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› Gender and health

- Three waves of gender and health
- Policies, politics and gender research
- Gender approaches to adolescent and child health
- Violence against women
- Gender equity in health policy in Europe

- Modernising the Professional Qualifications Directive
- Health capital investment
- Safer hospitals in Europe
- Long-term care reform in the Netherlands
- Cost-containment in the French health care system

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CONTENTS

CONTENTS

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EDITORS' COMMENT

The impact of gender inequalities on women's and men's health can take a number of forms, affecting not only health outcomes and health status, but also access to preventive and curative services. Moreover, the different health needs and opportunities available to men and women accompany them throughout their life course, from infancy to adolescence and adulthood. For these reasons, promoting policies that acknowledge the differential effects of gender roles and norms on health is crucial, not only to rectify any negative biases or inequities between genders but also to ensure the success of intended policy outcomes.

With the **Eurohealth Observer** section we commemorate the life and work of Dr Concepción (Concha) Colomer Revuelta, Director of the Women's Health Observatory of the Spanish Ministry of Health, who passed away in 2011. Her life-long work and dedication not only profoundly shaped gender mainstreaming in health policy within her native Spain, but also made a significant contribution to strategies and actions at the international level through the work of WHO, both within Europe and the Americas. As alluded to in the quote that accompanies our front cover image, which was taken by Dr Colomer herself in 2009, there are many stories that can shape women's and men's lives, and revealing the gender inequities that are part of those stories, along with other social determinants of health, is precisely the goal of policies that seek to promote fairness. With the help of our two guest editors, Isabel Yordi (WHO Regional Office for Europe) and Isabel de la Mata (European Commission), we publish a series of articles in memory of Dr Colomer that look at the history of gender equity policies, their importance in research and policy development, and how they play out within the specific contexts of child and adolescent health, and violence against women.

Moving on to the **Eurohealth International** section, our colleagues at the European Commission comment on how to modernise the Professional Qualifications Directive; a topic which was covered extensively in *Eurohealth*, Issue 17, Volume 4. This area has since moved forward following the Commission's proposal published at the end of December 2011. Next, Stephen Wright, *et al.* discuss the role of the hospital in the health system by identifying the main cost drivers, applying learning from other industries, and defining capacity through the functional use of space. Also on hospitals, an article by Charles D Shaw and colleagues reflects on a practical tool they have developed for implementing guidelines for safety and quality of care.

In our **Eurohealth Systems and Policies** section, Karine Chevreul and Isabelle Durand-Zaleski discuss recent policy efforts toward cost containment in the French health system and draw attention to new challenges. The final article, by Hans Maarse, provides an overview of the current long-term care reform in the Netherlands, acknowledging the common elements of increased individual responsibility, higher user charges and a reduced benefits package.

The **Eurohealth Monitor** section draws attention to new publications, i.e., the new *Health System Reviews* on Sweden, Poland and the Veneto Region in Italy.

We hope that you enjoy this issue and we welcome your comments and feedback to the editors.

Sherry Merkur, Editor
Anna Maresso, Editor
David McDaid, Editor

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Concha Colomer:
A champion for health equality

Living life to the fullest and trailblazing a professional path that benefits the neediest among us is the dream of many people. In that sense, Dr Concepción ('Concha') Colomer Revuelta led a charmed life because by sheer dint of her personality, talent, and dedication to a noble cause she made the dream come true. We all miss Concha – how could we not? – but we also know that her legacy will live on and continue to inspire for generations to come.

I was fortunate enough to enjoy her exquisite mind and friendship for over 25 years. That propitious first encounter, in an epidemiology summer seminar held in Amherst, Massachusetts, transmuted over the years into deeply entwined professional, personal, and family ties. I had many first-hand opportunities to witness the leadership and personal qualities that made Dr Concha Colomer an inspiration to the women's health movement in Spain, Latin America and the Caribbean. As the first director of the Women's Health Observatory of the Ministry of Health in Spain, she focused on improving research and strengthening the evidence base in this field, creating strong and sustainable networks with researchers and universities, and ultimately ensuring that this body of knowledge reached all those women and organisations who could put it to best use. These feats made her a *de facto* 'health and equality hero' who was much loved in her native Spain.

But the effects of Concha's work were palpable well beyond the borders of her home country. She also became a crucial ally for the Pan American Health Organization (PAHO), as we worked to improve outreach to women's organisations and develop evidence on gender disparities in health. Concha and her team also convened gender and health observatories from Europe and Latin America to share experiences, providing the inspiration for PAHO's mapping of more than 30 observatories of gender and health in the Americas. In 2009, the Spanish Women's Health Observatory, PAHO and the Ministry of Health of Chile organised a working meeting with a group of gender and health observatories and their health sector counterparts to identify better ways to collaborate. The outcome defined PAHO's collaboration strategy for a network of observatories, including a Concha Colomer Fund to continue fostering collaboration.

In October 2010, PAHO was fortunate to secure Concha's participation in a global conference of World Health Organization regional gender advisers and national health information systems officials seeking to improve health and gender indicators in health systems. Concha, in her generous and attentive way, shared her wisdom and experience as well as the achievements and setbacks of Spain's Observatory, stressing the essential role that sound and shared information that is able to differentiate the situation, needs, and opportunities for health of women and men, plays in improving the health of both. We could not anticipate then that it was Concha's farewell to the Region. Her lessons on equality and inclusion will not be forgotten. Her kind and inclusive ways will continue to bring smiles and warm the hearts of all those who were fortunate enough to know her. She was inquisitive, interested in everything human, calm and a good listener, yet her marvellous sense of humour and infectious laughter belied her irrepressible joy of life. She will continue to inspire PAHO and the growing network of gender and health observatories, and will keep us on our toes to ensure that we have the best disaggregated information on health, that it is widely disseminated, and that it is used by our constituents to frame public policies that lead to real change in the health of women and men.

Dr Concha Colomer was a true pioneer in calling our attention to the importance of incorporating a gender perspective to effectively address public health challenges. She was also a profound connoisseur and defender of the health promotion strategy and primary health care concept in the quest for Health for All. Her contributions to both our work and our personal growth transcend time and physical barriers, and such a significant and generous life certainly deserves commemoration. Thanks Concha, for the privilege of your friendship and your commitment to the sisterhood.

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THREE WAVES OF **GENDER AND HEALTH**

By: Carlos Alvarez-Dardet and Carmen Vives-Cases

Summary: Three main waves have been responsible for linking gender and health since the first gender studies appeared and were later disseminated into health sciences. The first wave was the "visibility and legitimatisation" of gender issues and women's health as objects of scientific study and possible policy action; the second involved acceptance of gender as a genuine health determinant; and the third, final, crucial wave in this political process of creating true gender policies included the Beijing Conference held in 1995, together with the work of the World Health Organization's Commission on Social Determinants of Health. In this article, we will describe Dr Concha Colomer's contributions to these fields.

Keywords: *Gender Studies, Women's Health Observatory, Social Determinants of Health, Gender Mainstreaming*

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* Carlos Avlarez-Dardet was married to Concha Colomer for 28 years, until her death in 2011. He had the opportunity to learn from her quiet leadership in gender and public health issues and shared a lot of common ground with her with regard to professional public health interests and projects at the University of Alicante, in the School of Public Health in Valencia (IVESP), and most recently in the Women's Health Observatory at the Ministry of Health in Madrid.

The first wave, visibility and legitimisation

The same surge in the feminist movement that resulted in the proclamation of 1975 as International Women's Year, the organisation of the First World Conference on Women in Mexico City and the United Nation (UN)'s Decade for Women for the period 1976–85, had its academic counterpart in the birth of gender studies. As is the case for many other issues which, today, are common in health sciences, gender studies originated elsewhere, in social sciences. The true point of departure was the publication of the book "Sex, Gender and Society" by Professor Ann Oakley in 1972.[1] The academic visibility of gender issues commenced and a new field in social sciences appeared under the name of Gender Studies, as a discipline in its own right. Gender studies focuses on the implications of values, actions and systems formed on the basis of definitions of masculinity and femininity and related beliefs.

The introduction of gender studies into the field of health led to the visibility of many 'new' health problems in women and their study as a relevant and legitimate field of scientific enquiry. Until then, both medicine and public health dealt with women from a narrow perspective focused mainly on reproduction and reproductive pathologies. However, gender studies shed light on several other conditions, laying the foundations for what would later be known as the gender-based approach to public health. This has helped to identify the ways in which health risks, experiences and outcomes are different for women and men, and to act accordingly.[2]

Amartya Sen, Nobel Prize winner in Economics, claimed that women were 'missing' in their millions[3] from population figures in Asian countries, in particular due to selective abortions. On the basis of various assumptions, he calculated that excessive female mortality accounted for a 6–11% deficiency in the total number of women, thus revealing what he called a "terrible story of inequality and neglect". It is suggested that major problems still exist amid what amounts to continent-wide denial by governments, donors, communities and families concerning excessive female mortality, discrimination and disadvantage.

> health risks, experiences and outcomes are different for women and men

Another prevalent topic that is traditionally confined to the private domain is violence against women (VAW). Today, it is commonly recognised as an extreme manifestation of gender inequality and a serious public health problem.[4] The UN declaration on the Elimination of Violence against Women defined VAW as any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.[5] Intimate partner violence has been identified as one of the common types of VAW that takes place within families and the perpetrators are almost exclusively men who are or have been in a close relationship with the women concerned.[6]

The contributions of Concha Colomer to this wave mainly derived from her earlier work in social paediatrics,[7] her commitment to women's participation, and her later contributions to the importance of the gender perspective in health policy and in human and financial resources.[8]

One of Concha Colomer's main achievements as Deputy Director General of the Health Planning and Quality Office, which is responsible for implementing National Health Strategies, was her involvement in promoting the first study on sexual health in Spain.[9] This research is an extraordinary source of data regarding the state of Spain's sexual health at that time and it laid part of the foundations for what is today the Spanish Health Service's National Strategy on Sexual and Reproductive Health. Concha Colomer encouraged and motivated the creation of working groups on fibromyalgia, endometriosis and rheumatic diseases, amongst others. These are all vitally important issues in the life and health of women that had previously been invisible within the androcentric frameworks of health care and biomedical sciences.

Second wave, acceptance†

Once the problems had been described and the stories told, gender appeared in scientific literature and media as a genuine determinant of both women's and men's health in the last decade of the 20th century. It is worth highlighting the impact that gender bias in research has in practice,[10] taking into account the two ways in which health service delivery and research can involve such bias: firstly, by assuming that women's and men's health situations and risks are similar, when in fact they are not; and secondly, by assuming differences where there are actually similarities. Hence, gender bias was described as a genuine, established mechanism used to discriminate against women in health services, firstly, as users of high tech cardiology medicine[11] and later, in many other settings, even primary health care.[12]

Of particular importance for the acceptance of gender as a health determinant was the impact of the Fourth World Conference on Women, held in Beijing in September 1995. This provided an opportunity for the world community to focus attention on areas of vital concern for women worldwide; concerns that stem from social problems that embrace both men and women and that require solutions for both genders.[13] One of the main objectives of the Conference was to adopt a platform for action which would concentrate on some of the key areas that had been identified as obstacles to the advancement of women within two of the main issues highlighted by the UN Commission on the Status of Women:

- inequality in women's access to, and participation in, the definition of economic structures and policies and the productive process itself; and
- insufficient institutional mechanisms to promote the advancement of women.

Beijing fuelled a worldwide feminist protest against male dominance in public administration and the creation of new institutions to deal with women's issues. These processes also had their counterpart in health, in response to the need to build up a gender-sensitive public administration. It was then that the notion of gender mainstreaming appeared as a strategy to achieve the goal of gender equity, which implies recognising the needs of men and women throughout the design and development processes of public policies.[14]

Concha Colomer was appointed as the first director of the Women's Health Observatory at the Ministry of Health in Madrid, initiating a role as an advocate for women's health within the Spanish government. The creation of the Women's Health Observatory helped to create favourable conditions for making advances on tackling many forms of gender inequalities in health, within a context that is traditionally characterised by a 'masculine hegemony'[15] of the mainstream policy-making processes.

† During the 1990s, Carlos Alvarez-Dardet was the editor of the *Journal of Epidemiology and Community Health* and edited a paper which mentioned the word gender in the title. He was aware that the use of the word 'gender' was forbidden by the formal style rules of the BMJ publishing group. If an author used the word 'gender' it was automatically changed to 'sex'. He argued his case poignantly in a meeting of the group's editors and eventually the use of the word "gender" was accepted. The world of science was strongly against the term gender not only due to openly ideological and political reasons, but also for more silent allegedly 'stylistic' motives.

Therefore, the coexistence of the Women's Health Observatory with other gender-specific policy institutions, such as the recently formed Ministry of Gender Equity and Social Affairs, and Concha's proximity to feminist advocacy groups, provided a suitable context for developing the reform of care during childbirth in 2008[16] and a National Strategy against VAW within the health services since 2005.[17]

> the need to build up a gender-sensitive public administration

Every year since 2005, Concha organised the Health and Gender Forum, a meeting place to forge alliances, to exchange ideas and to learn from each other where 'we realise that it is possible to change from a biomedical to an integral model that takes into account the gender perspective'.[18] The Forums were areas for experts and professionals to meet and share both national and international experiences, with a macro vision of the state of affairs available at all times from the Pan American Health Organization or the WHO European Region. Therefore, the Health and Gender Forums have grown to become spaces where it is possible to make health inequalities more visible and to generate opportunities for professional and institutional exchange in order to improve women's quality of life.

Concha's role as an advocate of feminism in social, political and professional associations is also worthy of note. With Rosanna Peiró, she developed actions to overcome male domination within the Spanish Public Health Association's activities (SESPAS),[19] producing pieces of research and founding the SESPAS gender group which, after her death, was renamed the Concha Colomer Gender Group at the Madrid meeting in 2011.

Third wave, gender policies

Once gender was accepted by the professionals and the public as a health determinant and institutions were set up to deal with the related issues, the process of developing gender policies got underway. Public policies on gender attempt to reduce gender inequities in societies and, in the particular case of health, they aim to reduce the negative effects of gender on both sexes. As Kawachi *et al*. have pointed out; gender equity is beneficial for both sexes.[20]

The WHO Commission on Social Determinants of Health echoed previous literature by creating a women and gender equity theme which acknowledged in its final report that 'Gender inequities damage the physical and mental health of millions of girls and women across the globe, and also of boys and men, despite the many tangible benefits it gives men through resources, power, authority and control'.[21] Thus, it raises awareness about the idea that gender is a relevant issue for both women and men.

Thanks to the development of gender policies in Spain, it has been possible to introduce specific public health initiatives into the political agenda in order to address gender-derived health problems. Such measures include the VAW Law (2004), the new Abortion Law (2010) and the new generation of policies implemented to deal with gender as a health determinant both in men and women, such as the law to promote the balance between work and family life of the working population (1999). More recently, the Equality Law (2007) could be considered as a legal tool for gender mainstreaming.

From her position in the Women's Health Observatory, Concha Colomer had the opportunity to advise the Spanish Parliament on the Equality Law and the Abortion Law, which is now being reconsidered by the current Conservative government.

As Deputy Director of the Health Planning and Quality Office, she did a superb job at gender mainstreaming. She succeeded in ensuring that all of the Spanish Health Service's health strategies included a gender approach and produced gender sensitive reports on each strategy in collaboration with other partners, such as scientific societies. At the end of the process, strategies were much improved by taking into account the gender effects on both men and women.

Conclusions

We have proposed a three-wave framework to help understand the spread of gender studies to the field of health, namely through visibility, acceptance, and development of gender policies. These waves did not occur consecutively; indeed, in some aspects they have occurred simultaneously. Each country has its own political process. Conversely, the three waves must occur in a specific political setting to reach an effective state of parity. Concha Colomer was a highly dedicated professional and citizen who made valuable contributions to these three waves from her professional positions and had a wide range of influence that extended throughout Spain, Europe and the Americas.

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EDITORIAL – POLICIES, POLITICS AND GENDER RESEARCH

By: Concha Colomer-Revuelta, Rosana Peiró-Peréz, Rosa M López-Rodríguez, Isabel Espiga-López, Isabel Sáiz-Martínez-Acitores and Isabel Soriano-Villarroel

Summary: We republish here an example of the work carried out by Dr Colomer and her efforts to promote to wider audiences the importance of adopting a gender perspective in research and policy development. This article was first published in the *Journal of Epidemiology and Community Health,* 2007;61(Suppl II):ii2–ii3. It is reproduced in full and without alteration with the kind permission of the journal's editors-in-chief and the BMJ Group.

Development of research on gender and health is scarce. Today, the importance of adopting a gender approach is widely acknowledged when it comes to planning and assessing policies, programmes and health services. But it is also obvious, on the other hand, that development of research on gender and health, and on women's health, that allows taking action to be based on scientific knowledge, is rather scarce.

More and more frequently research results are presented, either broken down by sex, or sex is included as a variable for study and analysis. We know that this is still insufficient for understanding health inequalities arising from gender, and for taking steps to reduce them. Gender issues are giving rise to growing interest, but their study has been kept away from medicine, for which the concern has chiefly been biology (sex and not gender), and where the broadly adopted model has been male disease. On close inspection, it may be seen that, broadly speaking, resources devoted to health and gender research in Spain have been, up until recently, rather scarce, both in terms of personnel and funding and, hence, yielded poor results[1] and limited application to policies.[2] Present development stems from the initiative, back at the end of the 1990s, of creating a task force within the Spanish Society of Public Health and Healthcare Administration (SESPAS).[3] This task force developed an observatory, debating forums at symposiums, and the inclusion of gender inequalities in SESPAS reports.[4,5]

In 2002, within the framework of convening research networks at the "Carlos III" Health Institute – the Spanish agency for biomedical research – the Research Network for Health and Gender (RISG)[6] was created. Throughout recent years the RISG has helped to promote this kind of research, conducting and spreading studies, and training female researchers. This supplement is intended to promote international dissemination of a part of that work carried out to contribute to the general knowledge of these subjects and to be shared by interested people and organisations in other countries.

Research on gender and health in Spain has been strengthened since 2005 by its priority line funding in national research grant proposals. This comes as a result of a Spanish government equality policy that establishes specific measures for action, targeting achievement of equality objectives in all sectors.[7] In the case of

the Ministry of Health and Consumer Affairs, this translated into the creation of the Observatory on Women's Health dependent on the National Health System's Quality Agency and into the inclusion of gender equity in the Quality Plan for the National Health System.[8]

Political support at the highest level also allows other actions that are relevant for research purposes, such as revision of information services, in health and within the healthcare system, to achieve whatever information to be broken down by sex, and the inclusion of variables enabling research on gender inequalities.[9,10] Also this support helps in the process of devising and financing the research, ranging from improving the quality of the applications, and designing of studies on gender and health, to gender awareness in application assessment processes. At all stages, shortcomings have been detected that have set in motion actions such as training and methodological support to emerging health and gender research teams. In this sense, the Observatory on Women's Health is working to develop a series of guidelines for gender mainstreaming in the different stages of research. The first, about research policies, is already available.[11]

Publication of research results, specifically in scientific journals, is basic for knowledge dissemination. It has been shown than gender stereotypes have some impact in this field by hindering women's work.[12]

These actions are expected to come to completion in the oncoming years, thus contributing to a deepened understanding of the magnitude and causes of gender inequalities in Spain, as well as in the whole scientific world, and hence providing knowledge for the kind of political action that may enable ongoing progress towards reducing these inequalities to thrive on.

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GENDER APPROACHES TO **ADOLESCENT AND CHILD HEALTH**: THE GENDER TOOL OF THE EUROPEAN STRATEGY FOR CHILD AND ADOLESCENT HEALTH AND DEVELOPMENT

By: Laura Cogoy and Giorgio Tamburlini

Summary: Gender is recognised as one of the most important social determinants of health. Integrating it into policy and planning is not only important for its ethical implications but also increases the effectiveness of child and adolescent health interventions and service delivery in general. The Gender Tool of the European Strategy for Child and Adolescent Health and Development is an example of how gender needs to and can be integrated into policy analysis and planning. It is an important tool for policy makers and public health specialists in the region. The leadership of Concha Colomer was instrumental to its development and the Tool has fostered further work in this area.

Keywords: *Gender Tool, Adolescent and Child Health, Health Inequities*

Gender inequities matter

Gender profoundly influences an individual's way of living, getting ill, seeking and receiving care. The failure to take gender into account in analysing the causal pathways of health and disease, as well as in developing health policies and programmes, leads to maintaining or even contributing to one of the most pervasive sources of health inequities. Gender roles and patterns are shaped well before birth and are therefore an important entry point for addressing health inequities early during childhood and adolescence and for understanding the impact of health differences between men and women during their entire life course.

Gender inequities may not always affect men and women in the same way, although women bear many disadvantages when it comes to access to and distribution of resources. Such inequities include differences in risk as well as in protective factors, and an imbalance between needs and access to resources, which leads to the reduced impact of standard child and adolescent health policies and services.

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Table 1: Nutrition: the prevention of overweight and obesity

Priority	Cross Sector Action	Health System Action	Health Service Action
Prevent overweight and obesity	• Enact regulations to avoid distribution of unhealthy snacks and soft drinks in school cafeterias • Incorporate nutritional education in school curricula • Enact legislation to regulate food advertising for children and adolescents in the media • Increase opportunities for physical activities at school • Ensure suitable and safe provision for play and physical activity	• Ensure that nutritional advice and interventions are integrated to other health (e.g. immunisations) and non-health day care programmes • Set up national programmes to promote healthy diet and physical activity for children and adolescents	• Screen for overweight at pre-school and compulsory school age • Provide individualised care and support to overweight and obese children and adolescents

Source:[2]

In 2005, the World Health Organization (WHO) Regional Office for Europe published the *European Strategy for Child and Adolescent Health and Development*.[1] The Strategy has been introduced in several countries as a guide for the development or revision of national strategies. Following the rapid circulation of the Strategy and discussions among experts, it soon emerged that there was a need to add a gender lens, particularly to the Action Tool.[2] This tool represents the "guide to action" by including a menu of effective policies and interventions for the seven priority areas, from maternal and neonatal health to psychosocial development. Therefore, in 2007 the Spanish Ministry of Health and Social Affairs' Observatory on Women's Health, under the leadership of Concha Colomer, supported the WHO Regional Office for Europe in its development and the Gender Tool was added to the set included in the Strategy.[3]

Life course approach

The aim of the Gender Tool was not only to provide a framework for policy makers to include actions aimed at addressing gender inequities but also to understand the relevance of gender issues from a life course perspective. From pre-conception to adolescence the factors influencing health outcomes are traced along a gender pathway and final unequal gender outcomes are identified.

> "Gender roles and patterns are an important entry point for addressing health inequities

During pre-conception and early pregnancy different negotiating power between men and women, due to specific gender roles, may have an impact on the use of contraception, pregnancy spacing and access to safe abortion, which ultimately may have a gender specific impact on health outcomes such as sexual violence, reproductive health and unsafe abortion. During pregnancy, access to high quality antenatal care depends on women's decision making power to attend antenatal care services.

Other examples become evident during a child's first year of life. Feeding style, access to immunisation, as well as early child development are also determined by gender pathways such as social and family support for breast feeding, working hour flexibility and maternal education. These ultimately determine the ability of a mother to breast feed, the eventuality and timeliness of proper vaccination, proper and early socialisation and positive fatherhood patterns.

Adolescence is a crucial time for the expression of gender roles and for the impact they have on health outcomes. Initiation of sexual intercourse, diet and physical activity, substance misuse and abuse, and injuries and accidents are heavily influenced by gender roles. A lifecycle approach to gender in child and adolescent health puts into evidence how from very early on gender, together with all the other main social determinants of health, has a powerful impact on the ultimate good health of children and adolescents.

Health priorities and gender equity

The second part of the Gender Tool, in fact, applies a gender lens to the generic priorities that had been identified in the Action Tool of the Strategy and highlights how almost all health needs, and consequently interventions and health policies, have inherent gender issues that need to be addressed in order to have equal impact and efficacy on both boys and girls, men and women. Table 1 highlights the example of how the Action Tool addresses the priority of preventing overweight and obesity.

Moreover, Table 2 illustrates how in the Gender Tool the gender pathway of each priority is analysed, followed by a list of specific gender-sensitive information that

Table 2: The gender dimension of overweight and obesity prevention

Priority	Gender Pathways	Information Needed	Health System Actions	Intersectoral Action
Preventing overweight and obesity	• Unequal or equal access to information and opportunities for physical activity • Extent of gender-based stereotypes about physical activity • Differences or equality in the priority placed on preventing obesity among boys versus girls	• Prevalence of overweight and obesity, stratified by sex, age, socioeconomic background and ethnic group • Data on diet and physical activity by sex and age	• Promoting gender-sensitive healthy eating habits and physical activity • Providing gender-sensitive services for obese and overweight boys and girls • Supporting schools in gender-sensitive screening and programmes for overweight and obesity	• Implementing programmes that promote equal opportunities for physical activity among boys and girls • Regulating aspects of information in the mass media about adolescent eating habits with a gender perspective • Implementing gender-sensitive nutrition programmes in schools

Source:[3]

is needed to properly address and monitor the impact of the health and cross sector actions, which are detailed in the last two columns of the table.

> understand the relevance of gender issues in a life cycle perspective

The example in Table 2 is taken from the Nutrition Priority (**see Table 1**). The Gender Pathway column identifies issues that are gender specific within the addressed priorities. So, for example, it highlights how both body image issues, as well as access to physical activities are different between boys and girls. The two "action" columns start from the suggestions of the *European Strategy for Child and Adolescent Health Action Tool* proposed under a gender perspective. Therefore, healthy eating promotion programmes, as well as overweight and obesity surveillance activities, need to be gender sensitive and address the different needs of boys and girls. For example, boys tend to have easier access to opportunities to be physically active, but social norms tend to treat obesity among boys as a "lesser" problem than among girls.

The Gender Tool in action

We have presented the Gender Tool as part of the training courses on "Public Health Approaches to Maternal, Neonatal, Child and Adolescent Health" held by the European School for Maternal, Neonatal, Child and Adolescent Health in Trieste over the last few years. Participants have found it appropriate and potentially very useful, although many have recognised that countries still lack information and data on gender inequities in their national context and that policy makers generally have little or no experience with this approach. Therefore, exposure through training programmes is one vital means to further support the use of the Gender Tool as a guide to analysis and policy.

WHO has used the Gender Tool to support the development of the Strategy on Child and Adolescent Health in several countries in the region, such as Albania and Tajikistan. This process triggered the need to identify gender responsive actions on adolescents' health and led to the series, *Young people's health as a whole-of-society approach: evidence for gender responsive actions,*[4] covering wellbeing, chronic conditions and disabilities, adolescent pregnancy, HIV/STIs, mental health, overweight and obesity, violence, injuries and substance abuse.

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VIOLENCE AGAINST WOMEN: THE SPANISH RESPONSE

By: Claudia García-Moreno

Summary: Violence against women is now well recognised as an urgent public health and women's health priority, as well as a human rights violation. Evidence across the world demonstrates the short and long-term health effects of intimate partner violence on women. In Spain, important initiatives to raise awareness in the health sector about gender-based violence include the establishment of an epidemiological surveillance system to document women's health problems; the creation of the Commission Against Gender-based Violence to co-ordinate programmes; National Health Service actions to implement specific commitments made in Spain's law on gender-based violence, including training for health professionals; and the development of a common protocol for a health care response to gender-based violence.

Keywords: *Gender-based Violence, Health Effects, Gender Inequality, Spain*

A sizeable problem

Violence against women is now well recognised as an urgent public health and women's health priority, as well as a human rights violation. It is also recognised that this violence is rooted in gender inequality and, in turn, serves to perpetuate this inequality. Nationally, representative surveys in Europe have estimated the lifetime prevalence of physical and/or sexual partner violence among women. For example, such prevalence rates are 32% in Finland,[1] 27% in Norway[2] and 25% in Germany.[3] In Spain, the prevalence of intimate partner violence is estimated to be 43% for emotional abuse, 8% for physical abuse and 12% for sexual abuse.[4] A recent study from Madrid found that in the last year 8.6% of women reported that they had experienced psychological violence, 2.4% physical violence and 1.1% sexual violence.[5] In 2011, Spain reported 61 women killed by a partner or ex-partner.[6] In Spain, following the passing of the Law on Gender-based Violence in December 2004, there has been increased awareness of the issue among both the general population and professionals from all sectors (health, education, justice and the media). During its tenure of the European Union Presidency in 2010 Spain also played a key role in promoting actions to address gender-based violence at the European level.

There is clear evidence across the world of the short and long-term health effects of intimate partner violence on women. These include, for example, physical health outcomes such as having difficulty walking, difficulty with daily activities, pain, memory loss, dizziness and vaginal discharge in the previous four weeks, as

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well as mental health outcomes such as significantly more emotional distress, suicidal thoughts, and suicidal attempts, among women who have suffered violence compared to women who have not.[7] Intimate partner violence has been associated with injuries, disabilities, unwanted pregnancies, abortions, sexually transmitted infections, including HIV/AIDS, depression, Post Traumatic Stress Disorder and other anxiety disorders, and a range of chronic health problems.[8,9] When it occurs during pregnancy it has been associated with miscarriage, premature labour and low birth weight babies.[10] Intimate partner violence has also been associated with increased infant and child mortality.[11]

> raise awareness in the health sector about gender-based violence

Health sector response to gender-based violence in Spain

In spite of the growing evidence of the importance of violence against women for women's health, the response of the health sector has been limited. In Spain, however, an important initiative to raise awareness in the health sector about gender-based violence was spearheaded in November 2003 through the establishment of an epidemiological surveillance system to document women's health problems. Every month the index of deaths (ratio of deaths that month and median of deaths occurring during the previous five years) due to intimate partner violence is published on a women's web page. The purpose is to give visibility to the problem of violence against women, including through the media, and in this way to work towards making it unacceptable.[12] This work is grounded on an understanding of the need to integrate gender dimensions into research and data analysis and the Women's Health Observatory has been instrumental in collecting data and raising awareness of women's health problems.

In September 2004, the Spanish National Health Service (NHS) approved the creation of the Commission Against Gender-based Violence. This was the first step towards coordination of programmes and health care actions that were already being undertaken in some of Spain's regions (autonomous communities). Subsequently, and over time, the NHS took action to implement the specific commitments made in the 2004 Law on Gender-based Violence. It was approved by parliament at the end of 2004. The law included, among other things, training for health professionals.

Concha Colomer played a critical role in moving these issues forward within the Ministry of Health, and more recently she had put in place the strategy for the identification of, and response to, violence against women in the health system. She brought to this a sound public health approach based on surveillance/data collection coupled with a firm commitment to a gender equality perspective and to equity. As the Head of the Women's Health Observatory and later as Deputy Director of Health Planning, Quality and Healthcare of the Ministry of Health, Social Policy and Equality she oversaw the production of yearly reports on Gender and Health and on Gender-based Violence starting in 2007. Reducing gender-based inequalities in health was the goal, through generating and disseminating knowledge that could enable a gender analysis of health problems and promote the integration of equity and gender equality in health policies and systems.

In relation to violence against women, important steps were taken to harmonise actions across all of the autonomous communities through the development of a common protocol for a health care response to gender-based violence. Similarly, a set of common indicators on health care provision in cases of gender-based violence were developed in the NHS.[13] Indicators included, for example, the number of cases detected within primary and specialist care levels, and others relating to the demographics of abused women and the type of care received. These served to: facilitate planning of the health care provided, promote improvements in quality and equity in health care provided to survivors of gender-based violence, and to facilitate the exchange of experiences and good practice among those involved in providing health care for women suffering from violence.

> development of a common protocol for a health care response

Moreover, and most importantly, quality criteria for training health professionals on the response to gender-based violence[14] were developed and substantial amounts of resources were dedicated to building the capacity of providers in primary health care and in specialist services, such as those for mental health and emergency care.

Concha Colomer's legacy

All of these programmes were dear to Concha's heart. I last saw her on 15 March 2011, only a few weeks before she died, presiding, along with the Deputy Minister, over a technical workshop to review the progress and achievements made in the implementation of the common protocol on the health care system response to gender-based violence. At the meeting, experiences were shared by the different autonomous communities in relation to training, the use of the common indicators and the implementation of the common protocol. The tremendous progress made was acknowledged while identifying the many things that still needed to be put in place. We closed the meeting together and she highlighted that the next step would be to update the protocol in two ways: first,

to include more specific interventions for the children of women suffering partner violence, an important step indeed if we are to break the cycle of violence; and secondly, to include vulnerable groups of women, such as immigrants, older women and women in rural areas. At the moment, the Women's Health Observatory is working on the collection and dissemination of good practices in the prevention and early identification of gender-based violence in the NHS.

We shall miss Concha's leadership, vision, good humour and *joie de vivre*, but we shall continue to be guided by her vision, her perseverance and her commitment to gender equality, women's health and addressing gender-based violence.

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TACKLING **GENDER EQUITY** IN HEALTH POLICY IN EUROPE: A PARTNERSHIP

By: Isabel Yordi Aguirre

Summary: Gender equity recognises that women and men have different needs and opportunities that impact on their health status, their access to services and their contributions to the health workforce. The underlying causes of the gender inequities that can be addressed by health systems and health care services include differences between men and women in their use of preventive health care, their health behaviours and in their access to health care and treatment. The World Health Organization aims to reduce these inequities by integrating gender into all of its health policies and programmes and by enhancing the capacity of its Member States to formulate and implement gender responsive health policies and strategies.

Keywords: *Gender Equity, Health Policies, Gender Mainstreaming, World Health Organization*

There is undeniable evidence showing that the gender roles and norms we adopt as we develop from childhood to adulthood, and the unequal access to power and resources between men and women, strongly impact on our health. It is also clear that the health sector can make a difference and needs to act when this impact is negative, unfair and avoidable for either women or men. The World Health Organization (WHO) has recognised this responsibility with the adoption of the *Strategy to integrate gender analysis in the work of WHO*[1] and the WHO Resolution 60.25.[2] The resolution calls for the WHO Secretariat and its Member States to integrate gender into health policies and programmes.

The WHO Regional Office for Europe took this Resolution seriously and in 2010 gender became a cross cutting priority, together with equity and human rights. This is the result of many years of work and of a strong partnership with a committed, supportive and visionary partner who also became a good friend: Concepción (Concha) Colomer Revuelta, Director of the Women's Health Observatory of the Spanish Ministry of Health, Social Affairs and Equality. Concha Colomer, to whom this issue of *Eurohealth* is dedicated, played a key role in supporting WHO to move forward gender mainstreaming in the health sector at a time when many Member States were going through a phase of "gender fatigue". This was the unfortunate result of mainstreaming policies that did not have the required financial and human resources, systematic approach or political commitment. Some policies that were developed were not based on strong

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evidence due to a lack of sex disaggregated data and gender analysis, or insufficient resources, capacity or mechanisms for their implementation.

> gender became a cross cutting priority

In spite of being a region with the highest levels of gender equality among its 53 Member States, there are also serious differences between women and men in mortality, morbidity, healthy life years and use and access to health services and resources. These differences are the result of a combination of biological and social factors. In the new WHO health policy for Europe, *Health 2020 policy framework and strategy*,[3]* gender equity is a core value and refers to fairness and justice in the distribution of benefits, power, resources and responsibilities between women and men to allow them to attain their full health potential. Gender equity recognises that women and men have different needs and opportunities that impact on their health status, their access to services and their contributions to the health workforce. It acknowledges that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.

It is also important to highlight that when we look at gender inequities, we recognise that men and women are not homogenous groups so their health and their experience of health systems are also determined by the interaction between gender inequities and other social determinants of health such as poverty, employment, education and ethnicity.

The underlying causes of the gender inequities that can be addressed by health systems and health care services include differences between men and women in their use of preventive health care, their health behaviours and in their access to health care and treatment, all of which affect health outcomes for women and men. The potential consequences of not addressing gender include persistent excess mortality among men, under use and inefficient use of health resources, poor user satisfaction and for some countries, perhaps a widening gap in health between men and women.[4]

WHO aims at reducing these inequities by enhancing the capacity of its Member States to formulate and implement gender responsive health policies and strategies. Our work follows four strategic directions: integrating gender into WHO's management, promoting the use of sex disaggregated data and gender analysis, establishing accountability mechanisms and building capacity.

> interaction between gender inequities and other social determinants of health

The partnership with Concha Colomer and the Women's Health Observatory has been crucial to implementing some of these strategic directions. The support and collaboration of the Observatory to develop the gender tool that accompanies the Child and Adolescent Health Strategy (see Cogoy and Tamburlini in this issue), the input of Concha Colomer into regional priorities such as the Tallinn Charter[5] and the development of *Health 2020,* her leading role in promoting the use of sex disaggregated data and gender indicators, and the experience of mainstreaming gender through the main health strategies in Spain–all these are initiatives that WHO treasures as best practices that have influenced our technical assistance to our Member States. One important aim of our years of working together was to create a regional platform that will serve to exchange experience and best practices, strengthen the capacity in the region and put gender equity in health onto the health agenda. Developing a strong network of focal points is the next step. For this, we miss Concha, both personally and professionally, but we hope that we can continue to build on her valuable legacy – what she believed in and was passionate about – improving gender equity for all.

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HOW TO MODERNISE THE PROFESSIONAL QUALIFICATIONS DIRECTIVE

By: Jürgen Tiedje and Andras Zsigmond

Summary: The European Commission has presented a proposal which aims to facilitate the mobility of health professionals through the use of new e-government tools, such as the European Professional Card and the Points of Single Contact. It also features a modernisation of the training requirements for certain health professionals, including doctors and general care nurses, and sets out the conditions for granting partial access to a profession. The proposal responds to public concerns about patient safety with provisions on effective and proportionate checks of migrant health professionals' language knowledge and the introduction of an EU-wide proactive alert mechanism to spread information about professionals who have been banned from practice.

Keywords: *European Commission, Professional Qualifications, European Professional Card, Mobility of Health Professionals*

Introduction

Facilitating the movement of patients, medicinal and pharmaceutical products as well as health professionals in the European Union (EU), whilst safeguarding public health and safety, is an important aspect of Single Market policy. The Single Market contributes to patient safety by helping to reduce waiting periods for patients requiring hospital treatment, improving access to products required by chronic disease sufferers, and is part of the solution to shortages of qualified health professionals in the health care systems of EU Member States. The United Kingdom has been a major beneficiary of these policies to meet its domestic needs.

In recent years, stakeholders have explored how to facilitate the movement of patients in the EU within the framework of the Patients' Rights Directive[1] and how to reduce the risks linked to medicinal products under the Directive on the Community code relating to medicinal products for human use.[2] The time is now ripe to review the principles governing the mobility of health professionals within the EU. In order to facilitate the free movement of professionals and their services, EU legislation lays down the framework for the mutual recognition of qualifications between EU Member States. The Professional Qualifications Directive (PQD)[3] applies when a professional permanently moves to another Member States (freedom of establishment) and

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Note: *The opinions expressed in this article represent the personal views of the authors and do not purport to reflect those of the European Commission.*

in – admittedly less frequent – cases of temporary mobility (free provision of services).

The modernisation of the system of recognition of professional qualifications is one of the twelve levers for growth and confidence set out in the Single Market Act.[4] Following a thorough evaluation conducted between 2010 and 2011, the Commission presented a legislative proposal for modernising the PQD on 19 December 2011.[5] This proposal is now being debated by the European Parliament and the Council of Ministers in Strasbourg and Brussels. Promoting mobility at European level might, at first glance, appear a contradictory policy goal for the UK which has cut recruitment of health professionals from third countries in recent years. Not so. The Single Market addresses the long-term objective of helping nationals from EU countries who benefit from the right of free movement (including health professionals educated in the UK but who seek a job in another EU/EEA country) against the background of an imminent shortage of qualified health professionals across Europe (current estimates point to a projected shortage of one million in 2020).

This article focuses on the main elements of the proposal which might be of particular interest to the health sector: the European Professional Card (EPC) and the Points of Single Contact as new facets of e-government; the modernisation of minimum training requirements, notably for doctors and nurses; the introduction of partial access; language skills of health professionals treating patients; and a Europe-wide alert system for the exchange of information about professionals who have been prohibited from practice.

European Professional Card

In the EU, professionals seeking recognition of their qualifications apply directly to the Member States where they wish to work. The PQD requires Member States to request any additional information and documentation which may need to be issued by the authorities in the country of origin and to take decisions on recognition requests within four months. In practice, recognition and subsequent registration processes often take longer and become costly for professionals. The concept of the EPC is designed to offer interested professionals simpler, cheaper and quicker procedures for the recognition of their qualifications.

> safeguarding public health and safety

Although various possibilities were considered by a steering group on the professional card in the course of 2011,[6] the EPC will neither substitute for registration procedures in Member States, nor allow patients to verify the credentials of a professional. Such ambitious objectives might be achieved in the long term but would require a more comprehensive development of the e-health agenda at European level. Similarly, initial ideas and projects looking into smart cards to be developed under the much larger e-health agenda appear too costly and too time consuming to be put in place. As a result, the shift towards an electronic certificate has been the main outcome of discussions with stakeholders in the steering group.

According to the Commission's proposal, the EPC could replace the decision on recognition of qualifications with a view to a permanent establishment as a self-employed or employed professional, though not the final authorisation to practise. To this end, it would not rely on current efforts at linking electronic domestic registers. Instead, the EPC would be transmitted as an electronic certificate through the tried and tested Internal Market Information System (IMI),[7] which allows competent authorities from different Member States to cooperate with efficiency and speed. The Commission has designed and will operate the framework for the electronic procedures based on this system.

Interested professionals will thus be able to initiate the procedures at the competent authority in their home Member States. However, the responsibility for granting recognition will remain within the competence of the host Member States receiving the electronic certificate, which will validate it before issuing it to the professional. The envisaged workflow is illustrated in Figure 1.

The proposal lays down the general framework for this new and innovative policy tool. The detailed implementation for each interested profession will be set out in individual implementing acts. When the card is introduced for a particular profession, its use will be voluntary for individual professionals but compulsory for the authorities in Member States. Consequently, the professionals will be able to choose between the simplified procedure enabled by the EPC, and the current procedure. The competent authorities will have to assist them accordingly. Some stakeholders call for limiting the reforms to further improving the functioning of the IMI, thus contesting the added value of the EPC. Such a limited solution might bring benefits to the authorities, but not to professionals. There are too many cases of professionals suffering delays in the recognition of their qualifications because the authorities in the host country need a clarification from the authorities in the Member States where the qualifications were awarded. E-government in general, and in particular the IMI, have the potential to address many shortcomings in the recognition system today and professionals should benefit from it directly.

An additional safeguard for professionals against delays also has been introduced: lack of reaction from the competent authority within the set deadlines will constitute tacit approval of the recognition request. However, this tacit decision would not prevent the host Member States from requiring registration before granting the authorisation to practise on its territory or from checking language skills before the health professional is recruited.

Points of Single Contact

The proposal foresees access to Points of Single Contact (PSC) for all interested professionals seeking recognition of

their qualifications in their contacts with competent authorities. This one-stop shop process would be ensured through the already established PSC in all Member States according to the Services Directive[8] (also see UK SPC[9]). Using the PSC will allow many more citizens to obtain all the information about the documents required to have their qualifications recognised and to complete all recognition procedures online, in one place. However, the PSC will not replace decisions of competent authorities.

Minimum training requirements

Several professions benefit from automatic recognition based on harmonised minimum training requirements defined in the PQD. This regime applies to certain health professions (doctors, general care nurses, midwives, dentists and pharmacists), but also to architects and veterinary surgeons. The minimum training requirements for these professions were set many years ago. The modernisation of the PQD has provided an opportunity to review and update them where necessary. Not all aspects can be presented in this article. The following are among the most significant.*

First, the proposal clarifies the minimum duration of training, as the current wording of the Directive led to diverging interpretations. With respect to the training of doctors, the minimum duration of basic medical training is currently expressed as minimum of six years "or" a minimum of 5500 training hours. The proposal has confirmed the cumulative application of both criteria, by stating that training must comprise a total of at least five years of study "and" at least 5500 training hours. The proposal also reflects recent educational reforms when, in the case of certain academic studies, it entitles Member States to express the minimum duration of study with the equivalent ECTS (European Credit Transfer and Accumulation System) credits, which might be relevant for universities in Scotland.

In contrast to continental Europe, stakeholders in the UK – notably in education – support the idea that duration should be subordinate to a list of competences. The Commission has agreed with this view to some extent. However, minimum duration of training remains a relevant and important criterion. Duration of training is an objective criterion for citizens who put their trust in health professionals whom they wish to be well trained. Doctors need more time to learn their profession than nurses; accordingly, a set of competences alone is not enough to guarantee public trust in their qualifications. A list of competences will not necessarily bridge such differences, as most of the competences focus on the future needs of labour markets (including in the context of health care systems) which differ between Member States. Thus, competences remain country specific and as such do not necessarily facilitate the comparison of the educational paths of different Member States in the context of recognition of professional qualifications. Despite this, the proposal sets the legal basis for a future introduction of competences to the minimum training conditions in a second phase,[10] as supported by a majority of stakeholders. Hence, further conditions might be laid down at a later stage via delegated acts.

> "simpler, cheaper and quicker procedures

As for nurses and midwives, the Commission proposed an increase to the minimum duration of general education required to start training as a nurse or midwife from ten to twelve school years. This is already the case in 25 Member States. However, the Commission did not foresee in its proposal a move towards university education. The minimum training required remains set at three years (amounting to no less than 4600 training hours) of training at university level or in vocational schools. The proposal has found support amongst stakeholders in the UK, but has met with fierce criticism in Germany.

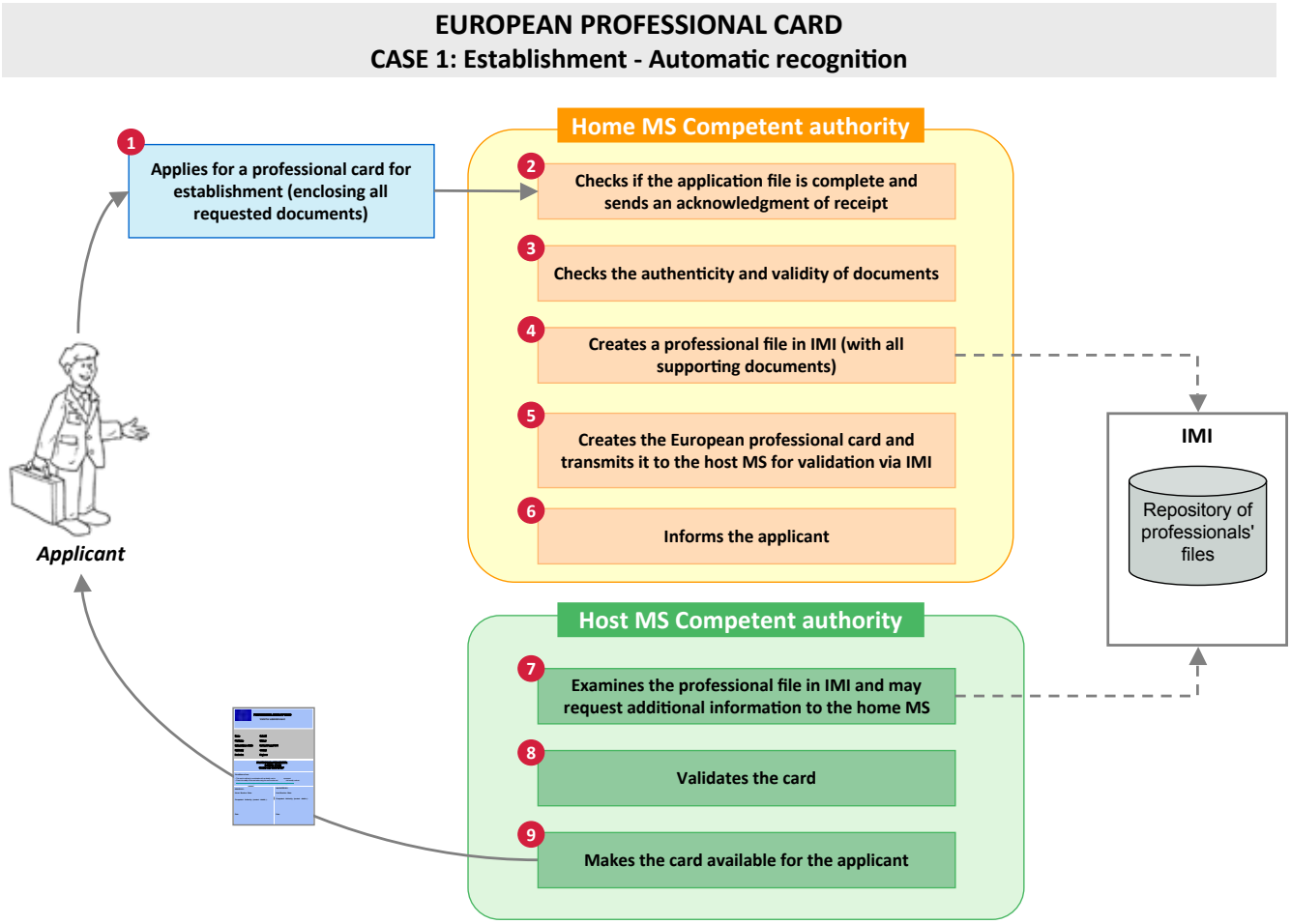
Partial access

Following the case law of the European Court of Justice (for example see Case C-330/03, *Colegio de Ingenieros de Caminos, Canales y Puertos*), the Commission has proposed to clarify the concept of partial access in the Directive. Partial access concerns access to only those activities within a profession which the professional is qualified to exercise in their home Member State. It is an idea which is relevant only in exceptional circumstances and which only helps if aptitude tests or adaptation periods would not sufficiently compensate for substantial differences between, for example, the necessary training in the UK and the training acquired in another Member State.

There is a lot of discussion about whether the principle of partial access should also apply to the health sector. There is a substantial body of opinion suggesting a complete exclusion of health professionals from the principle of partial access. The Commission has, however, sought to avoid establishing "positive" or "negative" lists of professionals which should be included or excluded from this principle. Instead, it invites Member States to decide on the basis of their national law, which activities are unconditionally reserved for certain professions. The proposal foresees that Member States may refuse to grant partial access if there is an overriding reason of general interest, such as public health, provided that the rejection is in line with the principle of proportionality and is duly justified. The Court of Justice has already confirmed that Member States may refuse access for non-doctors to certain activities reserved to doctors (see Case C-108/96, *Mac Quen*). Recently, a new case has been submitted to the Court regarding the potential application of the principle of partial access to the profession of physiotherapist in Greece (see Case C-575/11, *Nasiopoulos*).

* The proposal itself, as well as the presentations given at a public meeting on 2 February 2012, available at: http://ec.europa.eu/internal_market/qualifications/conferences/20120202-modernisation_en.htm

Figure 1: Proposed workflow under the EPC



Checking the language skills of health professionals

Controlling language skills of migrant health professionals is common sense. There has never been any doubt that ensuring the necessary language skills of health care professionals is an important task when it comes to safeguarding patient safety. Under existing provisions (Article 53), migrating professionals are already required to possess the language knowledge necessary in the host country. This provision should be implemented, respecting the principle of proportionality. Many stakeholders in the UK have asked questions relating to the interpretation of the current provisions, notably the principle of proportionality.[11]

What does proportionality mean in practice? First, the level of required language knowledge cannot be set equally for all professions. Whilst the client of an architect is able to inform the professional of the language in which he or she wishes to communicate, a hospitalised patient may not be able to do so. Furthermore, the required level cannot be the same for all professional activities within the same profession. A general practitioner will need to be able to communicate in English with greater fluency than someone working in a laboratory.

The proposal clarifies the existing rules and outlines how the principle of proportionality should be applied in practice. The language knowledge of a professional can be checked after the host country has recognised the qualification but before the professional takes up a position. In the UK, it would be up to national health services to organise language controls when recruiting health professionals, unless they wish a health care regulator to undertake such controls for them. The language check should be free of charge to the professional, it must be limited to one of the official languages of the Member States concerned, and the professional must have the possibility to appeal a decision before national courts.

> “ensuring the necessary language skills of health care professionals

Member States need to determine who will assume the competences and

responsibilities for language controls and set out clearly to professionals how the controls will work. Duplicate language checks, first by competent authorities and then by employers, should be avoided.

> an alert mechanism, with particular emphasis on health professionals

Alert mechanism

It is essential to the safety of patients to prevent the migration of professionals who have been prohibited from exercising their activities in their home country. The introduction of an alert mechanism, with particular emphasis on health professionals, was requested by many stakeholders (specifically, this had been one of the most important goals of the UK-coordinated Healthcare Professionals Crossing Borders Initiative). This is particularly important because there have been cases of doctors banned from practising in their home Member States who went to work in another Member States which was unaware of the ban.

The proposed solution strikes a balance between patient safety and the data protection rights of the professionals concerned. The alert system, based on alerts containing only the information necessary to identify the professional, is about to be created within the IMI.

Under the proposal, a Member State should address a proactive alert to the competent authorities of all other Member States concerning a health professional who has been prohibited from exercising the professional activity in its territory. This procedure would cover all professionals benefiting from automatic recognition, regardless of whether there is evidence that they will move from one EU country to another.

Other migrating health professionals (for instance, physiotherapists or doctors with third country diplomas) would be covered by the alert mechanism if any evidence of an intention to move to another country exists. The rationale for two different mechanisms lies in the different legal bases applicable to each category of professionals. Single Market legislation covering the EU cannot include elements which are reserved for the policy on security and justice under the EU Treaties, from which also the UK may opt out.

Conclusion

The modernisation of the PQD is an important milestone in the strengthening of the Single Market. The European Commission has presented a proposal that has the potential to facilitate the mobility of high-skilled professionals in order to address the challenge of filling high-skilled jobs and offer more possibilities to job seekers. At the same time, this proposal responds to public concerns about the safety of patients. This modernisation strikes a balance between these important policies.

The proposal is being debated in the European Parliament and in the Council, and the debates are being followed with a lot of interest by stakeholders. Once adopted, it could improve the situation of many practising professionals, national health care and education systems, and the opportunities available to future generations.

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INVESTING IN TIME: DECIDING ON HEALTH CAPITAL INVESTMENT

By: Stephen Wright, Bernd Rechel, Martin McKee and Barrie Dowdeswell

Summary: Hospitals are iconic and expensive – and deserve regular re-examination in a changing health care environment. The European Observatory and its partners carried out a major study on investment in hospitals, published as two books in 2009, that presented a thematic analysis and a series of case studies. Since then, the ongoing economic crisis has accentuated the importance of ensuring the appropriateness of the hospital as the core capital stock of the health system. In this article, we distil three central ideas. First, we argue that the capital cost for hospitals appears large but is dwarfed by the associated medical and utility costs. Second, we apply ideas from other industries about flow processing and the need to look for and potentially remove choke-points. Finally, we argue that hospital capacity can be identified in terms of the functional use of space ("hot floor", "factory", "office" and "hotel").

Keywords: *Hospitals, Capital Investment, Life-cycle, Flow Processing, Capacity, Beds*

Introduction: what about the crisis?

In 2009, the European Observatory on Health Policies and Systems and the European Health Property Network/ European Centre for Health Assets and Architecture published a pair of studies to inform those investing in hospitals.[1,2] The ideas contained within them had been developed during a period sometimes described as "The Great Moderation": inflation was low, economic growth in Western countries acceptable, and states were able to borrow freely on their own account to fund infrastructure (or could instead, and more controversially, turn to capital markets via instruments such as public-private partnerships, PPPs). At publication, in 2009, the economic crisis was a one-year-old event, with the collapse of Lehman Brothers occurring in the autumn of 2008. Now, chronologically, it is already well past its toddler years – but it does not seem to be growing up. Some recessions are 'V'-shaped, more feared are the 'W'-shaped or double-dip ones, but this one seems to be 'L'-shaped. Governments across Europe have pursued austerity programmes that have choked off growth and taken them deeper into debt, transferring private, including financial sector, deficits onto their own account and, ultimately, then to their populations and particularly savers. One way or another, austerity looks likely for many years ahead, with great pressure on the public sector to reduce its debt rather than adding to it. Some structured finance market PPP models have been recognised as inflexible and unaffordable in the long term and

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some indeed have collapsed, making the perspective for new capital funding very different from before.

The pressure on governments to reduce spending applies just as much to operational costs. In the European Union, the health sector accounts for almost 10% of Gross Domestic Product (GDP) (almost all for services rather than capital investment), and many governments see it as an expenditure that must be controlled. New technologies, together with the impact of ageing societies, do not make this easy.

> the *decision* to invest is critical even if the *cost* is not

Although the European Observatory books on capital investment originated in more comfortable times, their fundamental messages remain valid for Europe's current straitened circumstances. In large part, this is because the books anticipated the need to remodel health systems to make them more appropriate and, simultaneously, more affordable.

Context

Are we so used to looking at hospitals that we no longer see them as they are? The idea of the hospital is multi-faceted: pinnacle of the health system, centre for medical research and development, essential part of the urban fabric... Once built, it costs about 3–5% of GDP to run these institutions, so there is no doubt that we need to think carefully about their roles. What do they do or, more importantly, what should they do? And how, and how much, should we invest in their development?

It is questions like this that led the authors to produce the two books. The first was a set of case studies featuring eleven hospitals, hospital systems and financing methods. The second was a thematic book, exploring conceptual issues in hospital planning.

A number of contextual factors are addressed in the books, including trends in "marketisation" (the patient as consumer; privatisation and PPPs as delivery mechanisms), and changing health care technology, epidemiology and demography. The books also deal with issues of regional planning systems, the workforce, leadership, facility management and community impact. This article focuses on a subset of the "actionable" issues identified: life-cycle thinking, flow processes, and definitions of capacity.

Life-cycle thinking

The decision to invest in a new or renewed hospital is not to be indulged in lightly, given that the cost of so doing will veer upwards from tens of millions of Euros, with at least three hospitals under construction in Europe today involving capital expenditure well in excess of €1 billion. The first thing to note is that, paradoxically, this expenditure is in fact almost trivial. The total of facility management costs over the typical life-span of a building will be the same order of magnitude, and–much more important– the cost of the primary medical processes undertaken within them will be around fifteen times as much. There is an obvious but important point here. The capital expenditure may be comparatively small, but it has a major impact on what happens thereafter; the *decision* to invest is critical even if the *cost* is not.[3]

This approach underlines the importance of distinguishing between tactical and strategic decision-making. Tactical measures might take the form of truncating the planning phases and a "rush to certainty". However, merely achieving on-cost, on-time delivery will not guarantee the long-term strategic performance of buildings. Furthermore, the carbon and sustainability agenda requires a forward look over decades, in order to position the building, its services and the population's access to it in such a way that negative environmental implications are minimised.[4]

The take-home point is that the asymmetry of capital and operational expenditures, as well as the need for strategic decision-making and ensuring sustainability, can all be handled within a life-cycle framework, attempting to capture the entire implications of the investment decision from the beginning. However, a life-cycle framework is still far from being universally used in hospital capital planning today.

Go with the flow

When "health care technology" is mentioned, the immediate response is to think in terms of MRI scanners, laparoscopic surgery, innovative anti-cancer drugs and other impressive pieces of kit and process. But these are micro-level techniques or tools, often just enablers of a particular model of care. Technologies should support the model of care within which the individual components are delivered, as this will determine whether the intended goals are achieved. These models have changed dramatically in the last century – probably more than in most other economic sectors.

Models of care often remain hospital-centric, but are not usefully denominated only in terms of activities inside the hospital. What is important is the idea of whole-system care, where the patient's passage through the hospital is likely to be a modest proportion of the total journey. This is especially true for an ageing population, where patients typically will have multiple co-morbidities, few of which will demand admission and many of which are better treated in the community than in an acute care hospital.

Health care involves a combination of routine procedures and bespoke operations, with the latter more akin to craft-work than streamlined processes. The studies draw out the distinction between batch and flow processes, where the latter offer a much higher probability of consistent quality and contained cost. Thinking in "flow" terms leads to consideration of how to systematise care within the facility (and from it to the rest of the health system), using, for example, integrated clinical care pathways. It also leads to fruitful analogies with other

processing sectors, such as the application of lean production techniques. Critically, *lean* requires an avoidance of waste, including wasted time.

> requires an avoidance of waste, including wasted time

Hospitals expend an enormous amount of a patient's time, simply because it is free–to the institution of course, but not to the patient. From the traditional perspective of the hospital, the bed became a valid indicator; after all, that is where much of the waiting takes place. Beds, therefore, have a role in "storing" patients – but this echoes the passive view of the hospital. In reality, the choke point in a hospital is often not the number of beds, but it might be the capacity of operation theatres or intensive care units (or something else). It might indeed not be in the physical capital at all, but rather the human capital, which is much more important than the buildings. Indeed, relieving one constraint on operations will inevitably reveal another, but the process should be continued until the marginal costs of relieving the next bottleneck equal the long-term benefits of doing so.[5]

Hot, cold and in-between: the capacity of hospitals

Concepts of flow are thus important in improving hospital functioning. However, flow needs to be matched against capacity. This is by no means a simple task. Dealing with variable flows – of patients, staff, materials and utilities – is complicated. It requires quantitative modelling of all elements of care, and not just an assignment of numbers of patients by disease categories to norms of departmental space.

Some of the above analysis could be taken to imply that the curative facilities of the hospital – the parts most easily analogised as flow processes – are all-important. However, there are many types of capacity within the hospital. One way of analysing these different types is by modelling hospital space according to different functions.[6,7] The "hot floor" is the most iconic part of the hospital and includes operating rooms and intensive care units, but also imaging, and accounts for about 24–46% of floor-space. "Factory" facilities – laboratories, catering and laundry etc. – usually amount to 9–13% of floor space. The "office" space encompasses administration and consulting rooms (24–36% of floor space). Finally, the "hotel" accommodation of bedrooms and wards occupies about 21–27% of the total floor space. Each of these broad functional spaces has its own internal flow dynamics, and each can be seen to relate to the others across system boundaries that frequently generate friction. There are design principles that should apply to each, but they are quite different. The hot areas are distinguished by high capital cost and a short lifespan, and are the only areas that are truly medical. It is likely that they will determine the overall size of the hospital, with everything else being essentially a utility to service it. Factory areas are largely non-core activities, candidates for sharing among facilities, for example in clinical networks. Office and hotel spaces can be built and serviced like their commercial analogues, and with a possibility of re-use at the end of their lifespan.

The future is a foreign country: they do things differently there. The capital stock of hospitals needs to accommodate a universe of contingencies, many of which are unknown at present. A key point is ensuring flexibility within and between each of the functional areas outlined above – although possibly less so for the hot floor, which needs to be replaced on a short cycle anyway. This loose-fit principle applies not just to the building structure but also to the people working there. The financing of new capital must support rather than inhibit flexibility; we therefore believe that successful capital market tools will only emerge in models that prioritise true whole-system life-cycle thinking, and not emulate failed examples such as the United Kingdom's Private Finance Initiative, with its rigid contractual emphasis on buildings.

Conclusions

Groucho Marx suggested that "a hospital bed is a parked taxi with the meter running". Even without joining his club, we agree about the danger of the hospital becoming an expensive place going nowhere fast. The ideas discussed here – of taking the whole life-cycle into account, treating activities in hospitals as flows to be processed, and matching the installed capacity to those flows – will help to design hospitals that are less static, more efficient to run, and meet the needs of patients, staff and society. Having less money than we anticipated does not lessen the force of that argument.

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IMPLEMENTING RECOMMENDATIONS FOR **SAFER HOSPITALS** IN EUROPE: SANITAS PROJECT

By: Charles D Shaw, Elisabeth Jelfs and Paula Franklin

Summary: European expectations for learning across borders assume that practices will converge and that each Member State has standards and guidelines on hospital safety and quality of care. Much relevant guidance already exists but there is no mechanism to convert this into a practical tool for implementation at hospital level. The SANITAS project is developing a learning tool based on collected guidance and research from the Council of Europe, World Health Organization, European Union directives and research and European non-governmental organisations. Initial research was funded by *Agenas,* Italy's National Agency for Regional Health Services, but further funding is now required for field testing and the development of an interactive tool for self-assessment, or a framework for the development of national standards.

Keywords: *Policy, Safety, Hospitals, Europe, SANITAS Project*

Context of the European agenda: Public health policy and expectations

Three aspects of the policy context at European Union (EU) level have shaped the development of SANITAS (Self-Assessment Network Initial Testing and Standards). First, although the EU has been active in safety issues for many years, through legislation on areas such as organ transplantation and blood safety, there is now increased interest at EU level in learning across borders on quality and safety more generally in health care. In 2007, the European Commission (EC) funded a patient safety network at European level (EUNetPaS) to exchange knowledge, experiences and expertise between individual Member States and EU stakeholders – and to "provide support to countries less advanced in patient safety".[1] In 2012, the Commission and Member States will launch a Joint Action on patient safety and quality to consolidate this network and enlarge it to address these issues.[2]

Second, there is an assumption that safety standards will converge. Beyond sharing experience between countries, work at European level is now attempting to develop common thinking across countries, particularly on patient safety. In 2009, the Council of the European Union (which represents the executives of the Member States) passed a *Recommendation on Patient Safety*, including provisions on national patient safety programmes.[3] Although

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Box 1: Principal sources of guidance in Europe

- Council of Europe
- WHO: Regional Office for Europe, European Observatory on Health Systems and Policies, WHO Headquarters in Geneva
- EU guidance:
  – Legislation, Directives
  – Parliament, Council, Directorates
- EC research:
  – Reports, Publications, Projects

Box 2: Clustered concepts of safety in hospitals

1. Mission, governance, management
2. Patient orientation
3. Workforce
4. Clinical practice and patient care
5. Hygiene and infection
6. Human tissue and transfusion
7. Hospital facilities management
8. Medication
9. Surgery, interventions, anaesthesia
10. Records and communication

not binding, the Recommendation's implementation is being monitored by the Commission, with Member States reporting on their progress.

Third, there is a proliferation of international guidance on patient safety from numerous sources, from the World Health Organization's Safe Surgery work, to the Council of Europe's recommendations on medication safety, to the United Nation's campaign for hospitals that are resilient to disasters. There is also an increasing body of research through projects funded at EU level that make recommendations on safety and quality within a range of different health care settings, particularly hospitals*.

Challenges in implementation

Several factors stand between the issuance of authoritative advice and its application in hospital practice, including:

- No mechanism or clearing house to collate and integrate existing guidance.
- Much of the existing guidance is addressed as policy advice to governments rather than as practical tools for managers and clinicians in health care organisations.
- Many regional and national governments are unwilling or unable to interpret European guidance to health care providers at local level.
- An emphasis on preventing adverse patient events which is diverting attention from safety of the workforce and key determinants of hospital safety, such as the quality of clinical practice and the physical environment.

Taken together, these developments pose a number of different challenges for implementation. Despite a willingness of EU countries to work together, the differences between their approaches to patient safety are vast. Although there is a significant and increasing body of legislation, guidance and evidence on an EU and international level, there has been little attempt to gather this together in a way that is useful for health care organisations that are looking to base their practice on the best available evidence.

Developing a self-assessment tool for hospitals

The SANITAS project has developed organisational guidelines informed by the procedures that were used to develop clinical guidelines in the European AGREE project (Appraisal of Guidelines, Research and Evaluation in Europe).[4] This required discrete steps, including: definition of the subject; review of published evidence; drafting into a logical structure; consultation; field testing and evaluation. At the time of writing, this process was not yet completed.

> proliferation of international guidance on patient safety

Defining the scope of safety

Compared with the content of national quality plans and accreditation standards, much of the current guidance on "patient safety" makes little reference to key determinants of safety in hospitals, such as clinical practice, workforce and facilities management. These themes were added to the matrix used for literature searching, together with the recurring European theme of patients' rights.

Literature review

Documents identified from primary European sources (**see Box 1**) were allocated to one or more of ten themes. Each theme was then searched for gaps (e.g., elements measurable at hospital level) to be filled from secondary sources such as European non-governmental organisations (NGOs) and national agencies. References were excluded which were not freely available on the internet (e.g., ISO and other proprietary standards).

Empirical chapter structure

Based on the volume of directives, guidelines and recommendations relevant to hospitals in Europe, it is evident that common expectations go well beyond the current understanding of patient safety; thus, separate chapters were created for governance, patient orientation, workforce, clinical practice and facilities management (**see Box 2**).

* For example: **MARQuIS** (Methods of Improving Response to Quality Improvement Strategies), available at: http://www.marquis.be/Main; **DUQuE** (Deepening our understanding of quality improvement in Europe), available at: http://www.duque.eu/; and **QUASER** (Quality and Safety in European Union Hospitals), available at: http://www.kingspssq.org.uk/assets/files/QUASER%20abstract%20short%20version%20November%202010.pdf

Translating principles into measurable criteria

Each chapter of SANITAS starts with a summary of available guidance. Much of this is directed at national level or expressed in general terms which needs more explicit definition for use at hospital level. Criteria for assessment of compliance were derived directly from the guidance or from published accreditation standards, referencing specific sources where available.

Review of first draft

Working groups in ten Italian hospitals assessed version one according to whether criteria were relevant, understandable, measurable or achievable. Feedback was incorporated into version two for field testing.

Discoveries

Developing the self-assessment tool and conducting a pilot study provided valuable data on the three aspects of the EU policy context that SANITAS emerged from:

1) *Learning across borders:* Socio-cultural and institutional diversity in European health care requires sensitivity to variations in local legislation and the management of systems. Therefore, translation of EU-level policy and principles into practical solutions at hospital level benefits from field testing. The robust reference base that the tool uses – avoids repetition of "on" on systems which have been shown to increase the safety of patients and staff, provides a framework for safe patient care in different settings and countries. Furthermore, the tool is being developed to accommodate variations in concepts and time frames used at local level, as well as any relevant but absent assessment criteria indicated by the hospital working groups.

2) *Will European safety standards converge?* Although many principles on patient safety tend to be widely accepted across health care institutions, practicalities, attitudes and interpretations of the ideals vary widely. Patients' rights, professional accountability, and team-working emerged as issues that differ at a practical level. They have direct implications, for example, on cross-border care. The assumption that practices will converge is without ground until an evidence-based framework is formed that collates the best practices.

3) *The proliferation of international guidance:* Intergovernmental organisations are rich sources of advice but also leave many gaps to be filled by NGOs, national and regional governments, regulators and (health care) accreditation programmes. In addition, some key issues in patient safety fall outside hospital safety guidance literature (e.g., facilities management), and some potential sources are not freely accessible to the public (e.g., scientific research publications).

The results of SANITAS at this stage verify the need for hospital safety guidance in Europe which converts policy into practice for health care organisations. In response to this, the SANITAS self-assessment tool offers a framework for design or evaluation of safety systems across borders, at regional or national level.

Conclusions: Why is the issue of patient safety becoming urgent?

Recent policy developments, which are not specifically targeted at patient safety issues, have steered attention to the need for harmonised safety standards across the EU. Particularly significant has been the adoption of the Directive on Patients' Rights in Cross Border Healthcare. Indeed, Zanon[5] notes how this EU Directive poses a challenge for health care organisations, forcing them to think differently about how they "plan, finance and provide health care" (p.34). While the current debates focus mainly on the financial side of the Directive, and individual country planning of service delivery, SANITAS addresses the need to develop practical European patient safety guidance.

Many Member States need a robust policy for quality and safety in health care, and would welcome a timely European framework, if only to meet (by October 2013) requirements for "standards and guidelines on quality and safety laid down by the Member State of treatment".[6] The current EU Joint Action aims to identify and share good practices between Member States, but not synthesise them into a common tool for implementing policies and best practices across the EU.

Existing systems for external assessment of health care providers (accreditation, certification, regulation) are unlikely to harmonise safety management within and between EU countries.[7] In addition, even if governments could agree on standards for safety, the common acceptable denominator would be so low as to have little value. Thus, it falls to a consortium of NGOs to take the initiative to develop a model for voluntary self-assessment.

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COST CONTAINMENT IN FRANCE: ASSESSMENT OF CURRENT POLICY INITIATIVES

By: Karine Chevreul and Isabelle Durand-Zaleski

Summary: The French health care system is relatively expensive by international standards and efforts at cost containment have been challenging within a system that historically has had few restrictions on patient choice and consumption of services. Recent actions to address this issue include successful measures to encourage the use of gatekeepers within the system, but containing the costs of self-employed physician practice paid on a fee for service basis remains challenging. There has been a shift towards performance related incentives within doctors' contracts for medical practice improvement; however, the areas targeted only cover a small share of doctors' practices. Controlling expenditure in the private practice sector clearly remains a major challenge.

Keywords: *France, Cost Containment, Health Policy*

Background

The overall picture of the state of health in France is positive. Indicators such as life expectancy, life expectancy without disability and healthy life expectancy reveal that the overall health of the population is good.[1] Moreover, the French population enjoys a high level of choice of providers and is relatively satisfied with the health care system.[2]

In 2009, total expenditure on health in France was estimated at €227 billion or 11.8% of Gross Domestic Product (GDP), of which 76% was publicly funded.[1] As in many other countries, health care expenditure in France grew more rapidly than national wealth for many years, but it has risen even faster than in neighbouring countries (with the exception of the UK). Personal health expenditure per capita (€2724 in 2009) is higher than the OECD average, usually ranking third or fourth after the United States, Germany and Switzerland, depending on the year and data used. This growth mainly reflects an increase in the volume of care consumed.

This rising cost of health care is of concern in terms of maintaining the objectives of the health care system. This article therefore provides an overview of the organisation of the health care system, highlights challenges in containing costs, and then looks at measures to try and address this issue.

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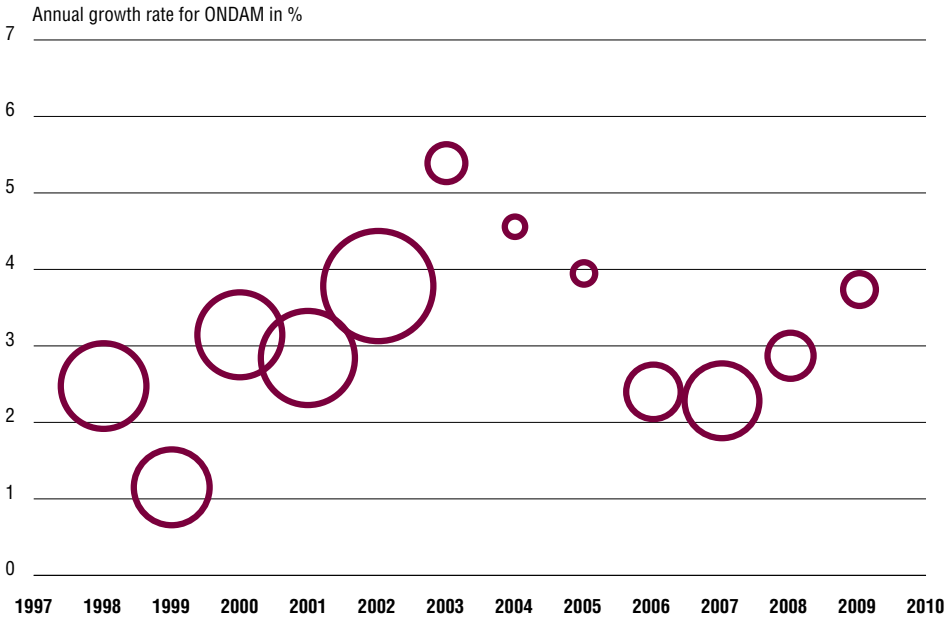
Figure 1: Annual growth rate in the national ceiling for health insurance expenditure (ONDAM and size of ONDAM overrun)



Data source: Eco Santé France 2012, provisional result for 2009 and 2010. Note: the size of the bubbles shows the size of the overrun as a percentage of ONDAM.

Organisation of health care system

The French health care system is a mix of public and private providers and insurers.[1] Statutory health insurance through social security is compulsory and nearly universal, while private insurance is complementary and voluntary. Providers of outpatient care are largely private. Hospital beds are predominantly public or private non-profit-making.

Eligibility for statutory health insurance (SHI) coverage is based upon residency in France. SHI includes a generous benefit package that covers a broad range of services and goods that are provided in hospital or defined in positive lists for outpatient care. The rate of coverage varies across goods and services, ranging from 15% for drugs with the lowest clinically proven benefit to 80% for inpatient care. There are several conditions for which patients are exempted from any co-payment, such as chronic conditions and services for pregnant women after the fifth month.[1]

Funding of SHI comes mainly from income-based contributions of employers and employees. Since 1998, employees' payroll contributions have been almost fully substituted by an earmarked tax called the "general social contribution" based on total income and not only on earned income as previously, reflecting an attempt to broaden the system's financial base. Additional revenue from specific taxes, such as "sin" taxes or taxes on pharmaceutical companies' turnover, accounts for around 13% of SHI funding.

Voluntary health insurance (VHI) provides reimbursement for co-payments and better coverage for medical goods and services that are poorly covered. Over recent decades, VHI has gained an important role in ensuring equity of access and in financing health care. It finances 13.4% of total expenditure on health, covering 88% of the population. Since 2000, a public complementary insurance (complementary universal health coverage) has also been offered on a voluntary basis to individuals with limited financial resources in order to ensure that measures increasing patient co-insurance do not increase social inequities in access. This program currently covers 7% of the population.[1]

Providers of health care services are either paid through SHI or directly by patients who subsequently are partly or fully reimbursed. Statutory tariffs are set through negotiations between providers and the SHI and/or the Ministry of Health. Primary care is mostly delivered in the ambulatory care sector by self-employed professionals, while secondary care is delivered in both ambulatory and hospital settings.

Growth in national ceiling for health insurance expenditure

There is no formal mechanism of resource allocation for the overall health care system or across sectors of care as there is in the UK's NHS system. The main resource allocation mechanism in place is the *L'Objectif National de Dépenses d'Assurance-Maladie* (ONDAM), a budget cap for SHI expenditure, which sets the overall level of statutory health insurance (SHI) expenditure and its distribution across six subsectors of care (care in private practice, care in hospitals paid on a Diagnosis Related Group (DRG) basis, care in other hospitals, health and social care for both older people and people with disabilities and other types of care). Between 1998 and 2010 the ONDAM target was never met. However, since 2003, the size of the overrun has decreased, showing the improving efficiency of this resource allocation mechanism (**see Figure 1**).

Overall therefore, the French system combines elements of various organisational models (**see Box 1**) and reflects a balance between different values, such as equity, freedom of choice and efficiency. However, the system has also suffered from structural difficulties that have provided the impetus for health system reform efforts, with cost containment as a central objective.

Cost containment policies

Cost containment efforts in France have adopted two distinct approaches. First, since the late 1970s measures taken to reduce expenditure growth mainly focused on the control of provider tariffs, volume of care provided and decreasing the cost of SHI, without being genuinely effective. Known as the "strict accounting cost-containment policy", these measures were strongly opposed by professional

Box 1: Features of the French health care system

- Lies between the Beveridge and Bismarck models combining SHI, a single public payer model and strong state intervention.
- Combines public and private health insurance, which finance the same services by the same providers for the same populations.
- Combines public and private care, including private profit-making hospitals.
- Publicly-funded system characterised by a high level of freedom of choice and largely unrestricted access for patients and freedom of practice for professionals.
- Complex and pluralistic in its oversight, with co-management by the state and the SHI

associations, particularly physicians. The ongoing conflict between physicians and SHI came to a peak in the early 2000s when doctors refused to sign an agreement on statutory tariffs with the SHI for several years until 2005.

Second, concern about the cost and quality implications of medical practice variations, such as the over-prescription of antibiotics, led to a concept called "medically based cost-containment policy". These measures have focused on the reduction of financial and equity losses resulting from medical practice variations, with the aim of improving medical practice. The main tools used are physicians' lifelong learning activities, development of practice guidelines by national agencies and the introduction of good practice commitments within professional agreements with the SHI. However, cost containment measures were implemented in a context of mistrust, with doctors refusing to accept any proposals coming from both the SHI and government. The fact that improvements in collective medical practice have been weak[3] is perhaps more reflective of this political context and the power of physicians than of the theoretical effectiveness of the measures implemented.

These weak results also explain the 2009 shift to an incentive-based approach in the form of individual contracts for practice improvement, *Contrat d'Amelioration des Pratiques Individuelles* (CAPI), similar to those see under the UK's Quality and Outcomes Framework. CAPI pay-for-performance incentives are used to achieve efficiency targets in primary care. They do not change the basis of fee-for-service payment but offer additional payments of up to 5% of general practitioner (GP) income. For example, targets to increase the percentage of generics prescribed and the use of low-cost statins have received much public attention. Despite the initial opposition of all the GP unions, which resisted the individual aspect of the contracts and advocated continuation of collective bargaining on all issues concerning quality and continuity of care in exchange for an increase in the basic fee for GP consultations, these contracts met with greater success than anticipated, with more than 20% of GPs signing contracts within the first year. Based on this success, the incentives were integrated into the 2012 collective bargaining agreement between physicians and SHI and offered to specialists as well. Despite the fact that its scope has been extended from 16 to 29 indicators, the areas targeted only cover a small share of doctors' practices. The question of how to improve overall prescribing practice remains high on the policy agenda.

Overall, the particular features of the French health care system make it more difficult to achieve the goal of cost containment. Controlling expenditure is a complicated task when there are no restrictions on either the freedom of consumption by patients or provision of care by professionals, in a system where care is largely publicly funded and retrospectively reimbursed and where local SHI funds do not have real financial responsibility but are often described as "blind payers" reimbursing care without regard for its appropriateness and efficiency. Not surprisingly, the French health care system is relatively expensive by international standards, and the slowing of expenditure growth, which most countries achieved during the 1980s, only occurred in France in the second half of the 1990s.

Gatekeepers and positive lists

Even though from a patient perspective, freedom of choice, access and consumption and the size of the benefit package are viewed as key attributes of quality, some cost-containment measures designed to address these factors have also been developed. As the high volume of care consumption has been attributed to patients being able to "shop around" for doctors, one idea advocated since the early 1980s to increase efficiency has been the introduction of a gate-keeper into the health care system. A first attempt to do this occurred in 1998, with the introduction of the "referring doctor" scheme, based on a voluntary participation by GPs. However, it was opposed by most of the physicians' associations and was adopted by only 10% of GPs and 1% of patients.

In 2004, this scheme was replaced by the "preferred doctor scheme". Under this system, each patient is asked to choose a physician as his/her first point of contact with the health care system, except with respect to certain specialists (gynaecologists, obstetricians, ophthalmologists, psychiatrists, neuro-psychiatrists and paediatricians). The system is backed by financial incentives that are mainly directed towards patients. If a patient has not registered with a preferred doctor (usually a GP), has registered with a preferred doctor but nevertheless visits another GP or visits a specialist without a GP referral, the SHI rate of coverage drops from 70% to 30%. In each of these three situations, doctors are allowed to charge a supplemental fee up to 19.1% of the official tariff. On the physician side, no per capita payment is offered, except for patients registered by SHI as having chronic diseases, who receive an annual per capita payment of €40 for drafting a coordinated care protocol. In order to keep incentives effective, VHI providers have been offered tax deductions for providing contracts that do not cover these additional fees *(contrats responsables)*.

> Controlling expenditure in the private sector clearly remains a major challenge

By 2010 80% of French patients had chosen a preferred doctor, of whom more than 99% were GPs. While the reform may succeed in improving the quality of care through better coordination of care pathways, the expected financial benefits have been partially offset by the additional payments made to physicians.[4] Moreover, concerns have been raised that the reform may increase socioeconomic inequalities in the use of specialist care because it increases the overall cost of access to specialists.[5]

Historically, the French health system has been considered generous in terms of services covered, with goods and services added to positive lists and rarely eliminated, with coverage decisions focusing on the level of coverage and price of services rather than whether they should be added to the list. Recently, however, the French health system has become more selective in terms of reimbursement. The idea of taking or keeping some services off the list is now accepted, especially for drugs and new products. For example, in the mid-1990s, removing some drugs with no proven efficacy from the positive list was proposed, but this was not politically easy to achieve, with implementation taking more than ten years. In 2003, the Ministry of Health finally decided to de-list hundreds of these drugs, implemented in three waves between 2003 and 2005. This gave the impetus to the de-listing policy and further decisions have followed. However, this remains a long and slow process.

New challenges

Despite three decades in the use of cost-containment measures, the debt accumulated by SHI was estimated to have reached approximately €160 billion in 2011. Moreover, following the economic downturn, since 2009 the annual deficit of around €10 billion has been more than double that of previous years.

Historically, the budget cap for SHI expenditure has been very soft, with parliament voting on an expected target but with no means to control actual expenditure over the course of the year. Indeed, statutory tariffs for self-employed professionals, medical devices and drugs are still negotiated on a multi-annual basis and, therefore, are fixed for a given period of time. There is no *a priori* control of the volume of care consumed, although two recent measures have attempted to turn ONDAM into a harder form of budget.

The first created an Alert Committee in 2004, while the second gave the head of the Directorate of Social Security in the Ministry of Health the power to present a financial rescue plan when the overrun exceeds 0.75% of SHI expenditure (which corresponded to €1.22 billion in 2010) or to introduce remedial actions during the year. These interventions, for example, can include a decrease in hospital tariffs set by the Ministry of Health and a freeze in the share of budgets allocated to special funds and to the health and social care sector.

However, what is striking is that these measures have barely touched services and goods delivered or prescribed on a private basis by self-employed professionals. Yet, this is, in fact, the area in which the level of overrun was greatest before 2010. For example in 2008, of the €930 million spent in excess of the overall target, €800 million was due to private practice expenditure, while only €130 million came from the hospital sector. In the meantime, the targets for the health and social care sector and other types of care through special funds were respected.

This suggests that, in addition to traditional measures that remove certain goods and services from SHI coverage and structural reforms that reduce duplication and inefficiencies, reorganisation of health care delivery and financing must be considered, in particular with respect to private practice. One important structural aspect of the French health system is fee-for-service payment for self-employed professionals, which may be considered as a basis for supplier-induced demand, particularly in areas with higher rates of professionals per capita and in the absence of incentives for improving care coordination and prevention.

The implementation of individual payment for performance contracts (CAPI) for doctors may be seen as a first step in reforming the fee-for-service model. However, this remains an extremely challenging policy area. One significant issue is the major role that is played by the Ministry of Health in the decision-making process. One can wonder whether any government can have the necessary political power and fortitude to defend these kinds of reforms. This difficulty was illustrated recently by the Minister of Health's reversal of the negative financial incentives imposed by the 2009 reform law for doctors who refused to sign a contract to deliver care in under-served areas. Controlling expenditure in the private practice sector clearly remains a major challenge.

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THE REFORM OF **LONG-TERM CARE** IN THE NETHERLANDS

By: Hans Maarse

Summary: Over the last few years long-term care (LTC) has rapidly become a major policy issue in Dutch health care policymaking. An important reason for this development is concern about the future financial sustainability of LTC. Fundamental reform of LTC is deemed necessary to curb the growth of LTC expenditures. This article gives a brief overview of current LTC reforms. The focus is on LTC for older people and others in need of long-term nursing or personal care because of physical and/or sensory disabilities or other chronic conditions.

Keywords: *Long-term Care, Personal Budgets, Older People, The Netherlands*

In the Netherlands LTC is provided by private not-for-profit organisations, in particular nursing homes, residential homes and home care provider organisations. Clients can also apply for a personal budget to organise LTC for themselves. In 2010 about 3.6% of the population made use of home care or institutional care in a nursing or residential home.[1] In Europe only Austria, Sweden, Norway and Switzerland have higher rates of use of care, while the average for Organisation for Economic Cooperation and Development (OECD) countries is 2.8%.[2]

LTC is mainly funded with public resources. In 2009 only 8% of total expenditure for LTC was paid privately by means of user charges. The percentage of Gross Domestic Product (GDP) spent on LTC is 3.5%, which is high compared to other European countries.[3] There are three schemes in operation for the funding of LTC. The Exceptional Medical Expenses Act (AWBZ: *Algemene Wet Bijzondere Ziektekosten*), in place since 1968, pays for the bulk of LTC. It is a national mandatory, contribution-based health insurance scheme which pays for personal and nursing care, counselling, medical treatment and accommodation. Clients are required to make co-payments based upon their incomes, age, family situation (single or married) and type of care. The minimum monthly co-payment is €145 and the maximum €2,097. Currently, a person in a nursing or residential home on average makes co-payments of €6,400 per annum. One recent plan that has been put forward by the government is to include a person's capital in the calculation of this co-payment.

The Social Support Act (WMO: *Wet Maatschappelijke Ondersteuning*), in place since 2007, pays, amongst other things, for domiciliary care. It is run by municipalities which receive a tax-funded state grant to provide services, which previously were covered by the AWBZ. Clients are also required to make an income-related co-payment for domiciliary care.

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Note: *This paper is a shortened version of a lecture given in April 2011 at a conference on the reform of LTC in Berlin organised by GVG – Gesellschaft für Versicherungswissenschaft und Versicherungsgestaltung e.V.*

Table 1: Trends in LTC expenditure, 2003–2009 (€ billions)

	2003	2005	2007	2009	Total Increase
AWBZ	10.9	11.4	11.4	12.6	**15.6%**
WMO	–	–	1.0	1.1	**10.0%**
PGB	0.7	0.9	1.3	2.0	**185.7%**
Total	**11.6**	**12.3**	**14.0**	**15.6**	**34.5%**

Source:[4,5]

Personal budgets (PGB: *persoonsgebonden budget*) constitute the third pillar in the funding of LTC. This publicly funded arrangement was introduced in the mid-1990s to give clients a choice on how to organise their own tailor-made care packages. Expenditure on this instrument has 'exploded' over the last decade from €413 million in 2002 to about €2.3 billion in 2010. However, these figures require qualification. A specific characteristic of the personal budget system in the Netherlands is that many young people with disabilities make use of the system in addition to older people. A recent report demonstrated that the bulk of the cost explosion is attributable to the increase in the number of young people applying for personal budgets.[3] Table 1 shows overall growth in LTC expenditure in the Netherlands between 2003 and 2009. While total expenditure grew by 34.5%, expenditure on personal budgets rose by 186%.[4,5]

Needs assessment

Traditionally, provider organisations were charged with the assessment of client needs under the AWBZ. This changed in the mid-1990s, when the government opted instead for a standardised procedure by means of universal and objective criteria. Needs assessment was institutionally split from provision and shifted to independent regional assessment bodies. The centralisation of needs assessment again culminated in 2005 with the creation of a national body for needs assessment to which the existing regional bodies were to be subordinate. This national body sets guidelines to determine who is eligible for what type and how much LTC they will receive.

The assessment of clients, often only by telephone contact, and which had been delegated to regional bodies, has always been criticised. In recent years, one can observe a trend to make provider organisations more responsible again by delegating the assessment of a number of client categories. The main purpose of this decentralisation is to reinforce professional self-responsibility in provider organisations and reduce bureaucracy. Municipalities may delegate the needs assessment of clients applying for WMO care to regional bodies, but are not obliged to do so and may set their own assessment criteria.

The growth of demand for LTC

The ageing of the population will lead to an increase in demand for LTC. Currently 15.3% of the population are aged 65 and older; this is expected to increase to 17.5% by 2015 and 23.7% by 2030. In 2050 about 40% of people aged over 65 will be 80 plus. There is much discussion about the implications of this ageing of the population for the growth of LTC demand. According to the Office for Social and Cultural Planning (SCP), annual growth in the LTC workforce averaged 1.8% between 1995 and 2005. However, in the view of the SCP, this percentage cannot be simply extrapolated to the future. If factors like health and education are taken into account, the estimate for the period 2010–2030 is just 1.2%.[6]

Reform of LTC

Current reforms to LTC involve a variety of programmes and policy measures. Among the most important are measures to put more emphasis on individual responsibility, upgrade the role of local government and health insurers, introduce access reforms and partially abolish personal budgets.[7]

More emphasis upon individual responsibility

Solidarity will remain the moral cornerstone of LTC, but solidarity cannot be sustained without individual responsibility. The availability of a wide range of publicly funded services for LTC has created a situation in which many people too easily rely upon these facilities in LTC. Individual responsibility should therefore be reinforced. In concrete terms, more responsibility means more private payments for LTC and a larger emphasis on the provision of informal care.

Upgrading the role of local government

The introduction of the WMO, in particular the transition of domiciliary care from the AWBZ to the WMO, has significantly strengthened the role of local government (municipalities) in LTC. In 2013, local government will also be made responsible for personal care, which currently is covered by the AWBZ. The assumptions underpinning this reform are that local government is best capable to deliver efficient, client-centred and integrated support to LTC clients because it is already responsible for various adjacent policy areas including housing, welfare programmes and local planning. The upgrading of the role of local government is accompanied by significant expenditure cuts which are politically sold as 'efficiency cuts'. Local government's responsibility does not mean that it provides LTC services itself however. Most municipalities use tendering as a tool for contracting external provider organisations to provide domiciliary care.

Upgrading the role of health insurers

The role of health insurers will also fundamentally change. At present insurers use a representation model in implementing the AWBZ. The essence of this model is that one insurer, usually the regional market-leader, is charged with the implementation of the AWBZ in one of the 32 regions on behalf of all insurers. The main task of the insurer in charge (the care-office or *zorgkantoor*) is to contract providers and inform clients, but it has no involvement in needs assessment. The representation model will come to an

end in 2013 when health insurers will be charged with the implementation of the AWBZ for their own insured populations. This reform may have significant consequences for the implementation of the AWBZ, in particular when insurers incur a financial risk (as is already the case for medical care under the Health Insurance Act).

> The role of local government has been significantly strengthened

Access reforms

Coverage under the AWBZ has been reduced somewhat by making eligibility criteria more stringent. A recently announced measure will require clients in residential care to pay a rent for their housing and living costs. Under the current regime the AWBZ pays most of the costs of residential care; clients are only required to make a co-payment. The transfer of domiciliary care services from the AWBZ to the WMO, and more generally the upgrading of the role of local government in LTC by the additional transfer of responsibility for services away from the AWBZ, also has potentially far-reaching consequences for access. Given that the AWBZ is a true social health insurance scheme, clients have a right to LTC if they are assessed as being eligible for care. This is not the case for the WMO.

In contrast to the AWBZ, the WMO is not an open-ended scheme. Legislation only obligates municipalities to compensate or support individuals up to the level where they can live autonomously and participate in social life. However, municipalities have great discretionary power on how to meet the terms of this compensation principle. For instance, they are free to decide on the size of the budget for WMO activities and if the budget is exhausted, they are not obliged to provide additional resources. They may also take the care giving potential of family members and/or the wider social network of the applicant into account and introduce some form of means-testing to determine the amount and type of compensation. In other words, compensation means that applicants should carry a greater individual responsibility for LTC.

Partial abolition of personal budgets

The cost explosion for personal budgets since 2000 was caused by various factors, including ambiguous guidelines and the generosity of the personal budget. The arrangement also attracted many new, mainly young, clients. In 1998, there were 13,000 budget holders, and in 2008 more than 148,000. A recent study concluded that about two-thirds of budget holders had opted for LTC because of personal budgets. They were not interested in care in-kind.[3] Other factors raising concern were rumours about fraud and the so-called monetarisation of informal care: individuals who once rendered unpaid informal care are now paid for their help. In her letter to Parliament,[7] the State Secretary for Health announced that only clients eligible for residential care (about 10% of current users) will retain the option of a personal budget. If they use this option, they can only purchase LTC services delivered by individuals or organisations which have been contracted by the regional care office in charge of the implementation of the AWBZ. Clients who no longer qualify for a personal budget will be offered care in-kind provided by contracted provider organisations. This partial abolition, which will see no new budget applications accepted from 2013 and the full restriction of the scheme from 2014, is highly disputed.

Conclusion

In summary, it can be concluded that LTC in the Netherlands is subject to various interconnected reforms. The common element of these reforms is a greater emphasis upon individual responsibility, an increase in user charges for receiving LTC and reductions in the benefit packages of publicly funded arrangements. The upgrading of the role of municipalities in LTC and the shift from entitlement (a client's right) to compensation (an obligation of municipalities) points in the same direction. The upgrading of the role of insurers in the implementation of the AWBZ will make insurers keener to increase efficiency. It seems evident that each of these reforms conveys a politically difficult message and that it will require some time before they are accepted. Politicians well realise that the ageing of the population means that their electorate is ageing as well. The political sensitivity of the reforms was well illustrated in April 2012 after the fall of the government (Cabinet-Rutte). The subsequent new coalition agreement with three former opposition parties to restrict the public budget deficit to 3% included various measures that have affected the reform of LTC. The most visible measure has been to largely revoke the partial abolition of the personal budget system!

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NEW PUBLICATIONS

Health System Review – Sweden

By: A Anell, A H Glenngård, S Merkur

Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2012

Number of pages: 159

Freely available to download at: http://www.euro.who.int/__data/assets/pdf_file/0008/164096/e96455.pdf

Life expectancy in Sweden is high and the country performs well in comparisons related to disease-oriented indicators of health service outcomes and quality of care. The Swedish health system is committed to ensuring the health of all citizens and abides by the principles of human dignity, need and solidarity, and cost-effectiveness.

The state is responsible for overall health policy, while the funding and provision of services lies largely with the county councils and regions. The municipalities are responsible for the care of older and disabled people. The majority of primary care centres and almost all hospitals are owned by the county councils. Health care expenditure is mainly tax funded (80%) and is equivalent to 9.9% of gross domestic product (2009). Only about 4% of the population has voluntary health insurance. User charges fund about 17% of health expenditure and are levied on visits to professionals, hospitalisation and medicines. The number of acute care hospital beds is below the EU average and Sweden allocates more human resources to the health sector than most OECD countries.

In the past, the Achilles' heel of Swedish health care included long waiting times for diagnosis and treatment and, more recently, divergence in quality of care between regions and socioeconomic groups. Addressing long waiting times remains a key policy objective along with improving access to providers.

Recent principal health reforms over the past decade relate to: concentrating hospital services; regionalising health care services, including mergers; improving coordinated care; increasing choice, competition and privatisation in primary care; privatisation and competition in the pharmacy sector; changing co-payments; and increasing attention to public comparison of quality and efficiency indicators, the value of investments in health care and responsiveness to patients' needs. Reforms are often introduced at the local level; thus the pattern of reform varies across local government, although mimicking behaviour usually occurs.

The new report was officially launched on 10 May 2012 in Stockholm at meetings hosted by the Ministry of Health and the Swedish Association of Local Authorities and Regions.

Contents:
Preface; Acknowledgements; List of abbreviations; List of tables, figures and boxes; Abstract; Executive summary; Introduction; Organisation and governance; Financing; Physical and human resources; Provision of services; Principal health care reforms; Assessment of the health system; Conclusions; Appendices.

Health System Review – Veneto Region, Italy

By: F Toniolo, M Bonin, A Aggio, ***et al***.

Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2011

Number of pages: 138

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The Veneto Region is one of Italy's richest regions and the health of its resident population compares favourably with other regions. Life expectancy for both men and women, now at 79.1 and 85.2 years, respectively, is slightly higher than the national average, while mortality rates are comparable to national rates. The major causes of death are tumours and cardiovascular diseases.

Under Italy's National Health Service, the regions are responsible for the organisation of health care and the provision of a nationally defined basic health benefit package. The Veneto Region also provides some extra benefits through its own regional budget. Historically, health budget deficits have been a major problem in most Italian regions, but since the early 2000s the introduction of efficiency measures and tighter procedures on financial management have contributed to a significant decrease in the Veneto Region's health budget deficit.

The Region's health system is governed by the regional government (*Giunta*) via the Departments of Health and Social Services, which receive technical support from a single General Management Secretariat. Health care is provided by 21 local health and social care units, two hospital enterprises, two national hospitals for scientific research and private accredited providers. Objectives for the health system are established by the Regional

Health and Social Care Plan, which also reflects the priorities and requirements laid out in the National Health Plan, and the agreements reached at the State-Regions Conference.

There are three particularly interesting management strategies that the Region has adopted. First, the Region has invested heavily in integrated, strategic planning and technical support processes, consisting of detailed plans. This ensures not only that the objectives and standards of all health services are defined and met but that they are integrated with social care policies and services. Second, the Region is undertaking a concerted reorganisation of the hospital sector. Where appropriate, some services are being removed from acute hospital settings and reconfigured for delivery at the primary care level; concurrently, a detailed functional and financial audit of the existing hospital stock is taking place. These measures are designed to better meet population needs and are also a means of containing costs and strengthening efficiency in health care delivery. Third, the Region has implemented activity-based payments for hospital services and is progressively implementing a "standard production costs" methodology.

Future challenges include the sustainable provision of the basic health benefit package; the adaptation of services to meet changes in demand, particularly due to ageing and chronic diseases; and the ever-present problem of keeping the regional health budget balanced.

Contents:
Preface; Acknowledgements; List of abbreviations; List of tables, figures and boxes; Abstract; Executive summary; Introduction; Organisation and governance; Financing; Physical and human resources; Provision of services; Principal health reforms; Assessment of the health system; Conclusions; Appendices.

Health System Review – Poland

By: A Sagan, D Panteli, W Borkowski, ***et al***.

Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2011

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Since the successful transition to a freely elected parliament and a market economy after 1989, Poland is now a stable democracy and is well represented within political and economic organisations in Europe and worldwide. The strongly centralised health system based on the Semashko model was replaced with a decentralised system of mandatory health insurance, complemented with financing from state and territorial self-government budgets. There is a clear separation of health care financing and provision and role of the Ministry of Health is largely constrained to setting the policy and regulating the system.

Compulsory health insurance, covering 98% of the population, formally guarantees access to a very broad range of health services. However, the limited financial resources of the National Health Fund (NFZ) means that broad entitlements guaranteed on paper are not always available. Private health care financing (mainly in the form of out of pocket payments) plays a larger role in Poland than in most other EU Member States and leads to inequities in financing and access.

Limited financing seems to be the biggest barrier in achieving accessible and good quality of health care services and in improving patient satisfaction with the system. Although initiatives to introduce voluntary health insurance, aimed at securing additional sources of financing, are not popular (there is a general aversion to cost-sharing in the population used to broad public coverage) and have so far failed, allocation of NFZ financing between various types of care has improved, e.g., thanks to the introduction of Diagnosis Related Groups. High levels of hospital indebtedness have been another long standing feature of the health system, and privatisation, although strongly opposed and politicised as a solution, has been progressing and is encouraged in the most recent legislation.

Initiatives in other areas have been more successful. For example, substantial activities have been undertaken to improve quality control, address the increasing shortage of health care personnel and to improve the health care information system. The report recognises that there is still some scope for improvement in these areas and that there are other problems, such as limited cooperation between various bodies within the health and social care sectors, that have to be addressed as well.

Findings from this report are accompanied by tables, figures and user-friendly graphs. The succinct conclusions include some policy implications and recommendations. An appendix including links to useful websites and information on the HiT series are also available.

Contents:
Preface; Acknowledgements; List of abbreviations; List of tables, figures and boxes; Abstract; Executive summary; Introduction; Organisation and governance; Financing; Physical and human resources; Provision of services; Principal health reforms; Assessment of the health system; Conclusions; Appendices.

NEWS

International

Cyprus Presidency of the Council of the European Union: priorities for health

There are seven key priorities for health under the Cypriot Presidency. **Healthy ageing across the lifecycle** is one of the main objectives of the European Health Strategy 2008–2013. Within the framework of the 'European Year of Active Ageing and Solidarity between generations', the Cyprus Presidency aims to underline the need to review the structure of health care services and redirect investments for cost reductions in the health care sector. It will further develop work in the area of healthy ageing by collecting evidence and highlighting best practices in the implementation of health promotion and disease prevention programmes. Key elements include multidisciplinary approaches involving both individuals and their communities, as well as their application across the lifecycle.

Another theme is **addressing serious cross border health threats**. Strong capacity building and collaboration mechanisms are necessary to cover all types of serious cross-border health threats and require that aspects of prevention and communication are also addressed. In December 2011, the European Commission adopted a legislative proposal to protect European citizens from a wide range of health threats whether chemical, biological or environmental in nature. The Cyprus Presidency will focus on advancing the discussions on this proposal and on activities for promoting the regional dimension of health security and capacity building.

In respect of the issue of **organ donation and transplantation**, the Presidency plans to adopt respective Council Conclusions, which will further invite the Member States, European Commission and the other EU institutions to develop concrete actions in ensuring public awareness on the importance of organ donation and transplantation and securing EU funds for the development of relevant programmes in this field.

Pharmacovigilance is also on the agenda given that in September 2010, the European Parliament approved the amendment of Directive 2001/83/EC and Regulation (EC) 726/2004 on pharmacovigilance (Regulation (EC) 1235/2010 and Directive 2010/84/EU) aiming at greater patient safety and safeguarding of public health. This new legislation came into force in July 2012.

Another priority is the regulation of **clinical trials** for experiments on humans, aiming at discovering or verifying the results of one or more tests of medicinal products. The requirements for conducting clinical trials within the EU are defined by Directive 2001/20/EC of the European Parliament and the Council, as amended by Directive 2005/28/EC. A proposal for revised legislation that regulates clinical trials is expected to be dealt with by the Working Party on Pharmaceuticals and Medical Devices during the Cyprus Presidency.

In March 2012, the Commission adopted a proposal for a Directive of the European Parliament and Council on the **transparency of measures that regulate the pricing of medicinal products** for human use, as well as their inclusion in public insurance systems. The proposed Directive aims to simplify the procedures and to replace Directive 89/105/EEC, which no longer reflects the complexity of pricing and reimbursement procedures within Member States. The discussion of the proposal within the Working Group on Medicinal Products and Medical Devices was initiated by the Danish Presidency and will be continued by the Cypriot Presidency, as well as within the European Parliament.

The Presidency will also initiate discussions on new legislative proposals to simplify and strengthen the current EU legal framework for **medical devices** to meet the growing expectations of European citizens. Recent incidents with breast implants and large metal-on-metal hip replacements have further revealed the need for increased coordination between Member States in order to guarantee patient safety.

More information at: http://www.cy2012.eu/en/page/health

Food: Commission adopts landmark list of permitted health claims

Health claims on food labelling and in advertising, for example on the role of calcium and bone health or vitamin C and the immune system, have become vital marketing tools to attract consumers' attention. Therefore EU consumers expect accurate information on products they buy, in particular on the health claims that products may put forward. On 16 May 2012 a list of 222 health claims were approved by the Commission. This list, based on sound scientific advice, will be used throughout the EU and should help remove misleading claims from the market before the end of the year. The list also provides legal clarity to food manufacturers on the health claims they can or cannot make. The administrative burden will also be reduced, since all enforcement authorities will, from now on, be able to rely on one list of authorised health claims and their conditions of use to verify if a claim is misleading or not.

Claims for which the authorisation process is complete will be listed in the Union Register of nutrition and health claims made on foods, as required by Regulation (EC) No 1924/2006 on nutrition and health claims made on foods. This Union Register is an interactive database and is on the Commission's website. Food manufacturers will have a period of six months to adapt their practices to the new requirements. From the beginning of December 2012 all claims that are not authorised and not on hold/under consideration shall be prohibited.

For more information on the Register: http://ec.europa.eu/nuhclaims/

Better use of health data will transform the health care landscape, says expert report

On 7 May a high-level group of experts warned that Europeans will only be able to benefit from the affordable, less intrusive and more personalised health care which Information & Communication Technologies (ICT) can bring if agreement is reached on how to use health data. The Task Force, headed by the President of Estonia, Toomas Hendrik Ilves, presented its report during the conference "Smart Health – Better Lives" in Copenhagen, co-organised by the Danish Presidency of the Council of the European Union and the European Commission. This 10th High Level eHealth Conference in 2012 brought together health ministers, government officials and stakeholders to promote innovation for smart health.

The report takes account of the fact that individuals are the owners and controllers of their own data, with the right to make decisions on access to their data and to be informed about how it will be used. It also remains the case that large amounts of data currently sit in different silos within health and social care systems.

The Task Force recommended that the European Commission create a legal framework and space to manage health-related data, as well as implement safeguards so that citizens can use health applications ("apps") in the confidence that their data will be handled appropriately. They also called for health data to be available in a form which is understandable, so as to support health literacy, emphasising also that eHealth applications must prove worthy of users' trust, as it is only then that users will make their data available for feedback on preventive care or for benchmarking and monitoring the performance of health systems. They also called for the creation of a 'beacon group' of Member States and regions committed to open data and eHealth, including pioneers in eHealth applications. Specific eHealth budget lines need to be responsive and enable the development of good ideas into fast prototyping and testing. Transparency should also be required from health institutions through procurement and funding criteria.

These recommendations will feed into eHealth-related EU initiatives, including the eHealth Network, which is being established according to the provisions of the Directive on patients' rights in cross border health care. In the second half of 2012 the Commission will also present the eHealth Action Plan 2012–2020 to scale-up eHealth for empowerment, efficiency and innovation.

The Task Force report is available at: http://ec.europa.eu/information_society/activities/health/policy/ehtask_force

65th World Health Assembly

The 65th World Health Assembly concluded on 26 May 2012. Six days of discussions involved nearly 3000 delegates, including health ministers and senior health officials from the World Health Organization's (WHO) 194 Member States, and representatives of civil-society organisations and other stakeholders. Twenty-one resolutions were adopted. They covered a broad range of health issues including: early marriages and pregnancies, humanitarian emergencies, mass gatherings, pandemic influenza preparedness, the social determinants of health and substandard/spurious/falsely labelled/falsified/counterfeit medical products.

Dr Margaret Chan was appointed for a second five-year term as Director-General of WHO with 98% of the Member States' votes. In her acceptance speech, Dr Chan pledged her continued commitment to improve the health of the most vulnerable. In addition, she said that the biggest challenge over the next five years will be to lead WHO in ways that will help maintain the unprecedented momentum for better health that marked the start of this century.

More information on the World Health Assembly at: http://www.who.int/mediacentre/events/2012/wha65/en/index.html

Roma health newsletter launched

On 15 May the first issue of the Roma health newsletter was published. It gives updates on recent events; lists reports, resources and professional opportunities and includes a feature on community monitoring for accountability for Roma health. Roma are the largest ethnic minority group in the WHO European Region: 10–12 million are estimated to live in the Region, including about six million in the European Union. Evidence indicates that these people can experience significant inequities in access to health systems, exposure to risk factors and health outcomes. The newsletter was launched by the WHO Regional Office for Europe in cooperation with the European Commission Directorate-General for Health and Consumers and the Inter-university Institute of Social Development and Peace at the University of Alicante.

More information at: http://www.euro.who.int/en/what-we-publish/newsletters/roma-health-newsletter

Country news

The Netherlands: new guidelines on use of antidepressants

Antidepressant drugs such as serotonin reuptake inhibitors (SSRIs) and tricyclic depressants should be prescribed as initial treatment only in cases of severe depression, says new guidance from the Dutch College of General Practitioners – *Nederlands Huisartsen Genootschap* – published on 7 June. Antidepressant treatment should be prescribed initially if a depressed individual experiences psychiatric comorbidities or significant problems in maintaining social functions.

The guidance recommends that drug treatment should not be "the first step" for patients exhibiting only "depressive symptoms", a new category distinct from depression. These depressive symptoms include tiredness, loss of concentration and blue moods. Those with these milder symptoms should be told that in most cases they will recover without the need for medications. In addition the guidance suggests that people with more moderate symptoms should be advised to regulate their sleep patterns, continue to work, and take up a sport such as jogging. They could also be referred to internet-based therapies and problem-solving courses.

Only if the condition becomes chronic should face to face psychological therapies or drugs be recommended.

Currently, over one million Dutch people take antidepressants each year at a cost estimated by the Utrecht-based Trimbos Institute for Mental Health to be more than €1.6 billion. Over 80% of these antidepressants are prescribed by general practitioners.

England: Introduction of bar codes 'will save NHS millions'

A new system to tackle variation in how much National Health Service (NHS) hospitals pay for products was announced by Health Minister Simon Burns on 10 June. Some hospitals are currently paying nearly three times as much as others for the same products like surgical gloves and stents. Introducing a fairer and more transparent bar code system, the government claims, will lead to significant savings for the NHS in a market which currently costs it up to £6 billion annually.

Currently there are a multitude of systems and approaches for procurement and for identifying products used by the NHS, resulting in a lack of consistent information. For the first time standard 'GS-1' bar codes on products will be used across the NHS making it easier to track and compare purchases. This also has great potential to improve patient safety. Bar coding systems have been shown to reduce medication errors, the risk of wrong-site surgery and the effective tracking and tracing of surgical instruments, equipment and other devices to improve record keeping and reduce error, malfunction and contamination. The single bar code system used across the retail sector is what makes supermarket price comparison websites, which help shoppers save money on their groceries, possible.

Leeds Teaching Hospitals NHS Trust is already pioneering the use of bar coding and managed to save more than £500,000 in the first year of operation. By scanning bar codes as equipment is used on wards, the system can track available stocks and forecast future orders. This means that the Trust no longer needs to ensure that surplus stock is available in case they run out – the system tells them exactly how much equipment they have in stock in real time so orders are more accurate.

The Department of Health will now run a central procurement of GS-1 bar coding systems for the NHS to allow Trusts to use bar coding. This means all NHS Trusts can take part in the same procurement, helping them to choose the right system and saving them the costs of running their own procurement exercise. The expectation is that all products should be identifiable by or carry GS-1 bar codes by the end of 2012.

France: New Drug Regulatory Agency Launched

A new *Agence Nationale de Sécurité du Médicament et des Produits de Santé* – National Agency for Medicine and Health Products Safety (ANSM) was launched on 1st May, 2012. The Agency was set up as a result of serious concerns over regulation at its predecessor, the *Agence Française de Sécurité Sanitaire des Produits de Santé* – French Agency for the Safety of Health Products (AFSSAPS) – following the off-label prescription of anti-diabetes drugs as well as the sale of defective breast implants. The ANSM will take over the role of AFSSAPS. It will provide doctors with independent information on drugs and will need to authorise any adverts for drugs or medical devices aimed at health professionals.

Its remit has been extended to include conducting independent research on the risks and benefit of drugs and promoting the work of patient organisations in educating the public. The new agency can also authorise expanded access to experimental medicines for large patient cohorts. A second new regulation will allow the temporary use of registered medicines for different indications, in the hope of reducing off-label prescribing. Funding of €157 million in 2012 will come from public funds rather than pharmaceutical industry fees. The board of directors will also include patient representatives. It will operate on a more transparent basis – for instance, with committee meetings in the public domain and the creation of an online directory of clinical trials cited in market authorisations.

More information in French at:
http://ansm.sante.fr/

Swiss voters reject extension of managed care

On 17 June Swiss citizens voted against introducing a managed care system proposed by the Federal Government. The plans were aimed at boosting integrated networks of doctors and other providers of medical services. There are already about 90 managed care networks in the country, particularly in German-speaking urban areas, but the objective of the government was for 60% of the population to be covered by managed care. Under the proposed system, patients would go to an integrated network where general practitioners and specialists would work together in one organisation. These managed care clusters would negotiate binding budgets with health insurers. General practitioners would act as gatekeepers to other medical services like specialised medical care, surgery or physiotherapy.

Supporters of the proposal argued it would result in spending cuts of about one billion Swiss Francs per annum and help improve the quality of health care in a country where health care costs have increased about 50% over the past 15 years. However, opponents, including many doctors, said it would result in a two-tier system at the expense of the less affluent population and specialist doctors. A key argument made was that patients would lose access to a doctor of their choice.

With a turnout of just 38% in the referendum, 76% of voters opposed the proposal. This implies that individuals will not receive any discount on health insurance premiums when enrolling in an integrated health network. Minister Alain Berset, Head of the Department of Home Affairs, which includes health affairs, described the outcome as a missed opportunity saying that "it shows once more how difficult it is to introduce reforms in this sector". He said the government would consider boosting e-health projects and the system of family doctors.

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