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2 EDITORS' COMMENT

Eurohealth Observer

3 HEALTH POLICY IN THE FINANCIAL CRISIS – Philipa Mladovsky, Divya Srivastava, Jonathan Cylus, Marina Karanikolos, Tamás Evetovits, Sarah Thomson and Martin McKee

7 COPING WITH AUSTERITY IN THE IRISH HEALTH SYSTEM – Steve Thomas and Sara Burke

10 ESTONIA: CRISIS REFORMS AND THE ROAD TO RECOVERY – Triin Habicht

12 GREECE: THE HEALTH SYSTEM IN A TIME OF CRISIS – Daphne Kaitelidou and Eugenia Kouli

15 A WINDOW FOR HEALTH REFORMS IN THE CZECH REPUBLIC – Tomas Roubal

Eurohealth International

18 THE PROPOSAL FOR THE PROFESSIONAL QUALIFICATIONS DIRECTIVE – THE PATIENT PERSPECTIVE – Rachel Seal-Jones and Jeremiah Mwangi

Eurohealth Systems and Policies

22 THE EVOLUTION OF OBESITY IN SPAIN – Manuel García-Goñi and Cristina Hernández-Quevedo

26 DO DANES ENJOY A HIGH-PERFORMING CHRONIC CARE SYSTEM? – Cristina Hernández-Quevedo, Maria Olejaz, Annegrete Juul Nielsen, Andreas Rudkjøbing, Hans Okkels Birk and Allan Krasnik

30 THE DUTCH HEALTH INSURANCE SYSTEM: MOSTLY COMPETITION ON PRICE RATHER THAN QUALITY OF CARE – Anne E.M. Brabers, Margreet Reitsma-van Rooijen and Judith D. de Jong

33 PHARMACEUTICAL MARKET REFORMS IN PORTUGAL UNDER THE MEMORANDUM OF UNDERSTANDING – Pedro Pita Barros

Eurohealth Monitor

37 NEW PUBLICATIONS

39 NEWS



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The global economic crisis has affected most sectors, including the health sector. Although rather unpopular, some governments have responded with policies aimed at reducing public spending on health care. Some of the more common reforms across countries have endeavoured to moderate the growing budgets for health services; rationalise the benefit packages; increase the share of health expenditure paid by private households; and implement wide-reaching reforms in the pharmaceutical market.

This issue of *Eurohealth* presents articles in the **Eurohealth Observer** section which detail the extensive austerity-driven reforms implemented in a variety of European countries – with specific case studies on Estonia, the Czech Republic, Greece, and Ireland. Each of these countries has been affected to differing degrees by the global economic crisis that began in 2008, and their policy responses in the health sector illustrate the magnitude of their economic woes and their prospects for recovery.

In the **Eurohealth International** section, following on from our previous issue (Volume 17, Issue 4), which covered stakeholder perspectives on the proposal for the Professional Qualifications Directive by the European Commission, we are pleased to reflect the important perspective of patients provided by the International Alliance of Patients' Organizations (IAPO). The IAPO identifies the positive opportunities afforded by the Directive, while drawing attention to the ongoing need to protect quality of care and patient safety.

In our **Eurohealth Systems and Policies** section, the increasing adult and infant obesity rates in Spain are analysed by Manuel García-Goñi and Cristina Hernández-Quevedo. They discuss some past programmes and strategies to tackle obesity in Spain, including the 2011 Law on Food Safety and Nutrition. Next, the authors of the recently published *Health System Review* on Denmark reflect on their findings on the performance of the chronic care system and the need for better co-ordination of services.

Another article in this section looks at the Dutch health insurance system. In the Netherlands, people are able to switch health insurer and some do so each year. Anne Brabers and colleagues study the motivations of citizens for switching and present some conclusions on the relevant drivers operating in this regulated market. Following on, Pedro Pita Barros covers the large number of reforms that have been implemented in the Portuguese pharmaceutical market over the last decade and more recently in response to the Memorandum of Understanding that Portugal has signed to obtain financial assistance from international lenders, with the over-riding aim of reducing public expenditure.

The **Eurohealth Monitor** section draws attention to new publications, i.e., the new *Health System Reviews* on Turkey and Russia and a book on health systems, health, wealth and societal well-being, followed by a brief news section that highlights some very recent and topical news related to the health sector.

We hope that you continue to enjoy the new look and structure of the journal and welcome your comments and feedback to the editors.

Sherry Merkur, Editor

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HEALTH POLICY IN THE FINANCIAL CRISIS

By: Philipa Mladovsky, Divya Srivastava, Jonathan Cylus, Marina Karanikolos, Tamás Evetovits, Sarah Thomson and Martin McKee

Summary: This article summarises the results of a study on how European countries have responded to budgetary pressures in the context of the global economic crisis. The study highlights the wide range of health policy responses and notes some of the trade-offs involved. To date, national governments in the European Union (EU) have been largely responsible for making these trade-offs but where countries are receiving bailout packages, international organisations are now directly intervening in national health policies. Regardless of who the decision maker is, these trade-offs should be understood and made explicit. Ideally, policy decisions should be guided by a focus on enhancing value in the health system rather than on identifying areas in which cuts might most easily be made.

Keywords: *Financial Crisis, Policy Response, Health System Reform, WHO European Region*

Concerns about the potential impact of the financial crisis on the ability of countries to achieve health system goals led the World Health Organization's (WHO) Regional Committee to adopt the 2009 resolution *Health in times of global economic crisis: implications for the WHO European Region* (EUR/RC59/R3a). Building on the momentum created by the WHO European Region's 2008 Tallinn Charter¹, the resolution urged Member States to ensure that their health systems continued to protect the most vulnerable, to demonstrate effectiveness in delivering personal and population services, and to behave as wise economic actors in terms of investment, expenditure and employment.

In a recent report WHO addresses the challenge of sustaining equity, solidarity and health gain in the context of the

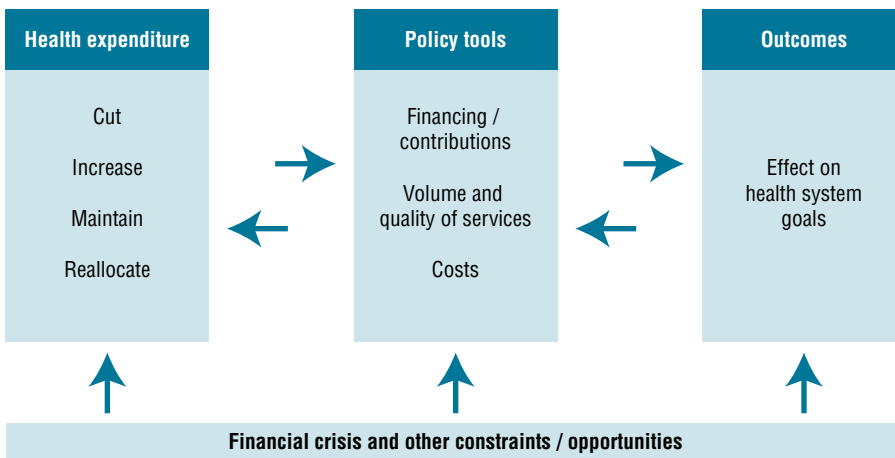
financial crisis and notes the diversity of health policies pursued by Member States in response to budgetary pressures.² However, to date there has been no systematic and comprehensive cross-country review and analysis of these responses. The European Observatory on Health Systems and Policies has now addressed this gap and preliminary results of the study are presented here.

Understanding health policy responses to the financial crisis

The study is informed by a conceptual framework for describing possible health policy responses to the financial crisis and other health system shocks. The framework includes three key dimensions: health expenditure options, policy tools, and outcomes (see **Figure 1**).

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Figure 1: Health policy responses to the financial crisis and other shocks



Source: The authors.

First, when confronted by a fiscal crisis, policy-makers may face pressure to maintain, decrease or increase current levels of public expenditure on health. With any of these options they could also reallocate funds within the health system to enhance efficiency. Political and ideological factors may influence these decisions as much as the magnitude of the fiscal constraint itself.

Second, a range of policy tools can be used to alter expenditure levels. These can be categorised as affecting:

- the level of contributions for publicly financed care (the size of the national health budget, social insurance contributions and transfers from the health budget, fiscal policy and private expenditure on health in the form of user charges and/or private health insurance)
- the volume and quality of publicly financed care (the statutory benefits package, population coverage and non-price rationing such as waiting times)
- the cost of publicly financed care (the price of medical goods, salaries and motivation of health sector workers, payments to providers, overhead costs and reconfiguration or coordination of care).

In many cases, policies will affect more than one of these factors. For example, altering the price of medical goods will not only change the unit cost of care; it may

also change the volume of medical goods provided and the level of contributions, if user charges are involved.

Third, when making decisions, policy-makers need to consider the impact of any proposed reforms on health system goals, including improving health, financial protection, efficiency, equity, quality, responsiveness, transparency and accountability.

Figure 1 shows how focusing on health expenditure should not be seen as an end in itself. Nor can changes to expenditure necessarily be equated with changes in efficiency. The point of trying to increase efficiency in the health sector is to maximise outcomes for a given level of public resources devoted to health care.⁴ It is not the same as simply cutting costs, especially where this leads to worse health outcomes. Efficiency gains imply achieving similar outcomes at lower cost, better outcomes at similar cost or better outcomes at greater cost, where the benefits exceed the extra cost involved.

There is a need to beware of superficially attractive solutions. For example, those based on greater use of market mechanisms often fail to acknowledge the presence of significant market failures in health care and health insurance, which have to be addressed through regulation. The higher administrative costs associated with regulation would only be justified by commensurately better outcomes, and often these do not materialise.

A decision to cut public spending on health in response to a fiscal constraint may undermine health system performance by reducing financial protection, creating or exacerbating inequities and worsening health outcomes. In addition to introducing new inefficiencies, cuts across the board fail to address existing inefficiencies, potentially tightening the fiscal constraint in the longer term.⁵

The three sets of responses exist in a context of constraints and opportunities within the health system and external to it. In the current financial crisis, large fiscal imbalances have left a number of countries with relatively little choice in their response; they are at such high risk of debt default that they are no longer able to borrow to finance government spending and therefore have had to implement deep public sector cuts. However, even for them, achieving fiscal balance should not be regarded as a primary goal of the health system – on a par with or even overriding other health system goals such as health gain or financial protection – since, if it were, it could be achieved by cutting public spending on health without regard for the consequences.⁶ The policy response in countries with no choice but to reduce health expenditure should therefore be on cutting wisely to minimise adverse effects and potentially facilitate efficiency-enhancing reforms in the longer run.

Fiscal preparedness has been key for countries, affecting the scale and intensity of health policy responses open to them. Countries with very high levels of debt before the crisis may be vulnerable to pressure to reduce expenditure on health and other public sectors, particularly if the government's ability to borrow has been compromised. In the health sector, countercyclical policies such as holding financial reserves earmarked for health or linking government contributions for economically inactive groups of people to average earnings in previous years may reduce pressure to cut health expenditure.⁷ Health systems' vulnerability to budget cuts may also be affected by existing inefficiencies that make it politically difficult to argue for maintaining the level of public expenditure on health during fiscal austerity. This is especially the case in comparison to other types of social

protection such as pensions, where there is less opportunity to make cuts through improving efficiency or productivity and entitlements are often more clearly defined than in the health sector.⁵

How did European health systems respond to the financial crisis?

A questionnaire was sent to a network of health policy experts in the 53 Member States of the WHO European Region to ascertain health policy responses to the financial crisis. Results were received in March–April 2011. In total, 45 countries responded and their responses were categorised according to the framework set out in Figure 1. Policy responses to the crisis varied and, in part, depended on the extent to which countries experienced a significant downturn in their economies. In some cases it was difficult to define whether or not policies were a response to the financial crisis, particularly when planned ‘unpopular’ policies may have become more politically feasible in the context of the crisis. Where possible, this was clarified with the policy experts.

Some countries introduced no new policies, while others introduced many. Some countries were better prepared than others due to fiscal measures they had taken before the crisis, such as accumulating financial reserves. There were many instances in which policies planned before 2008 were implemented with greater intensity or speed as they became more urgent or (more often) politically feasible in face of the crisis, particularly the restructuring of secondary care. There were also cases where planned reforms were slowed down or abandoned in response to the crisis. In almost all cases, evidence of the impact of policy responses to the financial crisis on health system performance was not yet available. For this reason the study relies on a review of the wider literature on health sector reforms to assess the policy responses against theory and evidence.

Internationally comparable data from 2008 to 2009 suggest that immediately following the crisis, per capita public expenditure on health grew in all but nine of the 53 countries of the European Region, but only fourteen

countries had an increase in public expenditure on health as a share of total government expenditure.⁶ Several countries reported cuts in the national health budget in response to the financial crisis. In some countries, a decline in the budget was partly caused by rising unemployment which reduced revenue from social insurance contributions. In a few cases, social insurance revenues and expenditures continued to increase, in part due to the countercyclical contribution rate paid by the state for economically inactive people. In countries that rely heavily on employment-based social insurance contributions, revenue flows can be maintained by lifting income or earnings ceilings, broadening the contribution base to encompass non-wage income or increasing transfers from the government budget.⁷ Unless a country is experiencing extremely high levels of debt, maintaining or increasing public spending on health should be sustainable as long as the spending is regarded as enhancing value relative to spending in other sectors.

Several countries increased or instituted user charges for certain health services in response to the crisis. In contrast, others reported expanding benefits. User charges increase the financial burden on households and have been shown to be equally likely to reduce the use of high-value and low-value care and are particularly likely to reduce use among lower-income individuals and older people, even when the level of charges is low.⁸ Applying user charges in primary or ambulatory specialist care may worsen health outcomes and lead to increased spending in other areas (e.g., emergency care). As a result, the potential for cost savings or enhanced efficiency is extremely limited. Targeted user charges selectively applied to low-value services or with exemptions or caps for poorer households or regular users of care are more likely to enhance efficiency.⁹ However, it may not be technically feasible to identify low-value care and the transaction costs involved may be significant.

In terms of policies intended to affect the volume and quality of publicly financed health care, in general, countries did not make major changes to the statutory

benefits package and the breadth of population coverage, although there were some reductions, usually at the margin. Conversely, some countries expanded coverage to protect the most vulnerable population groups. A fundamental objective of health policy at any time, but particularly during an economic crisis, is to maintain access to essential services for the population, especially for poorer people and regular users of health care. However, selective, evidence-based and transparent reductions in the scope of coverage represent a good opportunity for enhancing efficiency without undermining health system performance. While Health Technology Assessment (HTA) is more likely to be useful as part of a longer term strategy for enhancing efficiency than as a tool for quick decision-making, countries with established HTA programmes will be better placed to make informed decisions in times of economic crisis. Restricting eligibility for statutory coverage (e.g. on the basis of household income) may lead to an absolute reduction in public spending on health. However, this is likely to add to rather than alleviate fiscal pressure in the health system, partly due to the loss of contributions from wealthier households. Fiscal pressure is also worsened by segmentation of the national risk pool, which leaves the statutory risk pool with a concentration of older, poorer and sicker people, as well as people with non-contributing dependants.¹⁰

Lowering the breadth, scope and depth of coverage creates a role for voluntary health insurance (VHI). However, the market failures that characterise VHI, in particular information problems relating to adverse selection and risk selection, mean that those reliant on voluntary cover may be placed at risk, particularly older people and people in poor health.¹¹

Several countries increased taxes on alcohol and cigarettes or pursued health promotion policies such as encouragement for healthy eating, exercise and screening. These policies seek to lower the need for health care and are generally intended to lower the volume of publicly financed care provided. Evidence on the economic benefits of prevention has grown in recent years, supporting broad public health promotion and preventative measures.¹²

Finally, in terms of policies intended to affect the costs of publicly financed health care, many countries introduced or strengthened policies to reduce the price of medical goods or improve the rational use of medicines. In most cases these policies were part of ongoing reforms, but the crisis often prompted, sped up or intensified implementation. The crisis increased efforts to negotiate pharmaceutical prices in some national markets, highlighting the importance of the public authority as a monopsony buyer. However, the positive effects of price controls may be offset by increases in the quantity of drugs prescribed or a change in the product mix to include more expensive medicines. As a result, pricing policies should be combined with policies targeting health professionals to encourage rational prescribing and dispensing. Again, however, savings might be offset by increases in volume and therefore be short-lived. Policy-makers should promote generic medicines and inform patients on the benefits of switching from original to generic where appropriate.^[1]

Some countries reduced the salaries of health professionals, froze them, reduced their rate of increase, or used other approaches to lower salaries. Employee wages, salaries and allowances account for large proportion of public spending on health which helps to explain the policy focus on cutting salaries in many countries. However, these policies may exacerbate wage imbalances across countries, increasing health worker migration in Europe and other regions, and adding to problems of human resource shortages, which risks undermining quality and efficiency in the health system. A longer term view of increasing efficiency in the supply of human resources for health would consider a broader range of strategies, in particular changing the skill mix and substitution of health workers' roles.

Several countries have reduced the tariffs paid to providers or have linked payment to improved performance to realise efficiency gains and contain costs. Measures that target the supply side offer considerable scope to improve health system functioning in comparison to those focused on curtailing utilisation by

patients. Changes in how health care is purchased and providers reimbursed offer significant potential to enhance efficiency, quality and equity.

Several governments are restructuring their Ministry of Health, statutory health insurance funds or other purchasing agencies in an attempt to reduce overhead costs and increase efficiency. Reducing the number of civil servants or altering their employment conditions (tenure, pay, pensions) is one way of cutting public spending on health but risks loss of skilled staff. Reforming the health insurance market structure (e.g. by consolidating risk pools) can also reduce overhead costs. In addition, addressing fragmented pooling may contribute significantly to financial sustainability because a lower number of pools means less need for complex and resource intensive risk adjustment and, by strengthening the power of purchasers in relation to providers, may lead to better (more strategic) purchasing.

In many countries, the economic crisis created an impetus to speed up the existing process of restructuring the hospital sector through closures, mergers and centralisation, a shift towards outpatient care and improved coordination with or investment in primary care. Most countries are in the process of reducing hospital capacity to increase efficiency by closing unnecessary facilities and replacing expensive inpatient care with more cost-effective alternatives. These changes have generally been shown to have no negative impact on quality of care.^[2] Some governments have sought to finance capital investment through greater use of market competition, while others are opting for a publicly led approach to capital investment. However, the former approach, characterised by public-private partnerships (PPPs), has been highly problematic. It may act as a barrier to collaboration between facilities offering complementary services to a defined population, leading to fragmentation and duplication. Furthermore, PPPs do not generate new financial resources for the health sector but are simply a way of raising debt finance, often transferring risk to future generations. This may benefit governments that need to meet short-term

fiscal targets but does not necessarily reduce costs or increase efficiency in the longer term.^[3]

Conclusions

The study has highlighted the wide range of health policy responses to the financial crisis across Europe and noted some of the trade-offs involved. To date, national governments in the EU have been largely responsible for health policy and making these trade-offs. However, in Greece, Ireland and Portugal, bailout packages from the “troika” (the European Commission, the International Monetary Fund and the European Central Bank) and the resulting pre-conditions for receipt of funds mean that international organisations are now directly intervening in national health policy.^[4]

Regardless of who the decision maker is, these trade-offs should be understood and made explicit so that evidence can be openly weighed up and the underlying ideology tested against societal values. Ideally, policy decisions should be guided by a focus on enhancing value in the health system rather than on identifying areas in which cuts might most easily be made. Viewing fiscal balance as a constraint to be respected, rather than as an objective in its own right, allows decision makers to shift the terms of debate away from balancing the budget at any cost towards an emphasis on maximising the health system's performance.

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COPING WITH AUSTERITY IN THE IRISH HEALTH SYSTEM

By: **Steve Thomas** and **Sara Burke**

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Summary: The Irish economy contracted by 10.8% from 2008 to 2010 and the standardised unemployment rate increased dramatically from 4.8% in 2007 to 14.2% by January 2012. In response, austerity measures in the health sector aimed to contain costs and to target resources more effectively. Some of the policies also had the effect of shifting costs from the public purse to private households. Recruitment and salaries of health sector workers also have been targeted. The current government's plan to establish a universal health insurance system is a new direction for Ireland and one that will have gained appeal through the current economic hardship and the instability in the private insurance market.

Keywords: *Economic Crisis, Cost Saving, Health System Reform, Ireland*

While the Irish economy boomed in the Celtic Tiger years, public spending on health quadrupled between 1998 and 2008, rising from €3.6 billion to just over €16 billion.¹⁴ This was a very large increase but it needs to be viewed in the context of the prior decades of under-spending. In 2005, approximately 80% of overall health system financing in Ireland came from general taxes.⁵ Taxation revenues fell substantially in 2008 and 2009 as a result of the economic crisis⁶ and the economy contracted significantly (by 3% in 2008 and 7.25% in 2009).⁴ The Economic and Social Research Institute (ESRI) noted that the Irish economy contracted by 10.8% from 2008 to 2010 in what is one of the steepest falls in economic growth in an industrialised country since the 1930s.⁵ At the same time, the standardised

unemployment rate increased dramatically from 4.8% in the last quarter of 2007 to 14.2% by January 2012.⁶

Given this dire economic context, from 2009 to 2011 the Irish government made a number of key decisions which had major implications for the health system. In some cases it is difficult to ascribe direct causality to the economic crisis for these decisions; however, periods of crisis can be a good window of opportunity to push through reforms that have lain in wait. Below we summarise the range of policy responses, grouped into three broad areas, which aimed to contain health sector costs and target resources more effectively. Some of the policies also had the effect of shifting costs from the public purse to private households.

Policies targeting financial contributions to the health system

In terms of fiscal policy, the health levy, a surrogate income tax, was doubled to 4% in 2009 on all earnings up to €75,036 and raised to 5% on earnings above this amount. Moreover, tax relief for private nursing homes and hospitals was being phased out as part of a broader policy of ending property-related tax relief. No new tax reliefs have been granted since December 2010. Palliative care continues to be eligible for tax relief.

The health budget has been a primary area for cost saving measures. In 2010, over €1 billion of health budget savings were announced, but extra funds (€230 million) were made available for demand-led schemes such as the Medical Card, as enrolment in the scheme had been increasing because of the rise in the rate of unemployment and falling income levels.¹ Medical Cards confer free access to General Practitioners (GPs) and waive hospital inpatient fees for those under certain income thresholds, and most people over 70 years of age. Medical cards also allow holders to obtain prescription drugs for a fee of 50 cents per item.

“ 6.6%
cut for the
Health Service
Executive

In 2011, following a worsening economic situation and virtual collapse of the Irish banking system a further €2.2 billion was taken out of public spending. The overall budget for health was down by €746 million (a year-on-year 6.6% cut for the Health Service Executive (HSE)).² However, there were minor funding increases for cancer care (€10 million), homecare packages (€8 million), child protection (€9 million) and the Fair Deal (€6 million), which provides financial support for people assessed as needing long-term nursing. Most of the budget reductions in 2010 and 2011 were achieved through cuts in public sector wages, reductions in the numbers working in

the public sector and lower fees paid to professionals and pharmaceutical companies. In 2012, another €750 million is forecast to be taken out of the health system, this time coming from a reduction to frontline services with on average a 4% to 5% cut in provision despite a growing and ageing population.³

User charges have also increased. From 2009, for the two-thirds of the population without Medical Cards co-payments increased for public (17%) and private (20%) beds in public hospitals. There were also increases in hospital emergency department charges and in deductibles for the Drugs Payment Scheme, which reimburses non-Medical Card holders for the cost of drugs over a certain amount. The 2010 budget introduced a 50 cent charge per prescription for all Medical Card holders, up to a maximum of €10 per family per month. For the 70% of the population who pay for their own medications, the drugs reimbursement threshold was raised from €100 a month in 2009, to €120 in 2010 and to €132 in 2012.⁴

Policies targeting volume and quality of care

Policies in this area mainly affected population coverage of the health care system and the scope of the benefits package. In 2009, the entitlement to Medical Cards was removed from the 12,100 wealthiest people aged over 70 (equivalent to 3.4% of people in this group). This was an unpopular and significant landmark for health policy as it removed one of the aspects of universal care, free at the point of contact, in the Irish health care system. However, this was counterbalanced by increased health budget funds that were earmarked to cover the increasing numbers of people on low incomes who would be eligible for Medical Cards.

By December 2011, over 1.7 million people were covered by Medical Cards, up from 1.2 million in December 2007 – a 42% increase over 4 years.⁵ This reflects the policy objective to ensure that access to health care for the poor continued to be protected. Nevertheless, towards the end of 2011, there were many reports of

people experiencing significant delays in obtaining a medical card and in having them renewed, which has been viewed as a cost saving tactic.

Policies affecting the costs of publicly financed health care

A major policy trend has been to target the recruitment and salaries of health sector workers. In 2009, a moratorium was put in place on recruitment and promotion of health care personnel. Moreover, staff on leave and those whose temporary contracts were ending would not be replaced. The 2010 health budget introduced lower fees for contracted professionals (GPs and other health professionals), producing an estimated saving of €659 million; while in 2011, agency and locum staffing levels were lowered and early retirement and voluntary redundancies were proposed. Provider payments also were affected: from 2008, the annual fee paid to GPs who treat Medical Cardholders was reduced; in 2009, an 8% reduction on all professional fees was imposed, as was a cut to pharmacy fees by 24% to 34%; and further cuts in fees of 5% for health professionals were introduced in 2010 and 2011. In February 2012, a further 3,800 health service employees left the health system under an incentivised scheme.

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Administrative costs were also targeted. In 2009, there was a commitment to reduce the HSE's administrative, management and advertising costs by at least 3%. Further cuts in administrative spending were introduced in the 2010 health budget, including reducing HSE staff by 6,000

(with savings of €300 million), as well as additional efficiencies within the HSE of €90 million. The 2011 budget proposed cuts in administration of €43 million.

Finally, efficiency gains have also been a much vaunted policy tool. Measures to provide more services with fewer resources have included: increases in hospital day care (by 5%) in the first six months of 2009 relative to 2008 and above the 2009 target; increases in outpatient appointments by 3% between the first six months of 2008 and 2009 and the number of new outpatient attendances by 6% over the same period; and reductions in hospital capacity (by 519 beds between January and July 2009). There has also been a significant push towards shorter hospital stays assisted by the HSE Clinical Care Programmes.

“government has committed itself to a universal health care system”

Prospects

The elections in February 2011 saw the formation of a new coalition government (between Fine Gael and Labour) whose programme for government sets out a Universal Health Insurance (UHI) system.¹⁰ This is a historic move as it is the first time that a government has committed itself to a universal health care system. The policy is not a response to the current crisis although it will have gained appeal through the hardships that are being experienced and the instability in the private insurance market. It is cost neutral over the lifetime of the current government, but there is a major focus on lowering the cost base, providing care in the least expensive context and removing fees for accessing GPs, to be paid for through achieving efficiencies. The achievement of UHI is forecast to

take six years because of the structural changes that are required. It will probably necessitate an eventual increase in payments by higher income earners.

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New journal

The National Institute for Health Policy Research has launched the Israel Journal of Health Policy Research (IJHPR). This new, peer-reviewed journal seeks to promote intensive intellectual interactions between scholars in Israel and abroad regarding current issues in Israeli health care, as well as recent developments around the world that are relevant to Israel.

Generally speaking, the IJHPR will be publishing two major articles per month. Each of these articles will be accompanied by a commentary by a leading figure in the field which highlights the article's international significance. The target audience are those with an interest in health policy, health services research, or Israeli health care.

Published in January 2012, the first issue focused on the roles of physicians and patients in shared decision making and Israel's groundbreaking programme for monitoring the quality of care of community-based services.

Additional information about the journal, including open access articles, is available at: <http://www.ijhpr.org/>



ESTONIA: CRISIS REFORMS AND THE ROAD TO RECOVERY

By: Triin Habicht

Abstract: Estonia's economy contracted by over 14% in 2009 and unemployment rose to 15.6% that same year. Fiscal retrenchment measures across all public services also affected the health sector, with cuts in the health budget and reductions in the Estonian Health Insurance Fund's (EHIF) revenues, which led to, among other things, some cuts in the health benefits package and in prices paid to health care providers. There are signs of economic recovery in 2011 and 2012, reflected also in EHIF's increased revenues and the restoration of health services prices paid to providers.

Keywords: *Economic Crisis, Cost Saving, Health System, Estonian Health Insurance Fund, Estonia*

Between 2001 and 2007 Estonia had one of the fastest growing economies in Europe with annual gross domestic product (GDP) growth rates ranging between 6.7 and 10.3%.¹ The economic crisis in 2008 hit the country hard, mainly due to a severe slump in investment and consumption following the near collapse of the country's real estate market. In 2008, the economy contracted by nearly 4% and this negative growth continued into 2009 with a more drastic fall of over 14%. Since then, following large fiscal cuts and a surge in exports, the economic situation has improved markedly, with GDP returning to positive growth of 2.3% in 2010 and 8% in 2011.² Estonia now has the lowest public debt in the European Union (EU) at just 6.7% of GDP.³ In May 2009, unemployment had risen to 15.6% from 3.9% a year earlier. These high levels continued into 2010 and then stabilised in the summer of 2011 at 13.8%, bolstered by the economic recovery.⁴

In the midst of this economic turmoil, the government's main goal was to fulfil the Euro-zone criteria that were a precondition for Estonia adopting the Euro in January 2011. The main decisions affecting the health sector have been to restructure health expenditure in line with reduced budgets while simultaneously having the least possible effect on the financing of core health care services. At the beginning of the economic crisis, the health sector, and the national health insurance system in particular, was in a better position compared to other public sectors as the Estonian Health Insurance Fund (EHIF) had collected sufficient reserves during previous years of rapid growth. In addition, the health sector has been more flexible in responding to the crisis as most of the high impact changes in this sector (mainly expenditure cuts) were already in the pipeline before the crisis. Below we summarise the main policies that have affected the health care system.

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Policies targeting financial contributions to the health system

One of the major fiscal responses to the economic crisis was to cut expenditure. In 2009, the Ministry of Social Affairs (MOSA) health budget was cut by 24%. This reduction was partially achieved through cutting administrative costs within the ministry and by cutting the public health budget. The cuts focused on non-communicable diseases (NCD) while communicable disease programmes were protected. EU social funds were used to compensate for the reduction in the NCD budget but these funds will no longer be available from 2012.

“ a 15% co-insurance rate for nursing inpatient care was introduced

The reduction in the EHIF's expenditure was actually much lower, around 2% in 2009.⁹ In terms of social health insurance contributions, the EHIF's revenues were down by 11% in 2009 and by 5% in 2010, due mainly to increased unemployment and lower salaries. Initially, the government did not allow the Fund to deplete its accumulated reserves but as the crisis continued these reserves were gradually used to compensate for the reduced revenues.

User charges also were affected. In 2010, a 15% co-insurance rate for nursing inpatient care was introduced. This plan was proposed before the financial crisis as a means of including patients and municipalities in the co-financing of nursing care, but it was not possible to implement until after the crisis because it was unpopular.

Policies targeting volume and quality of care

The scope of health benefits coverage has been the major area affected, with the EHIF reducing the benefits package

in two ways. Firstly, the system for temporary sick leave benefits was reformed and responsibilities shared with patients and employers. Since July 2009, no benefit is paid during the first three days of sickness or injury (previously only the first day was excluded), the employer pays the benefit from the fourth to eighth day (this is a new cost-sharing mechanism as the employer did not participate previously) and the EHIF starts to pay the benefit from the ninth day (previously it paid from the second day). In addition, the rate of sickness benefit was reduced from 80% to 70% of the insured person's income. The sickness benefit rate in the case of caring for a child aged under twelve was reduced from 100% to 80%. The maximum length of maternity leave was reduced from 154 days to 140 days. In 2010, the measures on short-term sick leave benefits produced savings of EEK1.1 billion (€71 million) when compared to 2008.

Secondly, before 2009 all insured persons aged 19 years and over could apply for the dental care benefit of EEK300 (€19.18), but from 2009, only insured persons over 63 years of age and those eligible for a work incapacity pension or an old-age pension retained this right. The savings from these measures were €3.6 million in 2010 using 2008 as the base year.

Services also have been subject to some rationing through increases in official waiting times: maximum waiting times for outpatient specialists' visits increased in March 2009 from four to six weeks. Other policies that had been common before the crisis and that focus on health promotion and prevention include rises on VAT on alcohol, which saw a greater than average increase in 2008, and an increase on tobacco VAT in 2011.

Policies affecting the costs of publicly financed health care

Taking the opportunity to implement policies that already had been foreshadowed, in March 2010 MOSA amended the ministerial decree on drug prescriptions to support active ingredient-based prescribing and dispensing. The amendment did not change prescribing rules, but does require pharmacies to

provide patients with the drug with the lowest level of cost sharing and to note if patients refuse cheaper alternatives. Furthermore, in April 2010 the Health Insurance Act was amended to extend the application of price agreements and reference pricing to medicines in the lowest (50%) reimbursement category (which contains effective drugs and many less cost-effective drugs). Price agreements previously only applied to drugs reimbursed at higher rates. In September 2010, the EHIF launched an annual generic drug promotion campaign on television and billboards in cooperation with MOSA, the State Medicines Agency and the Association of Family Physicians. In another initiative in 2010, the EHIF and MOSA launched a new e-prescription system, which currently operates alongside paper prescribing. The new system makes active ingredient-based prescribing easier.

In contrast, a direct response to the economic crisis targeted payments to health care providers. In 2009, the EHIF reduced the prices paid for health services by 6%. The objective was to balance the health insurance budget without diminishing access to care. Before the crises, health service expenditures (also prices) increased very rapidly and therefore the 6% cut was not considered a big economic shock for providers. From 2011, the prices of health services were cut by 5% with the exception of primary care where the reduction was lower (3%).

“ in 2009 the prices of health services were cut by 6%

Prospects

Things have improved over the last year. In 2011, EHIF revenues increased by 6% compared to 2010, which was 2% more than forecast. This allowed the EHIF to not use its retained earnings in 2011 and all expenditures were covered by that year's revenues. Moreover, the EHIF's budget

for 2012 has increased approximately 8% compared to 2011, enabling it to restore prices for health services and to add some new services to the benefit package (e.g., liver and lung transplantations).

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GREECE: THE HEALTH SYSTEM IN A TIME OF CRISIS

By: **Daphne Kaitelidou** and **Eugenia Kouli**

Summary: The international financial crisis has had a tremendous impact on Greece's economy, exacerbating existing problems. The health sector has been seriously affected by the economic situation, and the two Memorandums of Understanding that Greece has signed since 2010 dictate a series of measures that focus on the reduction of public expenditure. A broad range of health care reforms and policies have been implemented, which represent the biggest shakeup of the health care system in decades. Irrespective of their positive policy goals, these measures have started to affect public access to the health care system and to increase the financial burden on patients.

Keywords: *Economic Crisis, Austerity Measures, Health System Reform, Greece*

Even before the advent of the global economic crisis that has had such a devastating effect on Greece, the country's health care system had been in a state of continuous crisis and in urgent need of deep structural reform. For over three decades, the main problems have included: a fragmented administrative and provision framework; low levels of public expenditure; significant private sector and out-of-pocket spending on health services by households; skewed human resource allocation; and a low level of primary care. In addition, the health sector faced economic difficulties even before the current crisis, with a large accumulating deficit and high recurrent costs. In the past, several ambitious reform attempts failed repeatedly owing to an array of interrelated economic, political and social factors that favoured the status quo.¹ In particular, powerful entrenched groups, such as doctors and civil servants, have

persistently safeguarded their professional interests and acted as major obstacles to reform.²

In May 2010, Greece was set under the supervision of the European Commission, the European Central Bank and the International Monetary Fund due to the country's spiralling public deficit and debts that threatened imminent bankruptcy. As part of the deal to secure a rescue package of loans to repay its sovereign debt, Greece signed a Memorandum of Understanding (MOU) that includes a series of health sector measures, focusing especially on the reduction of public expenditure. In February 2012, Greece signed a second MOU, which also included measures targeting the health care system. The main measures are presented below.

Policies targeting financial contributions to the health system

Three major strategies are affecting the resources available to the health system. In the context of the MOUs, public health expenditure must be reduced by 0.5% of Gross Domestic Product (GDP). Consequently, the health budget for 2011 decreased by €1.4 billion, with €568 million saved through salary and benefit-related cuts and €840 million saved through cuts in hospital operating costs.

In parallel, social health insurance (SHI) has been targeted in the cost cutting drive. From 2011, the government's (employer) contribution rate to one of the largest funds, the civil servants' social insurance fund (OPAD), was set at 5.1% of civil servants' salaries, while the contribution rate of the fund's retired employees will be gradually increased from 2.55% to 4% in 2013. Moreover, the contribution of insured people covered by the National Health Services Organisation (EOPYY, the new social insurance scheme covering approximately 95% of the population) for examinations in contracted private diagnostic centres has been set at 15%; prior to the merger of the SHI funds (see below) the contribution rate fluctuated between 0% and 25%, with almost 60% of the population paying no contribution for such examinations.

Thirdly, user charges have increased in an attempt to bolster the revenues of public facilities. From 2011, the examination fee in out-patient departments of National Health Service (NHS) hospitals and primary care health centres increased from €3 to €5, with exemptions for certain vulnerable groups.

Policies targeting volume and quality of care

Since June 2011, the benefit packages of the various SHI funds have been rationalised and unified to provide the same reimbursable services across all health insurance funds. As mentioned above, this process coincides with the effective merger of the health divisions of the four largest SHI funds (IKA, OGA, OAEE and OPAD, covering salaried employees, agricultural workers, the self-employed and civil servants, respectively)

under the newly created EOPYY. An example of this rationalisation process is the removal of some expensive examinations (e.g., polymerase chain reaction (PCR) test and thrombophilia screening) from the EOPYY benefit package. Such diagnostic tests used to be covered on an out-patient basis, even partially, but now they must be paid for out-of-pocket.

the health budget for 2011 decreased by €1.4 billion

Regarding quality of care, significant increases in the number of admissions to public hospitals have been reported (at least 24% in 2010 compared with 2009)⁹ and 8% in the first half of 2011 compared with the same period in 2010.¹⁰ As a consequence, it is estimated that waiting times also have increased. According to the General Secretariat of the Ministry of Health (MoH), out-patient visits to public health centres also increased by 22% in 2011 compared to the previous year. Although there are no official data, health care personnel verify the extended use of public services. Thus, these increases in the volume of patients in public facilities may have an adverse effect on the health system's capacity to maintain standards of care.

However, considerable efforts also have focused on preventive action. For the period 2008–2012, quite a large number of health promotion initiatives have been established in the areas of cardiovascular disease, cancer, obesity, nutrition, oral health, and maternal and child health. A smoking ban in public places also has been implemented.

Policies affecting the costs of publicly financed health care

Not surprisingly, the different cost-centres of the health system have been targeted in an attempt to reduce expenditures. Firstly, from 2011, cuts in the salaries of health

care personnel have been implemented. For example, nurses' salaries have been reduced by 14% compared with 2009.

In addition, temporary staff employed under fixed-term contracts have not had their contracts renewed and there has been a significant reduction in the replacement levels of retiring staff (for every five people retiring only one will be appointed).

Secondly, policies are focusing on the cost of medical products, particularly pharmaceuticals. The MOU aims to save €2 billion from pharmaceutical products (with a target of €1 billion in 2011), thus reducing pharmaceutical expenditure by 1% of GDP. According to estimates, pharmaceutical expenditure fell from €5.4 billion in 2010 to €4.4 billion in 2011 and, assuming targets are achieved, it is expected to fall even further in 2012¹¹, with a savings target of close to €1 billion in 2012 compared to 2011.

Moreover, from 2011, a positive list for reimbursable medicines was reintroduced (it was abolished in 2006) with a focus on generics. In parallel, the increased use of generics is being promoted in public facilities, with a policy that at least 40% of medicines used in public hospitals should be generics. In March 2012, a new law was passed stating that from 1 July 2012, doctors should prescribe by active substance rather than brand. In another complementary measure included in the second MOU, the maximum price of generic medicines cannot exceed 40% of their equivalent branded drugs. There also has been a reduction in value-added tax (VAT) for medicines (from 11% to 6.5%) to reduce prices for both citizens and health insurance funds. Finally, e-prescribing has been made compulsory (from 1 July 2012) and must include at least 90% of all medical activities covered by the health insurance funds (medicines, referrals, diagnostics, surgery). In terms of general procurement procedures in public hospitals, MoH data¹² show that a 21% reduction was achieved in 2011 (compared with 2010) on expenditure on pharmaceuticals, orthopaedic supplies, medical supplies, consumables and chemical agents.

A third category of cost saving measures has affected provider payments. A new pricing system for hospitals has been developed, based on Diagnosis Related Groups (DRGs), which will be used for setting hospital budgets from 2013. The other area of focus is pharmacies, with a reduction in pharmacists' profits of 15% to 20% and the establishment of a rebate system for sales over a predetermined threshold, from 2011. This has been accompanied by measures to liberalise the pharmacies market to introduce greater competition – pharmacies will be able to have more than one pharmacist working there and new pharmacies can be established in closer proximity to each other.

allow
the expansion of
private clinics
to build
infrastructure

Fourthly, other measures have focussed on provider infrastructure. From 2011, a series of hospital mergers and closures have been planned, including merging hospitals run by SHI funds and those owned by the NHS. Efforts so far have focused mainly on administrative mergers of adjacent hospitals and merging similar departments within the same hospital. In addition, new measures in the 2011 Health Law allow the expansion of private clinics to build infrastructure, develop new departments, units and laboratories, and expand the stock of hospital beds, within certain defined limits.

Fifthly, structural reforms aim to achieve significant efficiencies. The 2011 Health Law provided for the establishment of EOPYY as the country's primary health care body, under the supervision of the Ministries of Health and Social Solidarity and Labour and Social Security. Although EOPYY is now operating, there are still administrative difficulties that inhibit its full functioning. The aims of EOPYY are to coordinate primary care, regulate

contracting of health care providers and set quality and efficiency standards, with the broader goal of alleviating pressure on ambulatory and emergency care in public hospitals. As mentioned above, the health divisions of the main SHI funds have been transferred and are being integrated into this organisation.

Another significant development has been greater decentralisation. The "Kallikratis" Plan, introduced in June 2010, created thirteen regions to replace 76 prefectures and Greece's 1034 municipalities were reduced to less than 370. Under this re-organisation, regional health authorities are expected to play a much greater role in managing and organising the human resources of the NHS.

Prospects

The Greek health care system is currently navigating through a time of heightened crisis. The negative repercussions of this crisis have already led to increased demand for services – for example, admissions to public hospitals have increased. In particular, rising unemployment has led to falls in household income, resulting in patients seeking services covered by SHI rather than paying privately. This process will lead to additional pressures on the public health system, which is already overloaded. In addition, unemployment negatively affects the revenues of SHI, reducing the contributions of both employers and employees dramatically, and leading to larger deficits. Thus, the deficits of public hospitals and SHI funds are expected to increase, potentially affecting the quality of health services and patient satisfaction with these services. Moreover, austerity measures, particularly those that hit people directly, such as salary cuts for public sector employees, are deeply unpopular. The situation raises a number of concerns, namely that public access to the health system could worsen; the burden on family budgets could increase; the provision of health services could deteriorate; and private capital in the health sector could expand without adequate monitoring.

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A WINDOW FOR HEALTH REFORMS IN THE CZECH REPUBLIC

By: Tomas Roubal

Summary: While the Czech Republic has not been as exposed to the ill effects of the global economic crisis as other countries, its export-driven economy was hit by a fall in demand from its main trading partners. In parallel, accession to the EU strengthened government initiatives for much needed structural reforms in the health sector to cut unsustainable expenditure growth and to make it more efficient. The economic downturn, along with more limited public resources, has provided a unique opportunity for reforms that have been politically difficult to implement in the past.

Keywords: *Economic Crisis, Cost Saving, Health System Reform, Czech Republic*

The Czech Republic has had one of the most stable and prosperous economies in Central and Eastern Europe (CEE), particularly after joining the European Union (EU). Having learnt lessons from a smaller-scale financial crisis in the late 1990s, the country has exercised caution in the financial sector and its stable banking system has not been as exposed to the ill effects of the global economic crisis as other countries. However, the country's export-driven economy was hit by a fall in demand from its main trading partners, particularly Germany. As a result gross domestic product (GDP) fell by 4.1% in 2009, although it has slowly recovered since then, with GDP growth returning to positive, albeit moderate, values in 2010 (2.6%) and 2011 (1.7%).¹ The registered unemployment rate was 8.6% in 2011.² The country's public debt, at 40.5% of GDP in 2010, is among the smallest in the CEE.³

Accession to the EU strengthened government initiatives for much needed structural reforms, particularly within the pension and health care systems, to cut unsustainable expenditure growth and to make them more efficient. While

the country's health insurance funds had relatively high reserves, which were built up during the economic boom of the early 2000s, these reserves have slowly been depleted (although there are significant differences among the various funds). Moreover, the health care system previously had recourse to European structural and other funds, which are no longer available. Thus, taken together, the economic downturn, along with more limited public resources, have provided a unique opportunity for reforms that have been politically difficult to implement in the past, during times of abundance. Below, some of the main reform measures implemented since 2008 are presented.

Policies targeting financial contributions to the health system

While the Ministry of Health's (MoH) budget does not represent total public spending on health, it still suffered a cut of CZK2 billion (€81 million) in 2010, a decrease of 30% compared to 2008. In terms of social health insurance contributions there was no nominal increase in health insurance funds'

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revenues from 2008 to 2010 due to increased unemployment and decreased salaries. There are plans to raise the premiums for the self-employed to equalise the current disparities with salaried employees and to slightly raise the premium payment ceiling to increase contributions from higher earners. These measures are to be implemented in the near future. In terms of wider fiscal policy, in 2011 the government was considering earmarking some taxes for health financing, given that higher value-added tax on goods and services has negatively impacted on health care providers. However, no decision has been made yet.

“the economic downturn is a unique opportunity to implement politically difficult reforms

Cost shifting to households also has occurred through increases in user charges. From 2012, user charges for hospital inpatient stays have increased from CZK60 to CZK100 (from €2.40 to €4.00) per day. Moreover, new legislation enabled providers to charge fees for services that have the same medical outcome but are economically more costly than other comparable treatments. This concerns mainly more ‘luxurious’ services such as lightweight plasters, laser treatment to remove varicose veins, better quality lenses, and joint replacements (with the standard of clinical care remaining the same as that provided under the social health insurance system). Another measure that has had an indirect impact on patients is the MoH’s decision to cut the insurance funds’ reimbursement rate for prescription drugs

by 7% between 2009 and 2011. Patient co-payments for such medicines increased in cases where the importer/producer did not reduce its wholesale prices accordingly, or where pharmacies did not decrease their margins.

Policies targeting volume and quality of care

In terms of population coverage, 2011 saw a rise in the minimum level of health coverage for high risk conditions for foreign citizens residing in the country and responsibility for coverage was transferred to private insurance (resulting in higher premiums for foreigners).

In addition, longer term strategies are targeting the scope of the benefits package. From 2012, the list of reimbursed services will undergo Health Technology Assessment (also incorporating evidence from abroad) which may lead to a better definition of the basic benefit package. In parallel, the dissemination of clear information to patients on reimbursable services will be improved from 2012. Previously, many procedures were reimbursed at the physician’s discretion. Greater clarity is expected to rationalise the list of services reimbursed by social health insurance and thus may result in a reallocation of health expenditure from public to private (out-of-pocket) sources. However, out-of-pocket expenditures overall should not exceed 20% of health care expenditures.⁵ Another cost-saving measure introduced in 2011 focused on the mandatory use of positive lists for reimbursable drugs for MoH providers (for example, university hospitals, which have a 50% market share). Previously, the use of such lists was voluntary – and further positive lists are planned for other medical materials in 2012; these will be applied more broadly to other inpatient facilities.

Finally, more efforts are targeting health promotion and prevention, in particular with regard to changing lifestyle behaviours. Specifically, increases in consumption taxes on tobacco and alcohol are planned for 2013.

Policies affecting the costs of publicly financed health care

There has been a raft of policies geared towards reducing costs and introducing greater efficiencies in health care. Firstly, as part of a wider public sector savings drive, 2009 saw a 10% cut in expenditure on the salaries of public administration employees, including those working in the health sector (except health professionals such as physicians and nurses). Physicians were threatened with salary cuts resulting from proposed payment reductions to hospitals but they resisted (20% of them handed in their notice).⁶ As a result, the insurance funds did not reduce payments and salaries did not decrease. On the contrary, the MoH signed a memorandum of understanding with the hospital labour unions stating that physicians’ wages will rise over the next two years. However, part of the negotiation was that physicians accepted other health sector reforms which were implemented in 2011, including a freeze on hospital expenditures and the introduction of a Diagnostic-Related Groups (DRG) payment system.

“a decrease in health insurance funds’ revenues from 2008 to 2010

Providers have been made a particular focus of reforms. As already mentioned, in 2010 the budget for the reimbursement of hospitals by insurance funds was frozen. Furthermore, a change of hospital reimbursement mechanisms, from global budgets towards DRGs, is being implemented from 2012. In parallel, the restructuring of inpatient beds is being analysed with a view to decreasing the number of costly acute care beds and increasing the number of beds for follow-up care (and long-term care) in cooperation with the social sector. In

addition, new legislation on personnel and technical requirements has taken account of technological developments in medicine that make it possible to have a lower physicians per bed ratio and allows for the transfer of more competences to non-physicians. In the longer term, these developments could have a positive financial effect on providers, although quality concerns can arise and should be closely monitored.

A third group of measures has been introduced to try to reduce the cost of medical products. A simplified approval process for generic drugs to enter the Czech market was introduced in 2010, with further measures planned for 2012, while auctions for purchasing new medical equipment were introduced in 2011.

Finally, at the structural level, a change in law has occurred to enable the merger of social health insurance funds in order to create greater economies of scale and to improve efficiency; this process has already begun.¹ To bolster this effort, the government introduced a one-time redistribution of reserves between insurance funds which brought CZK4.5 billion (€180 million) into

the system but it also had the result of depleting nearly all reserves. A further reform initiative to improve insurance funds' management structures is planned for 2012.

Prospects

The revenues of the Czech health care system are closely linked with the economic situation, mainly through wages and health insurance contributions. In these times of economic downturn there is no possibility of increasing payments from the public budget and now health insurance funds' reserves are more or less depleted. Thus, the only way forward is to increase efficiency. In pursuing cost-saving measures, the government should look closely at the equity and quality implications of changes so that reforms do not negatively affect the population which, in the longer term, would decrease the country's economic potential.

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New Observatory publication

Governing Public Hospitals

Reform strategies and the movement towards institutional autonomy

Edited by: Richard B Saltman, Antonio Durán, Hans FW Dubois

European Observatory Study Series No. 25

Copenhagen: World Health Organization, 2011

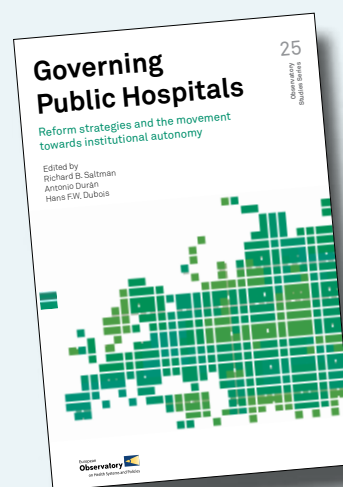
Number of pages: 259

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The governance of public hospitals in Europe is changing. Individual hospitals have been given varying degrees of semi-autonomy within the public sector and empowered to make key strategic, financial and clinical decisions. This study explores the major developments and their implications for national and European health policy.

The study focuses on hospital-level decision-making and draws together both theoretical and practical evidence. It



includes an in-depth assessment of eight different country models of semi-autonomy. The evidence that emerges throws light on the shifting relationships between public sector decision-making and hospital-level organisational behaviour and will be of real and practical value to those working with this increasingly important and complex mix of approaches.

Part I of the volume analyses the key issues that have emerged from developments in public-sector hospital governance models and summarises the general findings. Part II looks in detail at hospital governance in eight countries.

THE PROPOSAL FOR THE PROFESSIONAL QUALIFICATIONS DIRECTIVE – THE **PATIENT PERSPECTIVE**

By: Rachel Seal-Jones and Jeremiah Mwangi

Summary: The new proposal for the Professional Qualifications Directive will increase the mobility of professionals, including health care professionals, when moving between Member States. Although increased mobility can prevent shortages of skills gaps in health care systems, without sufficient measures to protect patients, patient safety and quality of care could be compromised. This article outlines the International Alliance of Patients' Organizations' perspective on the proposal and examines how patient safety legislation can be strengthened. Ultimately, for a modernised Directive to be workable, it is essential that patients continue to be involved in its development and implementation.

Keywords: *International Alliance of Patients' Organizations, Patient Safety, Quality of Care, Mobility of Health Care Professionals*

Introduction

The proposal to modernise the Professional Qualifications Directive contains significant changes to improve the mobility of professionals, including health care professionals, throughout the European Union (EU). Enabling the mobility of health care professionals can have great benefits to health care systems. Shortages of health care workers impact on the effectiveness of health care systems to deliver high quality care and have detrimental effects on patient care. Therefore, addressing the mobility of health care professionals is an important step in preventing shortages in skills gaps in health care systems and maximising patient care. Additionally, modernising

the Directive has the potential to raise professional and training standards in many countries across the EU. However, the mobility of health care professionals carries with it a risk to patient safety and quality of care if there are not sufficient measures in place to ensure that health care professionals have the qualifications and skills needed to practice in a particular health care system.

The International Alliance of Patients' Organizations (IAPO)

The International Alliance of Patients' Organizations (IAPO) is a global alliance that promotes patient-centred health care around the world

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(www.patientsorganizations.org). Its members are patients' organisations and patient-centred organisations of all nationalities across all disease areas that are working at the international, regional, national and local levels to represent and support patients, their families and carers. IAPO believes that for health care to be truly patient-centred, patients' needs and preferences need to be aligned with health care systems globally

“It is essential that all relevant stakeholders, including patients, are involved in the process”

When reviewing health care policy proposals, IAPO refers back to the core principles outlined in the IAPO Declaration on Patient-Centred Healthcare.² These principles of respect, choice and empowerment, patient involvement in health policy, access and support, and information should be foremost in policy-makers' minds when making decisions that affect the care patients receive. It is these principles that guide IAPO's comments on the proposed changes to the Professional Qualifications Directive.

In March 2011, the European Patients' Forum (EPF), IAPO's European sister organisation, set out its position on the proposed review of the Professional Qualifications Directive from the patient perspective.³ This position was endorsed by IAPO. Additionally, IAPO members, the Nursing and Midwifery Council (NMC) in the UK and the Patients Association, also based in the UK, have commented on the mobility of health care professionals in relation to changes in the Directive. All three of these organisations

have highlighted the importance of patient safety in their responses. To IAPO, this proposal is a vital opportunity to strengthen patient safety and ensure the highest possible quality of care for patients in the EU.

European professional card

The European Commission has proposed the introduction of a European professional card to facilitate the mobility of professionals wishing to work in another Member State through a streamlined administration process leading to faster recognition of the professional's qualifications. Additionally, the Commission believes that the card will increase confidence and transparency for Member States, employers and consumers.

The card will take the form of an electronic certificate which will allow professionals to provide services and to establish themselves in another Member State, with competent authorities in the home Member State assuming responsibility for creating and validating the card. Under the proposed system, the use of the Internal Market Information System (IMI) will become compulsory, as it will serve as the administrative basis for the exchange of information needed to validate the card. The Commission argues that this is essential for the effective functioning of the card and will further speed up recognition and increase confidence in the card.

The European professional card's introduction depends on whether professionals request it. The Commission has stated that the advantages of having the card will lead to more professionals requesting it. IAPO believes that this could lead to confusion for patients. The non-compulsory nature of the card will inevitably lead to some professionals having the card and others not having the card. The card may undermine patient confidence if it is perceived as a less stringent process, prioritising the mobility of health care professionals over patient safety. It could also work the other way, with patients being under the false impression that those without the card

are unfit to practise, as highlighted by EPF in their response to the Directive's Green Paper.⁴

There has been considerable opposition to the card on patient safety grounds. Health care professionals, regulators and patient groups have all expressed concern that such a system would be vulnerable to misuse and fraud. Some of these concerns will be addressed through the card's integration with IMI as outlined in the proposals. However, the Commission needs to provide a stronger assurance that the card will provide up-to-date information and explain how the card will be withdrawn in cases of misconduct. Additionally, the Commission has not clarified who will be able to access the card and whether the information on the card will be available to patients. If not, then it is unclear exactly how the card will increase transparency for patients. IAPO believes, as does EPF, that a better way to achieve greater transparency would be to publish an online database of health care professionals eligible to practise that is accessible to members of the public. One example of this kind of database is already operational in the UK through the General Medical Council (GMC).

Internal Market Information System

The proposal obliges national competent authorities to alert each other in cases where a health care professional benefiting from automatic recognition under the Directive is prohibited, even temporarily, to practise the profession.

IAPO believes this is an important step forward in the area of patient safety. Though not made explicit in the proposal, the alert should be closely linked to the card and assurances made that where an alert is issued on a professional, their card is suspended immediately. NMC also support such an alert system and state that: “the alert [should] be triggered for all sanctions which affect a professional's registration, not only where they have been banned from practising”.⁵ IAPO agrees with this statement and with EPF that a common definition should be developed of the criteria on the circumstances under which such as an alert would be initiated. This will help ensure that a robust and

consistent alert system that adequately protects patients is implemented across all Member States.

Partial access

The principle of partial access allows for a professional's activities to be limited to those reflected in the qualification gained in their home Member State. In the Green Paper, it was proposed that the principle of partial access could be extended to health care professionals. However, patient groups, health care professionals and regulators have opposed this extension on the grounds that it would: pose a considerable threat to patient safety; undermine minimum qualification levels; be impractical; and create confusion for patients, employers and regulators. IAPO is pleased that the new proposal asserts that the principle of partial access will now not apply to health care professionals. The exclusion of health care professionals from partial access is essential to protect patients, ensure high quality care and to increase transparency and confidence in health care systems across the EU.

The general system

The general system applies to professionals not covered by automatic recognition. In health care, this applies to professions such as psychologists and physiotherapists. Article 11 of the Directive stipulates five levels of qualifications which are based on the type and duration of training. When a professional applies for recognition of their qualifications for a profession under the general system, the competent authority uses these levels to determine whether or not the applicant can benefit from the Directive. Under the current system, where there is a difference of two or more levels between the qualification of the professional and the qualification required in the host Member State, the professional cannot benefit from the Directive. The proposal states that the qualification levels should be used as a benchmarking tool only and not as a basis for excluding professionals from the Directive.

IAPO believes that qualification levels are an important indicator for competent authorities and employers to judge whether a professional has the skills and

experience needed to practise. Using qualifications as benchmarking exercises only could have serious ramifications for patient care and compromise the safety of patients. This view is shared by the NMC which “strongly opposes the idea that no level should be used when comparing qualifications”.¹⁴ Such changes would undermine transparency and create an unclear system as regulators may be unsure what criteria they can use to assess whether a health care professional is fit to practise.

“ it is crucial that health care professionals demonstrate that they have the right to practice in their home Member State

Automatic recognition

The Directive provides a set of minimum conditions for the training of some professionals across the EU, including some health care professionals such as doctors, general care nurses, midwives, pharmacists and dentists. Member States are required to recognise professionals from other Member States upon presentation of qualifications which satisfy minimum training conditions in the Directive. These minimum training requirements are currently the sole basis for automatic recognition of the qualifications of these professionals.

In the case of temporary provision of services, professionals are obliged to demonstrate that they have the right to exercise in their home Member State and are not prohibited from practising the profession. There is no explicit provision for a similar requirement where a

professional wishes to establish themselves in another Member State, which poses a threat to patient safety. IAPO believes that it is crucial that health care professionals who wish to establish themselves in other Member States demonstrate that they have the right to practise in their home Member State in order for them to be recognised. This principle should apply to both temporarily mobile professionals and those wishing to establish themselves in another Member State.

Under the current framework, any individual who meets the minimum training requirements can have their qualifications automatically recognised, regardless of when the qualification was awarded. This has created situations where the NMC has had to register a nurse who had not practised for 20 years but benefited from automatic recognition rights.¹⁵ IAPO, along with EPF and the NMC, believe that that this is unacceptable and that continued professional development requirements should be addressed in the revision of the Directive. Furthermore, if the Commission does review these minimum training requirements, it is essential that all relevant stakeholders, including patients, are involved in the process.

Changes to minimum training requirements

The modernisation of the Professional Qualifications Directive provides an important opportunity to review and amend minimum training requirements and training durations. Current training requirements do not represent modern medical practice and automatic recognition assumes a comparability of training which is not always the case, with standards of training varying significantly across the EU. Under a modernised Directive, qualifications should no longer be the only indicator and a set of practical competencies should be developed alongside minimum training requirements. Practical competencies should include communications and team work skills to ensure that health care professionals have the skills they need to effectively communicate with and work with patients. These competences should be developed in consultation with all relevant stakeholders, including patients,

and automatic recognition should depend on professionals meeting both minimum training requirements and a set of practical competencies.

“the Directive can be used to drive up standards in health care across the EU

In the proposal there are changes to the professional requirements for some professions. Notably, the proposal increases the number of years that general education nurses and midwives need to benefit from automatic recognition from ten to twelve years. IAPO welcomes this increase, as it recognises the high level of skills needed for nursing and will result in higher quality of care for patients across Europe. This is an excellent example of how the Directive can be used to drive up standards in health care across the EU which can lead to improved outcomes for patients.

Language requirements

Language skills are essential to all health care professionals and especially for health care professionals that are in direct contact with patients. The proposal clarifies that the checking of language knowledge is to take place only after the host Member State has recognised the qualifications. In the case of health professionals, it also specifies that it is up to the health care system and patient organisations' to check whether competent authorities should carry out language controls where strictly necessary. IAPO believes that language skills are essential to ensure a high quality of patient safety. It is essential that patients are able to communicate with their health care professional to ensure that patients feel empowered and are able to understand the information they receive from their health care professional and are able to make informed decisions about the care

they receive.¹ It is also essential that health care professionals who are not in direct contact with patients have adequate language skills. Medical error can happen anywhere in the health care system and communication between health care professionals is of crucial importance.

Conclusion

A modernised Directive must balance the need to ensure that health care professionals are able to move between Member States with relative ease, ensuring that quality of care and patient safety are not compromised. This can be achieved by ensuring that minimum training requirements are assessed and amended to meet modern medical practice and ensuring that health care professionals have the language skills needed to communicate effectively with patients. Moreover, it should be ensured that the European professional card is integrated with IMI and is an effective tool to increase transparency and enhance patient safety and not just a means to improve mobility.

To make a modernised Directive workable, patients must continue to be involved in its development and implementation. It is also

essential that patients are involved in the monitoring and evaluation of the Directive. This will ensure that the Directive will meet the objective of facilitating greater mobility for health care professionals while guaranteeing patients receive safe, high quality, patient-centred health care.

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New HiT – Health system review on Hungary

By: Péter Gaál, Szabolcs Szigeti, Márton Csere, Matthew Gaskins and Dimitra Panteli

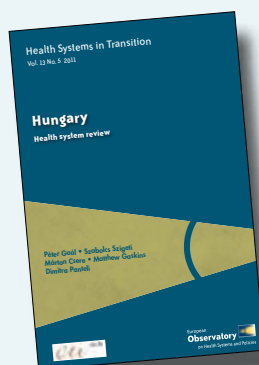
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The new HiT on Hungary provides key information on all aspects of the health care system, including the unitary health insurance system, out-of-pocket payments, health care delivery by both public and private providers and attempted reforms.

Despite significant improvements in recent years, many health outcomes remain poor when compared with European Union averages. Lifestyle factors – especially

the traditionally unhealthy Hungarian diet, alcohol consumption and smoking – play a very important role in shaping the overall health of the population.

Having achieved a successful transition from an overly centralised, integrated Semashko-style health care system to a purchaser–provider split model with new payment methods, challenges with sustainable health care financing remain. Since 2004 a variety of reforms aimed at reshaping the stewardship and organisation of the health care system have been attempted with varying success.



THE EVOLUTION OF OBESITY IN SPAIN

By: Manuel García-Goñi and Cristina Hernández-Quevedo

Summary: Considered the epidemic of the 21st century, obesity is a worldwide problem, affecting 260 million adults and 12 million children in the European Union (EU) alone. In Spain, adult and child obesity rates are increasing, in particular for women. Income-related inequalities in adult obesity in Spain also have increased over time, especially for women aged over 45. Although some regulatory initiatives have been approved to tackle child obesity, an evaluation of the effectiveness of alternative measures in other countries, such as “fat taxes” and improving education and availability of information for the population, would provide a better understanding of their application in the Spanish context.

Keywords: Obesity, Female, Child, Inequalities, Spain

The prevalence of chronic conditions increases with age, and it is estimated that before 2030, chronic diseases will account for 70% of the global disease burden and will be responsible for 80% of deaths across the world.¹ Although women present lower rates of mortality, there is a perception that they suffer higher levels of depression, psychiatric disorders, distress and a variety of chronic illnesses compared to men.²

Here, we focus our attention on obesity, which is one of the chronic illnesses considered to be the epidemic of the 21st century by the World Health Organization, given its impact on morbidity, quality of life and health care expenditure.³ Recent data for 2010 from the International Obesity Task Force (IOTF) illustrate the worldwide dimension of the problem: 1 billion adults are overweight and around 475 million are obese. The IOTF estimates that around 200 million children of school aged five to seventeen are overweight,

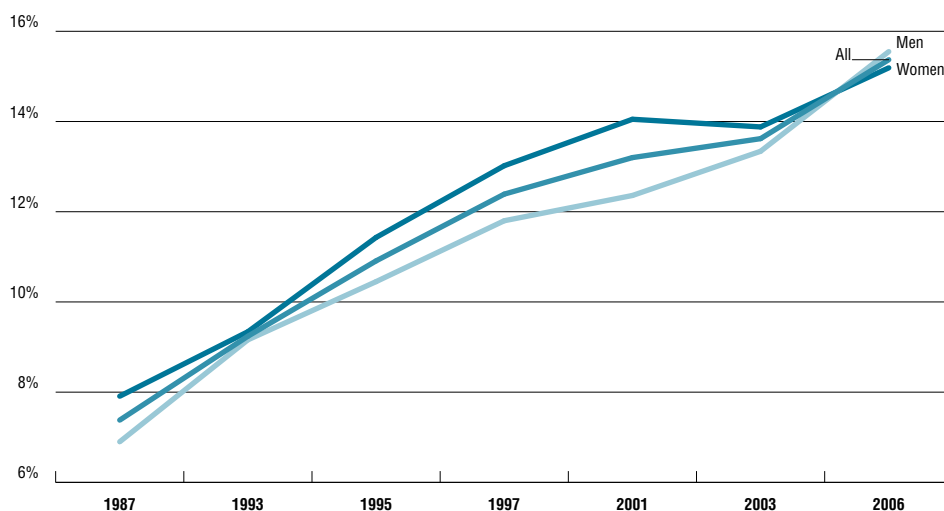
of which 40–50 million are classified as obese. In the European Union, approximately 50% of adults and more than 20% of children of school age are overweight or obese, corresponding to 260 million adults and more than twelve million children.

Spain is not an exception in the European context. According to the World Health Organization, Spain is one of the countries in the EU with the greatest prevalence of overweight (and obese) children. In addition, Spain is one of the countries where this condition has increased more substantially.⁴

Trends and inequalities in obesity in Spain

Evidence from the Spanish Health Survey shows how obesity prevalence, measured as a Body Mass Index greater than 30 kg/m², has substantially increased over time for the population aged over sixteen (see Figure 1). Although initially,

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Figure 1: Prevalence of obesity in adults in Spain by gender, 1987–2006

Source: [5]

in 1987, there was a higher prevalence of obesity for women compared to men, a trend maintained throughout most of the period considered, in 2006, the prevalence rate was slightly lower for women compared to men. [5] However, as these data are self-reported, they may not be providing the true picture. As Gil and Mora [6] show, self-perceived weight is underestimated, especially among women, and the size of that bias could be interpreted as the degree of women's dissatisfaction with their own body image.

“significant inequalities in obesity suffered by women aged 45 or under”

In Spain, not only do women present a higher prevalence of obesity over time, but being female is also relevant when inequalities in obesity are measured. A recent study by Costa-Font et al. [7] has shown evidence of income-related inequalities in obesity in Spain for the years 1987 and 2006, although patterns differ by gender and age groups. Inequalities in obesity for both men

and women are concentrated among the poorest individuals in society, especially among women, for whom inequalities have tripled during the period of study. Results by age group confirm that the above patterns remain for all subgroups, with significant inequalities in obesity suffered by women aged 45 or under in 2006. Hence, women at the bottom of the income distribution scale, aged 16–45, suffer more from obesity. Results also show that while income-related inequalities were similar for both men and women in 1987, by 2006, their magnitude had remained relatively stable for men while for women, these inequalities nearly tripled. Moreover, compared to men, the inequalities for women in 2006 were three times higher (see Figure 2).

These results are in line with results obtained for other countries such as England, where there is evidence of income-related inequalities in obesity for both women and men during the period 1997 to 2007. In England, the magnitude of income-related inequalities in health for female individuals was three times higher than for men in 1997, and they have not decreased over time, while for men, income-related inequalities in obesity are no longer significant. [8]

Whether these inequalities are persistent over time and hence, are also shown by children in Spain, is of special interest as the prevalence of obesity in children is the most important determinant of the

prevalence of obesity in adults. Spain presents the second highest prevalence of both obesity and being overweight in children in Europe. [9]

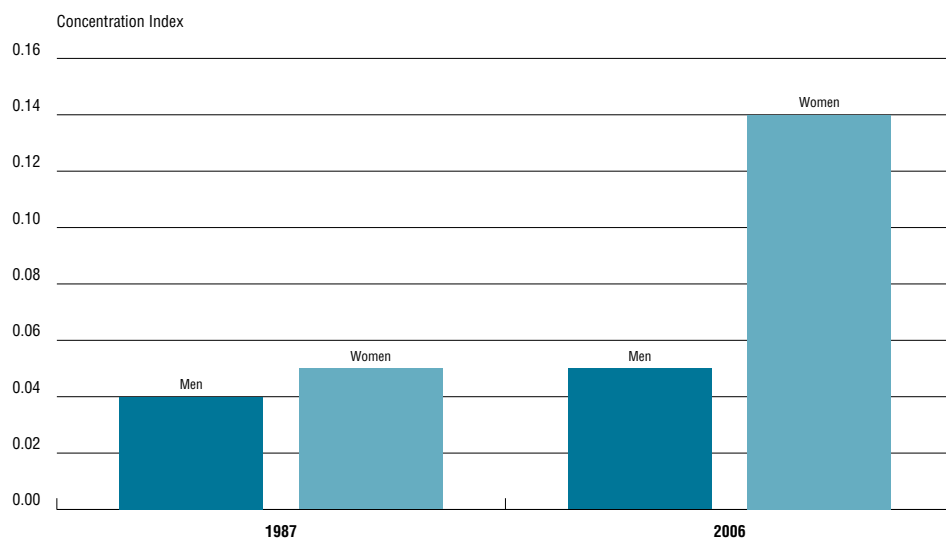
Child obesity trend in Spain

There have been a few studies providing data on the prevalence of obesity and overweight children in Spain. Deriving such data is controversial, as the Body Mass Index has to be considered together with both the age and sex of the child. Some studies on child obesity in Spain allow for international comparison following the IOTF methodology. These are the ENKID Programme (1999), developed in the late 1990s, and the PERSEO Programme, with data obtained in 2007 and 2009.

“evolution of obesity in children depending on gender”

These studies give us two important lessons. Firstly, the prevalence of obesity in children has increased in the last decade. Thus, in the Spanish regions for which we have data, the prevalence of obesity was 8.11% for children aged six to nine, and about 7.93% for children aged ten to thirteen in 1999. [10] These rates had increased to 10.79% in 2007, and 9.66% in 2009 for the two groups respectively. [11] Although other sources (albeit no international comparisons are feasible) show that the prevalence rate has stabilised in recent years [12] compared to the rapid increase in earlier decades (from the 1980s) [13], there are increasing concerns in the Spanish public health arena, particularly, as mentioned above, childhood prevalence is a determinant of adult obesity.

Secondly, these studies show the different levels and evolution of obesity in children

Figure 2: Income-related inequalities in obesity in Spain, 1987 and 2006 by genderSource: ⁵

Note: Results from Costa-Font, et al.⁴, are based on the Concentration Index (CI), which is a measure of association between the health-lifestyle variable considered and the ranking of individuals by socioeconomic status. A negative (positive) CI indicates that the lifestyle factor is disproportionately concentrated within the poorest (richest) individuals of the society. Although results are negative for the CIs obtained in Costa-Font, et al.⁴, here we present them in absolute terms to facilitate comparison.

depending on gender. The prevalence of obesity was high in boys aged 6 to 9 and 10 to 13 in 1999 (12.06% and 6.77%, respectively, according to data from the ENKID programme), while its level was significantly lower for girls in those age ranges (7.82% and 2.71%, respectively).⁹ However, about one decade later, according to data from the PERSEO Programme, the prevalence rate for obesity is fairly similar for both boys and girls, having remained stable for boys but increased significantly in the case of girls (11.13% for boys and 10.45% for girls aged six to nine years in the population of reference in 2007; and 10.01% for boys and 9.29% for girls aged ten to thirteen years in the population of reference in 2009).

Hence, since 1999 the child obesity prevalence rate increased substantially, with the exception for boys aged six to nine, especially for girls.

Moving forward

In Spain, a lifestyle change has taken place, together with an increase in the labour market participation of women. This has implied an increase in calorie intake due, among other reasons to the greater use of pre-cooked food or a reduction in its relative price.

Moreover, human energy expenditure has been reduced with less physical effort associated with production processes, the mechanisation of domestic tasks and the availability of transportation that has substituted for walking.

Since the late 1990s, some programmes and strategies have been developed to tackle obesity, such as the NAOS (Nutrition, Physical Activity and Obesity prevention) strategy by the Spanish Ministry of Health. Established in 2005, the strategy focuses on promoting healthy nutrition and physical activity, with special attention given to the lowest socioeconomic groups.

On 16 June 2011, the Spanish Law on Food Safety and Nutrition was passed by Parliament, containing measures related to combating child obesity and promoting healthy diets. Measures include: establishing a legal framework for implementing the NAOS strategy and the creation of an Observatory to study nutrition and obesity. The Observatory is charged with undertaking periodic analysis of the nutritional situation of the population and the evolution of obesity, reporting on policy evolution, providing the required evidence for policy design, and promoting education on nutrition and the benefits of physical activity.

In addition, the Law will establish mechanisms to monitor food served in schools; regulate the type of food and drinks sold in education centres; and facilitate the provision of information on food habits and physical activity by health services. A code of practice that regulates the advertising of food and drinks targeted at children under fifteen also has been implemented.

“reducing the spread of obesity, with special attention to child obesity”

With this Law, Spain has started a regulatory phase with the objective of reducing the spread of obesity, with special attention to child obesity, through educational and health system activities. However, there is a need to complement these measures with decisions at the private level, e.g. within the family environment, and to ensure that the scale of the problem is acknowledged by the population. In this respect, the current regulatory actions need complementary measures in the long-term. If income is a determining factor of the prevalence of obesity, the design of economic policies that promote healthy habits in the lowest income groups are required, and for that purpose, an evaluation of the effectiveness of measures such as the so-called “fat taxes” in Norway, Denmark and the US, should give us some guidance. However, jointly with the influence of inequalities in the distribution of income, inequalities in education are also related to obesity. This is particularly important for women, given that greater educational levels are associated with a lower prevalence of obesity and being overweight, although in the case of men, this relationship is not well documented.¹⁰ Existing evidence tells us two things: firstly, the worse-off are those more affected by the prevalence of obesity; secondly, individuals who

present the lowest level of income also have less information and lower levels of education. These factors may result in increased medical needs and health care utilisation, as well as encountering more barriers to access to health care due to suffering social exclusion. Therefore, policy measures focused on improving education and increasing the availability of information to the population, as well as the use of income redistribution mechanisms, may go some way to contributing to reduce the negative effects of rising obesity levels.

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New Observatory publication

Migration and Health in the European Union

Edited by: Bernd Rechel, Philipa Mladovsky, Walter Devillé, Barbara Rijks, Roumyana Petrova-Benedict and Martin McKee

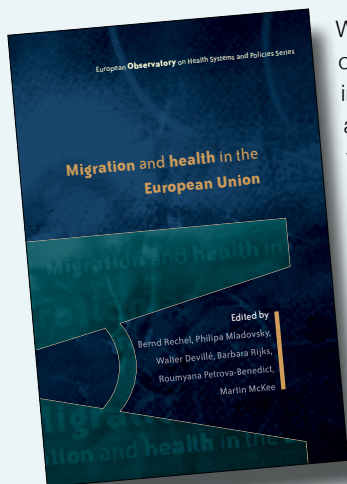
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Written by a collaboration of authors from three key international organisations, as well as leading researchers from across Europe, the book thoroughly explores the different aspects of migration and health in the European Union and how they can be addressed by health systems.

Structured into five easy-to-follow sections, the volume includes:

- Contributions from experts from across Europe
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- Conclusions drawn from the latest available evidence.

“This book provides an ample orientation to the field in the European context. Among other important raised issues, it underlines an all too often neglected fact; health is a human right.

By involving broad issues and problem areas from a variety of perspectives, the volume illustrates that migration and health is a field that cannot be allocated to a single discipline.”

Carin Björngren Cuadra, Senior Lecturer,
Malmö University, Sweden.

DO DANES ENJOY A HIGH-PERFORMING CHRONIC CARE SYSTEM?

By: Cristina Hernández-Quevedo, Maria Olejaz, Annegrete Juul Nielsen, Andreas Rudkjøbing, Hans Okkels Birk and Allan Krasnik

Summary: The trends in population health in Denmark are similar to those in most Western European countries. Major health issues include, among others, the high prevalence of chronic illnesses and lifestyle related risk factors such as obesity, tobacco, physical inactivity and alcohol. This has pressed the health system towards a model of provision of care based on the management of chronic care conditions. While the Chronic Care Model was introduced in 2005, the Danish health system does not fulfil the ten key pre-conditions that would characterise a high-performing chronic care system. As revealed in a recent report,¹ the fragmented structure of the Danish health system poses challenges in providing effectively coordinated care to patients with chronic diseases.

Keywords: Health System, Chronic Illness, Integrated Care, Health Management, Denmark

Increasing health care expenditure is a common trend in many countries. The proportion of gross domestic product (GDP) devoted to health has increased substantially across Europe. The underlying drivers of this escalating trend include: medical innovation, an ageing population and the related high prevalence of chronic diseases. Denmark is no exception. Health care expenditure in Denmark is slightly higher than the average for pre-2004 European Union Member States (EU15) (see Figure 1).

The prevalence of non-communicable chronic conditions, many associated with important changes in lifestyle, is forcing countries to move away from a traditional acute and episodic model of care, as it no longer meets the needs and preferences

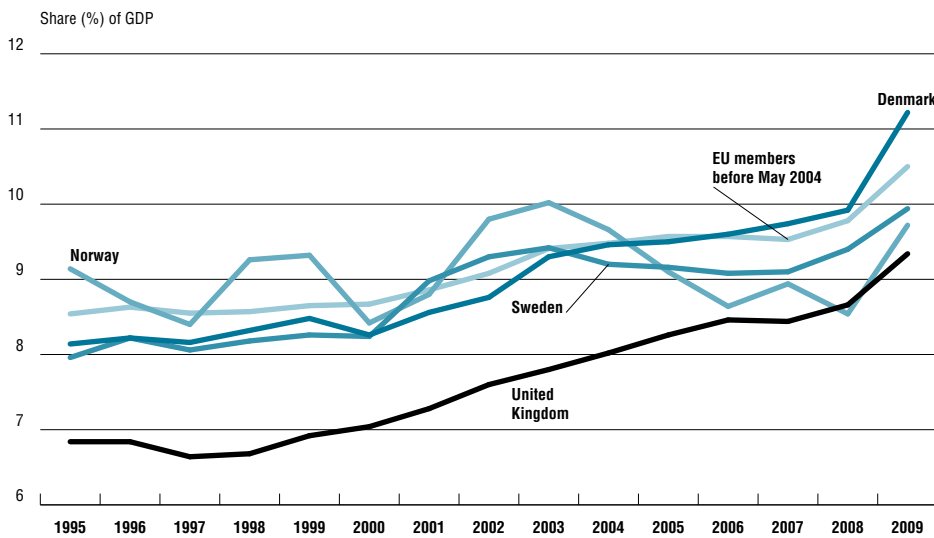
of patients with multiple and chronic disorders. This has been the case in Denmark, where there has been a national call for a paradigm shift in the way health care is organised, with a number of key white papers published by the Danish National Board of Health.²

Health status in Denmark

Throughout the world, chronic conditions are influencing the quality of life of individuals and are challenging health systems. It has been estimated that 70% of the global disease burden in 2030 will be due to chronic diseases, with an increasing number of individuals having multiple chronic conditions in their lifetime.³ Chronic conditions, including some forms of cancer, mental disorders, diabetes,

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Figure 1: Trends in health expenditure as a share (%) of GDP in Denmark and selected countries, 1995–2009



Source: [1]

obesity and pulmonary disorders, are increasing substantially. The World Health Organization estimates that the number of patients with diabetes will double from 2005 to 2030, while obesity has been categorised as a pandemic. [2]

“national call for a paradigm shift in the way health care is organised”

Denmark has also seen an increase in the number of patients suffering from chronic conditions. Danish health status is generally good and there is evidence of a substantial reduction of mortality and morbidity rates in the last two decades. [3] However, the Danish population lags behind compared to other Nordic countries with regard to life expectancy and socioeconomic inequalities in health and also registers worse results for some lifestyle factors with negative health effects.

While 79% of adult Danes perceived their individual health status as “good” or “very

good” in 2005, according to the Danish Health and Morbidity Survey (SUSY), 39.8% of the adult population reported that they suffered at least one long-standing disease. This share was slightly higher for women (41.7%) than for men (37.8%), and increased with age. Among them, musculoskeletal, cardiovascular, and respiratory diseases, as well as diseases of the nervous system and sensory organs, were the most frequent among the surveyed population. [4] A more recent national survey, the National Health Profile 2010, confirmed these trends (see [5] for a detailed explanation of these results).

A rise in the proportion of obese Danish citizens has also taken place, following the European trend. From the late 1980s to 2005, the proportion approximately doubled from 5.5% of the population to 11.4%. The share of people living in Denmark who are moderately overweight (i.e., with a body mass index between 25 and 30) has also increased, with approximately 41% of men and 26% of women characterised as overweight in 2005. By comparison, only 35% of men and 17% of women were overweight in 1987. [6] These results were confirmed by a study conducted in the Central Denmark Region in 2010, which showed an increase in the proportion of the population being

overweight in the period 2006 to 2010 [7], as well as the National Health Profile 2010 which found similar patterns. [8]

Tobacco use in Denmark has been found to be a contributing factor to mortality, causing approximately 14,000 deaths per year and 2,000 deaths related to passive smoking. [9] Alcohol consumption is high in Denmark; in 2008, the average consumption per inhabitant over fifteen years old was 10.9L of pure alcohol. This is similar to the EU15 average (10.8L) but higher than the average for the OCED as well as other Nordic countries. [10]

Tackling chronic diseases in Denmark

The Danish health system is mainly public and financed through national taxes. Although it is traditionally a decentralised health system with primary and secondary care responsibilities allocated locally, several reforms from 2007 have led to a more centralised approach, with a decrease in the number of municipalities and regions (see [11] for details on the reform processes and the different responsibilities of the state, regions and municipalities). Universal coverage is provided by the Danish health system, with all registered residents in Denmark being able to freely access most of the health care services provided – either directly or after referral by their general practitioner (GP). Although pharmaceuticals, dental care and some other services require a co-payment, chronically ill patients can apply for full reimbursement of their drug expenditure above a certain annual ceiling for a permanent or high drug utilisation level (see [12] for more information on user charges in the Danish health system).

The primary care sector in the Danish health system consists of private (self-employed) practitioners and municipal health services, with GPs acting as gatekeepers by referring patients to hospital or specialist treatment. Electronic medical records and integrated information systems have been major priorities in health information technology (IT) strategies since the late 1990s, with the focus on improving IT for chronic care. Electronic medical records are used by all primary care doctors, with 90%

of all clinical communication between primary and secondary care performed electronically in 2010.¹²

Since the late 1990s, different governments have launched comprehensive preventive public health programmes covering specific risk factors (e.g., tobacco, alcohol, nutrition, physical inactivity, obesity and traffic), age groups (e.g., children, young people, older people), health-promoting environments (e.g., primary schools, work places, local communities, health facilities) and structural elements (e.g., intersectoral cooperation, research and education) (for more information on different prevention initiatives through time, see¹³). The main aim of these national public health programmes is to provide individuals with the necessary knowledge and tools to be able to prevent disease, self-manage their chronic conditions and promote their own health status and care. The Healthy Throughout Life 2002–2010 programme is an example of these initiatives (see¹⁴ for a detailed explanation of these and other programmes).

In 2005, the National Board of Health produced a series of recommendations to improve the management of chronic care conditions in Denmark, following the American Chronic Care Model initially developed by Wagner et al.¹⁵ These include: emphasis on self-management support programmes, appropriate organisation of the health service delivery system, the use of decision support tools such as guidelines and disease management programmes, community participation and wide use of health IT, systematic patient education and rehabilitation initiatives, a strong primary care sector, regional coordinators, GPs in a coordinating role, patients stratified according to needs and interdisciplinary health care teams, among others.¹⁶ The regions and municipalities are, at the time of writing, also developing disease management programmes for cardiovascular diseases, chronic obstructive pulmonary disease (COPD) and musculoskeletal diseases.

Since 2006, the Chronic Care Model has been offered in more than 70 (out of a total of 98) municipalities.¹⁷ Different

initiatives to favour continuity within primary care have been implemented, such as pathway coordinators, and a special fee for GPs to act as coordinators of care for specific groups of chronically ill patients (see¹⁸ for further initiatives). New national efforts to provide integrated care have been observed. An example is the integrated cancer pathways introduced in the National Cancer Plan II, from 2007 and implemented by January 2009, which focuses on improving the integration of health care and coordination between departments, hospitals and the primary and secondary sectors.

Risk stratification of chronically ill patients (provided by the pyramid model of US-based Kaiser Permanente) has been of interest to Danish policymakers. The implementation of the model is taking place in all of the regions, but modified and applied according to local needs and settings. The criteria for stratification differ across the five regions and the focus also differs regarding the process (from care to rehabilitation).¹⁹ At the time of writing, the National Board of Health is working on a further development of the stratification criteria, including going beyond strictly medical criteria to psychosocial elements and self-management potentials, among others.

Several national strategies for digitalisation of the Danish health care system are being developed. A common strategy for the use of telemedicine has recently been acquired by the Danish regions, with the task of generalising experience in the use of telemedicine from pilot projects carried out in the different regions. Despite the ongoing development of telecare across Denmark, a new system of electronic monitoring of clinical data for patients with chronic illness, diagnostic measures and interventions in general practice has recently been agreed between the regions and GPs.

A high-performing chronic health system?

Ten key pre-conditions have been identified by Ham²⁰ to characterise a high-performing chronic care system (see Box 1).

The Danish health system satisfies, to some degree, most of the characteristics cited. The coverage of the Danish health system is universal and access is mainly free at the point of delivery. Different national health prevention programmes have been implemented since the late 1990s, as a first step to favouring self-management of chronic conditions by patients. This has been reinforced with the adoption of the chronic care model, allowing for risk stratification of the population, together with some efforts to provide integrated patient pathways.

“ provide individuals with the necessary knowledge and tools to be able to prevent disease

However, the fragmented structure of the Danish health system poses some challenges compared to an ideal high-performing chronic care system. While the primary care sector has traditionally been quite strong with the role of the GP as a gatekeeper and coordinator, patient pathways across primary/secondary care have been criticised for lack of coherence and continuity, due to the lack of appropriate communication systems among providers.²¹ Furthermore, the existence of different electronic health record systems across the country does not facilitate the development of full and functional electronic health record coverage within the health care sector in the near future. The value of initiatives regarding multidisciplinary team work within primary care, including the role of the many new municipal health centres for prevention and rehabilitation, is still uncertain, as are the effects on the quality of chronic care of improvements in communication between the different chronic care providers in primary and secondary services. The evaluation of the

Box 1: Ten characteristics of a high-performing chronic care system

1. Ensuring universal coverage
2. Provision of care that is free at the point of use
3. Delivery system should focus on the prevention of ill-health
4. Priority is given to patients to self-manage their conditions with support from carers and families
5. Priority is given to primary health care
6. Population management emphasised through risk-stratification of chronic ill patients
7. Care should be integrated to enable primary health care teams to access specialist advice and support when needed
8. The need to exploit the potential benefits of information technology in improving chronic care
9. Care is effectively coordinated
10. Link these nine characteristics into a coherent whole as part of a strategic approach to change

Source: ¹⁵

latest strategies designed at national level to favour coordination and integration of the Danish chronic care system would provide some guidance on the way forward.

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This article was largely based on the new **Health System Review for Denmark**.

Freely available for download from www.healthobservatory.eu



THE DUTCH HEALTH INSURANCE SYSTEM: MOSTLY **COMPETITION ON PRICE** RATHER THAN QUALITY OF CARE

By: Anne E.M. Brabers, Margreet Reitsma-van Rooijen and Judith D. de Jong

Summary: Consumer mobility is an important element of the Dutch health insurance system. The idea is that consumers who are not satisfied with the premium or quality of care can switch insurer. One fifth of the population switched insurer in 2006. In 2007–2009 the number of switchers stabilised at around 5%. However in 2011, the premium increased more than in previous years and consequently, the percentage of switchers increased to 8%, showing that the difference in the rate of premium is an important incentive. This is also confirmed by the motivations that people give for switching. The results illustrate that price competition exists in the system; however, competition based on the quality of care seems to be absent.

Keywords: Health Insurance, Reform, Switching Behaviour, Premium, the Netherlands

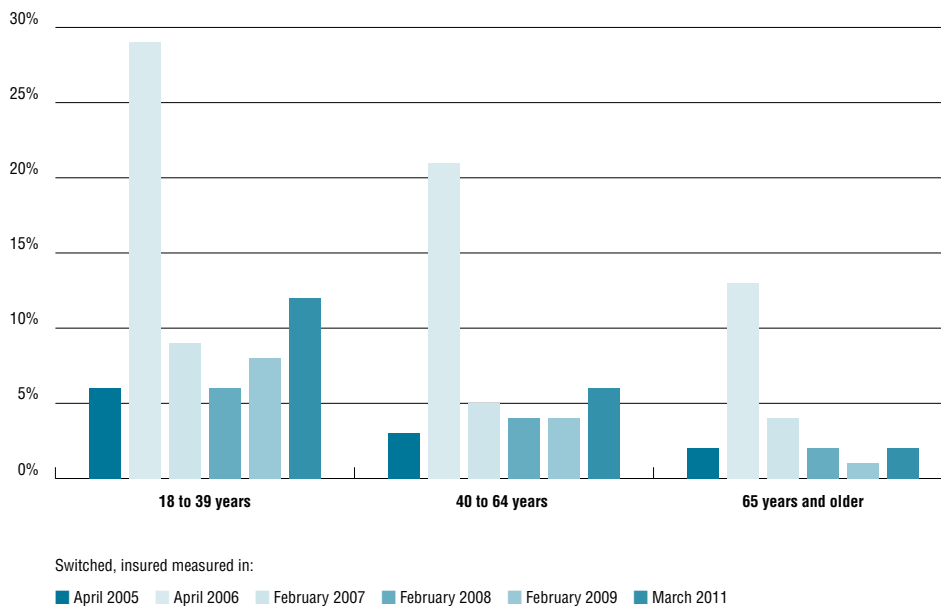
On 1 January 2006 a new health insurance law was introduced in the Netherlands.¹² This represented a major step towards a more demand-oriented system with managed competition. All insurers have to accept anyone who wants to enrol for the basic insurance package that is compulsory for everyone who lives in, or pays taxes on wages in the Netherlands. In such a system of managed competition consumer mobility plays an important role. Every year since, during an annual enrolment period, the population are free to change insurer and insurance plans. The assumption is that those people who are not satisfied with the level of premium or quality of care provided will opt for different insurers or insurance plans. It further assumes that everyone

has the same opportunity to switch. If these assumptions hold, they should force insurers to strive for a good balance between price and the quality of care.

However, for the system to work as intended, it is not only important that people actually switch, but it is also important to know the reasons why they switch. If they only opt for another insurer because of the price of their insurance premium, no information will be provided to insurers on the quality of care. As a result, there will only be price competition, instead of also having competition based on the quality of care. Therefore, the number of switchers, their characteristics and reasons for switching are important aspects of the new Dutch

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Figure 1: Percentage of switchers in 2005, 2006, 2007, 2008, 2009 and 2011 by age group*



Switched, insured measured in:

■ April 2005 ■ April 2006 ■ February 2007 ■ February 2008 ■ February 2009 ■ March 2011

Source: Dutch Health Care Consumer Panel. Note: * No survey was conducted in 2010.

health care system. Furthermore, since a number of countries are introducing market competition elements into their own health care systems, with a view to both quality improvements and cost containment, the results of our study are of international relevance.

The importance of price

When the health insurance law was introduced in 2006, one fifth of the population switched insurer. However, thereafter the percentage of switchers decreased to 6% in 2007, 4% in 2008 and 3% in 2009.³⁴⁵ Throughout this time switching was mostly based on considerations of price. The rate of switching between 2007 and 2009 was comparable to the situation prior to 2006 when approximately 3% and 6% of those publicly or privately insured respectively switched health care insurer.

In 2011, however, an increasing percentage of switchers was anticipated, given that insurance premiums increased by an average of 9.1% to €1,256 per annum, the highest rate of premium increase since the introduction of the health insurance law in 2006. Moreover, the increase in premium differed significantly between health insurance companies, with rates of increase ranging between 4.5% and 11.5%.

This has meant that there is a considerable difference of €276 per annum between the cheapest and most expensive basic insurance premiums.⁶

“ €276 per annum difference between the cheapest and most expensive basic insurance premiums ”

The objective of this article, therefore, is to analyse whether the new system does indeed work as intended, i.e. does switching provide insurers with incentives to aim for higher quality care at lower costs or does the system rely mainly on price competition, with an absence of competition based on the quality of care? We focused on consumer mobility in 2011, five years after the introduction of the

new system, highlighting characteristics and motivations for switching. This information is drawn from a regular survey of participants of the Dutch Health Care Consumer Panel, run by the Netherlands Institute for Health Services Research (NIVEL).⁷

An increase in switching

In 2011 more mobility in the population was observed with 8% of the Dutch population switching insurer. What do we know about the profiles of these switchers? 12% of people aged 18 to 39 years switched insurer in 2011, compared with 6% and 2% in the 40 to 64 years and 65 years plus age groups respectively (see Figure 1). The finding that young people switched more often than older people is consistent with results from earlier surveys. One explanation for this could be that young people have relatively good health compared to older age groups. As a result, they find it easier to compare insurance plans, probably only basing their choice on price, because they do not use health care frequently.⁸ Nevertheless, in 2011, the percentage of switchers increased in all three age categories compared with 2009.

What are reasons for switching or refraining from switching?

Given the importance of understanding motivations to change, our survey also asked respondents to give their reasons as to why they did or did not switch. Key findings are now presented.

The cost of premiums remains the most important reason for switching insurer

The cost of insurance premiums is by far the most important reason to switch insurer, with 52% of switchers giving this as a reason. In 2011 the importance of the premium in influencing the decision to switch was even higher than in previous years (36% in 2007, 25% in 2008 and 39% in 2009).⁹ In contrast, considerations of the quality of care appeared to play only a minor role in switching behaviour. Only 1% of switchers indicated that this was because they were ‘dissatisfied with the care arranged by their health insurer’,

while 4% cited dissatisfaction with the level of service provided by their insurer as a reason for switching.

“52% of all switchers cited the cost of insurance premiums as a reason for change

Many people do not switch because they are satisfied

In 2011, 55% of those people that did not switch health insurer indicated that they were satisfied with the coverage of their insurance. Other commonly cited reasons for not switching included ‘I’ve been insured with the same insurer for years’ (30%) and ‘I’m satisfied with the service of my health insurer’ (26%). One fifth (20%) of all those who did not switch insurer stated that they were satisfied with the quality of care arranged by their health insurance company. As such, it seems that quality of care is a reason to stay, yet it does not seem to be a reason to switch.

Furthermore, almost one fifth (19%) of all non-switchers indicated that one reason for this was that they know what to expect from their current insurer. 18% and 19% of those individuals who did not switch cited being ‘satisfied with the coverage of the basic insurance’ and ‘satisfied with the coverage of the complementary insurance’ respectively as being a reason for their behaviour.

One fifth of the total population did consider switching. Of these, 18% eventually refrained from switching because they could not be bothered to look for another better or cheaper health care insurer. Of those non-switchers who did not consider switching, 11% also indicated that they could not be bothered to look for another better or cheaper health care insurer. Moreover, compared to the latter group, those who considered switching

were more likely to state that they did not observe enough differences between health insurance companies (16% vs. 9%) or could not find another better or cheaper health insurer (16% vs. 10%).

People also perceive barriers to switching

Although various ‘positive reasons’ are most often mentioned as the principal reasons for not switching, some people perceive barriers to switching. It is important to monitor these barriers because they might be an indication of inequalities in the system. If some groups of people perceive more barriers than others, then certain population groups might be prevented from switching health insurer. Within the Dutch health care system, some barriers for switching have been removed. All insurers are, for example, obliged to accept everyone for the basic coverage package. Furthermore, health insurance companies provide a switching service aimed at overcoming barriers to switching. Nonetheless, the perception of barriers remains: 5% of those who did not switch in 2011 said this was because they feared running into administrative problems, while 3% feared not being accepted for complementary insurance.

“lack of competition on quality might be due to a lack of information

In conclusion

In 2011, the percentage of people switching insurer increased, in line with expectations. An increase in the number of switchers was expected because insurance premiums increased by more than in previous years. Our research confirms that the premium is indeed the most frequently indicated reason for switching health insurer. The differences in price appear to be big enough to provide an incentive for switching. Moreover, our results indicate that there is price competition in

the system. However, competition on the quality of care seems to be absent. As a result, health insurance companies have to keep their prices low to both attract and maintain subscriptions.

If the system is to function as intended, choice of insurer should be made on the basis of both premium and quality of care. The underlying idea is that due to switching, people provide signals on both the premium and quality of care. Consequently, health insurance companies should have an incentive to strive for a good balance between price and quality. The lack of competition on quality of care might be due to a lack of information on differences in quality of care, which consequently makes it difficult for individuals to factor quality into their decision on insurance provider.

We have indicated that some individuals also considered switching but ultimately did not do so. One of the reasons given for this was that they did not observe enough difference between health care companies. Apparently, for this group, the difference in premiums is not enough to switch insurer and moreover, they see no differences in quality. For competition on quality of care, people have to observe differences between health insurers and they have to consider such differences when choosing an insurer. It is possible that differences between insurers regarding the quality of care will increase in future, if insurers contract more selectively. Subsequently, this may become a more important factor in switching health insurer. However, it is evident from observation that premiums are easier to compare than quality of care, especially when it is unknown what care individuals might need in the future.

Therefore, it remains important to monitor the health insurance system, including the incentives that are given on both price and quality, in order to be able to evaluate whether the system works as intended. This is also important given that moving from a planned health care system to one with regulated competition and embedded market elements has been claimed to increase inequalities in access. As further market competition elements are introduced into the health care systems of other countries, monitoring the effects

of reform and any implications for possible inequalities can help provide insights on the circumstances where adverse effects might occur.

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PHARMACEUTICAL MARKET REFORMS IN PORTUGAL UNDER THE MEMORANDUM OF UNDERSTANDING

By: Pedro Pita Barros

Summary: The Portuguese pharmaceutical market has seen permanent and intense government intervention over the last decade. The financial assistance programme given to Portugal in 2011 and the associated Memorandum of Understanding (MoU) impose further changes in the market. The main objective of the more recent measures is to lower government expenditure and a mix of instruments is being employed: tougher pricing rules; promotion of a framework more conducive to competition from generics; reduction of distribution margins and more rational prescription patterns by doctors. Most of the measures set in the MoU have been adopted.

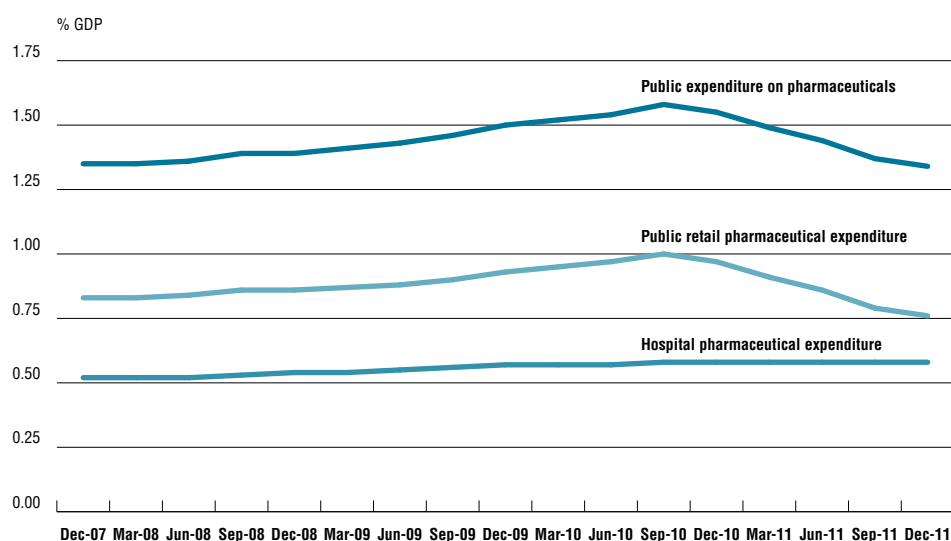
Keywords: *Pharmaceutical Policy, Distribution Margins, Rational Prescribing, Portugal*

The Portuguese pharmaceutical market has been subject to a large number of policy measures over the last decade. These included the introduction of a reference price system whenever competition from generics was possible (since 2003) and changes in the way the reference price is defined; administrative price reductions (2005, 2007 and 2010); several changes in co-payment rules and values; and the increased use of economic evaluation as a hurdle to the introduction of new products, both in ambulatory care and hospitals. Most of these measures were largely ineffective over the medium term, although since 2010 the package of measures seems to have had a noticeable impact on public expenditure, with a

reduction in public expenditures on pharmaceutical products in ambulatory care and a slight slowdown in the increase of hospital expenditures (**see Figure 1**). The administrative price reductions, introduced in 2010, included changes in the setting of maximum prices for pharmaceutical products and changes to co-payment rules for products included under National Health Service (NHS) coverage.

The MoU, signed in May 2011 under the financial assistance programme for Portugal, brought important changes to pharmaceutical policy. First, it set targets for public pharmaceutical expenditure. Second, it required changes

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Figure 1: Public expenditure on pharmaceuticals

Source: Author's elaboration based on Infarmed data. [\[2\]](#) [\[3\]](#)

to the structure of distribution margins. These two demands constitute new approaches to containing high public pharmaceutical expenditure growth. Additional requirements of the MoU include: the promotion of generics, use of clinical guidelines and the redefinition of the international referencing rules that establish prices of new pharmaceutical products. The latter is now focused on the prices of three countries with the lowest prices in Europe, but which have some broad similarities with the Portuguese economy.

Public pharmaceutical expenditure

Public pharmaceutical expenditure has clear targets set under the MoU: the Portuguese government should decrease such expenditure in both the hospital sector as well as in ambulatory care. The target is 1.25% of Gross Domestic Product (GDP) by the end of 2012 and 1% by the end of 2013. These targets were defined in line with European Union (EU) average values, according to the wording in the initial version of the MoU. The revised version (as of 9 December 2011) drops the reference to EU average values, but keeps the target unchanged.⁴

Estimates for Portugal's total public pharmaceutical expenditure at the end of 2011 are circa 1.34% of GDP, down from its highest value of 1.55% in mid-

2010. Therefore, despite the considerable effort expended so far, there is still an important reduction to be achieved in 2012 and 2013 to meet the target. Moreover, as illustrated in Figure 1, cost containment occurred only in ambulatory care, as hospital pharmaceutical expenditure is still rising.

“decrease pharmaceutical expenditure to 1.25% of GDP by the end of 2012”

A brief methodological explanation about Figure 1 is necessary. The targets of 1.25% and 1% of GDP for 2012 and 2013, respectively, are end-of-year targets. To build an index to measure how well the government is meeting the target, several issues need to be accounted for. Public expenditure on pharmaceutical products includes both retail pharmacy sales and hospital consumption. While retail pharmacy consumption data is available

with reasonable reliability from public sources (Infarmed, the regulator for pharmaceuticals), hospital consumption data, equally available from Infarmed, is noisier. Although both sets of data are available by month, hospital data often misses a couple of (relatively large) hospitals. Therefore, an overall value is estimated based on past values. Moreover, past and prospective GDP values are not available on a monthly basis. Thus, a simple weighted mean of values for current and past years is used, using the number of months in the current year that have elapsed as the weight.

Pharmaceutical prices

In Portugal, following market authorisation, an international reference pricing (IRP) system is applied to define the maximum market price. After this price is set, the pharmaceutical company can apply for the new product to be included in the positive list for reimbursement by the NHS. This price cannot be higher than the initially approved price.

The way prices are set was also subject to change. The IRP system prevailing before the MoU used the average price of the same product in four reference countries (Greece, Spain, Italy and France). The MoU required a redefinition of the system to use the lowest price of a set of three countries to be chosen based on the level of prices prevailing in their markets (“lowest prices within Europe” as stated in the MoU) and which have a comparable GDP to Portugal. The countries selected were France, Spain and Slovenia. The option of including countries within the Euro-zone seems to constitute a good decision, as it avoids confusion introduced by exchange rate changes and how such variations should be accommodated. The change does not constitute as radical a departure from the previous set of countries as might have been expected from the wording of the MoU. Nonetheless, it is expected that some prices will be lowered due to the new rules and no price can increase, even if the mean value over the reference countries is higher.

Table 1: Wholesale and retail distribution margins of pharmaceutical products

	Wholesalers		Retailers	
	Mark-up (%)	Fixed fee	Mark-up (%)	Fixed fee
≤€5	11.20	–	27.90	–
€5.01–€7	10.85	–	25.70	€0.11
€7.01–€10	10.60	–	24.40	€0.20
€10.01–€20	10.00	–	21.90	€0.45
€20.01–€50	9.20	–	18.40	€1.15
>€50	–	€4.60	–	€10.35

Source: Legislative Decree 112/2011 of 29th November.

Competition from generic pharmaceutical products

Several measures included in the MoU aim to increase competition from generics. Many of these measures are to be adopted within the first year of signing the MoU. The focus is on the price regulation of the market, administratively forcing lower prices. The measures already enacted include: a) setting the maximum price of the first generic to enter the market in its class at 60% lower than the price of the originator product (initially, it was set at 50% but later changed); b) automatic reduction of the price of the originator pharmaceutical product when the patent expires; c) resolving the legal dispute over intellectual property to ensure speedier entry of generics; and d) allowing substitution at the pharmacy of prescribed products by generics under certain conditions; the substitution may be refused by the physician, who has to provide a justification in the prescription, and refusal is also an option for the patient (Law 11/2012, of March 8). Moreover, pharmacies are forced by law to carry at least three of the five lowest-price generics in each class defined by a branded product.

Dealing with intellectual property disputes

A common strategy used by pharmaceutical companies to delay the entry of generic products in the Portuguese market was to initiate a challenge in the courts alleging infringement of intellectual property rights. Given the long time that the Portuguese courts take to produce a decision, the legal process itself worked as a delaying tactic.⁵ This issue was tackled in the MoU with the requirement

that administrative and legal hurdles to the entry of generics had to be removed by the end of 2011. In November 2011, a new law was enacted that requires the resolution of intellectual property disputes through arbitration, taking the problem out of the courts. Moreover, specific time limits are defined for these procedures to be completed.

“the MoU aims to increase competition from generics”

Distribution of pharmaceutical products

The wholesale and retail distribution of pharmaceutical products was also addressed in the MoU. Historically, retail pharmacies and wholesale distributors earned a margin over the consumers' price. The MoU stipulates that a new structure of margins, using a combination of fixed fees and regressive margins over the wholesale price must be defined (see Table 1). Before the new legislation package enacted for this purpose, the pharmaceutical wholesale margin was 8% and the retail pharmacy margin was 20%, both over the final price (at the consumer). These margins had been the subject of much discussion over the years and by the end of 2010 and early 2011, the possibility of moving to a different system of margins

was mooted. Therefore, the MoU proposal to combine regressive margins and fixed fees did not come as a surprise.

One of the stated aims of this change is to save €50 million in distribution costs. The savings target is reinforced by the requirement for wholesalers and retail pharmacies to pay a special contribution (clawback) if not enough savings are generated (although pharmacies in remote areas with low turnover may be exempt from this pay-back mechanism). This requirement will be monitored and assessed by the third quarter of 2013. A second objective of the margins change is to increase the incentives to pharmacies to offer patients the option of purchasing generics. Under the previous system, where margins were defined by constant percentual mark-ups over the final price, pharmacies had the incentive to favour the dispensing of products with higher prices. Thus, the new rules mitigate this relative incentive to dispense more expensive products (by not carrying generics products).

Prescription patterns

While many of the other measures in the pharmaceutical sector aim to lower prices, some also act on volume; that is, the prescribing patterns of doctors. This is usually a delicate matter and previously has not been explicitly and directly addressed by the Portuguese authorities. The MoU requires a monitoring system that regularly provides information on both the volume and value of prescribing by individual doctors. The system has been in place since October 2011 and for the moment is used to provide feedback to doctors. This has been made possible by another MoU condition: the establishment of a mandatory electronic prescription system for pharmaceuticals covered by the NHS. The system has been operating since August 2011 (with a few temporary exceptions due to operational reasons). In addition, the MoU calls for the adoption of international prescription guidelines in Portugal, to provide clear rules for more rational prescribing patterns. These guidelines would complement the feedback mechanism provided to doctors on their own prescribing. By September 2011, the Ministry of Health and the Portuguese

Medical Association had signed a protocol to compile clinical guidelines and to train auditors. The Directorate-General for Health is now making available an initial set of guidelines. The next step will be to ensure they enter current decisions in the NHS.

“
pharmaceutical
arrears in the
public health
sector was
estimated at
€3 billion

Governance of the system

The first revision of the MoU, dated 9 December 2011, introduced a governance change, setting up a one-stop shop for the price setting of pharmaceutical products. This provision was included in a legislative package approved at the end of 2011. The pharmaceutical regulator, Infarmed, is defined as the single point of contact, although the prices of pharmaceutical products should result from a joint proposal by Infarmed and the government department in charge of price setting (Directorate-General of Economic Activities). Most companies did not see the one-stop-shop issue as critical. The more relevant delays apparently occur during the assessment process for inclusion in the NHS positive list.

Remaining issues

At the time of writing (March 2012), one relevant issue to be resolved, and which has important implications for the pharmaceutical market, is the existence of arrears. These are mainly, but not exclusively, delayed payments to the pharmaceutical industry by NHS hospitals. Resolving the issue has two steps: the government must first make funds available to NHS hospitals to pay

these debts; and secondly, procedures must be put in place to avoid a future build-up of arrears. The first deadline for the government to present a solution to this problem was the end of September 2011, but the difficulties involved meant successive postponements of the deadline. The estimated value of arrears in the public health sector at the end of December 2011 was €3 billion (as reported in the government's budget for 2012). To provide a sense of magnitude, the NHS budget for 2012 is circa €7.5 billion. Moreover, the importance of this issue is demonstrated by one pharmaceutical company's recent decision to supply some NHS hospitals only under the condition of immediate payment.

Concluding remarks

For Portugal, the main challenge is to achieve the targeted reduction in public pharmaceutical expenditure and to this end a variety of instruments have been implemented: international reference pricing, changes to retail and wholesale distribution margins, monitoring of prescription patterns, promotion of generics entry and price competition. While the downward adjustment in public pharmaceutical expenditure had actually begun prior to the MoU, it is likely that the new set of measures will reinforce the trend.

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New Health System Review – Denmark

Maria Olejaz, Annegrete Juul Nielsen, Andreas Rudkjøbing, Hans Okkels Birk, Allan Krasnik, Cristina Hernández-Quevedo

London: European Observatory on Health Systems and Policies, 2012

Number of pages: 192

The new Health Systems in Transition (HiT) review for Denmark reflects recent health trends and structural changes in the Danish health system. Lifestyle related risk factors and chronic illnesses are increasingly becoming major health issues which are still more challenging as a result of the ageing population.

This has pressed the health system towards a model of provision focused much more on the management of chronic care conditions. Although this report reveals a system that generally provides high quality services within

each sector of the health system, the authors show that the fragmented structure of the Danish health system poses

serious challenges in providing effectively coordinated care. Traditionally characterised as a decentralised system, several reforms from 2007 have strengthened coordination and centralised control.

The new HiT will be officially presented at a meeting of the Chief Medical Officers taking place in Copenhagen on 12 April in the context of the Danish EU Presidency.

Feely available to download at:
http://www.euro.who.int/__data/assets/pdf_file/0004/160519/HIT_Denmark_080312.pdf



NEW PUBLICATIONS

Health System Review – Turkey

By: M Tatar, S Mollahaliloglu, B Sahin, S Aydin, A Maresso, C Hernandez-Quevedo

London: European Observatory on Health Systems and Policies, 2012

Number of pages: 211

Freely available to download at: http://www.euro.who.int/__data/assets/pdf_file/0006/158883/e95429-rev.pdf

The Health System Review (HiT) series consists of country-based reviews that provide a detailed description of a health system and

of reform and policy initiatives in progress or under development in a specific country. This report on Turkey presents an overview of the organisational structure, financing, delivery of services, reforms and future challenges in significant detail.

The report finds that Turkey has seen many improvements in health status in the last three decades, particularly after the implementation of the Health Transformation Program in 2003.

Since 2003, health services have been financed through a social security scheme and a purchaser-provider split in the health care system has been instigated. A performance-based payment system in Ministry of Health hospitals, introduction of a family practitioner scheme nationwide and the transferring of ownership of public hospitals to the Ministry of Health have served to significantly change the landscape of the health system.

Despite these reforms, however, several challenges remain. Inequalities between rural and urban areas and different regions of the country have been identified. Further, a comparative analysis with other European countries shows the scarcity of health care personnel in relation to Turkey's population. There is a lack of a referral system between primary, secondary and tertiary care, resulting in ineffective primary care and patients entering the system at whatever point they prefer. The report recognises that some reform initiatives are yet to be implemented and a decentralisation of health care governance and a more competitive environment for the operation of the health care system need to be promoted.

Findings from this report are accompanied by tables, figures and user-friendly graphs. The succinct conclusion includes some policy implications and recommendations. An appendix including

links to useful websites and information on the HiT series are also available.

Contents:

Preface; Acknowledgements; List of abbreviations; List of tables, figures and boxes; Abstract; Executive Summary; Introduction; Organisational Structure; Financing; Regulation and Planning; Physical and human resources; Provision of services; Principal health reforms; Assessment of the health system; Conclusions; Appendices.

Health System Review – Russian Federation

By: L Popovich, E Potapchik, S Shishkin, E Richardson, A Vacroux, B Mathivet

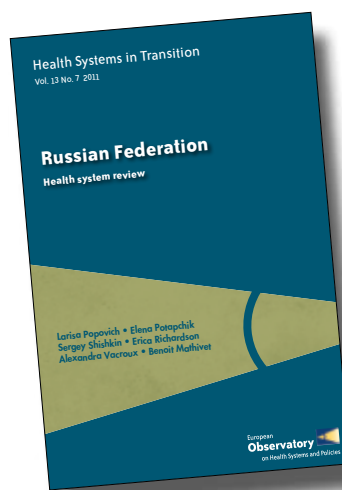
London: European Observatory on Health Systems and Policies, 2011

Number of pages: 217

Freely available to download at: http://www.euro.who.int/__data/assets/pdf_file/0006/157092/HiT-Russia_EN_web-with-links.pdf

At independence from the Soviet Union in 1991, the Russian health system inherited an extensive, centralised system, but was quick to reform health financing by adopting a mandatory health insurance (MHI) model in 1993. MHI was introduced in order to open up an earmarked stream of funding for health care in the face of severe fiscal constraints. While the health system has evolved and changed significantly since the early 1990s, the legacy of having been a highly centralised system focused on universal access to basic care remains.

In addition to information on reforms undertaken, the report highlights Russia's strengths and weaknesses in health care provision and delivery. Recent reforms include the federal reimbursement programme for pharmaceuticals in order to improve access to drugs for vulnerable groups and the National Priority Project (launched in 2006) to improve population health through better material, technological and human resources provision. Also, the number of physicians per capita in Russia has increased in recent years and is now one of the highest in the WHO European region.



However, the replacement of public expenditure on health by out-of-pocket payments signals a trend towards less equitable distribution of health care resources across and within regions. Further, the efficiency of social (and health) spending has been assessed as poor because similar health outcomes in terms of mortality are observed in other countries spending 30–40% less. The report shows that provider payment mechanisms are the main obstacle to improving technical efficiency. Improvements are also needed to ensure allocative efficiency. Currently, data show biases toward inpatient care at the expense of primary care services and comparatively high hospitalisation rates.

Findings from this report are accompanied by tables, figures and user-friendly graphs. The succinct conclusion includes some policy implications and recommendations. An appendix including links to useful websites and information on the HiT series are also available.

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Preface; Acknowledgements; List of abbreviations; List of tables, figures and boxes; Abstract; Executive Summary; Introduction; Organisation and Governance; Financing; Physical and human resources; Provision of services; Principal health reforms; Assessment of the health system; Conclusions; Appendices.

Health systems, health, wealth and societal well-being: assessing the case for investing in health systems

Edited by: J Figueras, M McKee

London: European Observatory on Health Systems and Policies, 2012

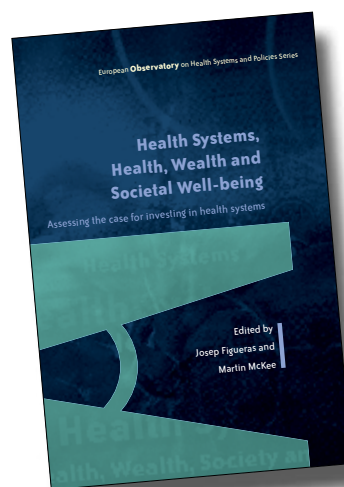
Number of pages: 448

ISBN: 9780335244300

Available to purchase at: <http://www.mcgraw-hill.co.uk/html/0335244300.html> (soon to be freely available online)

The evidence contained in the volume demonstrates how health constitutes a major component of societal well-being, is intrinsically valuable and has major impacts on productivity and the economy. It outlines how health systems serve to improve population health and equity and highlights the importance of continued investment and commitment to these ends. This publication originally served as background material for the World Health Organization (WHO) European Ministerial Conference on Health Systems in Tallinn in 2008.

The policy debate on health systems has been dominated in recent decades by concerns about sustainability and the system's ability to fund itself in the face of growing cost pressures.



Containing costs is undoubtedly a major priority for most health systems but a new wave of thinking, termed the 'health and wealth' debate, has brought to the fore the interrelationships between health status, health systems and economic growth. Increasingly better health is seen to be the driver of wealth, rather than the other way round, and can even be seen to reduce growth of health care

expenditure. The book therefore synthesises the evidence linking health systems, health and wealth, aiming to assist policymakers wishing to invest in health systems under constrained resources.

The book is organised into eleven main chapters, with boxes and figures throughout. The book begins with definitions, a conceptual framework and an outline of unilateral relationships between key concepts. Objectives and structure are then presented. Policy recommendations, given in the final chapter, draw together lessons from each chapter to conclude that societies should invest in health systems, provided that they have the performance assessment systems in place to demonstrate cost-effectiveness.

Contents:

Foreword; Acknowledgements; About the authors; List of tables, figures and boxes; Abbreviations; 1) Health systems, health, wealth and societal well-being: an introduction; 2) Understanding health systems: scope, functions and objectives; 3) Re-examining the cost pressures on health systems; 4) Economic costs of ill health in the European region; 5) Saving lives? The contribution of health care to population health; 6) The contribution of public health interventions: an economic perspective; 7) Evidence for strategies to reduce socioeconomic inequalities in health in Europe; 8) Being responsive to citizens' expectations: the role of health services in responsiveness and satisfaction; 9) Assessing health reform trends in Europe; 10) Performance measurement for health system improvement: experiences, challenges and prospects; 11) Investing in health systems: drawing the lessons; Index.

NEWS

International

European Commission proposes faster access to medicines for patients

Medicines should enter the market faster. With this intention on 1st March the European Commission proposed a new directive to streamline and reduce the duration of national decisions on pricing and reimbursement of medicines. At present after the quality, safety and efficacy of medicinal products has been established during the process of marketing authorisation, each Member State makes a further evaluation to decide whether a medicine is eligible for reimbursement, in compliance with the common procedural rules established under the 1989 Transparency Directive.

Under the new Directive such decisions would be taken within 120 days for innovative medicines, and 30 days rather than 180 days for generic medicines. The Commission also proposed strong enforcement measures if decisions are not made within these time limits, as these are often exceeded by Member States. It represents an important simplification measure and will repeal and replace the 1989 Transparency Directive, which no longer reflects the increased complexity of pricing and reimbursement procedures in the Member States.

The revision is a follow up to a Commission report on the pharmaceutical sector in 2009 which revealed long and cumbersome pricing and reimbursement decisions. Studies have shown that delays in pricing and reimbursement decisions can go up to 700 days for innovative medicines and up to 250 days for generics.

More information at: http://ec.europa.eu/enterprise/sectors/healthcare/competitiveness/pricing-reimbursement/transparency/index_en.htm

The European Innovation Partnership on Active and Healthy Ageing launches its “Invitation for Commitment”

The European Commission's European Innovation Partnership on Active and Healthy Ageing has formally launched its “Invitation for Commitment”, a call for all stakeholders who wish to be involved in implementing the Strategic Implementation Plan (SIP) adopted in November 2011. SIP outlines a common vision and a set of operational priority actions to address the challenge of ageing through innovation. The first set of specific actions will be launched during the European Year for Active Ageing and Solidarity between Generations 2012. This will include innovative ways to ensure patients follow their prescriptions – a concerted action in at least 30 European regions; innovative solutions to prevent falls and support early diagnosis for older people; co-operation to help prevent functional decline and frailty, with a particular focus on malnutrition; and the promotion of successful innovative integrated care models for chronic diseases amongst older patients, such as through remote monitoring. There will also be action to improve the uptake of interoperable information and communications technology (ICT) independent living solutions through global standards to help older people stay independent, mobile and active for longer.

More information about the partnership available at: http://ec.europa.eu/research/innovation-union/index_en.cfm?pg=home§ion=active-healthy-ageing

Alcohol in the European Union: consumption, harm and policy approaches

Alcohol is one of the world's top three priority areas in public health. In Europe, alcohol is the third leading risk factor for disease and death after tobacco and high blood pressure. People in Europe consume more alcohol – 12.5 litres of pure alcohol equivalent per year on average – than in

any other part of the world. A new report published as part of a project of the European Commission and WHO Regional Office for Europe uses information gathered in 2011 to update key indicators on alcohol consumption, health outcomes and actions to reduce harm across the European Union (EU). Edited by Peter Anderson, Lars Møller and Gauden Galea, the report updates the evidence base for some important areas of alcohol policy, and provides policy-makers and other stakeholders in reducing the harm done to health and society by excessive drinking with useful information to guide future action. It identifies a number of cost-effective policies that have proven that increased taxes, decreased availability and restrictions on marketing are effective in reducing the harmful use of alcohol.

The report is available at: http://www.euro.who.int/__data/assets/pdf_file/0003/160680/Alcohol-in-the-European-Union-2012.pdf

Country news

England: Radical reform of health and social care gains legislative approval

In England the Coalition government's health and social care reform bill finally gained legislative approval. This followed more than a year of debate in Parliament, coupled with lengthy consultation and often fierce opposition from health and social care professionals. The new Act will facilitate the most radical restructuring of the health service in England since the creation of the National Health Service (NHS) in 1948. From April 2013 it will give general practitioners control of around £65 billion of the NHS's £106 billion annual budget, cut the number of health bodies, and introduce more competition into services, all with the intention of reducing administration costs by one third. The government argues that these reforms are essential if health and social care services are to manage the needs of an ageing population and cope with the costs of new medications and other treatments.

The final Act is much different to that originally proposed, with much more focus on statutory structures to deliver accountability for public funds and an emphasis on collaboration and integration alongside competition. The legislation maintains the duty of the Minister for Health to be accountable to Parliament for the provision of the health service in England. Legal responsibility will rest with the organisations tasked with commissioning and providing health and social care services. New Clinical Commissioning Groups (CCGs) will replace Primary Care Trusts (PCTs); they will commission and pay for health care services. The government is determined that these consortiums will be different to PCTs – more autonomous and clinically led, and more effective at commissioning from powerful secondary care providers.

All NHS hospitals will become independent foundation trusts within the NHS and compete for contracts from the CCGs. Competition will be solely on quality and not on price. At national level a new NHS Commissioning Board will manage the CCGs, while local councils will take over responsibility for public health. One of the most contentious elements of the legislation is the provision that hospitals may ultimately be able to earn as much as 49% of their income from private patients.

The challenge now will be in the implementation of the Act, whose provisions run to 473 pages. Key issues include how the new CCGs will work with local councils to ensure the provision of appropriate services. Meantime, provider organisations will have to look at the sustainability of some of their services; it may be the case that some service providers may not be financially sustainable. Careful consideration will also have to be given to the way in which new rules on competition will be implemented in practice.

The Health and Social Care Act is

available at: <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm>

Pharmaceuticals: Commission calls on Italy to comply with EU rules on the marketing authorisation of generic drugs

On 26 January the European Commission formally requested Italy to comply with EU legislation concerning the marketing authorisation procedures of generic drugs. According to Directive 2001/83/EC on the Community code for medicinal products for human use, the processing of marketing authorisation procedures can be carried out without being affected by the protection of industrial and commercial property interests. On the other hand, the authorisation holder of a generic drug is not allowed to place a product on the market before the patent on the reference product has expired.

In Italy, a law prevents manufacturers of generic products from submitting their request for marketing authorisation prior to the penultimate year of the lifetime of a patent on a reference product. For example, if a patent on a reference product has a ten year lifetime, manufacturers will need to wait at least nine years before they are allowed to submit their request for marketing authorisation. As a result of this law, and of the lengthy procedure to secure the authorisation for marketing, manufacturers of generic products are placed at a disadvantage.

Therefore, the Commission asked Italy to ensure full compliance with European law. The request took the form of a "Reasoned Opinion" under EU infringement proceedings. If Italy does not comply within two months, the Commission may decide to refer the case to the European Court of Justice.

More information at: http://ec.europa.eu/health/human-use/legal-framework/index_en.htm on marketing authorisation procedures of medicinal products for human use.

Germany: Government plans new law to increase organ donation

Some 12,000 critically ill people in Germany are on a waiting list for organ donations and several die every day for lack of a life-saving organ. Current German law requires people to declare their willingness to donate. If a patient pronounced brain dead by doctors

has not made this decision, it is up to immediate family members to decide.

Following an agreement between all major political parties, the federal government now plans a new law that it hopes will prompt more people to consent to donation. The key difference in the new legislation is the leverage it allows to target citizens directly rather than issuing general appeals. The new law will require public and private health insurers to send everyone aged 16 plus information about how to become an organ donor.

Under the new legislation, which is expected to become law by July, all the insured will have the option of immediately opting to become donors, declining or putting off the decision. Insurance companies will be required to re-send the organ donor request information every two years to their customers. Additionally, federal offices that issue passports and driver's licenses will distribute information about organ donation.

There may still be amendments to this planned legislation, with some Parliamentarians wanting to prevent insurance companies automatically registering someone's organ donation wishes on their insurance card without individual consent.

The legislation follows years of discussion about how to increase the number of Germans who are both willing and registered to donate. Surveys show around 75% of the population would offer organs, but only 20% have a donor card that documents their consent. In Germany, the number of organ donors per million residents is 15, while in Spain, where those who do not want to donate organs have to issue a specific objection, the rate is 35. In Poland however, where individuals also have to opt out of being a donor, objections from family members have meant that only eight in every million residents have donated an organ.

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OBSERVATORY VENICE SUMMER SCHOOL 2012

Performance Assessment for Health System Improvement: Uses and Abuses

22–28 July 2012,
San Servolo Island,
Venice, Italy.



The Observatory Venice Summer School brings together in a stimulating environment high and mid-level policy-makers, who wish to increase their understanding of health system performance and its implications for policy. The Summer School draws on the latest evidence; a team of experts; the experiences of participants in practice; and a tradition of promoting evidence-based policy-making and fostering European health policy debate. It aims to raise key issues, share learning and insights and build lasting networks.

This year's theme

Health systems are coming under unprecedented pressures to constrain the relentless rise in health services expenditure while simultaneously improving health outcomes, responsiveness, and financial protection. Reconciling these conflicting performance pressures is a major preoccupation for many policy makers. Their task is made more challenging by the pressure for transparency and accountability and the increasing availability of comparative data, the interpretation of which is rarely straightforward. This year's Summer School focuses on how performance assessment can be used as an effective tool for the improvement of health systems.

Objectives

The 2012 Summer School will focus on how to: measure performance (within countries and in comparison with

others); assess the uses and abuses of performance assessment; draw practical policy lessons; and integrate performance assessment within health systems governance. This will include reviewing innovative approaches and identifying areas and strategies to improve performance, including financial, regulatory, managerial and information mechanisms.

Approach

The six day course combines a core of formal teaching with a highly participative approach involving participant presentations, round tables, panel discussions and group work. It draws on the latest evidence and a multidisciplinary team of experts from key organisations in the field, including WHO, OECD and the European Commission.

Modules

The course is organised around three modules. **Module 1** looks at the concept of performance assessment, including why there is a need for policy assessment and the domains of assessment such as population health, health service outcomes, equity, patient experience, financial protection and efficiency. Within the context of promoting healthy ageing, **Module 2** addresses the mechanics of assessing and analysing performance (within and across countries), using practical examples and resources. **Module 3** looks at how to make performance improvement happen, including integrating performance

assessment and analysis into governance structures and strategies; benchmarking and public reporting; target and priority setting; regulatory and financial incentives; and institutional mechanisms to link performance to health service management.

Accreditation

Summer School is accredited by the **European Accreditation Council for Continuing Medical Education** and participation counts towards ongoing professional development in all EU Member States.

How to apply

Summer School is primarily aimed at senior to mid-level policy-makers, with some junior professionals. All participants should be working in a decision-making or advisory institution that focuses on policy and management at a regional, national or European level.

The course fee is €1,950 and includes teaching material and lectures, full social programme, accommodation and meals for the entire duration of the course. The deadline for applications is **1 June 2012**. Early applications are encouraged as places are limited.

For more information and the application form please visit: <http://www.observatorysummerschool.org/>

For any questions email: summerschool2012@obs.euro.who.int