The Eurocrisis: Changed Framework for Healthcare and Lab Med Sectors

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In almost all European countries, the 2008/2009 economic and financial crisis has been characterized by a strong increase in government deficit and public debt. The reduction in wages and the increase of unemployment lowered the resources produced by taxes and social insurance contributions. The aging demographic and economic crisis and subsequent fiscal austerity policies have created concerns that public health and health systems will be adversely affected with a double impact on health systems as an increased demand on health services coinciding painfully with cuts made to government health budgets.

Poorer people are vulnerable housed, and an increase of alcohol and tobacco consumption have all led to poor health with increased incidence of suicide and mental ill health. Within the Eurozone, national inability to form independent monetary policy also limits policy options for combating the crisis. For Greece, Portugal, and Ireland, the EU tropik, namely the European Commission (EC), the International Monetary Fund (IMF), and the European Central Bank (ECB) have actually mandated public sector reforms, including reforms to the health sector, as condition for the receipt of funds, removing national policy autonomy in some areas of public policy.

John Daily, EU’s health commissioner, underlined that difficult times can indeed provide an incentive to think creatively and push forward in-depth reforms and contain costs, while building modern, responsive and sustainable systems fit for the future. What Europe needs now is to deliver more and better healthcare within sustainable health budgets and continue to protect and promote equitable access to care and the quality of care provided. More recently, the World Health Organization (WHO) has also addressed the challenge of sustaining equity, solidarity and health gain in the context of financial crisis, highlighting the diversity of health policies pursued by EU Member States in response to budgetary pressures.

The health sector makes up a massive 10% of the EU GDP, and health services together with associated organizations are among Europe’s largest employers. The pharmaceutical industry in particular is one of Europe’s most successful employers and exporters. The industry is under increasing pressure, as governments seek to drive down the price of medicines, and in some cases leave the bills unpaid. The EU and Member States are taking a number of measures to sustain their country’s economies, but to date there is no systematic cross-country analysis of health policy responses to the crisis. With the return to the principles of the excessive deficit procedure, meaning a deficit-to-GDP ratio of 3% and a debt-to-GDP ratio of 60%, eurozone governments are anxious to reduce public spending, or at least minimize its growth. Except for Germany, where the debate is the distribution of the surplus in social security accounts, and one or two countries such as Sweden and Poland, the crisis making itself felt, sometimes violently, is all the more striking because it follows years of healthcare spending growth exceeding the growth of the gross domestic product (GDP). Accordingly, Austria has reduced spending by EUR 1.7 billion between 2010 and 2013, or a reduction in GDP of 0.6%. Denmark limits annual growth to 0.3% and Spain has made EUR 15 billion in cost reductions between 2010 and 2011. In Latvia, the healthcare budget decreased by 25% between 2008 and 2010. Healthcare now represents only 3.6% of the Romanian GDP, while in Greece it is 11.6%. Hungarian public health expenses have gone from EUR 4 to EUR 1.2 billion with cuts of 40% in pharmaceutical expenses. In British hospitals, fees are frozen. The “Salva Italia” emergency package adopted in 2011 included hospital closings, the introduction of patient financial participation during hospitalization and regulation of access to regional hospital centers, and there has been a 40% decrease in hospital budgets in Greece. Several countries have reduced growth levels or frozen wages. In Portugal, healthcare professionals have seen wage reductions of 20% to 25%, while these reductions are 20% to 40% in Latvia, and 10% in Lithuania.

One new element for the EU is the direct influence of international institutions on certain healthcare systems with the implementation of bailout packages, like in Ireland and Greece in 2010 and Portugal in 2011. The picture is very diverse. It is difficult in certain cases to distinguish changes due to the crisis from those contemplated as part of reforms that were planned or underway. Some have been accelerated while others have stopped. In many countries, the crisis has accelerated restructuring of the hospital sector: closings, mergers, centralization, transfer to outpatient care and strengthening of coordination. Policies have been introduced or strengthened to reduce the price of medical goods or improve fair drug prescription.

However, it is not only healthy Europeans who are key to an eventual emergence from the crisis but also a well-shaped health sector and industry. In the EU context, this challenge also takes the form of a knock-on effect and this crisis is an opportunity for a successful reorganization of laboratory medicine. The IVD market revenue of 10.5 billion represents only 0.8% of the total healthcare expenditure. Laboratory medicine must undergo a revolution even if this is sometimes a painful experience. In France with the requirement to be accredited for 100% of examinations within 4 years. Major variations observed in terms of costs and results within and among countries suggest possible gains in efficiency. This means doing better with less, making better use of resources to cope with statutory rate reductions due to the crisis. It requires major investments, with, as a corollary, reduction in production costs for analysing. To insure their sustainability, these consolidations must accure over time, with an innovative and coherent medical plan taking into account the service rendered to patients and guaranteeing the complete independence of the decisions of medical biologists. This also means that young people must foster excellence and seize the opportunities for new careers: versatility, quality, molecular biology, research and development, management as well. Even in a difficult context, they can be trusted to be creative, strengthening the visibility of their profession, and promote Lab medicine as a key function in society. It is a daunting but an exciting challenge for us!

2nd EFLM-BD Conference on the Preanalytical Phase

Register now for the 2nd EFLM-BD European Conference on the Preanalytical Phase, March 1, 2013, in Zagreb, Croatia. Focusing on the management of the quality of preanalytical laboratory practices, the conference comprises a plenary session with interactive discussions and e-voting sessions to enable the exchange of ideas and knowledge related to some of the most common issues and everyday problems in the preanalytical phase. Scientific posters and case studies will be on permanent display and a poster session will be organized during the lunch break on day one.

Scientific Committee: Ana-Maria Simundic, Croatia (Chair); Michael Cornes, UK (Member); Kjell Grankvist, Sweden (Member); Giuseppe Lippi, Italy (Member); Mads Nybo, Denmark (Member); Svjetlana Kovalevskaya, Russia (Member); Ludek Sprogl, Czech Republic (Member); Zorica Sumarac, Serbia (Member); Stephen Church, UK (Member).

May I bring the Clinical Chemistry Trainee Council, a FREE web-based Educational Program (www.traineecouncil.org), to the attention of Trainees and Mentors in the profession? The journal Clinical Chemistry recently launched this new worldwide initiative and offers:

- Variety of educational materials including Clinical Case Studies;
- Q&A (a virtual roundtable discussion among a group of experts about a hot topic);
- Guide to Scientific Writing (a series of 14 articles);
- Webcasts (lectures by leading international scientists);
- Pearls of Laboratory Medicine (15 minute presentations about a laboratory test);
- CouncilChat (a chat room directed by 6 junior faculty members from around the world);
- More than 120 popular podcasts, which have been downloaded over 450,000 times in the last 2.5 years.

In addition, the journal periodically publishes interviews with world scientific leaders and articles about prominent clinical chemists (Inspiring Minds) that can serve as an inspiration to young scientists. The focus of the Council is broadening to include lectures and educational materials in all disciplines of laboratory medicine including microbiology, transfusion medicine, molecular diagnostics, and hematology.

In addition, later this autumn, the Council will launch a questions bank in laboratory medicine for those preparing for board certification or specialist exams in the US and the UK and elsewhere.

This program is currently available in its entirety in English and Spanish and will be launched in Chinese and Russian this year and in Arabic, Japanese, and Portuguese next year with the hope of becoming a primary educational resource for laboratory medicine trainees worldwide.

To register in the Council and gain access to all the materials free of charge go to www.traineecouncil.org; it takes less than a minute!

Belgian Society Elects New Leadership

The incoming administration of the Royal Belgian Society of Clinical Chemistry (RBSCC) is announced as follows:

New Executive Board 2012: President: Michel Langlois (AZ St-Jan Bruges); Vice-President: Pierre Wallemacq (UCL St-Luc, Brussels); Secretary: Joris Penders (ZOL Genk); Treasurer: Hugo Neels (ZNA Antwerp); IFCC Representative: Jean-Paul Chapelle (CHU Liège).

Full Board Members: Vic Blaton (EFLM past-president), Xavier Bossuyt (KU Leuven), Etienne Cavalier (CHU Liège), Jean-Paul Chapelle (CHU Liège), Joris Delanghe (Ghent University), Vincent Haufroid (UCL Brussels), Michel Langlois (AZ St-Jan Bruges), Caroline Le Goff (CHU Liège), Hugo Neels (ZNA Antwerp), Herman Nuyttens (Lab Nuytinck), Joris Penders (ZOL Genk), Marianne Philippe (UCL Brussels), Simon Scharpé (University of Antwerp), Flor Vanstapel (KU Leuven), Pieter Vermeersch (KU Leuven), Pierre Wallemacq (UCL Brussels), Fleur Wolff (ULB Brussels).

Functions managed by board members:
- Representative in IFCC Task Force for Young Scientists (via D Gruson): Caroline Legoff
- IFCC Task Force on Chronic Kidney disease (Integrated project): Joris Delanghe
- EFLM WG on Creatinine Standardization: Joris Delanghe
- EFLM Register Commission: Pierre Wallemacq
- EFLM Working Groups – Guidelines and cardiac Markers/ Michel Langlois
- EFLM representative: Michel Langlois

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July marked 200th meeting of the UK-based Association of Clinical Biochemistry (ACB) Council. It had been agreed at the previous meeting in March to ballot members on a change in the name of the Association, which reflects its wider membership. This was followed by an article by Mike Thomas published in the June issue of ACB News and notification of the electronic survey. The results of this ballot will be taken to the November Council meeting to allow sufficient time to make any necessary changes to the ACB constitution before they are presented to members at the AGM in April 2013.

Prof. Steve Barnett, Chief Executive of the Academy for Healthcare Science attended the March meeting to update Council on the developing role of the Academy. He described its main functions as acting as a voice for Healthcare Science, increasing the profile of Healthcare Science with the public, government, and commissioners, and setting up voluntary registers for those professions that do not have a statutory register. It is planned to have regular updates and communication with the Academy as work progresses.

The March meeting requires Council to sign off the ACB’s accounts before they are presented to the AGM. It was pleasing for the outgoing Director of Finance Terry Dyer to report a small surplus for the year. However, the Association’s finances will require careful management by his successor, William Marshall, if this trend is to continue in the current economic climate.

Reconfiguration and Public Profile
Pathology service reconfiguration was a topic of the day in July. Members gave updates on the East of England bid and other service reconfigurations. There appears to be considerable variation in engagement with pathology staff and the public in the different projects that have been launched. Concerns were expressed on the poor public profile of laboratory services generally compared to other specialties and the need for better interaction with the media so that the value of pathology in healthcare is fully understood.

The work of the Academy will address this gap to some extent but everyone needs to consider how to improve their interaction with patients, public, service users, and commissioners.

Photo: (From left to right) Mike Thomas, ACB President, Ruth Lapworth, ACB secretary, Terry Dyer, retiring ACB Treasurer at the AGM in Liverpool
Would it Be Reasonable for Microbiology Guidelines to Ignore PICO’s?

by Joseph Watine and Wytze P Oosterhuis

The main purpose of clinical practice guidelines (CPG) is to help healthcare professionals to make the best decisions for the care of their patients. The proliferation and success of CPGs are accompanied by misconceptions that may lead to a violation of evidence-based principles.

Many of the CPGs do for instance not properly apply the “PICO” (Patient, Intervention, Comparator, Outcome) method. Questions to be answered in CPG should be framed according to this principle for optimal applicability of the recommendations.

Let us examine, as an example, this recommendation, extracted from the latest edition of the Rémić guidelines (page 92):

“Antibiograms have to be performed for all isolates responsible for urinary tract infections.”

Such a recommendation answers a question which is not very specific about the “P” (do all patients with or without, particular symptoms or particular risk factors need to be tested the same?), and even less specific about the “O” (what are the expected benefits, or risks, or costs of performing antibiotic susceptibility testing in all populations of patients, in particular in terms of industrial pollution associated with manufacturing, performing, and then eliminating antibiograms?), and the “C” (is antibiotic susceptibility testing only the possible option? couldn’t the probabilistic approach be another option for treating some patients?)

This recommendation therefore lacks of medical, as well as of economical, and of ecological, pertinence.

Regarding the usefulness of performing antibiograms in case of urinary tract infection, an example of structured clinical questions could have been:

“In an young female patient with a first episode of uncomplicated cystitis treated by a quinolone (P), is antibiotic-susceptibility testing in order to change the therapy in case of in vitro resistance to the quinolone (I), increasing the likelihood of curing the patient, and/or increasing the financial, or ecological, costs and/or increasing the risk of selecting bacteria that are resistant to antibiotics (O), compared to just keeping the bacterial isolate in the lab for a few days, or weeks, in order to be able to perform later antibiotic-susceptibility testing in case therapeutic failure would occur (C)?

In our own example above, there are in fact three subquestions, at least, that would each need a systematic review of the literature. Based on the evidence thus examined, one would expect that the authors of the guidelines make an explicit judgment where both clinical benefits, and clinical costs, would be weighed against their financial, and ecological, counterparts. Such a judgment would be particularly difficult if, as it is probably the case, the evidence would suggest minor, or uncertain, benefits in terms of health, and certain benefits in terms of resources use. We cannot see how such a judgment could be wisely made by microbiologists alone. For example, should it be for microbiologists alone to decide how the collective resources have to be spent, and/or how the earth can be polluted?

This example also illustrates that if the authors of CPG wish to answer to questions that are pertinent, then they have to examine various categories of evidence (not just the evidence related to their own sub-speciality), and have therefore to work in a multidisciplinary spirit (which is also more likely to avoid as much as possible conflicts of interest). Such a spirit is certainly not that of the Rémić, which is strictly coauthored by microbiologists.

In conclusion, if recommendations in CPG do not answer to PICO’s, it is likely that its users are at risk of not precisely knowing:

• To whom the recommendations apply;
• Which clinical benefits, or harms, or risks, or costs, has/have to be expected if the recommendations are applied;
• If alternatives do exist, and at what benefits, or harms, or risks, or costs;
• What is the evidence that has been examined, and why some evidence was excluded.

Could anyone really trust CPG that do not answer to PICO’s?

References