

Activities of the Directorate of Health 2011– 2012

A brief summary

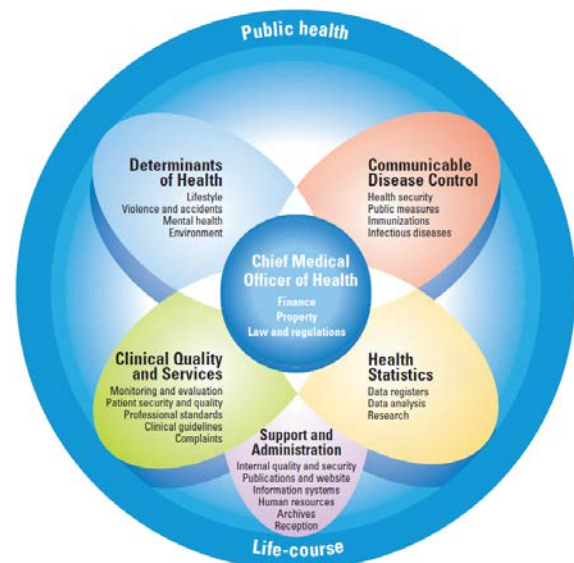
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First year after merger

After the merger of the Directorate of Health (DH) with the Public Health Institute on 1 May 2011, the DH moved from being an institution employing about 35 employees (in 30 full-time-equivalent positions) to one currently with 66 employees. As part of the ensuing reorganisation a new organisational chart (cf. figure below) for the DH was adopted in the autumn of 2011, reflecting its four core divisions (Determinants of Health, Communicable Disease Control, Clinical Quality and Services, and Health Statistics) in addition to Support and Administration and the Office of the Chief Medical Officer. The Division Heads and the Chief Medical Officer form the six-member Management Board of the DH.

One of the main priorities of the new organisation in its first year of operation has been strategic planning for the expanded institution and the formation of a policy statement for the period 2012–2016, which will be published this month. According to that policy the single most important aim of the DH is to promote the health and well-being of the population in Iceland on the basis of strong public-health measures and integrated health services that rely on the best available knowledge and professional experience at any given time. After the merger, the most important addition to its former responsibilities is the responsibility for numerous health promotional initiatives established and supervised by the Public Health Institute.



The merger itself became legally effective on 1 May 2011 with the enactment of an amended Directorate of Health and Public Health Act (No. 41/2007), after more than a year of preparation and planning at many levels, a period that turned out to be very trying for the whole staff. The move to new headquarters at Barónsstígur 47 in Reykjavík in August 2011 made a big difference in the process of unifying the two bodies and their employees into an operative whole. The past year, however, has also been a period of multiple technical and operative adjustments that have tested the patience of the staff and, in some cases, caused delays in the proper functioning of all divisions. At the same time, many of these adjustments have benefitted the work environment in improved, up-to-date hardware for all employees, among them the introduction of environmentally friendly, multifunctional network printers.



One big step towards unifying the two institutions was creating a combined web site (www.landlaeknir.is) that would include all the information and publications formerly accessible on two separate webs. The preparations for this step began in late summer of 2010 although the new web was not publicly opened until June this year. Besides having a completely new look, there have also been made some fundamental changes to the way users access the contents, with primary emphasis on meeting the needs of the main target groups visiting the web site. Another new feature makes part of the material accessible on the basis of the life stages being addressed.

Miscellaneous activities in the past year

I. Health Determinants

Health promoting schools

The DH aims to promote healthy habits among children and adolescent through various channels, e.g. through a holistic approach within health promoting primary (for age 6–15) and secondary (for age 16–20) schools. All the secondary schools in Iceland (31) now participate in the project and 47 primary schools (out of 175). A health promoting pre-school project is currently under development.

These projects are implemented through four major foundations of health: nutrition, physical activity, mental health and lifestyle (which deals with e.g. alcohol, tobacco and substance use). Through this initiative, the DH has shaped guidelines for school canteens, educational material promoting both nutrition and physical activity, and collaboration with various relevant agents in the community.

Physical Activity on Prescription

Physical Activity on Prescription is a pilot project currently being run within the Icelandic primary health care system. The project is based on a similar idea that has now been well established in Swedish health care, whereby licensed medical personnel offer a prescription for physical activity to their patients. The project has been developed and funded by the DH in collaboration with other stakeholders.

National Dietary Survey

A national dietary survey among adults was carried out during 2010–2011. The main findings, presented in January this year, are generally positive in comparison with the dietary habits reported in 2002. The mean consumption of saturated fat, sugar and salt has decreased although saturated fat and salt is still too high in the diet. Consumption of fruits, vegetables and whole-grain bread has increased but is still lower than recommended. Among positive findings was the fact that consumption of sugared soft drinks has decreased by 30% since 2002.

Keyhole, the Nordic nutrition label

The Icelandic Parliament, *Althingi*, has declared its positive position towards the Keyhole, the Nordic nutrition label, in a parliamentary resolution. Last winter, a bill of law was submitted to the Althingi containing the necessary legal provisions to facilitate the adoption of the Keyhole in Iceland. Several producers have shown interest in using the symbol for their products and some producers have, in fact, already put the label on their products.

Food Manufacture

Collaboration has been established with various parties within the private sector, e.g. the Federation of Icelandic Industries, in order to decrease the salt content of bread and to increase the availability of whole grain products.

The milk industry has been encouraged to fortify milk and milk products with vitamin D and recently a fortified low-fat milk product was launched on the market. Collaboration with Icelandic vegetable farmers has also been established to increase children's and young people's consumption of vegetables. In August 2011, an Icelandic regulation came into effect setting a maximum level on the content of industrially produced trans-fatty acids in processed foods. The regulation is in line with the Danish regulation.

Survey on tobacco use

A telephone survey on the use of tobacco was conducted in March and April 2012. This was the first survey covering the use of oral and old traditional nose tobacco as well as being part of the annual surveys on the prevalence of smoking. There were 3000 participants, 18 years and older, and because many of the survey questions involved the use of oral tobacco, the sample of men was unusually large, or $\frac{3}{4}$ of the whole.

The results of the survey confirm former findings of a steady reduction in the prevalence of daily smoking among both women and men in Iceland. At present, 14.2% of the population are daily smokers, 1.9% of men use old traditional nose tobacco every day and 3% are daily user of oral tobacco while 3.1% use old traditional nose tobacco on occasion and 1% are occasional users of oral tobacco.

Daily smoking is most frequent among young people aged 18–34 years, ranging between 19 to 22%, and slightly more so among young men than women. Daily use of oral tobacco is most common among young men; 15% among 18–24-year-old men and 13% among those aged 25–34 years. These figures are a cause of concern, particularly since the survey revealed that young men quite frequently both smoke and use oral tobacco.

II. Communicable Disease Control

Communicable diseases

An increase in the number of those diagnosed with HIV disease occurred in 2011 and the incidence rate in 2011 was around 6 per 100.000. This was the result of an increase in the number of I.V. drug abusers diagnosed with HIV as well the number of elderly heterosexuals. Two individuals diagnosed in 2011 were over 60 years old. The health care system needs to be on alert for older individuals with HIV.

As regards other sexually transmitted diseases there was no change in epidemiology in 2011.

Environmental pollutants

In 2011, studies were conducted on dioxin pollution in the environment. A minimal amount of the toxin was detected in humans.

From the very start of the eruptions in Eyjafjallajökull in the spring of 2010 and the Grímsvötn eruption in the spring of 2011 the effects of volcanic ash on health were studied. These studies revealed minimal effects on physical health in healthy individuals while some respiratory effects were observed in individuals with underlying respiratory illnesses (BMJ Open 2012;2:e000343).

Antibiotic consumption

Antibiotic consumption was similar in 2011 compared with 2010. Efforts were launched that year in cooperation with the primary health care to promote prudent use of antibiotics.

Immunisation

Pneumococcal vaccination (*Synflorix*) started in April 2011 for infants aged 3, 5 and 12 months. No catch up vaccination was introduced. In September 2011, HPV vaccination (*Cervarix*) of 12-year-old girls was started. Additionally, a catch up vaccination of 13-year-old girls was offered.

Vaccination coverage in the general national vaccination programme is around 95%.

III. Clinical Quality and Services

Safety and health service quality

Iceland scored number three, behind only the Netherlands and Denmark, when the Euro Health Consumer Index for 2012 was presented in the European Parliament in Brussels. Icelandic patients have extensive rights and are well informed, waiting time for health service is short compared with the other Nordic countries and the treatment outcomes are among the best in Europe. Dental care, however, is not included in the national health services.

Complaints in 2011

In 2011, the DH dealt with a total of **283** complaints from users of the health services (complaints have ranged from about 240 to 280 in the past few years). About half the complaints (143) were of a general nature about health services rendered, while access to health care was the cause for 47 complaints and diagnosis or treatment was the reason for another 42 complaints. None of the complaints handled in 2011 were serious enough to call for a suspension of professional licence, the most severe action taken in such cases.

The WHO Surgical Safety Checklist – safety in the operating theatre

The DH has had the WHO Surgical Safety Checklist translated and adapted for use in Icelandic operating theatres. Results of a pilot study carried out before its implementation by WHO revealed an overall significant reduction in mortality as well as morbidity of surgical patients. The adapted checklist has been sent for comments to various hospitals in the country and has been well received. As of this autumn, the plan is to use the checklist in all surgical operations in the country as part of an effort to promote safety culture in operating theatres.

Investigation into the incidence of adverse events in Icelandic hospitals

The first stage of the DH's investigation into the incidence of adverse events in Icelandic hospitals has now been completed. It is conducted in collaboration with the School of Health Sciences at the University of Iceland, the Landspítali University Hospital and the Akureyri Hospital and is based on the methodology of similar research in other countries. Data collection in Step 1 was carried out by means of examining 1000 randomly selected patient records from the two hospitals. Results of Step 1 showed that just over 30% of the records continue to Step 2 for further examination. These results are quite similar to those of comparable research in other countries. It is hoped that the final results will help raise consciousness regarding the importance of patient safety and its enhancement.

Quality of service and safety in nursing homes

In the past year, an effort has been under way to improve the quality of service and safety in nursing homes by means of numerous service audits of the homes. In addition, the DH has collaborated with the management and staff of the nursing homes in various ways to improve the quality of care, e.g. by giving

educational sessions for the staff and encouraging the employment of results from the RAI quality indicators.

Following the DH's examination of the results of the RAI indicators and the staffing figures for the homes, a correlation between quality of service and staffing has been confirmed and as a direct result of these findings the DH has initiated work on producing a new model for the desirable staffing in nursing homes.

Guidelines on health care for schoolchildren aged 6 to 16 years

The DH is at present finalising the elaboration of the DH's Guidelines on Health Care for Schoolchildren aged 6 to 16 years. These Guidelines, which will be implemented nationwide, cover content (primary, secondary and tertiary prevention), organisation and infra-structure, such as location of health care services, staffing and registration of health care data, as well the quality of schoolchildren's health care and ways of monitoring their health through pre-defined quality indicators, health indicators and operational indicators in children's health care.

QUALICOPC

The DH takes part in a European study entitled QUALICOPC (Quality and Costs of Primary Care in Europe), a multi-country study co-financed by the European Commission in the 7th Framework Programme. Its aim is to evaluate primary-care systems in Europe in terms of quality, equity and costs. In Iceland, collection of data for two surveys has been completed. One survey was carried out among a representative sample of 90 primary-care physicians and another one among their patients, 10 patients from the practice of each of the participating physicians.

Service for women with PIP breast implants

In total, about 400 women out of about 4000 with breast implants in Iceland had implants from the French manufacturer PIP. Only one surgeon was involved, who both imported and conducted the implantations since early 1990. Despite the fact that all health institutions in Iceland are required to send data on their services to the DH, those running private clinics had been reluctant to deliver such information for many years. Consequently, the DH did not have any reliable information on the status of breast implants in Iceland. To address the situation, the DH requested data on all breast-implant operations in Iceland since the year 2000. The plastic surgeons denied the DH access to this information, claiming personal protection of their clients. With the help of the Icelandic Medical Association they asked the Data Protection Authority (DPA) for advice regarding the data delivery. The DPA came to the conclusion that the DH did not have the legal framework in place to request such information. This came as a surprise as it has been the common understanding that the DH actually had the right to request any information it felt necessary to collect in order to fulfil its obligation to monitor the health services. Currently, the Parliament is debating how to fill in the legal loopholes that resulted in the decision of the DPA.

In early January 2012, the Icelandic health authorities invited all women with PIP breast implants to have an ultrasound of their breast implants. In total, at the end of May 2012, 354 women had accepted the invitation. Of these, 133 (38%) had intact implants, 208 (59%) had implants that leaked, 11 (3%) had intact implants but silicon in the axilla and two women showed up who had already had their implants extracted.

In February 2012, it was decided to offer explantation of all PIP implants at the Landspítali University Hospital but not new implants. On July 18, a total of 94 women had had their implants explanted. The decision not to offer new implants free of charge, or at least in the same operation, was criticised in the public media.

The health authorities, not excluding the DH, had to stand up to heavy public out-cry in the media regarding the PIP-breast implant scandal and its monitoring of the services. We felt it was mostly misguided and not based on actual facts. However, it called the attention of the general public and professionals to the importance of reliable health data. In addition it has increased general understanding of the importance of real-time information, also among the medical profession.

Registration of medical doctors from abroad

Many young Icelanders have sought and enjoyed medical education outside the country. Historically, this has been mostly in the Nordic countries. In recent years, however, Icelandic students with medical education from elsewhere, mostly from Hungary, have sought certification as medical doctors in Iceland. In line with common European rules and regulations on the free movement of workers, these students request an MD diploma without doing their post-graduate one-year service under the supervision of other doctors as required by graduates from the University of Iceland according to Icelandic law.

The DH has in recent months been analysing the situation of these students and the European regulations regarding this issue. An applicant for a recognition of his/her professional qualifications as a doctor must submit a Certificate of Conformity issued by the foreign authority concerned, confirming that the medical study programme in question meets the standardised minimum requirements of Directive 2005/36/EB regarding doctors with basic training. The competent authority does not recognise professional qualifications obtained abroad unless it can fully be certified that the applicant concerned has not had his/her license suspended, limited or revoked nor has been subjected to any such penalties as a result of serious professional misconduct or mistakes. Therefore, the applicant must submit a Letter of Good Standing.

Hungarian certificates and competent authority

As far as the DH can gather from official information on the health service legislation in Hungary (Act CLIV of 1997 on Health), health professionals who have successfully completed a recognised education/training programme in Hungary are entered into a basic registry maintained by the Office of Health Authorisation and Administrative Procedures (EEKH), cf. www.eekh.hu.

Information on the registration in the basic registry is presented in the Certificate of Conformity issued by the EEKH to confirm that the qualifications meet the stipulations of the Directive. A registration in this basic registry is one of the prerequisites to entering the health-care professional in question into another registry maintained by the same Authority, i.e. the Operational Registry. Being registered in this latter registry is a requirement for obtaining a right to work in Hungary as a doctor.

According to its website, the EEKH issues a Certificate of Good Standing on the basis of Section 110/A of Act CLIV of 1997, among other things. The certificates of this kind that have been submitted by applicants in Iceland confirm that no information exists to the effect that the applicant concerned has had his/her professional license suspended, limited or revoked nor has he/she been subjected to any such penalties as a result of serious professional misconduct or mistakes.

Icelandic citizens with a medical degree from Hungary have in recent years increasingly chosen to apply for a general medical license according to the Icelandic Physicians Act, after they have completed a one-year post-graduate service in Iceland, rather than applying for a recognition of their Hungarian diploma on the basis of the EU Directive.

To better distinguish certificates based on different background documentation, the DH is considering the issuing of two different certificates, since at present the difference lies in the citation of law alone. This may improve the understanding of the professional qualifications being recognised and improve the handling of applications for work by Icelandic health institutions.

Drug surveillance team

In December 2010, the Icelandic Health authorities received a letter from the WHO expressing concerns regarding the large consumption of methylphenidate in Iceland. The letter claimed that no other country in the world had a larger consumption on average per inhabitant. The DH's immediate response was to strengthen its surveillance of methylphenidate prescriptions and prescriptions for other misusable/abusable pharmaceuticals.

The DH has suggested that more discipline might be needed in the diagnostic process for ADHD, as statistics indicate that this condition might be diagnosed more frequently in Iceland than in other countries. One idea that has been discussed is setting up a specific ADHD diagnostic unit at the University hospital but such a unit is expensive. Another suggestion is to introduce a special card, issued on the basis of clear diagnostic criteria that would be required for getting a prescription of methylphenidate. The card would simultaneously be a reimbursement card. The feasibility of this approach is still under discussion.

In spite of the efforts of the DH, the consumption of methylphenidate has not decreased in the last two years - could at best be described as stagnant - and prescribed medicines do not seem to be decreasing in the illegal market. Therefore, strengthening of the legislation covering this area is required in addition to other firm measures.

IV Health Statistics

Electronic health record

As of 1 March 2012, the DH is responsible for the development, co-ordination, and implementation of an electronic health record (EHR) at a national level. The eHealth strategic plan of Icelandic health authorities supports the implementation of a lifelong electronic health record for every citizen, accessible to authorised professionals at point of care. Furthermore, citizens are to have secure access to their own personal health information.

Projects related to EHR implementation and coordination of health-care data standards will be managed by the Health Statistics division within the DH. This will correspond well with other projects managed by the division. Moreover, a specific unit is being developed within the division that will specialise in carrying out projects related to eHealth.

The DH emphasises users' involvement in the development of an EHR at a national level. Hence, professional user groups have been established. The role of the user groups is to identify and prioritise relative projects for effective and successful national EHR implementation in Iceland.

Steady progress has been made over the years toward increased IT use within health care in Iceland. Currently, all general practitioners have an electronic health record implemented, every hospital has an electronic admission-transfer-discharge information system, immunisation information is shared countrywide, and a majority of physicians have access to e-prescription, to name a few examples.

Current projects include, but are not limited to, central access to medication profiles and known allergies, connecting EHRs to a common national network, and procedures to improve data reporting for better monitoring of population health and health data benchmarking.

Report on breastfeeding and infant nutrition

In June 2012, the DH published the report *Breastfeeding and Infant Nutrition in Iceland, Children Born 2004–2008*. The report is based on data registered in all health-care clinics in Iceland. The main findings suggest that breastfeeding is both common and universal in the country. Although relatively few six-month-old infants are exclusively breastfed (8%), as advised by the World Health Organisation, three quarters of all Icelandic children are still breastfed (exclusively and partially) at this age. Furthermore, an apparent increase in the number of children breastfed for longer than six months is a pleasant development.

National data warehouse

During the past months national data collection, data analysis and dissemination of data for administrative purposes has been undergoing reconstruction. The activities of the DH require good access to timely and accurate information. In order to better fulfil these requirements a decision was made to start preparing the construction of a national data warehouse. The first phase of the warehouse is now under way. The main objective of the warehouse is to support comparison, surveillance and analysis of health-service activities, the use of services and health-status surveillance. The warehouse is supposed to facilitate the overview of health services so that both short-term and long-term changes can be monitored through the dissemination of accurate and accessible information over long periods.