Equally, patients, the public and the media have become more centrally involved, not least through their use of the disseminated performance information. Second, the growing attention on named individuals is challenging professionals' practice. Previously held claims of professional autonomy have been challenged, for example, by the disclosure of clinical performance on the internet (see next section). Third, performance measures are increasingly addressing (multiple) clinical outcomes rather than just inputs (such as staffing).

Performance in practice: a case-study

Case-studies can illustrate the shortcomings of existing performance systems and also the shifting parameters of performance in health systems. Here, the case of 'informal' performance is used to illustrate the need to broaden perspectives on performance.

The English performance paradigm has primarily been quantitative in nature, through measures such as rankings, league tables and performance indicators. These measures become the 'official' metrics, published by government agencies. They are retrospective in that they report previous performance from previous time

Table 1. The 'traditional' approach to performance[16]

Feature	Hallmarks of the traditional approach
1. Unit of analysis	Organisational level (such as the hospital, school or prison)
2. Specificity	Anonymous
3. Motivation	Intrinsic
4. Participation by practitioner	Voluntary
5. Focus	Inputs (e.g. staffing) and outputs (e.g. service delivery)
6. Purpose	Developmental and formative
7. Reference group	Professional peers (e.g. peer review by fellow clinicians)

Table 2. The 'emergent' approach to performance[16]

Feature	Hallmarks of the 'emergent; approach
1. Unit of analysis	Individual (such as the surgeon)
2. Specificity	Named
3. Motivation	Extrinsic
4. Participation by practitioner	Compulsory
5. Focus	Outputs and outcomes
6. Purpose	Judgemental and summative
7. Reference group	External

periods. Moreover, these data do not cover all of the areas which would enable rounded judgements to be made about an organisation's performance.[18] This approach can be described as 'formal' performance,[16] akin to the notion of 'hard' information.[16] Formal measures imply a degree of precision and are apparently objective statements. They also have a function as a 'safety net' for managers and others in that it directs attention to minimal standards of performance.[16] It thus tends to focus on 'poor' performance rather than improving good performance.

A different approach is the notion of 'informal' performance. This refers to the 'soft' information that is founded on subjective judgements and perceptions. It refers to the ways in which performance is conceived, constructed and managed through a series of subjective judgements. It can be found in notions of reputation, goodwill, tacit knowledge and credibility. Health managers might, for example, refer to another as a 'safe pair of hands' or on the need to 'keep an eye on them.' Others might question 'what is really happening?' despite the surfeit of formal performance data. Informal performance may be biased and incomplete but, if it affects agents' behaviour towards managing performance, it nonetheless has real effects. Informal performance comprises qualitative information that can be prospective. Goddard et al[16] suggest that informal performance plays substitution and complementary functions in relation to formal performance. The application of notions of informal performance is illustrated below.

Autonomy of NHS Foundation Trusts:

Since 2004, the policy of Foundation Trusts (FTs) in England has granted greater autonomy to high 'performing' Trusts as a way of enabling further performance improvements. In general, FTs have not 'performed' as expected,[19] raising the possibility that autonomy is not such a panacea after all. Technically, FTs do have the ability to exercise autonomy through their ability, for example, to retain savings and to avoid traditional NHS performance management mechanisms. However, it is apparent that many FTs have lacked the willingness to exercise such autonomy.[16] The reasons for this unwillingness include:

- the greater risk to which FTs are exposed;
- continued uncertainty about the components of health system reform (such as the extent of competition);
- the generally weak levels of engagement and legitimacy that FTs have secured from local stakeholders;
- the fear of negative impact of autonomous decisions upon the local health economy; and
- the degree of extant autonomy already enjoyed by these high 'performing' organisations.

There is a need to explore the informal performance aspects of FT managers' motivations and attitudes towards the award and use of autonomy.

Mid-Staffordshire NHS Foundation Trust:

As an FT, 'Mid-Staffs' was a supposedly high performing organisation. However, such performance was illusory. Its performance failings came to light when data revealed that:

"At least 400 patients died unnecessarily after undergoing treatment between 2005 and 2008 at the hospital, where regulators later found a catalogue of failings including poor accident and emergency care, bad hygiene, and patients being helped by relatives because staff were too busy".[20]

Moreover, its 'formal' performance had been less than ideal to become an FT, as Paton[21] notes:

"In the four years from 2002 until 2005 (the last year of the star ratings system which ranked trusts from 0- to 3-stars), Stafford had got, respectively, 2, 3, 0 and 1 star. Yet it was encouraged or 'invited' to seek FT status."*

* Star ratings were the previous formal performance metric in the English NHS

The performance paradigm was 'gamed' by Mid-Staffs' managers to meet targets, rather than necessarily delivering good patient care).[22] However, from the Francis inquiry, it appeared that patients and staff 'knew' about 'poor' performance:

"I remember at the time when our staffing levels were cut and we were just literally running around. Our ward was known as Beirut from several other wards. I heard it nicknamed that. ITU used to call us Beirut… I remember saying: this will have repercussions, this can't go on like this. Because relatives were regularly coming up to us and saying: my Mum has been buzzing for this long, there has been a buzzer going there for that long".

The behaviour of managers and perceptions of staff and the public tend to suggest that the informal performance of Mid-Staffs was apparent but overlooked by the dominant formal performance mode.

This case-study does not necessarily imply that informal performance should be prioritised above formal performance. Rather, both forms need to be considered, not least because the boundary between them is not fixed or permanent. It is thus vital to examine the interaction and reaction between the two in order to assess the ways in which performance is conceived, constructed and reproduced in local and national health systems.

Prospects for performance

This article has sought to take a critical look at the way in which notions of performance have been applied in the English NHS. It has shown that performance is a contested concept which does not necessarily determine specific courses of action. Performance is thus political, as Stewart and Walsh[23] argue that there is a "need to recognise the imperfections and limitations of [performance] measures, and to use them as a means of supporting politically informed judgements".

Research and policy needs to pay much closer attention to the contested nature of performance, for example through an examination of the interplay between formal and informal aspects of performance. This might be achieved by addressing the coherence, capacity and clinical engagement of performance paradigms.[5]

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Acknowledgements:
The research upon which some of this article is based was funded by the NIHR Service, Delivery and Organisation programme http://www.sdo.nihr.ac.uk. I am grateful to them for their funding and to the rest of the research team.

If neither altruism nor markets have improved NHS performance, what might?

Gwyn Bevan

Summary: This article considers three behavioural models of the incentives on managers of providers of health care to use information on their performance to improve, and evidence of the effectiveness of each model from the United States and the United Kingdom. The three models are: altruism, markets and reputation. This article outlines the rationale for the three models in the English National Health Service (NHS), the evidence from the US and the UK on each model, and concludes with a paradox.

Key words: National Health Service, devolution, performance measurement, targets

Three behavioural models may be used to understand the incentives on managers of providers of health care to use information on their performance to improve. First, *altruism*, that assumes that reporting to managers of providers of health care information that identifies scope for improvement will, of itself, generate incentives for improvement. Second, *markets*, that assume that public reporting of information will cause purchasers of health care and patients to switch from providers with poor to those with better performance; and thus that threats to market share will generate incentives for managers of poorly-performing providers to improve. Third, *reputation*, that assumes that if information is designed to rank provider performance in a way that the public can understand, then this generates incentives for managers of poorly performing providers to improve to remedy the damage to their reputation.

The rationale for the three models

Policies in England

Julian Le Grand[1] has nicely laid out the rationale for policies based on the model of altruism: the guiding assumption of the post-war British welfare state that all the key players were 'knights': 'politicians, civil servants, state bureaucrats, and managers were supposed accurately to divine social and individual needs in the areas concerned, to be motivated to meet those needs and hence operate services that did the best possible job from the resources available'. This Panglossian assumption is the only justification for the traditional British response of rewarding failing providers with extra resources. As Le Grand argues, this assumption was rejected by Margaret Thatcher's conservative government. This change was marked by the introduction, from 1989, of policies that reorganised the hierarchical NHS into an 'internal market' by creating 'purchasers' and 'providers' with the objective that 'purchasers' would contract with competing providers on grounds of price and quality.[2] The aim was to replicate the desirable characteristics of effective markets, in which competition systemically reduces costs and improves quality, and avoid the disadvantages of ability to pay being a barrier to access to health care.

The Labour Government elected in 1997, however, rejected the 'internal market' and re-introduced a policy based on the model of altruism (in a search for a 'third way') that again rewarded failing providers with extra resources. When this proved to be ineffective in tackling the problems of long waiting times in the English NHS, the government, in parallel with dramatically increasing funding for the NHS from 2000, also implemented a radically new system of performance management that penalised those that failed to deliver the government's priorities and rewarded those that succeeded.[3] This system of annual 'star ratings' of NHS organisations, which ran from 2000 to 2005, satisfied the four characteristics identified to have an impact through the reputation model,[4–7] i.e. the system of reporting performance must be:

- based on a ranking system;
- published and widely disseminated;
- easily understood by the public (so that they can see which providers are performing well and poorly); and
- followed up by future reports (that show whether performance has improved or not).

Hospitals that failed to achieve the government's waiting time 'key targets' (which included referral for a first outpatient appointment and elective admission) were at risk of being 'zero rated' and publicly 'named and shamed' as 'failing'. Ambulance services that failed to meet the 'key target' of 75% of ambulance response times to what may be life-threatening emergency calls (Category A) in less than eight minutes faced the same fate. From 2002, however, the government returned to policies that sought to develop a more effective 'internal market' with a particular emphasis on patient choice for elective

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care. Barber and Le Grand have argued the rationale for this new policy: that the system of 'naming and shaming' through 'star rating' was effective, but only in improving the systemic performance from appalling to mediocre, and that to deliver a high-performing English NHS it was necessary to re-introduce a market.[8,9]

Policies in the devolved countries

Devolution in 1999 offered scope for the governments in Scotland and Wales (devolution was largely suspended in Northern Ireland) to develop different policies for their NHSs. Although each country also introduced targets for hospital waiting times[7] and ambulance response times to Category A calls[6] there was no policy to 'name and shame' organisations that failed to achieve these targets. Indeed those who worked in the NHSs of Scotland and Wales perceived that such failure was rewarded by their governments. Later, when the government in England implemented policies that sought to create another 'internal market', the governments in Scotland and Wales abolished the purchaser/provider split.[10]

Evidence from the US

Two systematic reviews of the literature on reporting performance in the US found little evidence of markets being effective. The first found that information on provider performance "has only a limited effect on consumer decision making" and "only a small, although possibly increasing effect on purchaser behaviour".[11] Eight years later, another review[12] failed to identify this increasing effect: the general conclusion across various studies was that "publicly reporting performance data did not affect selection of hospitals". As Judith Hibbard[13] has argued, US evidence of the ineffectiveness of altruism is implicit in systems of public reporting that are not designed to damage the reputations of poorly-performing providers (i.e., do not satisfy the characteristics to do so). Two studies provide information on the comparative effectiveness of the three models.

An account of the impacts of the Cardiac Surgery Reporting System (CSRS) of New York State[14] emphasises that the key driver for change was the reputation model through adverse publicity from CSRS identifying outlier hospitals performing poorly. Neither markets nor altruism had much effect: "Market forces played no role. Managed care companies did not use the data in any way to reward better performing hospitals or to drive patients toward them. Nor did patients avoid high-mortality hospitals or seek out those with low mortality ... the impetus to use the data to improve has been limited almost entirely to hospitals that have been named as outliers with poor performance … hospitals not faced with the opprobrium attached to being named as poorly performing outliers have largely failed to use the rich performance data to find ways to lift themselves from mediocrity to excellence".

A controlled experiment in south central Wisconsin[4,5] looked at reporting information on quality of hospital care across three sets of hospitals: *public-report*, where a concerted effort was made to disseminate the report widely to the public; *private-report*, where the report was supplied to managers only; and *no-report*, where no information was reported to managers. If altruism were powerful, then there ought to be no difference between the public-report and private-report sets of hospitals, but the public-report set made significantly greater efforts to improve quality than the other two sets. The managers of hospitals in the public-report set did not see the report as affecting their market shares and later analysis showed that that they were correct: "There were no significant changes in market share among the hospitals in the public report from the pre to the post period".[5] The reputation model, however, was crucial: the managers of hospitals shown to have been performing poorly in the public-report group took action, because of their concerns over the impacts of the report on their hospitals' reputations.

Evidence from the UK

The Scottish Clinical Resource and Audit Group (CRAG)[15] pioneered the public reporting of information on hospital outcomes in Europe, but as the reports eschewed any ranking of performance, their effectiveness essentially depended on altruism. Evaluations of CRAG[16,17] concluded that CRAG reports had not been effective: the information was rarely used by staff in hospitals, the boards to which the hospitals were accountable, and general practitioners in discussions with patients. CRAG's own Clinical Indicators Support Team[15] came to similarly depressing conclusions on the reports' lack of impact.

Figures 1 and 2 report comparisons over time for performance for hospital waiting times in England, Wales and Northern Ireland (there are no comparable data for Scotland) in terms of numbers waiting more than six months for elective admission and three months for referral for a first outpatient appointment. Figures 1 and 2 show: dramatic improvements in England in reducing both waiting times after moving from a policy based on altruism (the 'third way' from 1997 to 2000) to reputation ('star ratings' from 2001); the policy based on altruism in Wales and Northern Ireland resulted in performance worsening initially after 2001; and although there was some improvement later in reducing waiting times for elective admission, this appears to have been at the expense of increasing waiting times for referral for a first outpatient appointment. Figure 3 reports comparisons over time for performance of ambulance services in response times to Category A calls in England, Wales and Scotland (there are no comparable data for Northern Ireland). This again shows dramatic improvements in England after the introduction of 'star ratings' from 2002; with much worse performance in Wales and Scotland.

From 2002, the government in England sought to re-introduce a market into the English NHS (and replaced 'star ratings' with the annual Healthcheck from 2006). Evaluations of this package of system reforms show that it has, however, so far, had disappointing results. The Audit Commission and Healthcare Commission[18] identified problems with implementing key elements of this package, little hard evidence of systemic improvements and longer-term concerns over its impact. A review[19] of the evidence on the impacts of the market-based policies introduced by the Thatcher and Blair governments concluded that "the reforms have not been proven to bring about the beneficial outcomes that classical economic theory predicts of markets" such as provider responsiveness to patients and purchasers; large-scale reduction in costs; and innovation in service provision; and that the NHS has incurred the transaction costs of seeking to introduce competitive markets without experiencing their benefits. This was echoed by the concluding observation of the review of commissioning by the House of Commons Health Committee: "a number of witnesses argued that we have had the disadvantages of an adversarial system without as yet seeing many benefits from the purchaser/provider split".[20]

Evidence-based policy making?

The evidence from the very different systems of health care in the US and the UK is surprisingly consistent: only for the reputation model is there strong evidence

Figure 1: Waiting more than six months for elective hospital admission

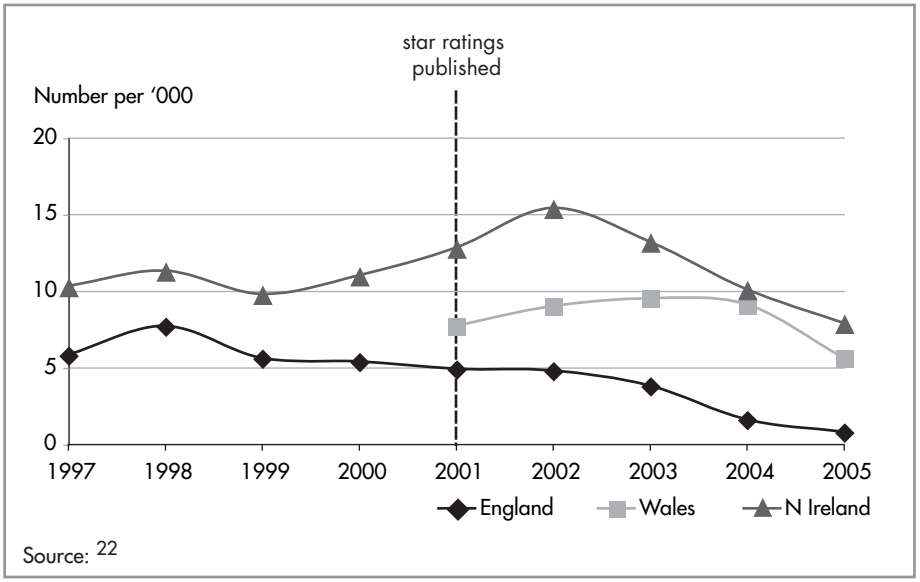


Figure 2: Waiting more than three months for referral to first outpatient appointment

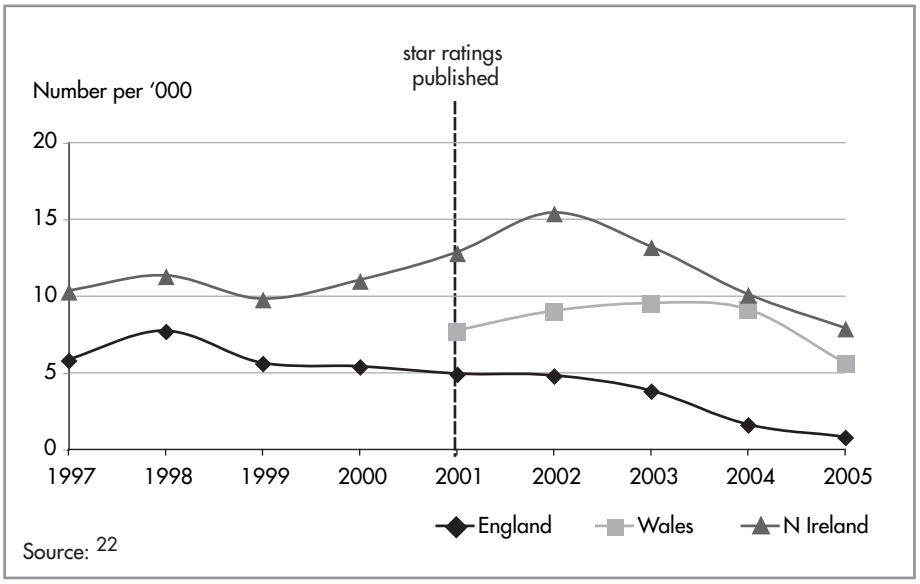
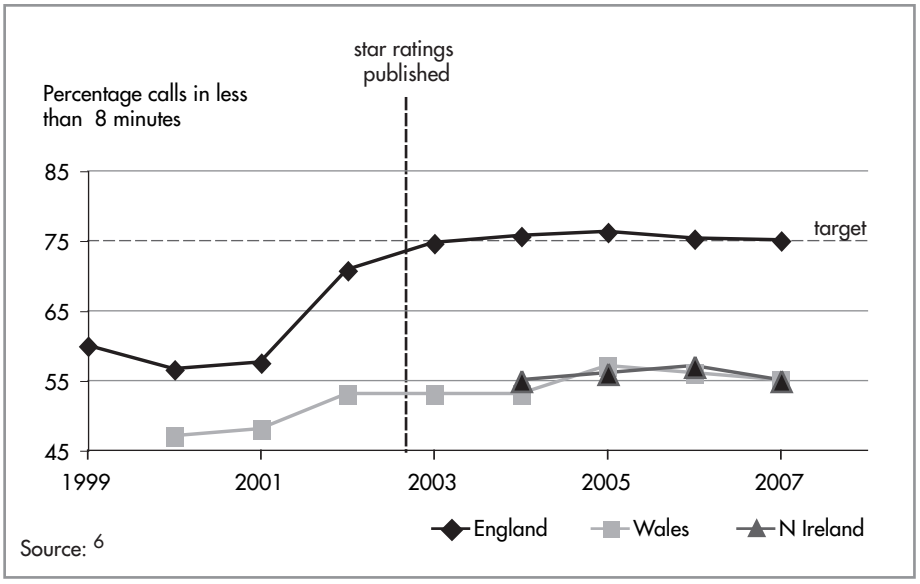


Figure 3: Ambulance response times to life-threatening emergencies



of its effectiveness. This finding is paradoxical because no UK government now is pursuing such policies. For governments of the devolved countries, policies based on altruism remain attractive. For the new UK government, which is responsible for the NHS in England, the new policies emphasise markets and the abandonment of national targets .[21]

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Improving performance in the English National Health Service

Chris Ham

Performance improvement in the English NHS since 1997 has resulted mainly from targets and terror. The Coalition Government elected in May 2010 is committed to reducing the use of process oriented targets, and instead will seek to bring about further improvements in performance through patient choice and provider competition. The adversarial political system in Britain contains the risk that newly elected governments will throw the baby out with the bathwater. Health policy makers should resist the temptation to reject policies inherited from their opponents and should seek to provide direction from the top and empower front line teams in taking forward reform.

Key words: targets, performance management, choice and competition

What is the evidence from 1997–2010?

A recent review by the King's Fund found that considerable progress has been made in improving the performance of the National Health Service (NHS) in England under the Labour Government first elected in 1997.[1] Notable achievements include major and sustained reductions in waiting times for treatment, reductions in rates of health care associated infections, improvements in areas of clinical priority such as cancer and cardiac care and progress in reducing rates of cigarette smoking. These achievements have resulted from substantially increased spending on the NHS linked to an ongoing programme of reform.

The Labour Government's reform programme focused initially on the use of government targets and national standards to bring about improvements. Examples included targets to cut the length of time patients have to wait for an appointment and standards set out in national service frameworks to improve clinical services. Subsequently, steps were taken to increase patient choice and stimulate provider competition, alongside measures to strengthen inspection and regulation. The most recent phase of reform has sought to place greater emphasis on the role of clinicians in improving the quality and safety of health care in recognition of the limits of targets as a means of achieving sustainable improvements in care.

Political devolution to the four countries that make up the United Kingdom since 1999 has resulted in different approaches to health care reform as well as different results. An analysis carried out by the Nuffield Trust compared the experiences of England with what has been achieved in Northern Ireland, Scotland and Wales in the last decade.[2] The analysis concluded that England had made greater progress than the other three countries over this period and it argued that the main reason for this was the greater emphasis placed in England on targets and standards as a means of reform.

This conclusion is echoed in other studies that have drawn attention to the role of 'targets and terror'[3] in contributing to waiting time reductions in England. Specifically, the strengthening of performance management, and the holding to account of NHS organisations for the delivery of the government's health policy objectives, has focused the attention of leaders at a local level on the implementation of high priority targets. The boards of NHS

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organisations, and particularly chief executives and their senior colleagues, know that their jobs are at risk if they fail to meet these targets, and this has had the effect of concentrating management effort on those targets seen as being of greatest importance.

Also significant has been the growing influence of the regulators, such as the Healthcare Commission, the body that oversees the quality of care, and Monitor, the organisation that regulates NHS Foundation Trusts, in reinforcing the focus on national targets and standards. Not only this, but also the regulators have intervened when NHS organisations have experienced financial difficulties or the quality of care they provide has come into question. I can speak from experience as a non-executive director of an NHS Foundation Trust about the large amount of time and effort local leaders spend ensuring that they meet the requirements of the regulators and keeping them at arm's length.

By comparison, patient choice and provider competition appear to have had a limited impact on performance to date. This was the view of a joint review carried out by the Audit Commission and the Healthcare Commission in 2008[4] and has been confirmed by recent research by the King's Fund into the way in which policy on choice has worked to date.[5] Similarly, empowering clinicians to improve quality and safety remains an aspiration rather than a day-to-day reality in most parts of the NHS, notwithstanding attempts to give GPs control over budgets under the practice based commissioning policy and to involve hospital doctors in service line management.

The Labour Government's approach to performance improvement was reviewed in three reports commissioned by the Department of Health during the NHS Next Stage Review in 2008. The reports highlighted the negative consequences of a command and control style of leadership, and the lack of engagement of clinicians in quality improvement. The picture painted in the reports was of an NHS driven by a culture of compliance where the opportunity for learning was crowded out by the fear of failure.[6] The implication was that much more attention should be given to achieving improvement bottom up rather than top down.

Implications for the new government

The election of a Coalition Government made up of Conservative and Liberal Democrat politicians in the May 2010 general election heralds a new approach to performance improvement in the English NHS. The government has already made it clear that less reliance will be placed on process oriented targets in future and more attention will be given to improving health outcomes, such as cancer survival rates. Patient choice and provider competition will also be given priority and renewed efforts will be made to empower clinicians to bring about improvements in care. Particular emphasis is being placed on the role of general practitioners who will be expected to take control over budgets with which to commission most care for their patients in a radical development of the practice based commissioning policy promoted by the previous government.

The question that arises is whether these policies will be sufficient to build on the progress made in England since 1997 and to enable areas of under achievement, such as improving productivity and focusing much more on quality and safety, to be addressed? In addressing this question, the results of recent research into high performing health care organisations around the world hold some pointers.[7,8] This research indicates that in many of these organisations performance improvement derives more from building internal capabilities for improvement than responding to external pressures such as targets, national standards and regulators. To borrow a phrase from Kaiser Permanente, performance improvement results from 'commitment rather than compliance', and depends critically on engaging clinicians in the work that needs to be done.

Evidence from Kaiser Permanente, as well as other high performing organisations such as Jonkoping County Council in Sweden, the Veterans' Health Administration and Intermountain Health Care in the US, also indicates that performance improvement requires a consistency of purpose over time and much greater stability in leadership than is usually the case in the NHS. Raising standards of care is not amenable to quick fixes, and patience is needed before the results of improvement efforts become apparent. Particularly important is investment in training and development for staff and building the leadership and change management capabilities to implement and sustain improvements over time. This includes setting goals for improvement, measuring progress towards their attainment and publishing the results.

The role of choice and competition in improving performance remains an issue of debate. In organisations like Jonkoping County Council competition works mainly through transparent reporting of information and comparing what is achieved in relation to other county councils in Sweden. Much the same applies in the Veterans' Health Administration (VA) where the use of comparative information on the performance of regional networks is used to stimulate improvement. In the VA and in Intermountain Health Care, there is a clear and consistent focus on the quality of care, underpinned by a culture of measurement and reporting. This includes investment in information systems and deep engagement by clinicians. By contrast, it has been argued that the ability of patients to choose another health plan and the threat posed by competing providers are important factors in enabling Kaiser Permanente to leverage the benefits of being an integrated system to achieve high levels of performance.[9]

One of the conclusions from research into high performing health care organisations is that skills in execution and implementation may have a bigger influence on quality improvement than the particular methods of improvement (for example, lean, total quality management and quality collaboratives) that are adopted. This reinforces the need to invest in internal capabilities for improvement to make a reality of change being driven bottom up instead of top down. If clinicians are expected to play an increasing role in performance improvement, then giving priority to the development of clinical leaders and providing them with the appropriate skills is likely to be necessary. This has obvious implications for the success of policies like commissioning in future.

The pendulum effect in health policy

As policy on the NHS in England migrates from targets and terror to empowered clinical teams as the main means of improving performance, together with a greater emphasis on patient choice and provider competition, there is the perennial risk that the pendulum will swing too far and too fast in the opposite direction. Studies of high performing companies have drawn attention to the need to work across a series of dualities in seeking to improve performance.[10] These dualities include:

– providing direction from the top and empowering front line teams to make change happen

- promoting competition where it offers the greatest potential and supporting collaboration where organisations need to work together to improve performance
- working through the hierarchy as well as building relationships through networks
- emphasising the importance of clinical engagement and leadership while valuing the role of managers
- managing the present and planning for the future

The adversarial political system in Britain contains the ever present danger that newly elected governments will, in colloquial terms, 'throw the baby out with the bathwater' and reject policies they inherit because they were developed by their opponents. At some future date these policies are refreshed when the preferred approaches of the politicians in power do not have the desired effects. This is precisely what happened on the election of the Labour Government in 1997 with the ending of the internal market experiment promulgated under the Thatcher and Major governments followed by its reinvention in a much more radical form by Tony Blair in 2002.

In the current context, there is a real risk that the contribution that targets and standards have made to performance improvement has not been sufficiently acknowledged by the Coalition Government and that some of the progress made since 1997 will be lost as a consequence. To make this point is not to argue for the new government to simply continue the approach taken by its predecessor. Rather, it is to make the case for policy learning in which governments build on what has worked rather than always returning to the drawing board.

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Health system performance management:

Quality for better or for worse

Niek Klazinga

Summary: There is a growing interest in measuring quality of care to help increase the value of health systems. This paper addresses the reasons and difficulties of health system performance measurement. It stresses the need for a thoughtful health system performance framework and illustrates the need of an adequate underlying information infrastructure with respect to mortality data, clinical registries, administrative databases and patient surveys. Various strategies are discussed that can help to turn health system performance measurement into health system performance management.

Key words: quality, health system, measurement, management

Although measuring quality of care remains a challenge for many health services, there is an increasing interest in not just assessing the quality of individual health system components but putting their performance in the context of the health system as a whole. This holistic system approach was enforced by the World Health Organization (WHO) Regional Office for Europe through the Tallinn Declaration in 2008[1] and more recently, the health ministers of the Organisation for Economic Co-operation and Development (OECD) countries came to consensus that alongside access, costs and prevention, quality of care is a key component in judging the performance of a health system.[2]

Policy makers are no longer solely concerned with the costs of health care, but have moved forward with genuine interest in health system performance. This asks, alongside information on structure, process and output measurement, for additional information on outcomes of care. The recent emphasis of the Minister for Health in England to shift the focus to outcome measurement underscores this development.[3]

Measuring health system outcomes can build on the long history of population statistics, but it is also challenged with the question of what outcomes can be properly attributed to the actual performance of health services. Apart from the challenge of measurement, the management challenge remains of how to link outcome measures to policy initiatives, such as financing (associating resource allocation to performance) or national quality improvement programmes. Thus Health System Performance Management asks for a clear conceptual model on what constitutes health system performance, data systems that provide the necessary indicators, and a policy and management system that actively uses this information for decision making.

Reasons for health system performance management

Health system performance assessment and comparability (both inter and intra national) have three primary goals including: accountability, strategic decision making and learning/improving.[4] The first of these reasons relates to a transparency agenda and enables governments to justify the resources allocated to health care and the value generated. The second reason focuses on areas where countries identify performance problems and where specific attention is needed; examples include the need for national cancer plans or primary care strengthening. Comparative data can help countries identify areas for possible improvement. In order to realise and see improvement, more detailed information on why certain countries perform better then others is needed. When all of these components are in place, benchmarking and mutual learning becomes the management goal.

This paper summarises some of the recent developments in health system performance measurement by addressing the underlying performance frameworks and the various data sources, including mortality statistics, clinical registries, administrative databases, medical records and patient surveys. It also explores how the measurement activities can then be linked to management, thus creating the basis for health system performance management.

Why performance measurement in health care is difficult

By nature, assessing the quality of health systems is not easy. In industry, per-

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formance measurement is considered to be possible when an organisation has concrete and simple products, when an organisation is product oriented or when there is an autonomous production process with isolated products. In this arrangement, causalities are known, quality can be defined in indicators, products are uniform and the environment is stable. Compared with these conditions, health systems are dealing with organisations that have patient-centred obligations and are highly value oriented with multiple products, strong process orientation and a production process confounded by many co-producers. Furthermore, health system products are interwoven and the causalities are unknown. There are difficulties in defining quality in performance indicators and challenges arise in the variety of products and the highly dynamic environment.[5]

The need for health system performance frameworks

As a consequence, it should be clear from the beginning that a limited set of measures on the outcomes of a health care system most likely does not do justice to all the underlying care processes and the quality with which these are performed. Outcome indicators can help to signal potential areas of under performance, but it would be naïve to assume that any set of measures exists, or will exist, that can be used in a one-to-one relation to manage the health care system.

It is not only the validity and reliability of individual performance indicators that are at stake here, but also the representativity (the volume of the underlying processes in the health system that can effect this indicator), relevance (the relevance of this outcome in relation to all possible health system outcomes) and usefulness (the ability of the indicator to help identify policies that can improve performance).

To assess the performance of a health care system it is therefore advisable to have a performance framework that considers carefully the various performance domains and assesses whether the indicators that populate a certain domain actually meet the criteria of validity, reliability, representativity, relevance and usefulness. Constructing a health system performance framework as such is not simply a neutral academic exercise but captures many political and managerial notions as well. It is thus advisable that such frameworks, for example developed in Canada, the United States, the Nordic countries and the Netherlands are based on a development process that involves the main stakeholders.[6]

The health system performance framework used by the OECD is based on several constructs: it considers health care as one of the determinants of health alongside environment, lifestyle and genetics (the classical Lalonde model). Four functions in the health system are identified (staying healthy, getting better, living with disabilities and coping with the end of life, as brought forward by the US Institute of Medicine) and it operationalises quality in three domains (effectiveness, safety and patient-centeredness) alongside access, cost and equity.[7]

The need for good databases: mortality data

Life expectancy and perinatal and maternal death have traditionally been considered statistics for health system performance assessment. Although the intuitive rationale of the relationship between health system performance and mortality seems appealing, it is far more difficult to attribute improvements in mortality to health care performance without considering other societal improvements in the welfare state.

In the search for appropriate outcome indicators, avoidable mortality (or more politically correct – mortality amendable to health care) has recently become popular again after an initial wave of research in the 1980s.[8] Avoidable mortality surely holds a promise for measuring health system performance, but the studies on its factual validity and the ideal list of indicators that should be used and included is still ongoing (i.e., the Avoidable Mortality in the European Union study, AMIEHS). It seems therefore premature at this time to link avoidable death indicators to financial policies such as regional resource allocation.

The same holds true for mortality statistics on hospitals. Hospitals Standardised Mortality Rates (HSMR) are increasingly used in countries to assess the performance of hospitals, but the debate on the validity of this measure is still ongoing.[8,9]

Not only for avoidable mortality and HSMR, but also for the development of more refined statistics on cancer survival, it is necessary that mortality data be adjusted for co-morbidity. This would assume either that in databases this information is available, or can be made available, though the linkage of databases.

However, mortality statistics poorly register co-morbidities without standardisation and linkages to mortality statistics in administrative databases where any co-morbidity data could be assessed. Even with administrative databases, often the morbidity information is hampered through data protection and privacy concerns, diminishing the possibilities of mortality data use for meaningful assessment of the performance of health systems covering representativeness, relevance and usefulness, as discussed earlier.

Unique Patient Identifiers (UPI) can provide the linkage of necessary databases, but national governments will need to strike the appropriate balance between the need to obtain performance statistics and the need (to fulfil justified expectations) for data protection.

The need for good databases: administrative data and clinical registries

Administrative databases and clinical registries form major sources of performance information about the health care system. Over the past few years the OECD through its Health Care Quality Indicator project has explored the availability and quality of administrative databases in its member states. Among the findings, information in mental health care and primary care databases are often not standardised and generalisable enough to serve as the basis for international comparable indicators on the quality of care.[10]

Hospital-based administrative databases appear to be the best developed sources of desired data, partly through their direct linking with reimbursement systems. Reported indicators on primary care, such as avoidable hospital admission rates for diabetes, chronic heart failure, asthma and Chronic Obstructive Pulmonary Disorder (COPD), are derived from hospital-based administrative databases, as are the reported indicators on 30-day case fatality rates for acute myocardial infarction and stroke.[10]

More recently, the OECD has been working with a subgroup of eighteen countries on the calculation of Patient Safety Indicators following the work of the US Agency for Health Care Research and Quality.[11] Although this work is still considered as research and development, it has identified some of the major challenges of improving administrative databases (and

likewise clinical registries). Recommendations to address these challenges include:

- advice to actively use Unique Patient Identifiers to link administrative databases and clinical registries in order to enhance the possibilities of measuring the outcome of hospital care and better identify disease co-morbidities that can be used for case-mix adjustment in constructing outcome measures;
- advice to include a 'present on admission' code in the database to better identify whether a condition such as a bed sore or an infection was already present at the moment of hospital admission;
- advice to have more extensive coding of secondary diagnoses (co-morbidities); the average number of secondary diagnoses codes per admission varies considerably between countries, thus hampering the international comparability.

The need for good databases: Electronic Health Records

Potentially an electronic version of the medical record would be an ideal basis for deriving information on quality of care. However even in the limited number of countries where this has been broadly implemented and is fully functioning, current use is limited. Most of the current debates on Electronic Health Records (EHRs) focus on data use for individual patients. The debate on secondary data use for population statistics, i.e., construction of quality measures, is less prevalent. However, an increasing number of countries, among them the US, Australia and the Nordic countries, are trying to put regulations in place that would facilitate the use of the EHR for quality measures.

The need for good databases: patient surveys

The most direct source to obtain information on care quality is from the patient. Increasingly patient surveys are used as a systematic tool to obtain information on quality of care. This may be information on the service delivery components of health care, but also on the effectiveness (the Patient Reported Outcome measures).

For the return of data collection through surveys in a sustainable, valid and reliable way, a systematic and national approach towards the measurement of patient experiences is warranted. The OECD has formulated some principles for such an approach.[10] In the meantime, the survey approach in many countries remains too ad-hoc and is not institutionalised enough to deliver a constant stream of comparative information on performance.

From health system performance measurement to health system performance management

A comprehensive conceptual framework and sufficient databases to calculate quality indicators are two of the three steps to turn Health System Performance Measurement into Health System Performance Management. For this third step a direct linkage of measurement activities with policy and decision making in the health care system is necessary. This linkage is first and foremost to be found at the national level in the health ministry. Are the data on health system performance actively used for assessing the system and does this result in strategic decision making and policies aimed at learning and health system improvement?

The OECD discerns four areas where the linkages can be made: health system inputs (professionals, organisations, technologies); health system design (allocation of responsibilities, public health alongside social care, primary, acute and long-term care); monitoring (quality of the data-infrastructure and the various mechanisms for monitoring services and professionals) and health system improvement (incentive structures and national improvement programmes). These linkages assume that health system performance serves as an anchor point in policies for the coordination of care, patient-centred care, health technology assessment and clinical evaluation, patient safety and pay for performance.

Quality governance thus becomes far more than issuing national reports on health system performance. It is a systematic management challenge to assess and improve the performance of the system as a whole. These efforts can be strengthened when measures used in health system performance frameworks are directly related to the measures used for assessing the performance of specific parts of the health care system, pertaining to both services and individuals.

The agenda to develop performance measures should not be isolated from policies on certification and accreditation, guideline development, quality system development, national audits and national improvement programmes on quality and patient safety. Only then will Health System Performance Management become a reality.

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Mythbusters

Myth: If a drug makes it to market, it's safe for everyone

Progress in drug science makes it tempting to assume that 'newer' means 'better and safer'. However, researchers caution against this thinking, advising physicians not to prescribe new treatments when existing ones will do.

Pharmaceuticals save many human lives and improve the quality of numerous others. For example, thanks to new antiretroviral therapies, AIDS – once a rapidly progressive and deadly disease – is now a manageable chronic condition. And chronic conditions such as diabetes can be managed with a range of medications tailored to patients' needs. With these advancements in pharmacology, it's no wonder that Canadians generally trust that the drugs they use are safe and effective. Furthermore, according to a recent poll, Canadians have confidence in public authorities and drug companies to keep them healthy and safe.[1]

Despite the various measures in place to enhance drug safety, adverse drug reactions remain one of the top ten leading causes of death in Canada.[2] Research shows that hospital admissions from adverse reactions are high and that many are preventable.[3,4] Experts estimate that over 95% of adverse reactions go unreported.[5]

Out with the mould, in with the new?

Drugs have been used for millennia, ever since certain plants were observed to have healing properties. For example, extracts of willow bark have been used for centuries to reduce fever. These extracts contain a chemical similar to aspirin. However, pharmacology as a science has existed for just around two centuries.[6] Some important discoveries were serendipitous like the finding that penicillin – a by-product of a type of mould – can cure infection. However, in recent decades drug research and development has become increasingly sophisticated. Drugs can now be developed to isolate specific protein molecules in target tissues (for example, Tamoxifen interferes with a specific hormone receptor in breast cancer cells).

Progress in drug science makes it tempting to assume that 'newer' means 'better and safer'. However, researchers caution against this thinking, advising physicians not to prescribe new (and usually more expensive) treatments when existing ones will do.[7] In fact, new drugs have a one in five chance of being stamped with a 'black box warning' (required by the US Food and Drug Administration if a drug may have serious or even fatal side effects), or being withdrawn from the market within 25 years of approval (half of all withdrawals occur within two years of approval).[7] Seen through this statistical lens, the newness of a drug does not guarantee its safety.

Drugs on trial

Before receiving regulatory approval, new drugs undergo clinical trial research to determine if the drug produces the intended effect. Trials also identify possible side effects and their associated harms. This information helps regulators weigh the benefits and harms of drugs.

However, clinical trials have limitations. Certain people (such as those that are old, young, pregnant or suffering from other medical conditions) may be excluded from clinical trials meaning that their susceptibilities to adverse reactions are not uncovered .[8] This is especially concerning since the greatest users of pharmaceuticals are the elderly.[9] As well, participation is often restricted to patients who would use the drug only for its intended application, which isn't always the case. These trials cannot anticipate a clinician's decision to prescribe 'off-label' (prescribing an approved drug for an unapproved

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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/PublicationsAndResources/Mythbusters.aspx
This paper was first published in 2010.

application) or in opposition to clinical guidelines. Furthermore, the international standard suggested for the number of participants in trials[10,11] is not large enough to detect very rare but nevertheless serious adverse reactions.[8]

Because clinical trials do not mimic real life, the occurrence of unexpected adverse reactions is almost inevitable in the post-market setting. In fact, research shows that pre-market clinical trials only detect about half of all serious adverse reactions that surface once the drug is in widespread use.[12]

The ultimate trial

Once a new drug is approved (and only a handful are approved annually), it is put to the ultimate test of safety: application in the market. However, it may require years of drug exposure before any safety concerns about adverse reactions become apparent.

In Canada and the US, drug companies are required to report adverse reactions to the federal government, whereas health care professionals and the public are encouraged to report on a voluntary basis. The voluntary element leads to underreporting, making it impossible to know the true frequency and severity of adverse reactions. In addition, the typical prescriber often cannot identify or is unaware of the full spectrum of a drug's harms due to unreported adverse reactions. This lack of information can undermine efforts to prescribe only the safest drugs.

Conclusion

It cannot be assumed that progress in drug science means that all drugs on the market are safe for everyone. There is no 'magic bullet' drug that offers all benefit and no harm (for example, some people have allergic reactions to penicillin that can be fatal). Ultimately, it is up to patients and families, in consultation with a health professional, to decide whether to take a drug. What's most important is having a thorough understanding of the potential benefits and harms of any drug so that informed decisions may be made. In this respect, the recent establishment of the federally-funded Drug Safety and Effectiveness Network,[13] which will fund research on the safety and effectiveness of drugs in the 'real world', is a step in the right direction. The bottom line is that the more information we have available, the more we are able to understand the impact of adverse reactions on individuals, the health care system and the economy.[5]

This issue of Mythbusters is based on an article by the 2010 Mythbusters Award recipient, Ms Tenneille Loo. Tenneille is a master's candidate at the University of British Columbia, Vancouver, British Columbia.

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

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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.

Financial integration across health and social care: Evidence review

Helen Weatherly, Anne Mason, Kath Wright and Maria Goddard

Edinburgh: Scottish Government Social Research, 2010

ISBN: 978 0 7559 7832-8

73 pages

Freely available online at: http://www.scotland.gov.uk/Publications/2010/02/19133206/0

This report looks at an Integrated Resource Framework (IRF) which was jointly developed between the Scottish Government, NHS Scotland, and the Convention of Scottish Local Authorities (COSLA). The aim is to shift the investment away from the acute sector and towards health improvement and prevention.

Presented in this report are the results of a rapid review that was commissioned to inform an evaluation of the IRF, which is to be piloted at five sites in Scotland. The review assessed the international literature on financial and resource mechanisms to integrate care both within health care, as well as across health and social care. Integrated resource mechanisms (IRMs) were identified and assessed from an economic perspective.

The review of empirical studies of IRMs identified several factors critical for the success of the IRF. It also highlighted methodological challenges that provide lessons for evaluating the IRF. Of primary importance for the IRF pilot evaluations is an appropriate choice of study design. This will help ensure that observed effects can be reliably attributed to the intervention. Equally, the selection of an appropriate comparator(s) is critical. A common dataset, to which all Health Boards can contribute, will facilitate analyses of the effects, costs and unintended consequences of different IRF models.

The review found tentative evidence that financial integration can be beneficial. However, still lacking is robust evidence for improved health outcomes or cost savings. Thus, appropriately designed pilot studies of the IRF may help determine the potential costs and benefits of financial integration in Scotland.

Contents:

Acknowledgements; Executive summary; Introduction; Objectives; Methods; Results; Discussion; Summary; Lessons from the review; References; Glossary; Tables; and Appendices.

Funding and performance of healthcare systems in the four countries of the UK before and after devolution

Sheelah Connolly, Gwyn Bevan and Nicholas Mays

London: Nuffield Trust, 2010

ISBN: 1-978-1-905030-40-8

144 pages

Freely available online at: http://www.nuffieldtrust.org.uk/publications/detail.aspx?id=0&PRid=675

The health services of England, Scotland, Wales and Northern Ireland are all funded by the UK taxpayer, but each country has developed different systems of governance and different methods of providing health care. This report examines the impact of political devolution by studying key performance indicators for the NHS in the four countries at three points in time. The report also undertakes a comparison of NHS performance in the English regions and the devolved countries.

Key statistics for the NHS in the four countries are examined before and after devolution. Performance is tracked against a number of key indicators, including expenditure, staffing levels, activity, crude productivity of staff and waiting times.

The research suggests the NHS in England spends less on health care and has fewer doctors, nurses and managers per head of population than the health services in the devolved countries. Nevertheless, England is found to be making better use of the resources it has in terms of delivering higher levels of activity, crude productivity of its staff, and lower waiting times.

Historical differences in funding levels may have been the cause of some of these trends, which are not directly related to policy differences following devolution. Some divergence reflects the different policies pursued by each of the four nations since 1999, in particular the greater pressure put on NHS bodies in England to improve performance in a few key areas such as waiting and efficiency. In England, there was extensive use of targets, strong performance management, public reporting of performance by regulators, and financial incentives towards these ends.

Contents:

Acknowledgements; Foreword; Summary; Introduction; Devolution: background, arrangements and their implications; Methods, Cross-country comparisons; Comparisons of Scotland, Wales and Northern Ireland with English regions; Discussion; Appendix.

WEBwatch

Please contact Azusa Sato at a.sato@lse.ac.uk to suggest web sites for potential inclusion in future issues.

European Commission – Mental health and wellbeing information

http://ec.europa.eu/health/mental_health/policy/index_en.htm

The mental health section of the European Commission public health website contains a wide range of information on this topic and on activities undertaken as part of the European Pact for Mental Health and Wellbeing. Recent additions include documents from the recent Pact conference on promoting social inclusion and tackling stigma held in Lisbon in November 2010. There are also links to a new Eurobarometer on mental health, as well as information on policy documents, forthcoming events, consultations and projects.

FEANTSA – European Federation of National Organisations working with the Homeless

http://www.feantsa.org

FEANTSA is an umbrella group of not-for-profit organisations which participate in, or contribute to, the fight against homelessness in Europe. It has more than one hundred member organisations, working in close to thirty European countries, including twenty-five EU Member States. Most of FEANTSA's members are national or regional umbrella organisations of service providers that support homeless people with a wide range of services, including housing, health, employment and social support. The website provides information on working groups, policy work, events and publications – the annual *European Journal of Homelessness*, the tri-annual magazine *Homeless in Europe* and the monthly newsletter, *the Flash*. The website is available in English and French.

Eurocarers – European Association Working for Carers

http://www.eurocarers.org

Eurocarers seeks to represent and act on behalf of all informal carers, irrespective of their age or the particular health need of the person they are caring for. The organisation pursues philanthropic, educational and scientific ends with regard to the representation of carers. The website contains a library with information on relevant EU policy documents, a factsheet, information on good practice and past research projects, as well as links to past presentations by members of the organisation.

Eurocare – The European Alcohol Policy Alliance

http://www.eurocare.org

Eurocare is a network of some fifty voluntary and non-governmental organisations working on the prevention and reduction of alcohol related harm across twenty-two countries in Europe. With a secretariat based in Brussels, it aims to raise awareness among European, national and regional decision makers of the harms caused by alcohol (social, health and economic burden), ensuring that these are taken into consideration in all relevant EU policy discussions. It also promotes the development and implementation of evidence-based policies aimed at effectively preventing and reducing this burden. The website includes detailed country profiles on alcohol use and policy, a range of published papers and reports, key factsheets and links to European research projects.

Belgian Healthcare Knowledge Centre

http://www.kce.fgov.be

The Belgian Knowledge Centre is a federal institution that has been operating since 2003. Its mission is to produce studies and reports to advise policy-makers on health care and health insurance issues. It is active in three major research fields: analysis of clinical practice and development of recommendations of good practice; assessment of health technologies and drugs; and health care financing and organisation. The website provides full access to completed reports, as well as information on current studies. The majority of reports are available in English, with others in Dutch and French. Summaries in Dutch and French are also provided.

HeRA – Norwegian Electronic Health Library Open Research Archive

http://hera.helsebiblioteket.no/hera

HeRA is the Norwegian Electronic Health Library's (Helsebiblioteket) open research archive for hospitals and other health institutions in Norway. The archive contains research publications already published (post print archiving), such as full-text peer reviewed journal articles, reviews, reports and other publications. The site contains advanced search options and in many cases links to full reports and journal papers. Many of these reports and papers are published in English, with other material available in Norwegian.

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

Conclusions from Employment, Social Policy, Health and Consumer Affairs Council

The formal meeting of health and social ministers under the Belgian Presidency of the European Union took place in Brussels on 6 and 7 December. In respect of health, ministers reached political agreement on a draft regulation on food information for consumers. They also exchanged views on the follow up lessons to be learnt from the A/H1N1 pandemic, and in particular on the joint procurement of vaccines and antiviral products. During lunch, ministers exchanged views on the joint report of the Economic Policy Committee on health care systems in Europe. Furthermore, the Council adopted three sets of conclusions on: investing in Europe's health work force for tomorrow; innovation and solidarity in pharmaceuticals; and innovative approaches for chronic diseases.

New labelling rules for food

The Council agreement on new legislation on food labelling is designed to ensure that food labels carry essential information in a clear and legible way, enabling consumers to make informed and balanced dietary choices. One of the key elements agreed by the Council is the mandatory nature of the nutrition declaration: the labelling of the energy value and the quantities of some nutrients (fat, saturates, carbohydrates, protein, sugars and salt) should become compulsory.

As a general principle, the energy value and the amounts of these nutrients would have to be expressed per 100g or per 100ml, but could also be indicated as a percentage of reference intakes. However, food business operators could also use additional forms of expression or presentation as long as certain conditions are met (e.g. they do not mislead consumers and are supported by evidence of understanding of such forms of expression or presentation by the average consumer). All elements of the nutrition declaration should appear together in the same field of vision but some elements may be repeated on the 'front of pack'.

Many alcoholic products will be exempt from the new rules, although this decision will be reviewed within five years. Non-prepacked food would also be exempted from nutrition labelling, unless member states decide otherwise. The text of the political agreement reached by the Council will be reviewed legally and linguistically before it is formally adopted at one of the forthcoming Council sessions as its first-reading position. This text would then be forwarded to the European Parliament for its second reading. The European Parliament adopted its first-reading position on 16 June 2010

Pandemic A/H1N1

Ministers exchanged views on the follow up to the Council conclusions on the lessons learnt from the A/H1N1 pandemic adopted in September 2010 and in particular on the joint procurement of vaccines and antiviral products.

Recalling the weaknesses of the individual procurement of pandemic influenza vaccines and antivirals during the A/H1N1 influenza pandemic, in terms of equitable access and purchasing power, many ministers argued in favour of the joint procurement of pandemic vaccines and antiviral medication. A large majority of delegations agreed that framework contracts that member states may enter into on a voluntary basis constitute the most suitable form for a joint procurement. It is expected that this would strengthen the member states' negotiating position in discussions with the pharmaceutical industry and ensure equitable access to vaccines. The need to further clarify some outstanding issues, such as the question of product liability and the compatibility with competition rules before taking any decisions, has been highlighted.

A broad majority of ministers also recognised the need for a common minimum coverage of pandemic vaccines and agreed that the vaccines for covering this common minimum should be delivered prior to all other additional orders and on an equitable basis. Ministers wished to target the common minimum coverage at strategic sectors such as health care workers, policemen and firefighters. The suggestions for such a common minimum cover rate varied between 2% and 20%, with many delegations stressing the need to take account of national specificities as well. Some delegations considered the definition of a common vaccination strategy as a precondition for setting up a common minimum cover rate.

The Council's attention was also drawn to the fact that an indication of the expiry date for vaccines can, if exceeded, further reduce citizens willingness to being vaccinated, even though the vaccines in question would still be safe and effective. Commissioner for Health and Consumer Policy, John Dalli, announced that the Commission would take work on a joint procurement scheme further in the Health Security Committee. With regard to the shelf life of vaccines, Commissioner Dalli said that he would ask the European Medicines Agency (EMEA) to continue working with the industry on this issue.

The discussion was a follow-up to the conclusions adopted on 13 September 2010 in which the Council invited the Commission, inter alia, to report on and develop, as soon as possible and no later than December 2010, a mechanism for the joint procurement of vaccines and antiviral medication which grants member states, on a voluntary basis, the right to common acquisition of these products or common approaches to contract

negotiations with the industry, clearly addressing issues such as liability, availability and price of medicinal products as well as confidentiality.

Innovation and solidarity in pharmaceuticals

The Council also adopted conclusions on innovation and solidarity in pharmaceuticals, calling upon member states to take initiatives to promote the rational and responsible use of valuable innovative medicinal products with a view to obtaining an optimal clinical outcome and an efficient management of expenditure. The European Commission and EU countries should continue to work towards a stronger prioritisation in the allocation of resources for pharmaceutical research to increase the probability of valuable innovations. They should also give priority to revising the clinical trials directive with the aim of ensuring an improved regulatory framework for developing medicinal products. Furthermore, they should examine the possibilities of enabling an efficient cross-border exchange of clinical data, and take appropriate initiatives to establish interoperable registries, for instance on rare diseases. They should also examine how to facilitate availability to innovative medicinal products throughout the EU.

Chronic diseases

The Council adopted conclusions on innovative approaches for chronic diseases in public health and health care systems, inviting the member states to further develop patient-centred policies in the field of chronic diseases. The EU countries and the Commission are called upon to start a reflection process with a view to optimising the response to the challenge of chronic diseases. This reflection should cover inter alia health promotion and prevention of chronic diseases, health care, research into chronic diseases and comparison of chronic diseases at European level. The outcomes of the reflection process should be summarised in a paper by 2012. The conclusions take into account the results of the conference organised by the Belgian Presidency in Brussels on 20 October 2010. Chronic diseases are one of the presidency's priorities in the field of public health.

Council conclusions are available at www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/118254.pdf

Council of Ministers acts against adverse effects of medicines

On 29 November the EU Council of Ministers adopted a regulation and a directive aimed at strengthening the EU system for the safety monitoring of medicinal products for human use (pharmacoviligance), to better protect public health. The EU pharmacovigilance system seeks to detect, assess and prevent adverse effects of medicinal products placed on the market in the European Union. It also ensures that any product, which presents an unacceptable level of risk, can be rapidly withdrawn from the market.

Member states will remain central for the operation of a pharmacovigilance system, but their responsibilities are clarified. Under the new rules they will collect information on suspected adverse drug reactions, not only if the product was used within the terms of the marketing authorisation, but also in case of overdose, misuse, abuse and medication errors.

A new scientific committee within the European Medicines Agency (EMEA), the Pharmacovigilance Risk Assessment Committee, will also advise the EMEA's Committee for Medicinal Products for Human Use, which remains responsible for issuing an opinion, on the risk-benefit assessment of centrally-authorised medicinal products for human use. Provision is also made to allow adequate funding for pharmacovigilance activities through the collection of fees charged to marketing authorisation holders for obtaining and maintaining EU marketing authorisations and for other services provided by EMEA and national competent authorities.

The existing EU pharmacovigilance database, the "Eudravigilance database", will be strengthened and become a single point of receipt of pharmacovigilance information for medicinal products for human use authorised in the EU, thus facilitating early discovery of adverse reactions. In order to ensure transparency in pharmacovigilance issues the EMEA will also create and maintain a European medicines web portal.

In terms of the pharmacovigilance obligations of industry, as under the current rules, the marketing authorisation holder must establish a pharmacovigilance system to ensure the monitoring and supervision of its authorised medicinal products. The requirements for applications have been simplified. Marketing authorisation holders will have to submit only key elements of their pharmacovigilance system, rather than a detailed description of the system. On the other hand, they will have to maintain a detailed file on site for possible inspections by the competent authorities.

For more information about the directive, www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/118080.pdf

EU health strategy undermined by failure to draw on wealth of experience at sub-national level, warns CoR

Europe's regions have a wealth of experience in developing and implementing health strategies that remains untapped at the European level, the Committee of the Regions (CoR) warned on 2 December 2010. The failure to fully involve sub-national authorities as legitimate partners in the development of future initiatives will undermine the European Commission's efforts to improve the quality of health care and health services across the EU.

Speaking after the adoption of his opinion on the role of local and regional authorities in the implementation of the EU Health Strategy at the CoR Plenary Session in Brussels, rapporteur Adam Banaszak said that "local and regional authorities are still insufficiently involved in the implementation of the European health strategy despite the key role that they play in, for example, providing health care services or developing prevention campaigns. The European Commission could do much more to involve local and regional actors while dealing with health issues, such as inviting them to take part in working groups, and should build on their experience in areas such as assessing health inequalities between regions. But above all it needs to make sure that there is sufficient financial support for local and regional authorities in the field of health care, not least by making it easier for them to access existing European funds for health-related programmes, in particular those involving cross-border cooperation. For the CoR it is also important for health objectives to be included in the Europe 2020 strategy with a view to achieving intelligent and balanced development that can help combat social exclusion."

One of the clear messages for EU Health and Consumer Policy Commissioner John Dalli, who was invited by CoR President Mercedes Bresso to present the

European Commission's position in the Plenary Session, is the need for more effective indicators to assess the level of health inequalities across Europe. "The Lisbon Treaty makes territorial cohesion one of the key pillars of the EU, yet in the field of health care there are still substantial differences across regions, even within countries. European-funded projects have, for example, established a set of regional indicators that give a far more accurate picture of health inequalities than the methodology currently in use. The Commission should support such projects and ensure that their follow-up helps regions to tackle inequalities in health care and meet other future challenges," said Banaszak.

The Committee of the Regions is committed to working closely with the European Commission on key issues such as disease prevention and health promotion, through the recently established technical platform, which brings together officials from local and regional administrations, experts and stakeholders, EU officials as well as interested CoR members to discuss a wide range of health-related issues with policymakers.

The opinion can be downloaded at http://tinyurl.com/2fc8ekx More information on the Committee of the Regions at http://www.cor.europa.eu/

Commission launches consultation on active and healthy ageing

The European Commission is seeking the views of public and private organisations, companies and individual citizens on how Europe could scale up innovation to meet the challenges of the ageing population in Europe, and in particular on a pilot European Innovation Partnership (EIP) on active and healthy ageing, as set out in the Innovation Union Flagship Initiative, launched on 6 October. Between 2010 and 2030, the number of Europeans aged over 65 will rise by nearly 40%, posing huge challenges but also offering great opportunities for Europe's society and economy. The EIP, which the Commission has proposed should be launched in 2011, would seek to meet three goals: to improve the health and quality of life of older people, enabling them to live active and independent lives; to contribute to the sustainability and efficiency of health and social care systems; and to foster competitiveness and business opportunities. The online consultation runs until 28 January 2011.

John Dalli, European Commissioner for Health and Consumer Policy said: "Europe needs to prepare for the future ageing of its society and the use of innovation shall be one of the tools at our disposal. This is why I am very pleased that the very first of the Partnerships is on Active and Healthy Ageing: it will imply a close cooperation across different policies covering public health, research, digital and industrial policy."

Neelie Kroes, Commission Vice-President for the Digital Agenda said: "People are living for longer – and should be able to do so as actively and independently as possible, with the help of innovative solutions such as fall-detection and prevention devices, easy to use social interaction services to overcome loneliness, and smart use of information and communication technologies in the home. We need input from stakeholders to make sure the future Innovation Partnership can help to make these ideas a reality for Europe's senior citizens."

The consultation invites interested stakeholders, such as organisations representing older people and patients, hospitals and care service providers, health and care professionals, insurers, ICT and health companies, public authorities and individual citizens, to help identify current barriers to innovation and opportunities in the field of active and healthy ageing. Contributors can also share existing and future initiatives which could be undertaken at European level and advanced in a collaborative way. These should focus on how innovative solutions can bring promising and tangible outcomes to benefit the elderly.

The European Innovation Partnership on Active and Healthy Ageing, as a headline target, aims to increase the average healthy lifespan in the EU by two years by 2020. It seeks to improve older people's quality of life and to lead to more efficient care solutions. It will focus on applying innovation on a larger scale than today in areas such as health promotion, prevention, early diagnosis and treatment, integrated and collaborative health and social care systems, independent living and assistive technologies for older people.

The Commission will analyse the responses to the consultation, in order to obtain a clear view of the innovation potential and capacity in the multiple areas that affect ageing today. The responses will help the Commission to plan the next steps for the EIP.

The consultation document is available at http://tinyurl.com/2asqav8

European countries urge greater action on chronic disease prevention and control

On 26 November ministers and officials from around 40 European countries ended a two-day consultation on global and regional efforts to prevent and control the increasing deaths and suffering caused by non-communicable diseases (NCDs), as well as their effects on economies and development.

The meeting, held in Oslo, Norway, was a critical step in Europe's build-up to next September's first-ever United Nations General Assembly High-level Meeting on the Prevention and Control of Non-Communicable Diseases. "NCDs are becoming a major health challenge all over the world, and the cost of not taking action is unacceptable," said Norwegian Minister of Health and Care Services Anne-Grete Strøm-Erichsen. "Countries in the European Region need to share our own domestic experience with other nations on what does and does not work in the fight against NCDs."

Key outcomes of the Oslo meeting include the following.

- National health plans will give higher priority to NCDs.
- Many countries called for the inclusion of NCDs into global development initiatives and related investment decisions. The official development assistance currently received is insignificant for the fight against NCDs.
- The participants concluded that NCDs are a threat to development that neither the developed nor developing worlds can afford. Additional research is needed to halt and reduce premature death from this cause. Cost-effective policy interventions need to be implemented to reduce people's exposure to NCD risk factors and strengthen health care services for those with chronic diseases.

The United Nations summit will focus on the four main types of NCDs: cancer, diabetes, cardiovascular diseases and chronic lung diseases. They are responsible for more than 60% of global deaths (35 million); nine million of these deaths

are premature (in people aged under 60 years). Deaths from NCDs can largely be prevented by low-cost measures targeting four key risk factors: tobacco use, harmful use of alcohol, poor diet and physical inactivity.

Globally, NCDs heavily affect developing countries, particularly the poorest, which have weaker health systems, poverty and lower protection against the risk factors. As a result, marked increases in prevalence are projected. In Africa, deaths from NCDs are expected to increase by around 25% by 2020.

In the WHO European Region, NCDs annually account for more than eight million deaths (over 80% of all deaths in the Region), including 1.5 million premature deaths. Three out of four premature deaths from NCDs in the European Region (1.1 million) occur in low- and middle-income countries.

"The challenge posed by NCDs is not one just for the health sector alone to tackle, but for all sectors to fight together, including foreign affairs, development cooperation, urban planning, finance, education and transport," stated Dr Ala Alwan, Assistant Director-General for Health Action in Crises at WHO headquarters in Geneva. "More and more people are dying and suffering from these diseases, which are causing enormous health and economic impacts globally. In particular, poor and vulnerable people are affected in the world's poorest countries."

More information on the meeting at http://www.euro.who.int/en/home/conferences/regional-high-level-consultation-on-noncommunicable-diseases

Landmark declaration signed on the health of children with intellectual disabilities

On 26 November health policy-makers from the 53 countries in the WHO European Region signed a declaration expressing their commitment to improving the lives of children and young people with intellectual disabilities by improving their access to high-quality health care. The declaration was signed at the WHO European Conference *Better Health, Better Lives: Children and Young People with Intellectual Disabilities and their Families* in Bucharest, Romania.

Despite tremendous efforts in recent years, major challenges remain in helping intellectually disabled children lead healthy lives. Intellectual disabilities affect about five million children and young people in the Region, the majority living in poorer countries. More than 300,000 live in institutions, often remaining for life. Unless urgent action is taken, this number is expected to rise by about 1% per year over the next ten years.

"Children with intellectual disabilities have the same rights to health and social care, education and protection as other young people. They should have equal opportunities to live stimulating and fulfilling lives in the community with their families, alongside their peers," stated Zsuzsanna Jakab, WHO Regional Director for Europe. "The declaration that our Member States have adopted today in Bucharest recognises that these children have greater health needs yet they encounter major barriers in gaining access to effective health promotion and care. If they gain access to services, their needs are often either missed or neglected. The declaration maps out concrete actions that will empower these children to achieve their full potential in life."

The declaration builds on some fundamental principles. Children with intellectual disabilities and their families need effective and comprehensive care from community-based services. Providing this entails a major shift from models based on institutional care to those that give priority to community-based living and social inclusion. People living in poverty have a disproportionately high incidence of disability. Families with vulnerable members, including children with disabilities, are all too often trapped in chronic poverty.

The declaration also challenges the public health community to draw a true picture of the problem and its scale. Accurate and meaningful data on disabled children are hard to find. Official statistics rarely reveal much about their situation or the problem's extent. "Supporting the reform of child care systems has been a priority for UNICEF (United Nations Children's Fund) in eastern Europe and central Asia for the last twenty years. We can report partial success. The reforms have delivered many new services across the region, especially alternative family-based care, and this is a significant achievement. But, sadly, what we are seeing is that children with disabilities are usually the last ones to benefit from these services. Most disturbingly, the institutionalisation of children with disabilities continues as a stable trend, untouched by any reform. In many countries, children with disabilities represent as many as 60% of all children in institutions. For us, this is an indication of the failure of systems to provide tailored responses to families with disabilities and children with disabilities themselves," underlined Steven Allen, the UNICEF Regional Director for Central and Eastern Europe and the Commonwealth of Independent States.

National legislation and policies need further development. Few European countries have policies that explicitly address the needs of intellectually disabled children and young people. To fill these gaps, the declaration includes an action plan covering ten priority areas with concrete interventions for groups of young people differentiated by their age, vulnerability and evolving capacities. The first results of carrying out this plan are expected towards the end of 2015.

The declaration is supported by UNICEF, the European Commission, representatives of intellectually disabled young people and their families, providers of social and education services, and non-governmental organisations.

More information at http://www.euro.who.int/en/what-we-do/health-topics/diseases-and-conditions/mental-health/activities/intellectual-disabilities

European Court of Human Rights rules that Ireland's abortion laws breach human rights

On 16 December the European Court of Human Rights ruled in the case of A, B and C versus Ireland (application number 25579/05) that Ireland's laws banning abortion breach European human rights law. In a landmark and binding case that could have implications for other European countries, the court ruled that Ireland had breached the human rights of a woman (case C) with a rare cancer who feared it would relapse if she became unintentionally pregnant. The woman was unable to find a doctor willing to judge whether her life would be at risk if she continued her pregnancy to term.

The court concluded that neither the "medical consultation nor litigation options" relied on by the government constituted an effective or accessible procedure. "Moreover, there was no explanation why the existing constitutional right had not been implemented to date," the court ruled. The woman was awarded €15,000 in damages.

While abortion in Ireland remains a criminal offence under 1861 legislation, a technical constitutional right to abortion does exist following a 1992 Supreme Court ruling. In a controversial judgment known as the "X case", the court established the right of Irish women to an abortion if a pregnant woman's life was at risk as a result of the pregnancy. However, successive governments have not legislated on the issue, and several constitutional referenda variously aimed at either enacting or revoking the judgment have proved inconclusive. Ireland and Malta are the only member-states of the Council of Europe in which abortion remains illegal.

The European court case was filed in 2005. In 2009 it had an oral hearing before the court's grand chamber. This 17-judge court is reserved to hear cases that raise serious questions affecting the interpretation of the European Convention of Human Rights. As a signatory to the European Convention on Human Rights – now incorporated into Irish law – the government is obliged to remedy any breaches of the convention.

The two other Irish women (A and B) who took cases before the court in Strasbourg, France, were unsuccessful in their bids. The first woman, who was claiming the right to an abortion because she was living in poverty and felt unable to raise the child, had her case struck down. Her case, if successful, would have forced Ireland to legislate for abortion on demand. The second of the two unsuccessful candidates ran the risk of an ectopic pregnancy, in which the foetus develops outside of the womb. Her case also was rejected because there was no clear medical certainty over the diagnosis of an ectopic pregnancy.

All three women were among an estimated 4,000 Irish women who travel to Great Britain for an abortion each year (Abortion is also not available in Northern Ireland). The Irish government defended its laws and said Ireland's abortion laws were based on "profound moral values deeply embedded in Irish society". It argued that the European Court of Human Rights has consistently recognised the traditions of different countries regarding the rights of unborn children. However, it maintained that the women's challenge sought to undermine these principles and align Ireland with countries with more liberal abortion laws.

Reacting to the judgement, the Taoiseach stated that the judgement would have to be carefully studied. In practice, any response will be delayed until after the imminent general election early in 2011. Both main parties – the current governing Fianna Fail party and the main opposition Fine Gael – have policies opposed to abortion. Ireland's third party, the Labour Party, supports the introduction of abortion. Welcoming the judgement, Senator Ivana Bacik, the Labour Party's Justice Spokesperson said that "the European Court ruled that we must have greater clarity in our law, through passing legislation which will ensure that the right to a life-saving abortion is put into effect. I very much welcome the ruling and urge the Government to introduce legislation now as Labour has already recommended, to provide clarity about the conditions under which the X case judgment may be implemented by doctors."

The Irish Family Planning Association has said that the ruling 'leaves no option available to the Irish State other than to legislate for abortion.' The Association, which represented the three applicants in the case, has said the move is necessary in order to protect women at risk. Earlier, the Catholic Primate Cardinal Seán Brady said that the judgment does not oblige Ireland to introduce legislation authorising abortion. The Cardinal has said the Strasbourg Court decision 'raises profound moral and legal issues which will require careful analysis and reflection.' He stated that the judgement leaves future policy in Ireland on protecting the lives of unborn children in the hands of the Irish people. Meantime the National Women's Council of Ireland has welcomed the ruling and called on the Government to legislate for a woman's right to have an abortion if her life is at risk.

The full text of the judgement is available at www.echr.coe.int/echr/ homepage_EN

COUNTRY NEWS

England: The Internet is first choice for health advice

NHS Choices (www.nhs.uk) is the official website of the National Health Service (NHS). In addition to providing thousands of pages of NHS accredited content on conditions, treatments and healthy living, it allows the public to compare and comment on the performance of hospitals, general practitioners (GPs) and many other NHS services. More patients than ever before are now going online to find health information and self-diagnose, saving the NHS millions of pounds a year, according to two separate reports published on 9 November.

The NHS Choices 2010 Annual Report shows there has been a 10% increase in the number of visits to the NHS website in 2010 compared to 2009, taking the number of times people logged on to the site to well over 100 million. On average this was more than 200,000 visits per day. During the height of the flu pandemic nineteen million people turned to NHS Choices to find information on swine flu, while over 40,000 patients have posted comments about hospitals and GP practices. The site is now the biggest health information site in Europe, regularly attracting nine million users a month.

Separately, Paul Nelson, Joanna Murray and Muhammad Saleem Khan at Imperial College London surveyed 4,200 people and found that 70% of patients use the internet to search for health information. 37% of those who logged on to www.nhs.uk reduced their GP call-outs and appointments as they found the information they needed before contacting their doctor. Given that an average GP visit costs £32, this is the equivalent of saving the NHS £44 million a year. The report's authors noted that these savings were conservative: there are likely to be other considerable savings associated with the opportunity users have to act on health advice offered by NHS Choices.

NHS Choices has now partnered with over 170 external organisations, such as patientopinion.org.uk and mumsnet, to allow patients to access reliable health information across the board. This has led to twenty-five million people viewing information on NHS Choices via partner websites. NHS Choices also topped the consumer magazine *Which?* recent investigation into medical websites, saying the site "excelled for its breadth of information" and that the site contained "medically robust information".

The reports come at a time that the government in England has recently launched a consultation on how information and technology can help people take more control of their health and make the best choices for themselves and their families.

Commenting on the two reports, Junior Health Minister Simon Burns said that

"every day we use the internet and technology to organise our lives, and increasingly when it comes to our health. For example, more and more people are taking the information they have found online with them when they consult their GP. It is important they can find accurate, trusted information from sources such as NHS Choices. It is vital that every penny spent on the NHS counts, and the Imperial College research shows that tools like NHS Choices can help deliver savings."

The NHS Choices annual report and the Imperial College London research report can be found at www.nhs.uk/annualreport

UK: Government decides against generic substitution of medicines

Following the Government's consultation on proposals to implement generic substitution entitled 'The proposals to implement 'generic substitution' in primary care, further to the Pharmaceutical Price Regulation Scheme (PPRS) 2009: Consultation Document', which was open during the period January to March 2010, the new Coalition Government has now abandoned plans to put this scheme in place. The consultation proposed to allow for medicines that were prescribed by brand by the prescribing practitioner, to be dispensed as a generic medicine where that prescribing practitioner consented.

The main driver behind the consultation was that of cost savings to the NHS, to save the additional expense of branded medicines wherever possible. By implementing generic substitution, the pharmacist would have the option to dispense a cheaper generic medicine in situations where patients' health would not be compromised. Other reasons given in support for generic substitution included giving patients greater access to their medicines, as the pharmacist would be able to substitute the branded medicine for a potentially more readily available generic alternative.

Secondly, it was suggested that by prescribing and dispensing generically, the health care professionals involved would be more acutely aware of the treatment regime for each patient, as the generic name gives health care professionals a greater indication of the mode of action of each medicine. This would, it was further mooted, lead to a decrease in any potential risk of prescribing a second incompatible medicine or duplicating the prescribing of the same medicine.

The Government has now published its response to the consultation, stating that the generic substitution proposal will not be going ahead. The analysis of responses showed no clear consensus on the way forward. The consultation reported a strongly held perception by respondents that generic substitution posed a threat to patient safety. If the proposals were to be implemented, these concerns would arise in the delivery of frontline services, impacting on the workload of professionals. The consultation did not conclusively establish the cost effectiveness of generic substitution. There was also a strong sense that the effort involved was simply too great for the potential gain.

Health Minister, Lord Howe, said that "we know that there are valuable savings to be made from the use of generic medicines where it is clinically appropriate. However, we believe that national plans to enforce generic substitution in primary care are too prescriptive." He did however add that "we want patients to get the drugs their doctors recommend at the best price for the taxpayer. Patients should be reassured that we are looking at more appropriate ways of supporting the use of generic medicines and, in the long term, value-based pricing will help to ensure we pay a price for drugs which better reflects their value."

More information on responses to the consultation at www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_120431

Germany: Health minister highlights benefits of health promotion to business

On 8 December at an event on workplace health promotion in Berlin, German Federal Health Minister Dr Philipp Rösler highlighted the importance of health promotion as a factor in the economic success of companies. He stressed that these benefits could be realised by small and medium sized enterprises, pointing to recent scientific studies suggesting that better workplace health promotion could reduce health care costs and sick leave by about one quarter. The Minister recognised that more needs to be done to raise awareness of the benefits of workplace health promotion. Many companies only rarely benefit from effective strategies. He encouraged health insurance funds and companies to work hand-in-hand in this task.

Investing in workplace health promotion is a voluntary activity for employers, but it is mandatory for health insurance to make provision for such services. As an incentive for employees to invest in measures to improve health in the workplace income tax breaks are in place to the tune of €500 per annum. The event saw the presentation of different good practice examples covering a range of different areas including diet and physical activity, stress management, leadership and tackling mental health problems such as depression and burn-out.

Thematic Conference: Promoting Mental Health and Well-being at Workplaces

In related news, the EU German Federal Ministry of Health will organise, in cooperation with the European Commission's Directorate General for Health and Consumers and the Directorate General for Employment, Social Affairs and Equal Opportunities, a EU-conference 'Promoting Mental Health and Well-being at the Workplace' on 3–4 March 2011. The conference will create an opportunity to raise awareness about the relevance of mental health and well-being for workplaces and exchange and improve cooperation on challenges and opportunities in workplace mental health and wellbeing. It will also contribute to a wider dissemination of good mental health practices in various workplace settings and present state-of-the-art research findings, highlight leadership examples and good practices in mental health promotion at workplaces, and it will discuss the role of policymakers, and healthcare and social security systems in this context.

A German language workplace health promotion brochure produced by the Ministry of Health can be downloaded at http://tinyurl.com/34amxdr. More information on the European conference on Promoting Mental Health and Wellbeing at the Workplace is available at http://ec.europa.eu/health/mental_health/events/ev_20110303_en.htm

Ireland: Unique cross border hospital service established

A unique model for planning and managing a cross border hospital service has been established between the Health Service Executive Dublin North East and the Southern Health and Social Care Trust in Northern Ireland. This cross border collaboration has seen Ear, Nose and Throat (ENT) waiting lists in the

HSE Dublin North East (HSEDNE) area significantly reduced by facilitating ENT consultants from Northern Ireland's Southern Trust to work in Monaghan Hospital. It is also enabling HSE DNE ENT patients to access inpatient care in Northern Ireland's Daisy Hill and Craigavon Hospitals. Funding for the 'start up' period of this scheme has been provided by the European Union's INTERREG IVA programme which was secured by Co-operation and Working Together (CAWT), the cross border health and social care partnership. The partnership comprises the Health and Social Care Board and the Public Health Agency in Northern Ireland, the border counties of the Health Service Executive (HSE) in the Republic of Ireland and the Southern and Western Health and Social Care Trusts in Northern Ireland. As part of the initiative Monaghan Hospital has been collaborating with the acute hospitals in the Southern Health and Social Care Trust in Northern Ireland over the past twelve months, to get the cross border service up and running. The amount of funding secured for cross border ENT services is €3.77 million for the whole of the CAWT border region.

To date, under this cross border scheme, 2,270 people living in the Dublin North East area have received ENT outpatient appointments in Monaghan Hospital with day case treatment also available if required. Additionally, 859 Southern Trust patients have been seen in ENT clinics in either Craigavon or Daisy Hill Hospitals. CAWT's Chief Officer, Mrs Bernie McCrory outlined the significance of this new cross border ENT service. She said "CAWT is managing twelve European Union funded cross border health and social care services and projects and the biggest portion of our activity is focused on acute hospital services. This unique partnership serves as a model for other cross border hospital services currently in the planning stages. Both partners to this cross border ENT service, the Southern Trust and the HSE DNE, are committed to its longer term continuation, which is already bringing real health benefits to the local border populations."

To support the establishment of this cross border ENT service, nurses from Monaghan hospital engaged in observational training in the Southern Trust, with the approval of the Nursing and Midwifery Council (NI) and An Bord Altranais (Irish Nursing Board). The two Southern Trust consultants, Mr Kaluskar and Mr Farnan, already registered with the General Medical Council in Northern Ireland, are now registered with the Irish Medical Council, which enables them to treat patients in the Republic of Ireland. Once the EU funding period has elapsed the cross border ENT service will continue as a permanent collaborative service between the HSE DNE and the Southern Trust.

More information at www.cawt.com/acute

Hungary: Dissolution of the Health Insurance Inspectorate

On 26 September 2010, the Healthcare Insurance Inspectorate (EBF) was dissolved. The tasks that had been performed by the EBF for more than three years have been taken over by other authorities. The EBF had come into existence on 1 January 2007. One of its main tasks was to supervise promotional activities related to medicinal products and therapeutic medical devices directed at health care professionals. It was also responsible for the supervision of the activities of health care service providers to ensure that patients' rights were protected during the performance of such activities. In addition, the first instance decisions of the National Healthcare Insurance Administration (OEP) – the responsible authority for the inclusion of medicinal products and therapeutic medical devices in the public reimbursement scheme – could be appealed before the EBF.

As a consequence of the dissolution of the EBF, the tasks pertaining to the supervision of promotional activities related to medicinal products and therapeutic medical devices directed at health care professionals have been transferred to the Chief Medical Officer's Office (OTH). The supervision of the operation of health care institutions is now the task of the Regional Institutes of the National Public Health and Medical Officer's Service, which, together with the OTH, will continue to pursue ongoing proceedings previously initiated by the EBF. Further, the Act abolished the possibility of making the administrative appeals the EFB used to hear against OEP decisions related to the inclusion of medicinal products or therapeutic medical devices in the public reimbursement scheme. Consequently, these decisions can now only be challenged before regular courts. During its existence, the EBF was particularly active in supervising the promotion of medicinal products and therapeutic medical devices, maintaining a rather strict interpretation of the relevant laws.

Spain: Stricter rules on prescribing

From 2011 doctors in Spain will be able to prescribe the exact number of pills of certain drugs. Initially 25 drugs will be covered by the scheme. Pharmaceutical companies will have to start gradually changing the format in which they market these drugs, so that quantities of pills contained in the packets or boxes can be adapted to the most common treatments. Patients will receive the exact number of pills they need to treat their disease, avoiding an accumulation of products in their homes, while improving the quality of the service they receive.

The savings achieved with 'single-dose prescriptions' combined with the fall in the price of medicines manufactured under patent, will reduce the government's drug bill, which in 2009 reached approximately €12.5 billion. The move will save Spain €300 million per annum according to Health Minister Leire Pajín.

In December 2010, the Health Ministry also started promoting generic drugs with a campaign to raise awareness of the quality and efficiency of the generic option. In 2010 generics accounted for just over 10% of cost of drugs in pharmacies, compared with 6% in 2003. A key objective of the new campaign is to improve the image of generic drugs among the public and promote their use. Community pharmacies will be actively involved in the strategy, whilst training and information for doctors and other medical professionals on the safety, effectiveness and quality of generic medications will also be improved.

The way in which reference prices for drugs are set is also to change. This will now be based on the cheapest drug in each medication group rather than being based on an average of the prices of drugs in the group. In future drugs costing more than this reference price may be replaced by a generic version, unless the patient pays the difference in price.

More information in Spanish at http://www.msc.es/gabinetePrensa/notaPrensa/desarrolloNotaPrensa.jsp?id=1934

News in Brief

Eurobarometer on mental health

Released to mark World Mental Health Day, a new Eurobarometer survey reveals that 15% of respondents across EU Member States sought professional help for psychological or emotional problems and 7% took antidepressants over a twelve month period. It also illustrates the continuing discrimination faced by people with mental health problems, noting that those with the most negative experiences have most socioeconomic difficulties, while those affected by physical or emotional problems tend to be those under social and financial stress.

The survey can be accessed at http://ec.europa.eu/health/mental_health/eurobarometers/

New EU Health at a Glance report

The European Commission (DG Health and Consumers) jointly with the Organisation for Economic Cooperation and Development (OECD), has issued the report *Health at a Glance: Europe 2010*. This report provides a useful insight into the current situation of health in the EU.

The report compiles data from the OECD, Eurostat and the WHO and presents key trends on health, health systems and health spending in the 27 EU Member States, plus the three European Free Trade Association countries (Iceland, Norway and Switzerland) and Turkey.

The report notes that life expectancy at birth in the EU has increased from 72 years in 1980 to 78 years by 2007. Health spending has risen in all EU Member States, often increasing at a faster rate than economic growth. In 2008, EU Member States spent, on average, 8.3% of their GDP on health, up from 7.3% in 1998.

The report is available at www.oecd.org/health/healthataglance/europe

European regions launch health technology consortium

On 7 October some of Europe's most advanced regions in health care technology launched a consortium to increase and accelerate health care innovation. The Health-Ties consortium, supported by a three year grant from the European Commission, has been set up to strengthen the research potential of European regions through encouraging research driven clusters of universities, research centres, companies and regional authorities. The consortium consists of Medical Delta (the Netherlands), Life Science Zurich (Switzerland), Oxford & Thames Valley (United Kingdom), BioCat (Spain) and the mentoring region Észak-Alföld (Hungary).

The consortia will map what is needed to speed up the transfer of idea-to-product and analyse regional research and development needs. It will focus on four major disease areas: cardiovascular diseases, cancer, neurodegenerative diseases and infectious disease. In addition, it will involve medical doctors and patient groups in the development of the new technologies and will share innovations with other EU regions.

Further information about the consortium is available at http://www.oep.org.uk/?p=930

Sweden: the future need for care

By 2050 the proportion of older people in the Swedish population is expected to have increased from the present level of 17% to 25%. The population is ageing, health is improving and life expectancy is rising. In response, the Swedish Ministry of Health and Social Affairs has compiled a description of how demographics, health, morbidity and mortality will develop over the next forty years, and what impact this will have on the need for health and social care services for older people. A unique model is used to simulate how a statistically representative population of 300,000 individuals age year by year up to 2050.

The report can be accessed at http://www.sweden.gov.se/content/1/c6/15/36/57/d30b0968.pdf

New Health Evidence Network policy briefs

Two joint HEN-European Observatory on Health Systems and Policies policy briefs and two policy summaries were prepared at the invitation of the Belgian Federal Public Service – Health, Food Chain Safety and the Environment, for the Belgian EU Presidency Ministerial Conference on 'Investing in Europe's health workforce of tomorrow: scope for innovation and collaboration' that took place at La Hulpe, from 9 to 10 September 2010. The publications reflect key priority areas for European policy/decision-makers in respect of future health workforce needs, and where learning from comparative experience is crucial to informing future policy choices.

One brief looks at how to create conditions for adapting physicians' skills to new needs and lifelong learning and the second at how to create an attractive and supportive working environment for health professionals. Policy summaries focus on future health workforce needs, and the use of audit and feedback to health professionals to improve quality and safety.

The publications are available at http://tinyurl.com/3xuazhp

New web publication series gives overview of ECDC's disease surveillance for Europe

A new European Centre for Disease Prevention and Control (ECDC) series of web publications presents an overview of surveillance activities, explains the finer points of disease surveillance and shows how data are collected and used in order to provide maximum protection for European citizens and their families. The web publications feature three main messages:

1. Surveillance is essential to understanding the epidemiology of infectious diseases;
2. European surveillance supports other EU and national public health efforts; and
3. Surveillance data provide scientific evidence, allowing for a better targeted public health response.

More information at http://ecdc.europa.eu/en/healthtopics/spotlight/spotlight_surveillance/

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

ISSN 1356-1030