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How the new guardians of public health are investing heavily in tobacco companies

When public health doctors move to local authorities next year, they could find that their pensions are being partly paid by the profits of the tobacco industry, **Jonathan Gornall** reports

Judging by the three day programme for this year's conference of the Local Authority Pension Fund Forum, the people who administer in excess of £137bn (€170bn; $218bn) on behalf of 4.6 million members in England put ethical concerns on a par with other considerations when making investment decisions.

"Shareholder responsibilities" was the title of the 17th annual conference, held this week at Bournemouth's Highcliff Marriott Hotel, and among the topics discussed were investor concerns about media standards, "fat cat" pay, and the ethical crisis in banking. There was, however, not a murmur about the ethics of investing in tobacco, despite the fact that most local authority pension funds in England have direct investments in the industry.

The full scale of the investment by local authority pension funds in the tobacco industry has come to light for the first time thanks to research carried out by a public health specialist. The issue is likely to come to a head in April next year, when responsibility for public health is to be transferred from primary care trusts to local authorities—along with the estimated 5000 NHS staff working in the sector.

Stewart Brock, a public health specialist working on tobacco control at NHS Somerset, made Freedom of Information applications to all 78 local authority funds in England. He discovered that all but 10 of the 78 had direct investments in one or more national or international tobacco companies, with a combined value of £1.64bn.

The total value of investments in tobacco is, however, likely to be much higher. Many, if not most, of the funds—including the majority of the 10 with no direct holdings—have indirect investments, through pooled funds.

Brock, who has set up a blog site to publicise his findings (http://tobaccofreepensions.wordpress.com), has also taken the graphic step of linking the annual toll of more than 83 000 deaths in England from tobacco use to each of the fund areas. The highest number of smoking related deaths is the 4897 in Greater Manchester, where the pension fund has £58m invested in tobacco.

Manchester is one of the 10 heaviest investors. The fund most heavily invested in tobacco is West Yorkshire, which had 3764 smoking related deaths last year. West Yorkshire was the only scheme that refused to divulge information to Brock, but its report and accounts for 2012 show that, as of 31 March, its investment in two tobacco companies was worth £161.5m.

Brock proposes "an alternative return on investment, to be used as a local advocacy tool… the ROI [return on investment] in terms of dividends is equal to about £525 per death in England on average."

Peter Morris, director of pensions for the Greater Manchester Pension Fund, said its managers were "fully aware" of "special interest groups [that] regularly demand that investments are reconsidered."

All investment decisions were kept under constant review. However, "restrictions can have an adverse effect on returns and the cost of any poor performance would have to be borne by the council-tax payer," said Morris.

Ian Greenwood, chairman of the Local Authority Pension Fund Forum, was unavailable for comment.

Conflicted interests

Martin Dockrell of the campaign group Action on Smoking and Health says the prospect of local authority employees benefiting from shares in tobacco companies while urging people to quit smoking "creates more than a moral dilemma; it creates a direct conflict of interest." It would, he says, also be a breach of Britain's commitment to the World Health Organization's Framework Convention on Tobacco Control.

Britain became a party to the tobacco control convention in March 2005. Article 5.3 states: "In setting and implementing their public health policies with respect to tobacco control, parties shall act to protect these policies from commercial and other vested interests of the tobacco industry."[1]

Britain's commitment was re-emphasised in the current government's tobacco control plan for England, published in March 2011. The government, it stated, took "very seriously" its obligations as a party to the convention.[2]

So far, though, there is no sign that it will compel local authorities to drop tobacco companies from their investment portfolios. A spokesman for the Department of Health told the *BMJ*: "We are encouraging local authorities to follow the government's lead and take all necessary action to protect their tobacco control strategies from vested interests."

For Gabriel Scally, professor of public health and planning at the University of the West of England and a former regional director of public health, "having more than £1.5bn of public sector pensions invested in the tobacco industry is an absolute disgrace."

The government, he says, has been "told repeatedly by the public health profession that this is unacceptable, but it is, of course, reluctant to act because, as with everything else, it seems to feel that it's a matter for localism to reign supreme and for local authorities to make their own decisions.

"Of course, it is ignoring the fact that it has got international obligations around the public sector and its engagement with tobacco."

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Other countries, however, have been more proactive. The Norwegian Government Pension Fund—one of the largest in the world, with assets of £400bn—ceased investing in tobacco in 2010. It was, said the country's finance minister, important that the fund's ethical guidelines "reflect at all times what can be considered to be the commonly held values of the owners of the fund"—that is, the Norwegian people.

And in July this year First State Super, one of Australia's largest pension funds, also announced it was turning its back on tobacco investment "following strong feedback from employers and those working in health services, who represent 40% of our total membership." The move also reflected the fact that "governments are introducing initiatives to dissuade consumers from purchasing tobacco products." It would not, insisted the fund's administrators, compromise returns.

Fiduciary difficulties

Some local authorities in England are investigating their options. In November last year Devon County Council's investment and pension fund committee concluded that "any exclusion of investments on ethical grounds would . . . present problems," not least because case law regarding fiduciary responsibility was "at best unclear and any decision on excluding investments on ethical ground could be subject to legal challenge." Devon has £27.7m invested in tobacco and 1941 smoking related deaths.

Norfolk County Council, which administers the Norfolk Pension Fund, with a total direct and indirect exposure of £44m to the tobacco industry (and 1511 deaths), has sought guidance from the Department for Communities and Local Government, the regulator of the local government pension scheme. It is also awaiting the result of a possible Law Commission investigation into the proposal in the Kay review that the currently muddy legal concept of fiduciary duty to investment matters requires further clarification.[3]

Currently it seems that only one of England's local authority pension funds—that run by the London Borough of Newham—excludes tobacco from its investment portfolio and it does so not on ethical grounds but because "tobacco companies may face large liabilities from outstanding court actions."

This, says Dockrell, could be one way forward for other funds wary of breaching their fiduciary responsibility towards their members. Fiduciary responsibility, he says, is "used by pension fund managers like garlic to ward off the vampire of ethical investment," but "we would argue that the regulatory response, nationally and internationally, makes the tobacco industry in the long term a bad investment."

According to a spokeswoman for the NHS Business Services Authority, which administers the NHS pension scheme for England and Wales, the estimated 5000 NHS staff who transfer to local authority employment "will be allowed to remain members of the NHS pension scheme as long as they remain in their current role."

However, for staff who move posts—for example, through promotion—or are recruited after 1 April 2013, "a small working group involving all the key parties, including trade unions, is considering pension options."

TOP 10 HEAVIEST ENGLISH LOCAL AUTHORITY INVESTORS IN TOBACCO COMPANIES

Local authority	Tobacco investment shares and bonds (£)
West Yorkshire Pension Fund (including Leeds and Bradford councils)	125 700 000
Hampshire County Council	94 905 000
Merseyside Pension Fund	84 358 812
Lancashire County Council	70 553 347
Teesside Pension Fund	70 407 340
West Midlands Pension Fund (including Birmingham, Coventry)	67 782 000
South Yorkshire Pension Fund (including Sheffield City Council)	62 782 998
Greater Manchester Pension Fund	58 134 319
Derbyshire County Council	57 136 573
Durham County Council	50 799 561
Total	742 559 950

Source: Freedom of Information requests.

Jonathan Gornall is a freelance journalist, London, UK
jgornall@mac.com

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- News: Greek doctors plan action over government's failure to pay them (*BMJ* 2012;345:e5462)
- News: Greeks feel effects of drug shortages caused by austerity measures (*BMJ* 2012;344:e3589)
- Blogs: Kathi Apostolidis: Demolishing the Greek national healthcare system the amateur way

GREEK ECONOMIC CRISIS NOT A TRAGEDY FOR HEALTH

Despite the stories of doom, cuts to healthcare spending in Greece will not necessarily be all bad for patient care, argues **Lycourgos Liaropoulos**

In the past two years, I have been interviewed by the media in the United States, United Kingdom, Japan, Holland, and Greece. One persistent line of questioning has been whether Greeks are "dying on the street," or getting "kicked out of hospitals." Since horror stories increase newspaper circulation, the press has even discovered mothers who "were denied their babies after delivery until they paid the state hospital bill."[1] There is also talk of a "dramatic rise in suicides."[2] An article in the *Lancet* last year, which referred to a deterioration of health status, was widely reproduced by the Greek press but criticised by the academic community as irrelevant because the evidence was dated.[3] But as far as the actual effects on health that the article discussed, it is definitely too early to know.

The other reports are also exaggerated. The incident with the overzealous hospital administrator who demanded payment to hand over the baby has not been duplicated. There is anecdotal evidence of delays or shortages in particular hospitals at certain times, but no evidence of denial of services to patients. The economic crisis has limited some people's use of health services, but there is no evidence that it has affected health.

Attempted suicides and demand for psychiatric help have indeed risen as Greece struggles to cope with the worst economic crisis since the second world war. Experts say the numbers are relatively low—less than 600 a year.[4] But increases in suicides, attempted suicides, the use of antidepressant medication, and the need for psychiatric care nevertheless cause alarm in a nation not accustomed to the problem. Before the financial crisis began in 2009, Greece had the lowest suicide rate among countries in the Organisation for Economic Cooperation and Development (OECD)—2.8/100 000 inhabitants. This may be partly because of low reporting. According to the health ministry, there was a 40% rise in suicides in the first half of 2010. There are no reliable statistics for 2011, but experts say Greece's suicide rate has probably doubled to about 5/100 000. That is still far below the 17.3/100 000 in Finland or the OECD average of 11.3/100 000.[4]

For a person who is on a low income and has no health insurance, Greece is still a better place to be sick than the United States. This is not to say that the situation won't get worse. According to the latest figures from Eurostat, a statistics database run by the European Commission, Greece has the second highest share (20%) of people below the poverty line in Europe. If the depression persists, the better than average Greek health statistics of 2009 will undoubtedly get worse.

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Economic woes

Since 2009, Greece has faced serious economic difficulties. The country has just negotiated a second bailout of its ailing economy with the aim of getting debt down to 120% of gross domestic product (GDP) by 2020. So far Greece has received nearly €119bn (£96bn; $153bn) from the "Troika" —the International Monetary Fund, European Commission, and European Central Bank. Bailout conditions imposed by the Troika have unleashed an austerity programme on Greeks, including reforms to the health service to generate efficiencies and improve transparency.[5] The health sector, which in 2009 spent close to 10% of GDP, must cut expenditure to 9% of GDP or €5bn by 2014.

Such a huge restructuring is bound to have serious repercussions, the exact nature of which is only now unfolding. Already, vital social services have been caught up in the massive spending cuts. The hot topic is the fate of unemployed people as they lose their health insurance and the ability of the public system to meet these new demands.[6] Unemployment for all workers is currently at 25.4%, with 630 000 long term unemployed. The harsh austerity programme is also making itself felt in pensions and take home pay in both the public and private sectors.[7]

Unsurprisingly, public sentiment has been badly affected. Trust in government, the political parties, and public institutions has sharply declined. Support for the two centre-right and centre-left parties that have dominated Greek political life for 35 years has plummeted. Besides being implicated in serious corruption and mismanagement scandals of the past, both parties are heavily blamed for the crisis. But the finger of blame is also pointed at Europe.[8]

Crisis of management

But the scale of these cuts would be easier to absorb if the health service wasn't so poorly managed. Instead of making across the board cuts, Greece should target excessive spending.

Until a few years ago, health expenditure was poorly accounted for in Greece. The country has only just adopted the System of Health Accounts (SHA), a reliable European standard for measuring health expenditure. The lack of dependable health expenditure data severely limited the country's ability to detect weaknesses in its health policy; it hid the fact that the problem was not the size of health expenditure but how it was spent.

Health expenditure rose rapidly in the so called "happy decade" of 2000-9, but it did so in a grossly inefficient and provocatively corrupt health system. Construction of the SHA data now shows that money was concentrated on hospital care at the expense of prevention, long term care, home care, e-health, and efficient management methods. It also documents the wasteful use of high end technology. Greece tops the OECD countries for numbers of magnetic resonance and computed tomography scanning units (mostly private) and examinations per 100 population—

Lack of an organised primary care system, a referral system that gives control of beds to hospital doctors, and the absence of independent emergency departments make admission to the hospital a matter of private arrangement between patient and doctor, often aided by an under the table payment

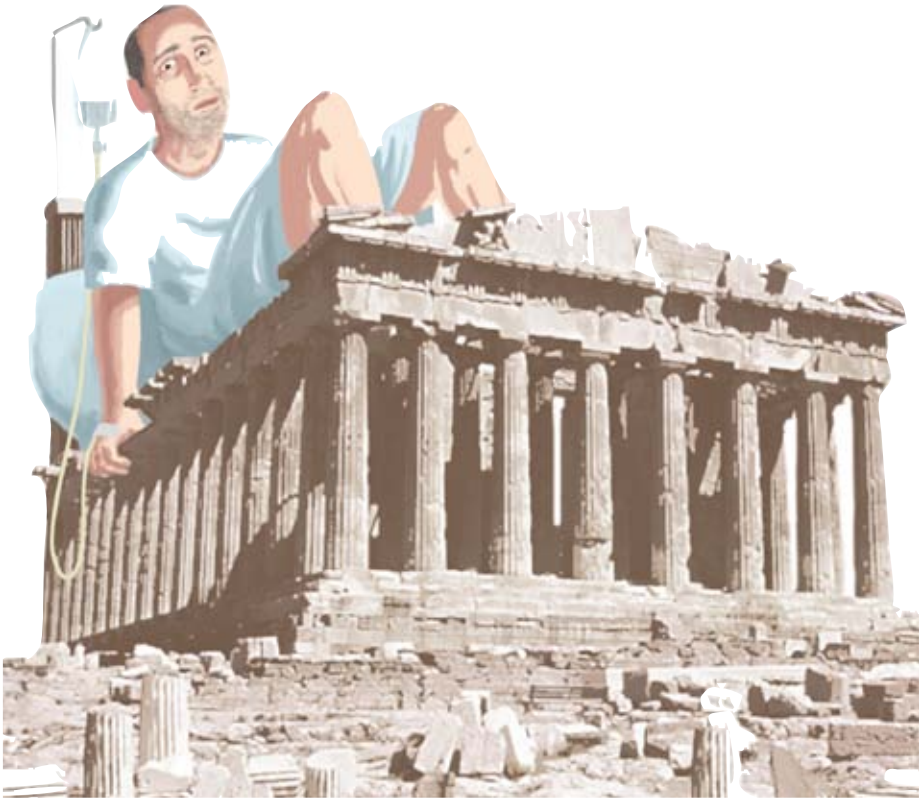
1 in 10 Greeks is scanned each year.[4] Drug costs more than doubled from 2005 to 2009, adding roughly €1bn a year to health costs. Interestingly, during that period the Ministry of Health systematically thwarted efforts to adopt the SHA. In fact, the National Statistical Service, the government general directorate that was replaced by the independent Greek Statistical Authority in 2010, did not publish any figures on health expenditure for 2008 and 2009. Even GDP figures were revised twice, drawing severe criticism in the press for methodological "leaps."[9]

It's the system not the money

Several characteristics make the Greek healthcare system particularly vulnerable to the economic crisis: the high prevalence of informal "under the counter" payments, the public health insurance system, and inefficient organisation and management. Successfully tackling these problems could provide the savings required for fiscal adjustment.

As public expenditure declined, private expenditure increased from 30% of total health expenditure in 2009 to 34% in 2011. Private spending has traditionally filled gaps in social insurance coverage—for example, dental (31%), long term, and private hospital care (18%); physician services (20%); and drugs (20%). It also covered organisational inadequacies through a culture of under the table payments, mostly to doctors, to gain access to needed quality care. These payments were estimated in 2005 at €2bn.[10] As the crisis deepens, more people cannot afford the private payments. Although the effect of this on access and use of services is not yet known, public survey results reported in the press show that demand for public hospital and primary care has increased by 20%.

Public health insurance is the second systemic weakness. Funded by employment related contributions in the private sector and taxes in the public sector, it has been devastated by the depression. Although people remain covered for the first 18 months after losing their job, with 25% unemployment, many are without cover. There are reports of the church, non-governmental organisations, medical associations, and individual health providers rallying to help. The only solution to this problem is to abolish employer related insurance, revamp tax collection, and adopt tax funded national health insurance. However, although this is beginning to be discussed, it is unlikely to happen quickly.



The third systemic weakness is inefficient organisation resulting from cronyism, corruption, and political negligence, which the press often criticises. Lack of an organised primary care system, a referral system that gives control of beds to hospital doctors, and the absence of independent emergency departments make admission to the hospital a matter of private arrangement between patient and doctor, often aided by an under the table payment.[10]

Crisis as an opportunity

Some health costs cannot be reduced without severe consequences for the quantity and quality of care because prices are determined in international markets (drugs, supplies, energy, etc). For example, medical supplies and drugs for inpatients were recently estimated at 29% of total hospital expenditure for 2010, falling only to 21% in 2011, despite serious efforts to reduce costs.[11] Nevertheless, there remains plenty of scope for savings elsewhere.

Savings in excess of €1.3bn or 17% were realised between 2009 and 2011 in public and private hospital care. But public hospitals are still a major target in the effort to direct resources to better uses. Archaic procurement mechanisms and senseless legal procedures for tenders on hospital supplies and equipment, induced demand by medical practitioners, and the overuse of medical technology, usually associated with fraudulent behaviour, are areas where major savings can occur. Tools such as centralised electronic procurement and electronic prescribing have also not yet been brought fully into play.

Restructuring and modernisation of public hospitals could also produce substantial savings and better quality of care. Greece has many old and small hospitals, often close to each other. Neighbouring hospitals face both staff shortages and low occupancy rates, and merging them would undoubtedly lead to better use of resources and improve the quality of care.[12]

In conclusion, the economic crisis does not need to hit patients hard. There are smart ways to make the savings required in the health sector and the economic crisis can be seen as an opportunity to improve the system.

Lycourgos Liaropoulos is professor emeritus, University of Athens, Athens 15127, Greece
lliaropo@nurs.uoa.gr

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