identify their own learning needs on the basis of their encounters during the course of their clinical practice.[12] This approach to learning does not easily align with many of the educational approaches that are offered by various providers. The provision of prepared learning packages may reduce costs, but such packages are not useful to the learner and are not likely to be effective.

A harmonised system that can maintain professional competence across Europe is achievable, but all policy makers and providers will need to appreciate that professional competence is holistic and that it may be difficult to demonstrate the effectiveness and cost effectiveness of different educational approaches. However, this should not hinder the development and implementation of CME that respects the needs of the learner and that uses interactive approaches led by a facilitator.

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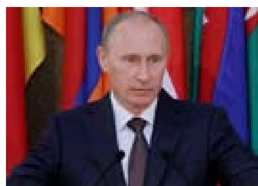
Protecting health in hard times

Europe's health ministers exchange experiences on the impact of the economic crisis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Health ministers from across Europe came together in Moscow in September at the 60th meeting of the European regional committee of the World Health Organization. High on their agenda was the ongoing economic difficulty facing many of their countries. Their experiences varied. Some had seen their budgets frozen whereas others had experienced real cuts. A fortunate few, however, had seen budget increases, as a result of recognition by their cabinet colleagues of the necessity of protecting the most vulnerable at times of crisis. As ministers and institutional partners shared experiences and challenges, they endorsed WHO Europe's call to move forward as a region under a consolidated European Health Policy, which will foster effective and coordinated action to bolster health systems in the face of evolving challenges.

Three main messages on the financial crisis emerged from member states during a technical briefing devoted to this topic. The first was the need for health ministers and their advisers to engage actively in discussions about the economy. There was confusion among politicians, media commentators, and the public about the differences between deficit and debt (for example, the United Kingdom has a high deficit but relatively low government debt) and between debt held by government, banks, the non-financial corporate sector, and households.[1] Terms such as "unsustainable" are used widely to describe levels of debt even though in most western European countries they are well below the International Monetary Fund's definition of unsustainability.[2] Debate on how to respond is often oversimplified, with little awareness of historical evidence,[1] and, as the IMF has recently noted, it may not give sufficient priority to the social consequences of retrenchment.[2] There was particular concern that some finance ministries, urged on by the media, are using the economic difficulties to pursue an underlying objective of shrinking the state.

The second message was the need to protect those who are the most vulnerable. Epidemiological research shows the profound health consequences of unemployment and, although less well recognised, fear of unemployment.[3-6] Research on previous economic crises shows that higher unemployment is associated with increased suicide rates.[6 7] Yet it also shows that, with increases in social welfare and in particular active labour market policies that keep people in work or return them rapidly to the workforce, this is not inevitable. This is apparent in a comparison of Spain and Sweden, both of which faced severe economic problems in the late 1980s and early 1990s. Whereas Spain saw a relative increase in suicides in this period, in Sweden, with its strong welfare state and active labour market policies, the long term decline in suicides continued uninterrupted. Those present at the briefing supported a call from one international agency present to "pump resources into mental health services," reflecting concerns that in many countries they had been weak even before the current economic difficulties.

Delegates gave many examples of how they were seeking to do this. The Moldovan health ministry has successfully negotiated additional funding for the health insurance fund from the finance ministry. The Icelandic government, facing an extremely severe crisis, has negotiated cuts to the health budget with the IMF that were only half as large as in other areas. A few countries had been forced to cut salaries of health workers but many, including Greece and Ireland, were looking at how to cut the large bill for drugs using reference pricing (paying a standard price for all drugs with the same active ingredient). This approach could lead, indirectly, to price reductions for other countries that benchmark their

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prices internationally. As one international agency noted, there is still substantial scope to save costs through greater generic substitution. However, the smaller countries drew attention to the difficulty they faced in negotiating with the drug industry.[8]

The third message was that the crisis could be used to implement desired reforms that had proved difficult in the past. The Latvian government has engaged in a long awaited, and much needed, reduction in the number of hospitals and an upgrading of emergency care. The Spanish government plans to use a new public health law to shift resources away from individual (and often expensive and ineffective) prevention measures, such as screening for prostate cancer, towards population based health protection and health promotion programmes of known effectiveness.[9] Special emphasis is placed on integrating public health practice with primary care and supporting healthy choices.

Such measures should not be confined to the health sector. Recalling the concept of "health in all policies" set out by the Finnish presidency of the European Union in 2006,[10] ministers stressed the importance of recognising how health and health services contribute to economic growth and how developments in other sectors contribute to health. Thus, the World Bank drew attention to the road building programme in Russia, a private-public partnership designed to create employment and make driving safer as part of efforts to reduce traffic accidents.[11]

Although the sustainability of health systems and the methods to deliver health care are debated even in times of economic growth, the current financial crisis has raised the pitch of the debate. This was acknowledged in the presentation of the proposal for the WHO European region's new European Health Policy, in which the financial sustainability of health systems was cited as one of seven primary challenges currently facing health systems. These challenges are best tackled through a renewed commitment to evidence based public health and public health infrastructures[12]; the strengthening of health systems and the empowerment of health ministries; collaboration between national and regional partners; and wisdom accumulated from a long tradition of past public health initiatives, which has created an opportunity for shared learning across Europe. Above all, the ability of health systems to cope with budget shortfalls in the face of higher population needs will require a coalescence of technical, political, and social leadership, spearheaded by national health ministries but extending to everyone with the potential to improve health.

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Dabigatran etexilate in people with atrial fibrillation

Has some benefits over warfarin, but evidence on long term efficacy and safety is lacking

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Atrial fibrillation affects about 1.2% of the population in the United Kingdom and accounts for about a sixth of all strokes.[1 2] Its prevalence increases steeply with age, from 0.5% of those aged 50-59 years to 10% of those over 80.[1] Strokes are more disabling in patients with atrial fibrillation and have higher 30 day mortality than those of arterial origin.[3 4] Because of the ageing population, the burden of stroke caused by atrial fibrillation is expected to rise sharply over the next few decades unless more effective thromboprophylaxis can be given to the population at risk.[3]

When compared with placebo or no antithrombotic treatment, warfarin reduces the risk of stroke by about two thirds in patients with atrial fibrillation,[5] but this drug is underused because it is inconvenient and causes bleeding. Antiplatelet treatment with aspirin is much less effective than warfarin—it reduces the risk of stroke by about a fifth compared with placebo.[5] Adding clopidogrel to aspirin improves the effectiveness of antiplatelet treatment to prevent stroke but the combination remains significantly less effective than warfarin.[6 7] Current guidelines recommend warfarin for patients with atrial fibrillation at high risk of stroke (previous stroke or embolism or more than one of the following risk factors: age ≥75 years, hypertension, diabetes, or congestive cardiac failure), either aspirin or warfarin for those at moderate risk (only one stroke risk factor), and aspirin for patients at low risk for stroke (no stroke risk factors).[8]

Dabigatran etexilate is an oral prodrug that directly inhibits thrombin. It has a half life of 12-17 hours and 80% is excreted by the kidney. Unlike warfarin, dabigatran etexilate has a predictable anticoagulant effect and does not require routine coagulation monitoring. In 2009 the Randomized Evaluation of Long Term Anticoagulation Therapy (RE-LY) trial, was published. This trial compared dabigatran etexilate 110 mg or 150 mg twice daily (this dose comparison was double blind) with open label adjusted dose