BORDER CROSSING **Tessa Richards**

Time to tune into Europe

Clarifying the legal framework for cross border care is in everyone's interests

Romania and Bulgaria celebrated their debut into the European Union with fireworks. Britain greeted their accession with newspaper features warning of labour markets being swamped by yet more eastern Europeans, doctors and nurses among them, of course. Nothing surprising there—Britain has honed Euroscepticism into an art form. What it has arguably been less good at, not least in the health arena, is interacting constructively with the Brussels institutions. Their processes may be Byzantine, but understanding them is necessary to influence their decisions.

Admittedly it has not been easy. Until recently the EU has consistently stated that health services were a matter for national governments. As a result, few health professionals anticipated how the medical landscape would be changed by EU legislation enshrining the right to free movement of goods, services, and people. Fewer still foresaw the massive revolution that the "48 hour" European Working Time Directive would trigger.

But there is still plenty to play for. Health has risen up the EU's political agenda. The appointment of a commissioner for health and the establishment of DG Sanco—the health and consumer protection directorate general, small and underfunded as it is relative to trade and industry—bear witness to this.

It has also become a lot easier to tune into Brussels. The EU institutions now take "transparency" seriously, and last year DG Sanco launched a multilingual health portal (http://health.europa.eu). Through this anyone can access, free of charge, mindbogglingly detailed information on how, where, and what the EU does on health. Included are links to key consultations.

These include one on the European Commission's 10 year health strategy and one on cross border care. The second was launched last autumn to inform draft proposals for legislative and non-legislative action aimed at providing "legal certainty" on cross border health care and "supporting cooperation" among member states' health systems.

This sounds innocent enough, but it has provoked a flurry of concern among health experts. Under European law patients have the right to seek, and be reimbursed for, non-emergency medical care in an EU country other than their own. The problem is that there are many grey areas in the terms and conditions under which this applies. Patients and health authorities are being left struggling to deal with clinical and administrative uncertainties. DG Sanco seeks to sort this out by defining "how care should be authorised and paid for, whose rules apply, and what happens when things go wrong."

Cross border care may not be common in the United Kingdom, with the exception of patients living on the Irish border and sun seeking migrants to southern Europe, but it is in some parts of the EU. The drivers include sound geographic and demographic reasons, as one of this week's Analysis articles shows (p 188).

So why the concern? Some fear that EU legislation in this area will erode countries' rights to run their health systems autonomously; others that the EU seeks to turn health services into just another commodity, where economic imperatives will override social ones. There is also a fear that ill thought out EU legislation could provide a legal boost to health tourism, which could decimate the health budgets of poorer states if they have to pick up the tab. That some commercial healthcare providers are already doing a good line in web advertising would suggest that this fear is not wholly unfounded.

In fairness the European Commission is aware of this concern. The health commissioner, Marcos Kyprianou, has stated that the "framework" he seeks is one that "reconciles greater individual choice with the sustainability of health systems overall." The Department of Health, which is collating the UK response to the consultation, agrees.

"There is a fear that ill thought out EU legislation could provide a legal boost to health tourism, which could decimate the health budgets of poorer states if they have to pick up the tab"

"Any future EU legislation should be 'cost neutral,'" said its spokesman. "States must be allowed to define their own basket of care. We can't reimburse patients for care received abroad that we don't provide here, and member states should be allowed to prioritise treatment for their own residents over other EU nationals travelling to them specifically for treatment."

"Defining the way forward will not be easy," admits the spokesman for the strategy unit of DG Sanco. "Within each member state there is a tension between what health services patients want and what the state can afford to provide." The commission does not seek to stop member states shaping their own services, but it is committed to providing a mechanism for patients to get care in another member state, be assured of its quality, fully informed about its costs, and clear about who shoulders the responsibility for ongoing care if things go wrong.

Clarifying the legal framework for cross border care is in everyone's interests. Currently the law in this area is lurching from pillar to post in response to ad hoc decisions on individual patients made by the European Court of Justice. The commission believes that EU action, including legislation, will not only streamline and safeguard cross border care but also fuel cooperation, stimulate mutual learning, and raise standards of care across the whole EU.

The legislation is likely to take a couple of years to evolve. Paying attention to it now will reap more dividends than complaining after the legislative horse has bolted.

Tessa Richards is assistant editor, BMJ
trichards@bmj.com

THE WEEK IN MEDICINE

Is killing pain worth the risk?

MPs argue that the regulator went too far when it banned co-proxamol

The story so far

MPs staged a last ditch attempt to get an effective ban on the painkiller co-proxamol overturned last week. The bid was ultimately thwarted but it gave a valuable insight into how patients and doctors are handling the phased withdrawal of the once popular analgesic two years after the uncompromising decision was made.

Co-proxamol is a prescription only analgesic that combines paracetamol (325 mg) and dextropropoxyphene (32.5 mg). It has few side effects and is popular with patients with chronic pain. But it is also the second most frequent means of suicide with prescribed drugs in England and Wales, second only to tricyclic antidepressants. Concern about the number of such deaths was expressed in the *BMJ* as long ago as 1980.

In 2004 the Medicines and Healthcare products Regulatory Agency announced a phased withdrawal of the painkiller. A review by the agency found that around 300-400 people a year die as a result of taking too many tablets either deliberately or by mistake. That co-proxamol is potentially very toxic was highlighted in a 2005 study in the *British Journal of Clinical Pharmacology*. It found that an overdose of co-proxamol was more than 10 times more likely to be fatal than one of co-dydramol or co-codamol.

The *BNF* in 2006 rated co-proxamol as having little more analgesic effect than paracetamol alone, but it was more hazardous. "An important disadvantage of co-proxamol is that overdosage is complicated by respiratory depression and acute heart failure due to the dextropropoxyphene. Rapid treatment is essential," it said.

The drug will be available under prescription until the end of the year, after which unlicensed co-proxamol will be prescribed only on a named patient basis. General practitioners have been withdrawing co-proxamol since summer 2005—but despite the evidence backing the decision to ban, fans of the drug are still hoping to keep it on the market.

A chance to reconsider

In an adjournment debate in the House of Commons last week, Labour MPs Anne Begg and Howard Stoate urged the agency to reconsider. It should be possible to address the high incidence of suicide among those using co-proxamol, without a full ban, they argued.

"I was told that full strength paracetamol would be just as effective an analgesic as co-proxamol. That is simply not true"
Labour MP **Anne Begg**

PA/EMPICS

Begg, who has the genetic condition Gaucher's disease, was a co-proxamol user until her GP took her off the drug following the regulator's ruling. But attempts to find an alternative to co-proxamol have been unsuccessful, she told the Commons: "I was told that full strength paracetamol would be just as effective as an analgesic. That is simply not true. I have found alternatives, although paracetamol supplemented with dihydrocodeine is probably more powerful that co-proxamol."

Last summer there were problems with the supply of the drug, possibly because of confusion over its status, she reported. Her concern was that the supply of the drug would dry up for good—even for those with named patient status. Stoate, a former GP, said that of 72 000 patients who continue to use co-proxamol, there were some for whom no other drug would do. He quoted a GP, who is a prescribing lead in south London. "The problem is that every practice has a number of people who have no alternative analgesic. I'm aware of several patients who have tried everything else and nothing works."

A Norfolk GP said it was a valuable drug because of its low side effects. He told Stoate: "In 20 years of practice I have seen more side effects from co-dydramol and co-codamol and more lives wrecked by dihydrocodeine addiction."

Stoate also bolstered his argument with the words of the president of the British Society of Rheumatology, Andrew Bamji: "It is unreasonable to withdraw a drug from those who understand the risk."

There has been a huge drop in the number of prescriptions from 435 250 in January 2005 to just over 70 000 in August 2006. Only 1350 were new prescriptions.

Begg said the decision to go ahead with a phased ban created huge confusion, and she quoted *Pulse* magazine. "It had the headline 'GPs demand U-turn on co-proxamol ban.' Its own survey showed that 70% of GPs and 94% of rheumatologists demanded that MHRA revisit its decision," she said.

Instead of de-licensing co-proxamol, why not make it a controlled drug under schedule 3 of the Misuse of Drugs Act 1971, said MPs. Prescriptions would be initiated at specialist level, but GPs could make repeat prescriptions, and they could be restricted for chronic, rather than acute, pain.

But according to health minister Caroline Flint, many of the drug related suicides associated with co-proxamol involved people who

MEDISCAN

had not been prescribed them. She used the example of a troubled teenager, coming across the tablets in "granny's medicine cabinet." Flint said only 367 letters had been received from concerned patients over the past two years.

She estimated that 100 lives had already been saved from a phased withdrawal of the drug and warned that controlling it could see usage levels shoot back up.

What next?

The MHRA is offering doctors the opportunity to prescribe on a named patient basis what will, in effect, be an unlicensed drug after December 2007.

The main manufacturer has confirmed to the Department of Health that it intends to continue producing co-proxamol following the cancellation of the licences at the end of 2007. "If there is clear clinical need, it will still be possible to prescribe co-proxamol, but in a more targeted way," said Flint.

But this won't be viable, says Stoate. "Few GPs, if any, will wish to expose themselves to the possible threat of litigation by doing so, however strong the patient's need for the drug. In practice, the solution amounts to a comprehensive ban." Instead the agency should have the courage to trust GPs who are, "highly trained and well paid, to make decisions on a daily basis that require them to tread the fine line between therapeutic benefits and the disadvantages of drugs," he said.

One blogger (navabs.blogspot.com), Navabs, an investment banker from Essex, who has ankylosing spondylitis, said of the decision, "Where does it leave me? It keeps us normal. Why do I have to pay the price for suicidal people abusing a miracle drug? The [alternatives] lack the 'kick' that co-proxamol has."

Rebecca Coombes, journalist, London
rcoombes@bmjgroup.com

WHAT'S ON BMJ.COM

British policy makes sex workers vulnerable

Sophie E Day and Helen Ward

We welcome the timely call for decriminalisation of sex work in the editorial by Goodyear and Cusick (*BMJ* 2007;334:52-3). The murders of sex workers in Ipswich have led to the repetition of stereotypes that only serve to dehumanise women in the sex industry and make them more vulnerable. We wish to highlight some further flaws in the evidence used by the government and others in justification of their demonising of sex workers.

There is no evidence that 90% of UK sex workers are addicted to heroin or crack or that 45% were abused as children. These data, along with numerous alternative versions in the media, are attributed to the Home Office consultation exercise *Paying the Price* (2004), but we have heard nothing about the many responses that refuted these stereotypes in detail. Our research in London has followed sex workers from the mid-1980s to 2000, and our study is, to our knowledge, the only one to provide evidence of the impact of prostitution on women's lives over time.

We have shown that drug use is widespread and that problem drug use is associated with multiply disadvantaged women. Injecting drug use was uncommon in our studies (for example, 7% of women attending our project from 1998 to 2002 reported ever injecting drugs), and crack use declined towards the end of the 1990s. Alcohol use, however, is a condition of work in some sectors, such as clubs, and "addiction" has become more common, as indeed it has among the rest of the UK population.

Violence is found throughout the industry. In our study two women were murdered, and both worked indoors. One murder was never resolved; the other woman was murdered by her boyfriend, who then killed himself. Research participants across all sectors of the industry described assaults, but experiences of violence outside work, when their children were taken into care or when they suffered domestic violence, were the most harrowing.

Street workers do not form a discrete workforce: they also work indoors and in jobs outside the industry. In our follow-up of sex workers to 2000, street workers had greater occupational mobility than women working in other sectors of the industry.

Among the women we followed to the year 2000, 37% (31/84) undertook further, higher, or vocational education, which they funded through their own earnings. However, only half of these women then left the sex industry, despite the occupational choices this training had presented—and, of course, it is always assumed that sex workers would never continue their work if they had any other options.

The most significant health problems reported in our studies related to stigma and criminalisation. Media reports about drug abused victims from broken families forced to expose themselves to madmen on the streets—without any reference to the laws, policies, or damaging stereotypes about "bad women" that put sex workers at risk—simply exacerbate their problems. Reports about regulation elsewhere have been misleading about the possible solutions. Thus, the so called failure of street toleration zones in the Netherlands has nothing to do with "drug abuse": it is impossible for the great majority to work legally, as they are undocumented migrants.

Similarly, the recent reforms in New Zealand have provided an important model, since these reforms were the first to allow women to work together indoors freelance without requiring them to raise substantial capital, acquire a licence, and manage the business (through which employees are commonly exploited heavily in "legal" businesses elsewhere). Similar changes have been recommended, but not acted on, in the United Kingdom.

It is British policy that makes sex workers vulnerable, whether they work outdoors or indoors. In the last 10 years these policies have become more punitive through the arbitrary use of antisocial behaviour orders (ASBOs), street "cleaning" purges, fines, imprisonment, and deportation. We endorse calls for decriminalisation and amnesty from those who organise and work closely with prostitutes, including the International Union of Sex Workers and the English Collective of Prostitutes. These will be key measures towards stopping the violence. They will also be central to wider advocacy for health and health care. Criminalisation and stigma are associated with significant mental health problems; they make workers vulnerable to violence; they foster misinformation about the industry and workers' health needs; and they also make contact with health professionals difficult. Without decriminalisation and amnesty, how are we to provide substantial sectors of the UK workforce with basic services, including health promotion, screening, and treatment?

Sophie E Day is professor of anthropology, Goldsmiths College, London
Helen Ward is clinical senior lecturer, Division of Epidemiology, Public Health and Primary Care, Imperial School of Medicine, St Mary's Campus, London

Competing interests: HW is co-editor of the BMJ Group journal *Sexually Transmitted Infections*.

This article was posted on 15 January 2007 as a rapid response to the editorial by Goodyear and Cusick (13 January 2007). The full response, with references, is at www.bmj.com/cgi/eletters/334/7584/52#154185.