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EDITORS' COMMENT

In our last issue for 2018 we have an expansive collection of articles spanning the delivery of various community level services, increasing health coverage and policy reforms aimed at health system strengthening.

The **Observer** section opens with an article on a new method aimed at potentially improving people's access to their medicines via 'hub and spoke' community pharmacies. The author studies the occurrences of such a model in European countries finding it is most commonly used to help older people who take multiple medicines. Further, some evidence is given for countries interested in the hub and spoke model to take note. Keeping the focus on older people, Spasova and colleagues provide an overview of long-term care arrangements for older people across 35 countries. Based on their recent report for the European Commission's European Social Policy Network, their article outlines four key challenges facing all of the countries' long-term care systems and lays out concrete policy recommendations for meeting them.

In our **International** section, we turn to efforts currently being undertaken to strengthen tuberculosis prevention and care services in Eastern Europe and Central Asia, with a particular emphasis on adopting a people-centred model of service delivery at community level. With eleven countries involved in the TB-REP programme, which is designed to support policy change and implementation, this article highlights the different ways that the participating countries are tackling this persistent public health concern. Dental care advertising is the subject of the article by Grolleau. In the context of an important case heard by the European Court of Justice, the 2017 ruling confirms the importance of the relationship of trust between dentists and their patients. Moreover, he brings up interesting points, e.g. about the difference between how companies, unlike professionals, are not bound by a code of practice.

Next, we look at various reforms that have taken place across very different health systems in recent years. Our jam-packed **Systems and Policies** section starts off with Austria, where Schmidt and colleagues explain how shifting care away from hospitals and towards ambulatory settings has required a change in health system governance arrangements to increase co-ordination across different funders and providers rather than a change in responsibilities *per se*. This context-specific and innovative solution is part of efforts to strengthen the primary care system overall. On the same topic, our article on Bulgaria sheds light on the combination of factors, from funding incentives to legal obstacles, which continue to impede its health system from reducing its over-utilisation of hospital care.

Following on, in discussing the Spanish health system, the principle of universal coverage was threatened by policy measures aimed at securing the sustainability of the health system following the economic crisis. Hernández-Quevedo reflects on this and discusses recent reforms which work to protect those who were previously excluded from coverage or experienced access barriers. Also on the subject of coverage, Richardson and Berdzuli outline how Georgia is steadily tackling the goal of achieving universal health coverage for its population. Since 2012 a series of measures have been put in place to expand the population groups with access to a growing set of publicly funded health services.

Based on their experience in the Kyrgyz Republic, a team of experts (Edwards et al.) discuss the important policy tool of strategic planning for health systems. They showcase the lessons learned, including the prioritisation of goals, development of effective implementation machinery, and the importance of being part of a wider national planning process. Rounding off, the final article looks at a new national policy in Sweden which provides a subsidy on glasses for all those aged 8–19 years old. They reflect on what improvements can be made one year after the reform.

We wish all our readers a happy holiday season and healthy new year!

Sherry Merkur, Editor

Anna Maresso, Editor

David McDaid, Editor

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HUB-AND-SPOKE DISPENSING MODELS FOR COMMUNITY PHARMACIES IN EUROPE

By: Bernd Rechel

Summary: This article explores experiences in Europe with models of "hub-and-spoke" dispensing for community pharmacies. It finds that one of the most common forms of this type of model is automated "multi-dose dispensing" for older people who take multiple medicines, either in nursing homes or at home. Although now firmly established in the Nordic countries and the Netherlands, evidence on outcomes and costs is limited and does not allow firm conclusions. There is some indication that multi-dose dispensing might reduce overall drug use and improve treatment adherence, but would increase inappropriate drug use and result in fewer changes in drug treatment. Evidence on cost implications is missing so far.

Keywords: *Pharmacies, Dispensing, Hub-and-Spoke Dispensing, Multiple Chronic Conditions*

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Introduction

The United Kingdom is currently considering the introduction of a "hub and spoke" dispensing model for community pharmacies (**see Figure 1**). In this model, dispensing, which is currently only allowed between pharmacies belonging to the same retail business, would take place across legal entities. Both entities would need to be registered pharmacies, but only the "spoke" pharmacy would be required to have a contract with the National Health Service (NHS). The Department of Health issued a consultation document with the proposed amendments in March 2016.[1]

What is "hub-and-spoke dispensing"?

While the term "hub and spoke dispensing" is not widely used outside the United Kingdom, it is possible to identify relevant experience from other European and non-European countries, in which prescriptions are collected from a "spoke" pharmacy, medication is prepared centrally in a "hub" and then delivered back to the "spoke" pharmacy which dispenses it to the patient. This is sometimes called "centralised dispensing" and is often related to processes of automation ("automated dispensing") and to attempts to prepare centrally various medications for the same patient ("multi-dose dispensing").

A 2017 publication on the impact of automation on the pharmacist workforce[2] identified the following centralised dispensing models:

- Automated multi-dose drug dispensing for older patients in Australia, Denmark, Finland, Norway, Sweden and the Netherlands.
- Selective centralised dispensing for patients with stable chronic conditions in South Africa.

Both of these models follow a “hub-and-spoke” design but are limited to particular groups of patients.

In the first model, these are mainly older people, either in nursing homes or living at home, who take multiple medicines. The medicines are re-packaged automatically into unit-dose bags for each administration. These single dose disposable sachets are labelled with patient data, medicine contents and the date and time for intake.[3] Repackaging is increasingly consolidated at central locations and distributed to the consumer or the local pharmacy for collection.

> Repackaging is increasingly consolidated at central locations

In the second model, dispensing takes place through a “chronic dispensing unit” within the public health sector in South Africa. This unit was established to maintain medicine supply to people with chronic conditions, including HIV/AIDS. Once patients are stable, the health facility pharmacy sends their prescriptions to the central dispensing unit which makes use of a semi-automated dispensing process. Dispensed medications are sent to the health facility for collection by the patient.

Multi-dose dispensing – experience in Europe

Within Europe, the use of “hub-and-spoke” models thus relates in the first place to multi-dose dispensing to older patients in the Nordic countries and the Netherlands. This was confirmed by a survey undertaken in 2016 by the Pharmaceutical Group of the European Union in which it asked its country contacts about the existence of inter-company hub-and-spoke models in other EU Member States; 17 responses were received.[4] Of those, only four countries reported the existence of a “hub-and-spoke” model: Belgium, Denmark, Finland and Germany. However, multi-dose dispensing is also being used in Sweden, Norway and the Netherlands. Some country examples from across Europe are given below.

Belgium

In 2012, a Royal Decree was published describing the conditions for “individual preparation of medication” (IPM) as it is called in Belgium. Since then, community pharmacies exclusively are allowed to de-blister solid oral medicines and to dispense them in weekly dispensers. In the case of automated “individual preparation”, the activity may be outsourced to another community pharmacy. Several pharmacies have developed services for outsourced IPM that are often used for the provision of medication in homes for older people, but rarely in ambulatory care.

Since the providers of automated dispensing are always community pharmacies, there are no real “hubs”. There are about a dozen community pharmacies that provide this service to homes for older people or to other community pharmacies. The provision of automated dose dispensing (ADD) to homes for older people has been driven by economic incentives and the desire to achieve a large scale of medications, with a decrease in price, but also a decrease in quality of care and individual follow-up of patients. While in theory patients are entitled to choose their pharmacy, in reality contracts are negotiated between providers and institutions for older people. Outside of homes for older people, there is no real demand for ADD. Some pilot projects have been initiated, involving home nurses, but these have not been rolled out. The service is not covered by health insurance benefits, but needs to be paid for out-of-pocket.

Germany

Hub-and-spoke models of dispensing, such as in multidose dispensing for patients receiving multiple medications, are the exception rather than the rule in Germany. There are generally no pharmacy chains, but there are some “hubs” (*Blisterzentren*) which operate industrially, on the basis of contracts with pharmacies which order medicines for their patients according to prescriptions. In general, however, the German legal framework, especially the rules on reimbursement by the Statutory Health Insurance Funds, determines that only complete packages in the officially authorised sizes shall be dispensed to patients. Since 2005, individually prepared dispensing (*patientenindividuelle Verblisterung*) can take place if prescribed by a doctor explicitly and by special exception. It is mainly used in the context of the supply of medicines to nursing homes, with older patients as the main target group, but remains the exception.

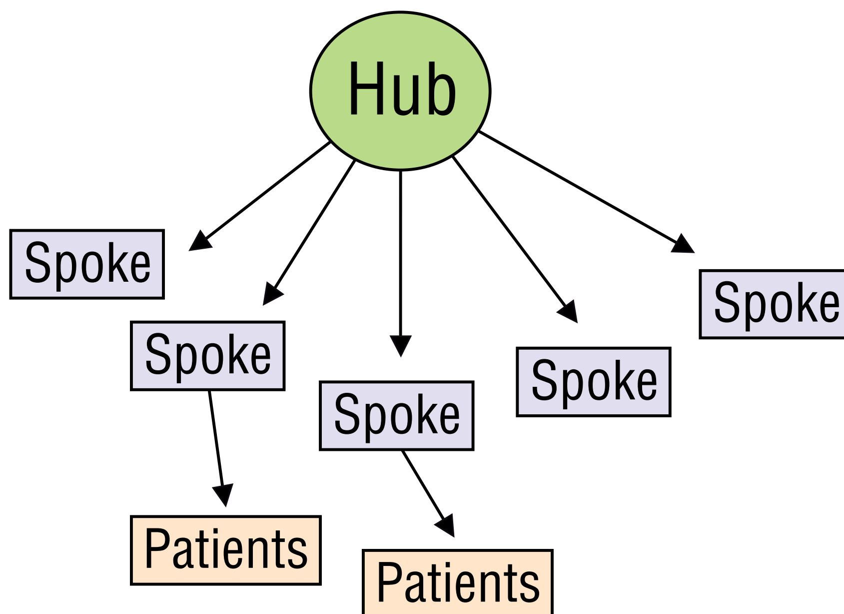
Sweden

Already in the 1980s Sweden successively replaced manual repackaging of multi-dose medications from pharmacies with automated multi-dose drug dispensing. The Swedish medicines agency published guidelines on dose dispensing in 2010.[5] In fact, Sweden has, per capita, the largest number of patients receiving multi-dose dispensing worldwide.[6] In 2009, there were 185 000 patients using ADD,[5] with between 180 000[7] and 190 000[8] users in 2011. There are now approximately 200 000 patients receiving multi-dose dispensing (2018). About 35% of them change annually, as many of them are older people who die. About 80% of users in 2011 were 65 years and older; about 40% of users lived in ordinary housing, while about 60% lived in nursing homes.[7] In 2018 about 50% of recipients of multi-dose dispensing were living at home and 50% were living in nursing homes.

Finland

In Finland, ADD was launched in 2002 and implemented through legislation in 2011. At the end of 2016, there were 49 500 patients using the ADD service.[8] In Finland, ADD takes predominantly the form of multi-dose dispensing (called “dose dispensing”

Figure 1: Hub-and-spoke dispensing



Source: Author's compilation

While ADD services in primary health care are widely promoted and used in the Nordic countries and the Netherlands, evidence on outcomes is so far very limited.[5] A study pointed out in 2014 that there was no conclusive evidence with regard to patient safety and adherence using ADD automated multi-drug use dispensing.[7] A systematic review of the influence of ADD on the appropriateness of medication use, medication safety, and costs in primary health care published in 2013,[5] only identified seven relevant studies. None were randomised controlled studies, but four studies used controls. The review concluded that evidence on appropriateness and safety is so far limited, but that overall the few identified studies suggested that patients using ADD have more inappropriate drugs (see below), although ADD may improve medication safety in terms of reducing discrepancies in medication records between GPs and home care services. The review did not identify any studies related to costs.[5]

in the Finnish context). The Ministry of Social Affairs and Health recommends the ADD service for older patients using primary health care services either at home or in nursing homes to ensure safe medication. Most customers (about 95%) of dose-dispensing, who are either living in nursing homes or at home (approximately equally split between the two locations), are entitled to publicly funded multi-dose dispensing. The remaining 5% of customers must request to have their medications provided in the form of multi-dose dispensing. For them, the service is only reimbursed by the public insurance system for patients aged 75 years and over and using six or more reimbursable prescription medicines that are suitable for ADD. There are plans to change the legislation, so that whoever has a physician prescription for multi-dose dispensing can be reimbursed.

Netherlands

In the Netherlands, both centralised dispensing (such as for repeat prescriptions) and multi-dose dispensing (for patients taking multiple medications) are widely used.[9] ADD robots can be located in community pharmacies, but more often community pharmacies tend to purchase this service from a pharmacy that is specialised in ADD.[3] Responsibility for clinical and accuracy checks lies with the spoke pharmacy, as the hub is not a registered pharmacy, but rather a supply unit.[10] There were 360,000 ADD users in 2011.[8] The largest provider of automated customised packaging of medications in the Netherlands, including multi-dose drug dispensing (MDD), is the Pharmacy Voorzorg in Limburg, serving approximately 145,000 customers through 540 pharmacies.[11]

Limited evidence on outcomes and costs

Almost all of the studies on what is termed in the United Kingdom "hub-and-spoke dispensing" relate to ADD services in primary health care in the Nordic countries and the Netherlands. ADD has been introduced to improve medication safety and treatment adherence, particularly in older patients with multiple medications. Additional anticipated benefits are a reduced workload for dispensing staff in pharmacies and nurses administering the medication, and the avoidance of stockpiles of medication at home.[3]

Overall and inappropriate drug use

A nationwide cohort study of all primary care patients in Finland aged 65 years and older who were enrolled in the ADD service in 2007 (n=2073), with a control group matched by gender, age, area of residence and number of prescription drugs reimbursed, found that overall drug use was decreased after the initiation of the ADD service compared to the controls.[8]

However, ADD may introduce new types of medication errors. A pragmatic randomised controlled study of patients using six community pharmacies in the Netherlands, with 63 patients in the intervention group and 55 patients in the waiting-list group, found a high number of drug-related problems among patients using multi-dose dispensing, as identified by a medication review.[12] Several studies from Sweden have found that patients using ADD are at an increased risk of receiving inappropriate medicines such as long-acting benzodiazepines, anticholinergic medicines, and three or more psychotropic medicines and that there are fewer changes in their

pharmaceutical treatment.[5] [13–17] This may occur because prescriptions are less likely to be checked and changed.

provide services to older people who take multiple medicines

Treatment adherence

A study examined self-reported medication adherence and knowledge of older patients (at least 65 years old and taking at least five oral drugs) receiving their drugs via multi-dose drug dispensing (MDD users) with patients receiving manually dispensed drugs (non-MDD users). The study was based on the random selection of 112 MDD users from eight community pharmacies in the Netherlands, with 96 non-MDD users matched on age and gender.[18] The study found that older patients receiving their drugs via MDD reported a higher self-reported medication adherence (81% versus 58%) compared with patients receiving manually dispensed drugs, despite a lower knowledge and lower cognitive function among patients receiving MDD.[12] [18]

Conclusions

Several countries in Europe have embraced models of "hub-and-spoke" dispensing that are somewhat similar to those anticipated in the United Kingdom. These are in particular the Nordic countries and the Netherlands. However, "hub-and-spoke" dispensing seems to be predominantly used to provide services to older people who take multiple medicines, either at home or, more commonly, in nursing homes. It is known as "multi-dose dispensing" in which medicines are re-packaged automatically into unit-dose bags for each time of administration. Multi-dose dispensing most often takes place for clearly defined groups of patients, often with a minimum age and a minimum number of prescribed medications; it tends to be reimbursed by the statutory health system.

Although now firmly established in these countries, evidence on outcomes and costs is limited and does not allow for firm conclusions. There is evidence from Finland that found that multi-dose dispensing might reduce overall drug use, but studies in Sweden found an increase in inappropriate drug use and fewer changes in drug treatment. There is also some indication of improved treatment adherence, but so far evidence on cost implications is missing.

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CHALLENGES IN LONG-TERM CARE IN EUROPE

By: Slavina Spasova, Rita Baeten and Bart Vanhercke

Summary: This article describes the national provision of long-term care (LTC) in 35 European countries, with a focus on arrangements for older people. It points to the four main challenges common to all countries: 1) access and adequacy of LTC provision, 2) quality of formal home care as well as residential services, 3) employment of informal carers, and 4) financial sustainability of the national systems. Since all European countries will continue to face significant LTC system challenges, a series of recommendations are presented to help overcome these.

Keywords: *Long-term care services for older people, Home Care, Deinstitutionalisation, Informal care*

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Note: This article draws on the analysis in the recently published Synthesis Report: Spasova et al. (2018) *Challenges in long-term care in Europe. A study of national policies,* European Social Policy Network (ESPN), European Commission. Free download at: https://ec.europa.eu/social/main.jsp?langId=en&catId=1135&newsId=9185&furtherNews=yes

Introduction

Long-term care (LTC) is considered an 'invisible social welfare scheme'[1] for two reasons. First, in most European countries, LTC financing and provision involve a mix of intertwined health care and social care. Second, LTC relies heavily on unpaid 'invisible' care provided by relatives, mostly women, whose social rights are still only a side-issue for social protection systems. At the same time, LTC is gaining visibility in policy discourse and reforms at both national and European Union (EU) level. Emphasis has been placed on the development of home-based and community-based care, including in the proclaimed European Pillar of Social Rights (EPSR).*

This article draws on a recent Synthesis Report from the European Social Policy Network (ESPN) on *Challenges in Long-term care in Europe,*[2] which provides a comparative analysis of reports drafted by national ESPN experts in 35 European countries. The report showed that issues related to LTC are gaining visibility in European countries, in a context of population ageing and changing labour and family patterns. Indeed, as a result of women's increasing participation in the labour market, and the rise in pensionable ages, the pool of informal carers, in particular for older people, is shrinking. At the same time, LTC demand will continue to increase with population ageing. The percentage of EU citizens aged 80+ is projected to increase from 4.9% to 13% over the period 2016–2070.[3]

In this context, national social protection systems face four main challenges with regard to LTC for older people:

1) **access and adequacy** linked to the underdevelopment of publicly funded formal LTC services and a lack of complementarity between formal and informal LTC;

* Principle 18 of the EPSR states that 'Everyone has the right to affordable long-term care services of good quality, in particular home-care and community-based services'.

Box 1: Official Country Abbreviations

EU countries	
AT	Austria
BE	Belgium
BG	Bulgaria
GR	Croatia
CY	Cyprus
CZ	Czech Republic
DK	Denmark
EE	Estonia
FI	Finland
FR	France
DE	Germany
EL	Greece
HU	Hungary
IE	Ireland
ET	Italy
LV	Latvia
LT	Lithuania
LU	Luxembourg
MT	Malta
NL	The Netherlands
PL	Poland
PT	Portugal
RO	Romania
SK	Slovakia
SI	Slovenia
ES	Spain
SE	Sweden
UK	United Kingdom

Non-EU countries covered by ESPN	
MK	Former Yugoslav Republic of Macedonia
IS	Iceland
LI	Liechtenstein
NO	Norway
RS	Serbia
CH	Switzerland
TR	Turkey

2) **quality of care**, which is at risk due to the significant increase in demand and lack of quality control in many countries;

3) **employment of carers**, women in particular, who are often informal carers and may need to quit their jobs due to caring responsibilities;

4) **financial sustainability challenge**, linked to population ageing and increasing public spending on LTC.

How easy is it to access LTC services and how affordable are they?

First, access to and affordability of services can be hindered by the fragmentation of LTC. In general, LTC provision and funding are split horizontally and vertically, i.e. between health care and social care as well as between territorial entities. Fragmentation of provision between health care services and social services often leads to a lack of coordination between entities, which in turn affects waiting periods and administrative procedures (e.g. in BG, CY, CZ, EE, FR, LT, LV, RS, SI, UK).† In addition, regional responsibilities for LTC have resulted in disparities in LTC provision in many countries.

Second and more importantly, there are access issues related to the underdevelopment of formal services, both for home care and community-based LTC and residential care. One of the main solutions proposed in national policy making and EU discourse is to develop access to home-based services in order to enable older people to live independently at home as long as possible. However, the availability and affordability of home-based services is a significant issue in most EU countries. This discourse has been coupled with an emphasis on replacing residential care with community and home-based care, or in other words, de-institutionalisation, in several countries. Nevertheless, the picture is far from clear-cut in this respect and several trends can be observed.

With regard to home care, there is a clear divide between European countries. Home and community-based services are most developed in the Nordic countries (DK, FI, IS, NO, SE) and some Continental European countries (e.g. AT, BE, DE, FR, LU, NL). By contrast, those in need of LTC in Southern (e.g. CY, EL, ES, MT, PT), Eastern European countries (e.g. BG, CZ, EE, LV, LT, MK, PL, RO, RS, SI, SK) and the UK face insufficient availability of home care provision, or provision often targeted at persons with a high degree of dependency.

As for residential care, the long-term outcome of the (de-)institutionalisation process is mixed (**see Figure 1**).

In Nordic countries, a significant process of de-institutionalisation can be observed, and emphasis has been placed on the development of home care. At the same time, the Nordic countries still have among the highest percentages of LTC recipients in residential facilities.[5] The situation is similar in some Continental European countries, even though a bit less straightforward.‡

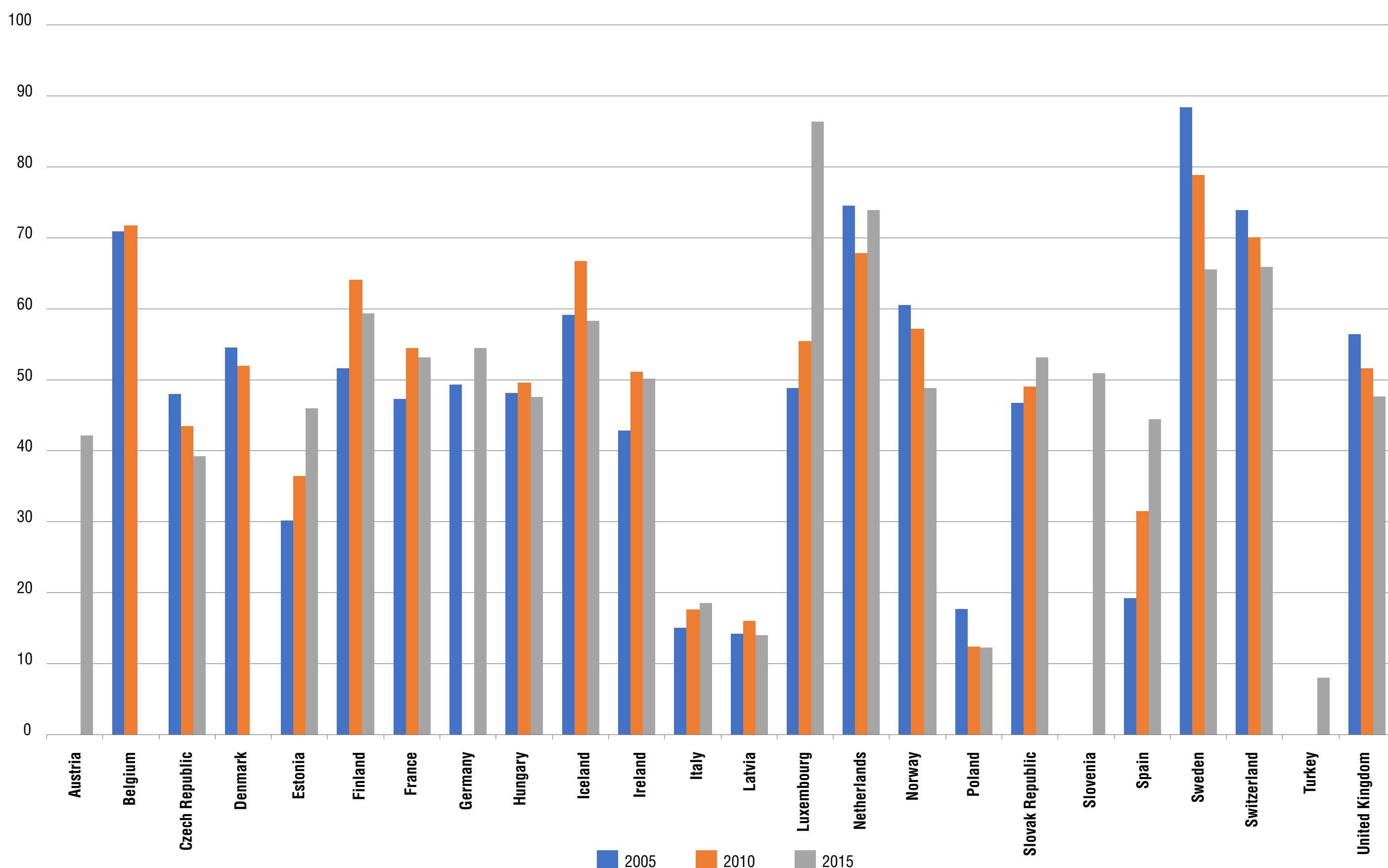
In Southern Europe (e.g. ES, IT, PT), however, there is a clear trend towards increasing the number of LTC beds for people aged 65+, due to changes in labour market structure (more women working), increase in the pensionable age and changes in the family structure (and norms). In Eastern Europe, the reasons for increasing demand and shrinking supply of care are very similar, but the situation concerning residential care supply is less obvious. In some countries there has been a slight but steady fall in the number of residential beds since the 2000s (e.g. LV), while in other countries there has been a certain increase in the number of residential beds (e.g. BG, EE, LT, RO). In both Southern and Eastern Europe, demand strongly exceeds supply for both institutional and home care provision.

Access to LTC is also hindered by issues related to adequacy of care. Adequacy is extremely difficult to measure, as very few

† Countries which have developed along similar lines are listed in brackets (the lists are not necessarily exhaustive) see also the 35 ESPN national experts' report.[2] The list of country abbreviations can be found in Box 1.

‡ With regard to people receiving formal (paid) LTC in institutions (other than hospitals). LTC institutions refer to nursing and residential care facilities which provide accommodation and LTC as a package.

Figure 1: Beds in residential long-term care facilities per 1000 population aged 65 and over, (2005, 2010, 2015)



Source: OECD. Ref.[4]

Note: Residential LTC facilities comprise establishments primarily engaged in providing residential LTC that combines nursing, supervisory or other types of care as required by the residents. Excluded from the indicator: hospital beds reserved for LTC and beds in residential settings such as adapted housing that can be considered as the individual's home.

countries have indicators or surveys to do so. We considered care as "adequate" if it provides sufficient and affordable social protection to cover the existing needs for LTC care. Sufficiency and affordability of LTC has been assessed according to the national context and is based on the limited data available. Affordability has been hampered by budget cuts in LTC provision in many countries (e.g. DK, IE, UK). In other countries, it has or may become an issue because of a strong long-term trend towards privatisation and marketisation of LTC and the rapid growth of a commercial sector (e.g. BE, DE, DE, FI, LT, RO, UK). Finally, affordable care may be an issue because of the above-mentioned fragmentation of care financing and provision.

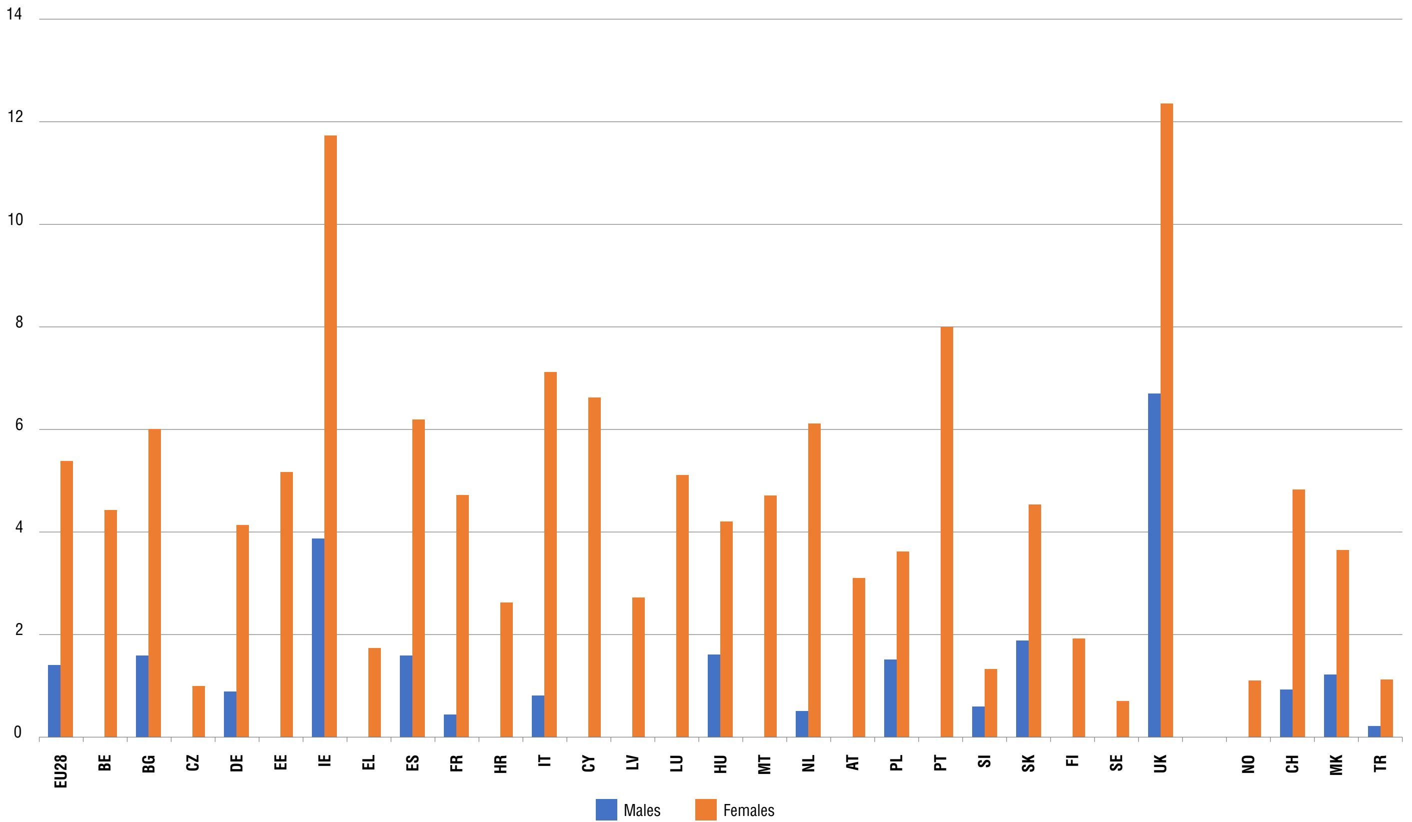
The quality of LTC: a long road ahead

The quality of LTC is key to maintaining and improving the quality of life of frail older people, both in residential and home care settings. However, the requirements in place vary substantially according to the type of care, i.e. residential care or home care. Whereas the home care sector remains mostly unregulated, residential care is governed by stricter requirements. These quality control measures seem to be a first step to ensuring quality commitment, but in some countries there are problems in implementation due to limited resources, a lack of qualified inspectors and/or a lack of transparency in the process.

Again, with regard to quality standards, there is a clear geographical divide between Nordic countries and, to some extent, Southern and Eastern European states. The former have developed indicators and there is general satisfaction with the quality of care (e.g. DK), while Southern and Eastern European countries often lack well-developed measurement tools, and care quality is considered problematic. Many aspects of quality are not covered by existing national indicators.

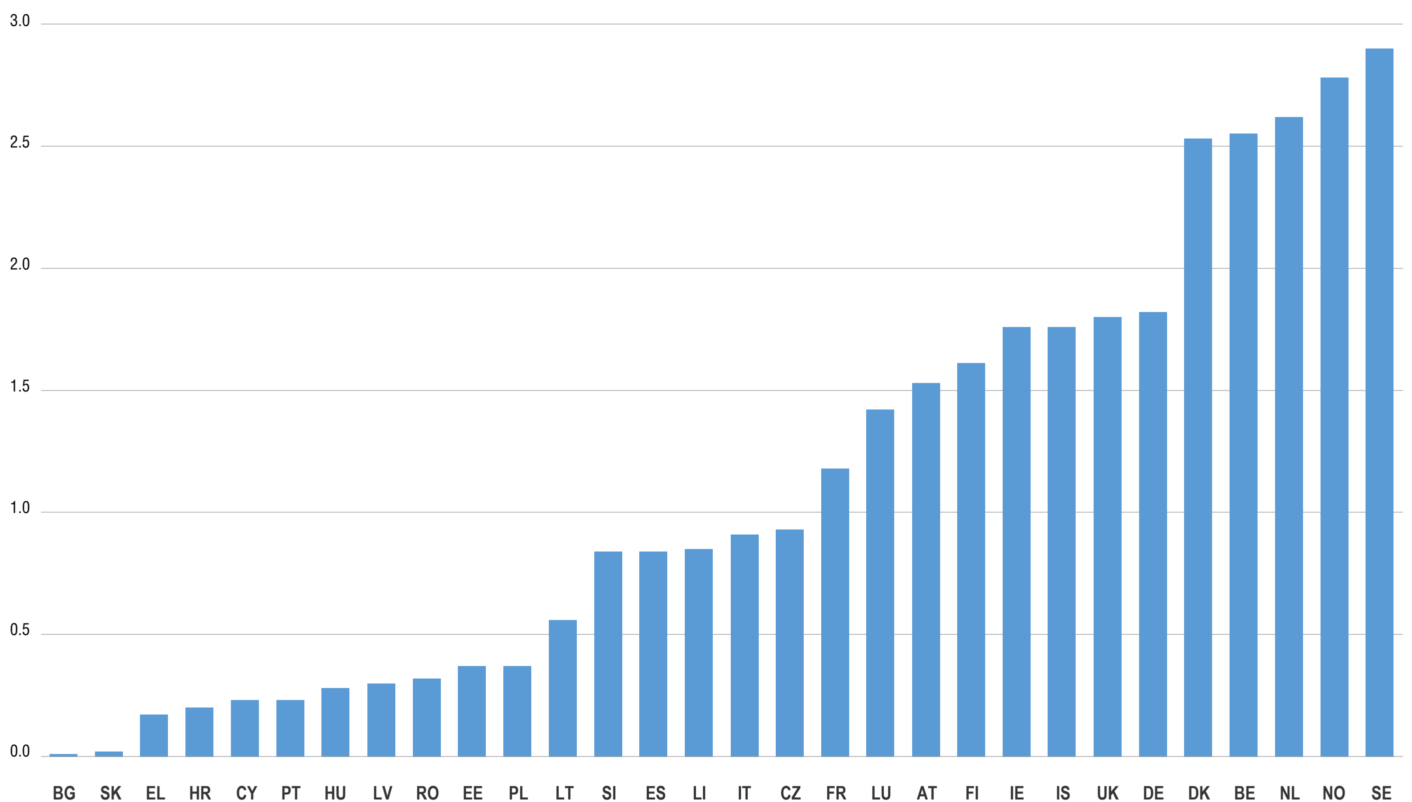
The quality of jobs and working conditions in the care sector also play a role in this context. The attractiveness of the sector remains low, as it is often depicted negatively, due to poor working conditions and job precariousness (low income, lack of training, high workload and high levels of stress). This leads to a severe shortage of qualified professionals.

Figure 2: Percentage of inactive men and women (aged 50–64) not working on the grounds that they are looking after children or incapacitated adults (2016)



Source: Eurostat, Ref.[6]

Figure 3: Long-term care expenditure (health) as a percentage of GDP, 2015



Source: Eurostat, Ref.[8]

Working and caring: can they (really) be combined?

There is a high incidence of informal care in most European countries. An informal carer is a person who provides care, in principle unpaid, to the care-dependent older person, not on a professional or formal employment basis and in general a person with whom the care-dependent has a social relationship. Family responsibilities for parents are even enshrined in law in some countries (e.g. HU, LV, LT). The main reasons for the high incidence of informal LTC are the shortage of accessible formal LTC facilities, the poor quality of LTC, the non-affordability of LTC, and, finally, the traditional model of intergenerational and family relations.

It is difficult to estimate the number of informal carers for older people. Data from the Labour Force Survey (LFS) show that looking after children or incapacitated adults was the main reason for inactivity for 5.4% of inactive women aged 50–64 years old in 2016 in the EU. The equivalent percentage for men was 1.4%. With figures of respectively 11.7 % (compared with 3.9% for men) and 12.3% (compared with 6.7% for men), Ireland and the UK have the highest shares of female inactivity on the grounds of care (**see Figure 2**).

It should be noted that migrants play a specific role in informal care provision, as families frequently rely on them to assist with care tasks for older people. However, there are frequent issues with regard to their qualifications and working conditions (e.g. irregular contracts, low social protection coverage etc.)

The financial sustainability of LTC provision: the unknown equation

Public expenditure on LTC as a percentage of Gross Domestic Product (GDP) has been increasing over the past 20 years in European countries, and is expected to grow by 70% – from 1.6% to 2.7% of GDP – between 2016 and 2070, due to population ageing. However, projections vary widely between countries. Nordic countries and Eastern countries are expected to spend generously on LTC.[7] Currently, Nordic and Continental countries are among the leaders in expenditure on LTC (e.g. SE 2.90%, NL 2.62%, BE 2.55%, DK 2.53%) while Eastern European countries score the lowest values at around 0.3% (e.g. BG 0.01%) in 2015 (**see Figure 3**).

Looking into the different challenges facing national LTC systems, financial sustainability may be made more difficult by several issues. It may be affected by fragmentation of care due to a lack of coordination between health and social care entities. An absence of clear financial strategies by the territorial entities responsible for LTC may also lead to unpredictable LTC spending.

The high incidence of informal LTC is one of the main factors accounting for the financial sustainability of the current LTC

Box 2: Recommendations

Access to and affordability of LTC

1. The development of home-based services should go hand in hand with strong prevention and rehabilitation policies, to ensure that people can continue to live for as long as possible in their own home if they so wish. Home care should be available to all persons with LTC needs and not only to the most care-dependent older people.
2. While prioritising home care over residential care, countries should avoid policies which reduce the supply of residential institutions without providing sufficient home-based services. An appropriate national policy mix should be found, which provides sufficient residential care facilities. Planning of the number of care places should be based on an objective assessment of the population's needs, adapted to the regional situation.

Quality of care

3. Countries should apply stricter standards to the various providers, and above all should extend the scope of services offered to cover home care. Effective checks on and supervision of the quality of care should be reinforced.
4. Member States should agree on a common set of indicators to assess the quality of LTC. To do so, a major step forward would be to reach an agreement on a common EU definition of quality of care.

Informal carers and domestic workers

5. Where cash benefits are provided, payment should be made subject to proof that it is used to pay for care. If cash benefits are used to recruit domestic workers, this recruitment should be made conditional upon a formal employment contract with the care worker. If the cash benefit is used to compensate the informal carer, the involvement of the carer should be defined in a multidisciplinary care plan.
6. Stronger support for informal carers should include: (1) improved social (security) rights for informal carers; (2) providing adequate training, upskilling and recognition of skills; (3) enhanced possibilities to remain in the labour market (e.g. part-time carers' allowances, flexible arrangements) and to return to it later.

Financial Sustainability of LTC

7. Countries should aim to gather and update evidence and data on sustainability in order to plan the funding of the LTC policy mix (benefits and services).
8. More effective and cost-efficient measures should include an even stronger emphasis on rehabilitation and social investments (e.g. in prevention strategies, innovative technologies and social services).

systems in many European countries. In Portugal, the work performed by informal carers is estimated at over 2% of GDP (while formal care is estimated at 0.2%).

Looking forward: recent reforms and debates

LTC provisions have been subject to reforms in most European countries over the past ten years (2008–2018). Three broad trends can be identified: first, the readjustment of the LTC policy mix and namely the move away from residential care towards home care and community-care; second, measures addressing financial sustainability (most often introducing budgetary restrictions), in particular during the crisis period (e.g. DK, ES, PT, IE, UK); and third, reforms aimed at improving the access and affordability of provisions, including increased LTC funding, improving eligibility conditions and benefit levels, tackling interinstitutional and territorial LTC fragmentation, and recognition and improvement of the status of informal carers (e.g. AT, FR, CZ, PT, PL).

Recommendations

The challenges listed above require solutions. Our main recommendations are listed in **Box 2**. For a more exhaustive discussion of the policy recommendations, see Spasova *et al.* 2018.[2]

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PEOPLE-CENTRED TB PREVENTION AND CARE IN EASTERN EUROPE AND CENTRAL ASIA

By: Regina Winter, Ihor Perehinets, Masoud Dara, Martin van den Boom, Stela Bivol and Hans Kluge

Summary: The importance of health system strengthening for improved TB prevention and care is highlighted in The United Nations Sustainable Development Goal 3, which includes targets to move towards universal health coverage and to end the TB epidemic. The TB-REP project actively supports eleven countries from Eastern Europe and Central Asia and is implemented by WHO Regional Office for Europe and other partners from 2016 until the end of 2018. One of the key objectives of the Project is to support countries to develop and adapt key policies on a people-centred model of TB service delivery, appropriate mechanisms for TB services, as well as financing and human resources for TB programmes planning. The project countries are taking different approaches in implementing the people-centred TB model of care and adopting health policies depending on their overall health systems readiness and broader health system transformation agenda.

Keywords: *Multidrug-resistant Tuberculosis, People-centred Care, TB Prevention, TB-REP*

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Introduction

Universal health coverage (UHC) is high on the political agenda in many countries and is vital for achieving better health and well-being for people of all ages. UHC can provide disease prevention, health promotion and treatment for both communicable and non-communicable diseases. Related to the former, tuberculosis (TB) remains a public health concern in the WHO European Region as health systems face the challenge of multidrug-resistant TB (MDR-TB). MDR-TB rates in the WHO European Region are over twice as high as those in other WHO regions for both new cases and previously treated patients. Of the 30 countries considered to have a high burden of MDR-TB globally, nine are in the WHO European Region, mostly in Eastern European and Central Asian countries (EECA). According to the WHO Global

TB report, every day, around 900 people fall ill with TB and 65 people die of it across the Region (2017).[1]

Presently, the treatment practices for TB are characterised by a high level of hospitalisation, high average length of stay and outdated models of TB care. Moving towards models of care that can treat MDR-TB strains requires mechanisms that support multidisciplinary models of care; acceptance of people-centred practices with strong primary health care (PHC) systems and services; cooperation between different care providers; enhanced clinical skills and high levels of staff motivation; involvement of communities and civil society, as well as national policies towards people-centredness – all the elements that EECA health systems are struggling with.

The WHO Regional Office for Europe actively promotes and supports a comprehensive multicomponent approach to strengthening health systems that aims to bring significant improvements to TB prevention and care outcomes. The critical element of national health system transformation to improve performance is political commitment to design and implement robust policies on people-centredness. A key effort to promote this approach and respond to the regional challenges described above is the TB Regional Eastern Europe and Central Asia Project (TB-REP) on Strengthening Health Systems for Effective TB and DR-TB prevention and care (**see Box 1**).

Box 1: The TB REP project

TB Regional Eastern Europe and Central Asia Project (TB-REP) on Strengthening Health Systems for Effective TB and DR-TB prevention and care is financed by the Global Fund to Fight AIDS, tuberculosis and Malaria and is implemented by the Center for Health Policies and Studies (PAS Centre, Moldova), as the principal recipient, and the WHO Regional Office for Europe, as the technical lead agency, in collaboration with partners, over three years from 2016 to 2018. The project has been deployed in 11 EECA countries – Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

The overall goal of TB-REP is to reduce the burden of TB and halt the spread of drug resistance by increasing political commitment and translating evidence into the implementation of a people-centred model of TB care. The expected outcomes are:

- For countries to adopt key policies on people-centred TB service delivery, TB care financing and human resources for TB programmes
- Use hospital care rationally, based on clearly defined and adopted admission and discharge criteria
- Have roadmaps for countries to incorporate people-centred policies for sustainable and effective TB prevention and care.

The Global Fund performance framework helps to follow up countries' achievements, based on agreed indicators and milestones. (**see Figure 1**)

People-centred model of TB care

People-centred health systems are defined as a design of core health system functions (governance, health financing, service delivery, human resources for health) that prioritise the needs of individuals, their families and communities, both as participants and beneficiaries for high quality comprehensive and coordinated services delivered in an equitable manner and involving people as partners in decision-making.[2] WHO has encouraged outpatient treatment since 1999[3] and has recommended ambulatory treatment of MDR-TB since 2011.[4] According to the WHO policy documents, in particular the WHO *End TB Strategy,* the first pillar underpins the "integrated, patient-centred TB care and prevention" and focuses on early detection, treatment and prevention for all TB patients, including children, and aims to ensure that all TB patients not only have equal, unhindered access to affordable services, but also engage in their care.[5] This is also stipulated by the Roadmap to implement the Tuberculosis Action Plan for the WHO European Region 2016–2020.[6]

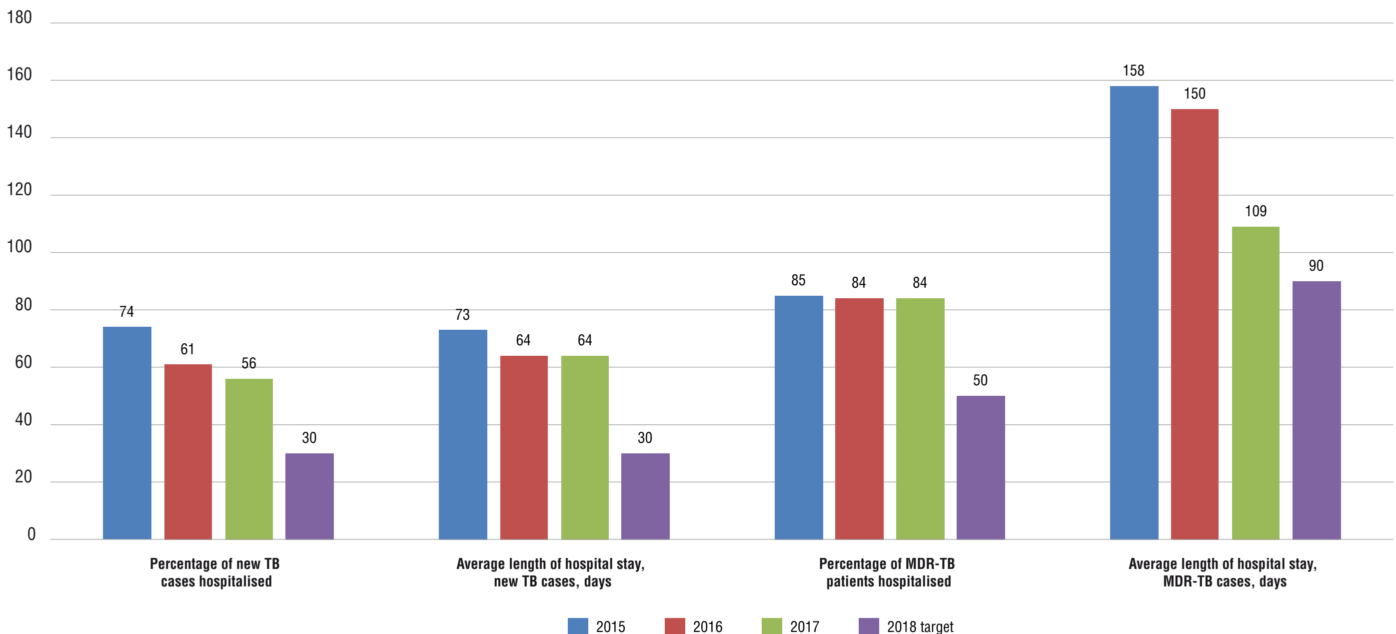
To operationalise the concept of people-centredness for the particular model of TB care, a working group has developed a blueprint of policy options.[7] Released in 2017, this document provides a vision for a people-centred model of TB care and presents a design of this model, which focuses on meeting the health needs and expectations of people throughout the life-course with a strong PHC system and community. This model requires the preventive, ambulatory, community and home care sectors to enhance their capacity to plan, implement and monitor integrated models of care to address TB. Further, hospitals need to be reconsidered as one of many links, not the only one, in a health service delivery network, where patients move seamlessly between different settings based on their needs. Taking into consideration health financing, it is important to develop and implement payment mechanisms which do not have inbuilt incentives to provide unnecessary services such as hospitalisation but rather contain incentives to motivate health professionals in PHC to provide the services.[7]

Policy response

In order to understand how the project countries are adopting key policies, on a people-centred TB model of care a special survey was conducted in a two-step process. As a first step, the WHO Regional Office for Europe, jointly with the PAS Centre developed a questionnaire, which was sent to the TB REP focal points† for data collection. This questionnaire was developed based on the Global Fund

† The TB REP focal point is a high-level government representative, who was appointed to oversee and support the implementation of this project in the country with the engagement of relevant ministries and other relevant stakeholders.

Figure 1: Overview of quantitative indicators 2015 versus target 2018



Source: TB-REP data

Note: This data was provided in January and is only partial.

monitoring and evaluation framework. In the second step, national documents, regulations and policies were analysed and supported by desk research, and in some cases TB REP focal points were interviewed.

> transforming TB services through health system strengthening

The survey and desk research revealed that some of the countries, such as Armenia, Kazakhstan, Kyrgyzstan, Moldova and Uzbekistan have introduced people-centred TB national policies and have included three health system functions strengthening in their national policies.

According to 2016 base line data, the number of countries, which have adopted key policies on health system strengthening and TB was relatively low at around 45%. The repeat survey in 2018, showed that more than 73% of the countries introduced key policies on people-centred TB prevention and care in 2017, which shows an increase of almost 50% compared to the baseline (**see Table 1**).

EECA countries have had different opportunities and approaches to introducing elements of the people-centred model of TB care, which depend on their health systems' maturity or ongoing health systems transformation. For example, Armenia started by changing the financing of TB hospitals in 2014 and introduced fixed and variable budgets at the hospital level to achieve better performance of TB services.

Later in 2016, Armenia introduced a *National Strategy for TB control for 2016–2020*. As emphasised in the Strategy, "the goal is to prevent the spread of tuberculosis in the Republic of Armenia and reduce the number of patients with drug-resistant tuberculosis (…) through coordinated screenings carried out **in primary health care** organisations among people having been in contact with tuberculosis patients and in high risk groups".[8] Here, the discourse clearly underlines the importance of PHC and provision of TB services within PHC. This strategic approach is supported by the updated hospitalisation and discharge criteria in Armenia's national guidelines on TB control.

In 2018, Armenia took one step further to broaden the transformation of TB services when the Ministry of Health initiated a reform to optimise the network of TB services providers. The key areas of this phase target strengthening the regulation of inpatient and outpatient TB services and improving the financial mechanisms for outpatient TB services. The main objectives are to strengthen ambulatory care and carry out the outpatient TB services through existing TB units of regional polyclinics.

Belarus provides another example. In 2017, it initiated further steps toward implementing a people-centred model of TB care through pilot project in the region (oblast) of Brest, focusing mainly on the reorganisation and optimisation of TB services at oblast level and reforming financing mechanisms for TB care. A regional budget was introduced which helped to solve the problem of financial and administrative fragmentation. As a result, the number of TB beds in hospitals was reduced by 33% by 1 January 2018, while money was kept in the TB service to incentivise staff to provide people-centred care.[9]

Table 1: Key policies on health system strengthening for TB prevention and care implemented prior to, and after, 2016

Key policies	People-centred model of TB health service delivery		TB financing and provider payment mechanisms		Human resource planning for TB	
	2015	2017	2015	2017	2015	2017
Armenia	yes	yes	yes	yes	yes	yes
Azerbaijan	no	no	no	no	no	no
Belarus	yes	yes	no	no	yes	yes
Georgia	no	yes	no	no	no	yes
Kazakhstan	yes	yes	yes	yes	yes	yes
Kyrgyzstan	yes	yes	yes	yes	yes	yes
Republic of Moldova	no	yes	no	yes	no	yes
Tajikistan	yes	yes	yes	yes	yes	yes
Turkmenistan	no	yes	no	no	no	no
Ukraine	no	no	no	no	no	no
Uzbekistan	no	yes	no	yes	no	yes
Percentage of 'Yes' answers	45%	73%	36%	55%	45%	73%

Note: Data from 11 countries for 2017, based on WHO Europe survey, 2018

Kyrgyzstan has also initiated a pilot and introduced financing mechanisms for the successful completion of TB treatment for PHC workers in Chui oblast in 2017. Here, it is important to mention that Kyrgyzstan showed high level policy coordination between the Ministry of Health, National TB Programme and the Government. Several strategic documents addressing TB prevention and care with a health systems approach have been developed over the past few years. Payments have been initiated of $USD 175 for treatment of sensitive TB and $USD 350 for MDR TB cases; 10% of this goes to the family doctor and 75% goes to the nurse of the family doctor. According to the preliminary evaluation, the treatment success rate of TB patients is 100%, based on provision of TB services close to the patients in PHC and at home, therefore making it more people-centred.

A fourth example from the WHO survey, Republic of Moldova, introduced policies after 2016, in particular a roadmap on implementing a people-centred model of care for TB in 2017. The roadmap describes the interventions on the people-centred model of TB prevention and care, namely restructuring the hospital sector of the physio-pulmonology service in line with objectives to reduce hospital admissions and length of stay, and increasing and strengthening the role of outpatient specialised, primary care and community settings for the early detection of TB and case management of TB/MDR-TB.[10] Provider payment arrangements are now undergoing review and mixed payment models are being used for all levels of care – hospital and outpatient care, as well as providing patient support. Furthermore, some policies regulate the salaries of medical professionals working for public institutions contracting with the National Health Insurance system for early detection of TB cases. Strategic purchasing of TB services is ensured by the National Health Insurance Company, which applies the criteria for contracting health facilities based on performance indicators.

Lessons learned and the way forward

Improvements are being made

Based on the survey, only a few project countries did not introduce formal policies on the people-centred model of TB care in 2017, but they are continuing to strengthen TB services and are also taking steps to improve their model of TB care to make them more ambulatory based. For example, Azerbaijan is currently working on a new ministerial order with the aim of improving prevention, early diagnosis and treatment, as well as strengthening the regulatory and methodological framework governing TB control. The order will include the package of services provided by TB units, departments, dispensaries, and hospitals as well as TB care models, based on a service mapping exercise by settings, facilities and type of services. Furthermore, the requirements for outpatient and inpatient treatment, as well as hospitalisation and discharge criteria, will be described.

Action plans and other supporting documentation aid progress

The survey analysis and interviews clearly showed that in some countries policymakers should consider strengthening policy responses to TB, and in some others enhance existing policies by developing supporting documents such as roadmaps, action plans and concept notes. The development of roadmaps, action plans and concept notes with clear steps, interventions and possible initiation of pilot projects could be seen as one of the next steps to help countries on their way to sustainable changes in their TB models of care.

Clarifying governance structures is key

Some country examples show that the strengthening of all health systems functions are highlighted in national policy documents, but at the same time they do not clarify the governance structure and accountability framework by defining the leading agency, the role of each actor in TB care activities with their responsibilities, or set respective accountability mechanisms to assure the implementation of a people-centred model of care.

Purchasing practices need to be reassessed

Furthermore, some national policies do not align health worker resources and financing of TB services, which are crucial components in every health system reform. The survey highlighted that the transition from hospital-based TB care to ambulatory treatment is proving difficult, given the current financing of TB services. The lack of a split between purchasers and service providers, as well as strategic procurement, make it difficult to implement people-centred TB care.

The people-centred TB care model is adaptable to country-specific needs

As part of the TB-REP, high-level missions were conducted to the project countries to advocate for the effective engagement of governments and their commitment to changes in the national health system that would strengthen TB services. Together with the national working groups on TB, established in line with the TB-REP project, it was possible to define an appropriate TB care model, adapted to the national country context and health system challenges, and supported by the TB-REP technical missions. Furthermore, civil society organizations in the TB-REP countries supported this and other TB-REP actions through a bottom-up approach supporting national efforts.

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Bulgaria: Health system review

By: A Dimova, M Rohova, S Koeva et al

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Despite marked and notable progress in some health indicators such as infant mortality, Bulgaria lags behind EU averages. This derives from unsteady improvement patterns and a steeper increase in, for example, life expectancy in other countries, therefore, Bulgaria records a relatively low-level life expectancy. This situation is further exacerbated by large socioeconomic and regional health inequities.

Poor health status is also partly related to the under-performance of the Bulgarian health system, which is demonstrated by high levels of amenable mortality. While the share of gross domestic product spent on health expenditure has increased (up to 8.2% in 2015), the Bulgarian social health insurance system provides an insufficient degree of financial protection. Out-of-pocket spending represents nearly half of health spending (47.7% in 2015), which is three times higher than the EU average. Accessibility and quality of care is also threatened by imbalances in the allocation of resources. Health professionals are concentrated in urban areas and still too many interventions are performed in hospital settings.

A lot of these problems have been acknowledged in various reform initiatives and particularly in the 2015 National Health Strategy; however, only a few have been successfully implemented. A political vision and broad consensus among all stakeholders is needed to end the standstill.

ADVERTISING DENTAL SERVICES: CAN EU LAW RELY ON PATIENTS' TRUST AND PROFESSIONAL DIGNITY?

By: Cédric Grolleau

Summary: In the Vanderborght case-law of 2017, the European Court of Justice set a solid framework for organizing the free circulation of commercial communication of dental services in the internal market[†]. It establishes that while national legislative bans on such advertising is not compatible with EU law, commercial communications cannot breach either patients' trust or professional dignity. Thus, advertising can be subject to supervisory measures. Nevertheless, this framework faces a double challenge because some dental companies are not bound by a code of practice, and as new advertising technologies are being developed ahead of legislative planning, these factors test the longevity of the concept of professional dignity as applied to dentistry. An evaluation of the effects of advertising on health care costs and provision would be advisable.

Keywords: *Internal Market, Professional Advertising, Commercial Communication, Patient Safety, Dentists*

Background

In the recent Vanderborght judgement[*] of 4 May 2017, the European Court of Justice (ECJ) set a clear principle that any absolute ban on advertising dental care services within Member States' national law is incompatible with EC law: the Treaty *"must be interpreted as precluding national legislation (...) which imposes a general and absolute prohibition of any advertising relating to the provision of oral and dental care services"* (Decision C-339/15, Luc Vanderborght, para.76). However, the judgement also clarified that when dealing with public health, free competition and free circulation of commercial communication* of dental services in the internal market cannot be outside of any control whatsoever. On the contrary, the judgement introduces two criteria: such commercial communication cannot breach a patient's trust, nor can it undermine health professionals' dignity.

* In this preliminary ruling, the European judge dealt with the situation of a dentist in Belgium practising professional advertising in blunt contradiction with domestic law which imposes a general and absolute prohibition of any form of advertising.

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Professional rules are needed to uphold high standards of integrity

The relevance of professional rules has been recognised for a while within EU legislation (see the 'Unfair Commercial Practices Directive', 'Directive on electronic commerce', 'Directive concerning misleading and comparative advertising'). When it comes to public health, the judgement in the Vanderborght case-law explains its justification in detail. Confirming the importance of the relationship of trust that should be maintained between dentists and their patients, it concludes that:

"The extensive use of advertising or the selection of aggressive promotional messages, even such as to mislead patients as to the care being offered, by damaging the image of the profession of dentist, by distorting the relationship between dentists and their patients, and by promoting the provision of inappropriate and unnecessary care, may undermine the protection of health and compromise the dignity of the profession of dentist"(para.68–69).

Consequently *"the content and form of the commercial communications (...) may legitimately be subject to professional rules"* (para.46) in order to ensure that the confidence which patients have in those professions is not undermined. Currently, in autumn 2018 in France and Luxembourg, professional bodies are considering how to draw conclusions from the Vanderborght case-law and to consequently adapt rules for health professionals.

The specificity of health professionals is underlined by the EU judgement

A past ECJ judgement has explained the safeguards attached to the nature of health care professions, for example pharmacists; *"It is undeniable that an operator having the status of pharmacist pursues, like other persons, the objective of making a profit. However, as a pharmacist by profession, he is presumed to operate the pharmacy not with a purely economic objective, but also from a professional viewpoint. His private interest connected with the making of a profit is thus tempered by his training, by his professional experience and by the responsibility which he owes, given that any breach of the rules of law or professional conduct undermines not only the value of his investment but also his own professional existence."*(Decision C-531/06, Commission vs Italy, para.61–62).

> aggressive promotional messages may undermine the protection of health

The Vanderborght case-law goes further in that it purports to explain this peculiar *"responsibility"* within the specific field of (health) professionals advertising their services.

There is no blank cheque in the EU on advertising in the health sector

This protection of health profession's dignity should be read as a solid rationale given that in 2017 the Court reiterated it in the case-law dealing with Belgium's prohibition of advertising of plastic surgery. In this decision, the EU judges stated that the Unfair Commercial Practices Directive 2005/29 *"must be interpreted as not precluding a provision of national law (...) which protects public health and the dignity and integrity of the professions of plastic surgeon and plastic doctor by prohibiting any natural or legal person from disseminating advertising for procedures relating to plastic surgery or non-surgical plastic medicine"* (Order C-356/16, Wamo BVBA, para.24).

In other words, free competition and free communication in health care provision may have adverse effects if they are not supervised. The criterion of professional dignity can be of use in this regard.

Patients' trust and professional dignity guide the proportionality test

The Vanderborght case-law will be of direct use in the near future. When considering the proportionality of regulation applied to professionals wanting to advertise their services, this latest Treaty interpretation provided by the ECJ for dentistry can be added to the numerous criteria listed by a more recent secondary law relating to the proportionality test, i.e. Directive 2018/958 (of 28 June 2018 *on a proportionality test before adoption of new regulation of professions*), which enters into force on 30 July 2020. In practice, this Directive should be read in light of the Treaty's interpretation in the Vanderborght case.

First challenge: 'corporate dentistry'

The framework now established, though solid and nuanced, faces a double challenge. First, there is the unfair competition of 'corporate dentistry'. Unlike professionals, a company is not bound by a code of practice; and some national legislators in Europe have tried to address this situation. In France, corporate dentistry took mainly the form of 'dental centres'. They bypassed the dentist's code of ethics and, doing so, used professional advertising for dental care that dentists could not compete with (such as distribution of flyers; giant signs; comparison). After years of litigation, in 2017, the Supreme Court sentenced those centres for unfair competition. The Law was subsequently amended accordingly and professional advertising of 'dental centres' has been reduced to the provision of factual information (see Ordonnance n° 2018–17 of 12 January 2018 on the conditions of establishment and operation of health

† Broader than 'advertisement' or 'announcement', a commercial communication in Europe refers to *"any form of communication designed to promote, directly or indirectly, the goods, services or image of a company, organisation or person pursuing a commercial, industrial or craft activity or exercising a regulated profession."*. See Article 2(f) of Directive 2000/31/EC of 8 June 2000 *on certain legal aspects of information society services, in particular electronic commerce, in the Internal Market* (Directive on electronic commerce).

centres *(relative aux conditions de création et de fonctionnement des centres de santé)*).

In Spain, the competition between practitioners and dental companies has not been streamlined as yet. The Spanish General Council of Dentists *(El Consejo General de Dentistas)* has been advocating for over a year for new legislation that would override the rules of professional associations, regulate health advertising for all professionals and apply throughout the country. The national legislator has not made up its mind at the time of writing.

Second challenge: unforeseeable advertising technologies

The second challenge brought to the Vanderborght case-law relates to the constant development of new technologies in advertising, which are often way ahead of any legislative planning.

Some of these technologies test the longevity of the concept of professional dignity as applied to dentistry. Such is the case of self-promotion videos on YouTube as well as mHealth† applications. As stated in *"The Privacy Code of Conduct on mobile health (mHealth) apps"‡*, facilitated by the European Commission, the sustainability of apps in general – including mHealth apps – is often supported by some form of advertising, be it of commercial or of professional nature.[1] In Belgium, the solution that has been submitted to the national legislator in September 2018 is to regulate professional advertising for all health professions in general and through few but key principles.[2] In this approach, the nature and use of authorised technologies and media are not regulated. In a single provision, the draft law states that professional information *"must be truthful, objective, relevant and verifiable, and must be scientifically sound"*. The professional information that is communicated cannot encourage the practice of superfluous examinations or treatments and may not aim to search actively for patients. Moreover, professional information relies on and refers only to original professional titles listed by the government, be it in a video or on a mobile health application.

But 'advertising' in EU law also covers the use of a domain name and furthermore the use of metatags in a website's metadata, as highlighted by another ECJ decision: such *"use of metatags is a promotion strategy in that it aims to encourage the internet user to visit the site of the metatag user and to take an interest in its goods or services"* (decision C-657/11, Belgian Electronic Sorting Technology, para.59–60). This raises the question of how to regulate dentists who use metatags to rank themselves higher up in search-engine results used by patients? Is it still *"truthful, objective, relevant and verifiable, and scientifically sound"? Can the "relationship of trust which must prevail between a dentist and his patient" and "the protection of the dignity of the profession of dentist"* emphasised by the EU judgement be preserved when metatags are used by a health care professional as *"a promotion strategy"*.

Last but not least, telemedicine takes place under the E-Commerce Directive whereby the principle of country of origin prevails. In other words, the dentist–as a service provider–should comply only with the national law of the country of establishment of his or her clinic. Therefore, when it comes to professional advertising, dentists are not bound by the legal order of the patient's country where the service is received (see Article 3 of Directive 2000/31 of 8 June 2000 *on certain legal aspects of information society services, in particular electronic commerce in the Internal Market*). In this specific situation of cross-border health care services, in addition to the Vanderborght case-law, coordination between national legislators would be advisable.

What about an evaluation of the effects of advertising?

On 12 June 2015, the European Commission's independent expert panel on effective ways of investing in health published its final opinion on competition among health care providers.[3] The report identifies various conditions across EU Member States that need to be considered such as, among others, *"adequate information about provider prices and quality"* and *"facilitating comparison by patients"*. Needless to say, those conditions rely on professional advertising. However, the expert panel also appears keen to stress that: *"Competition in health care provision will not solve all health system problems and may have adverse effects. Neither economic theory nor empirical evidence support the conclusion that competition should be promoted in all health services"*.

This concern has also been recently relayed by the Conseil d'Etat in France in May 2018 in a report on *Rules applicable to health professionals in information and advertising.*[4] Taking note of the prospect of increased competition at the European level, which is particularly pronounced in the border regions, and taking note of possible *"adverse effects on the protection of public health, especially when it comes to drug consumption or the provision of health care",* the Conseil d'Etat recommends *"to put in place tools to evaluate the effects of advertising or commercial communication on health care costs as well as effects, ultimately, on health care provision in France through competition between providers in the European Union and in the rest of the world."* (Recommendation 14).

In its final recommendation addressed to the government, the Conseil d'Etat goes even further and proposes that EU Member States engage in co-ordinated dialogue and decision-making to achieve better coordination of legislation establishing the rules applicable to health professionals' advertising (Recommendation 15). Ideally, such an evaluation and such coordination could help to assess the efficiency and longevity of the criteria of patient's trust and professional dignity in a developing digital single market.

† mHealth is a term for the use of mobile phones and other mobile technology in health care.

‡ The core of the Code of Conduct consists of practical guidelines for app developers.

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AMBULATORY CARE ON THE RISE? LESSONS FROM THE AUSTRIAN HEALTH CARE REFORMS

By: Andrea E. Schmidt, Florian Bachner, Lukas Rainer, Martin Zuba, Julia Bobek, Lena Lepuschütz, Herwig Ostermann, Juliane Winkelmann and Wilm Quentin

Summary: Previous reform efforts in Austria, which aimed to shift patients away from costly inpatient hospital care towards ambulatory or day-care, were hampered because of conflicting incentives for stakeholders. Since 2012, a major health reform introduced a new target-based governance system that improved coordination, led to joint financial and health targets, as well as efforts to strengthen primary health care. Progress has been made in increasing same-day discharge rates and reducing inpatient treatment of ambulatory care sensitive conditions. Yet, in order to increase progress, further reforms are needed to streamline financial responsibilities, and improve access to social health insurance (SHI) funded ambulatory care.

Keywords: *Health Reform, Social Health Insurance, Ambulatory Care, Governance, Austria*

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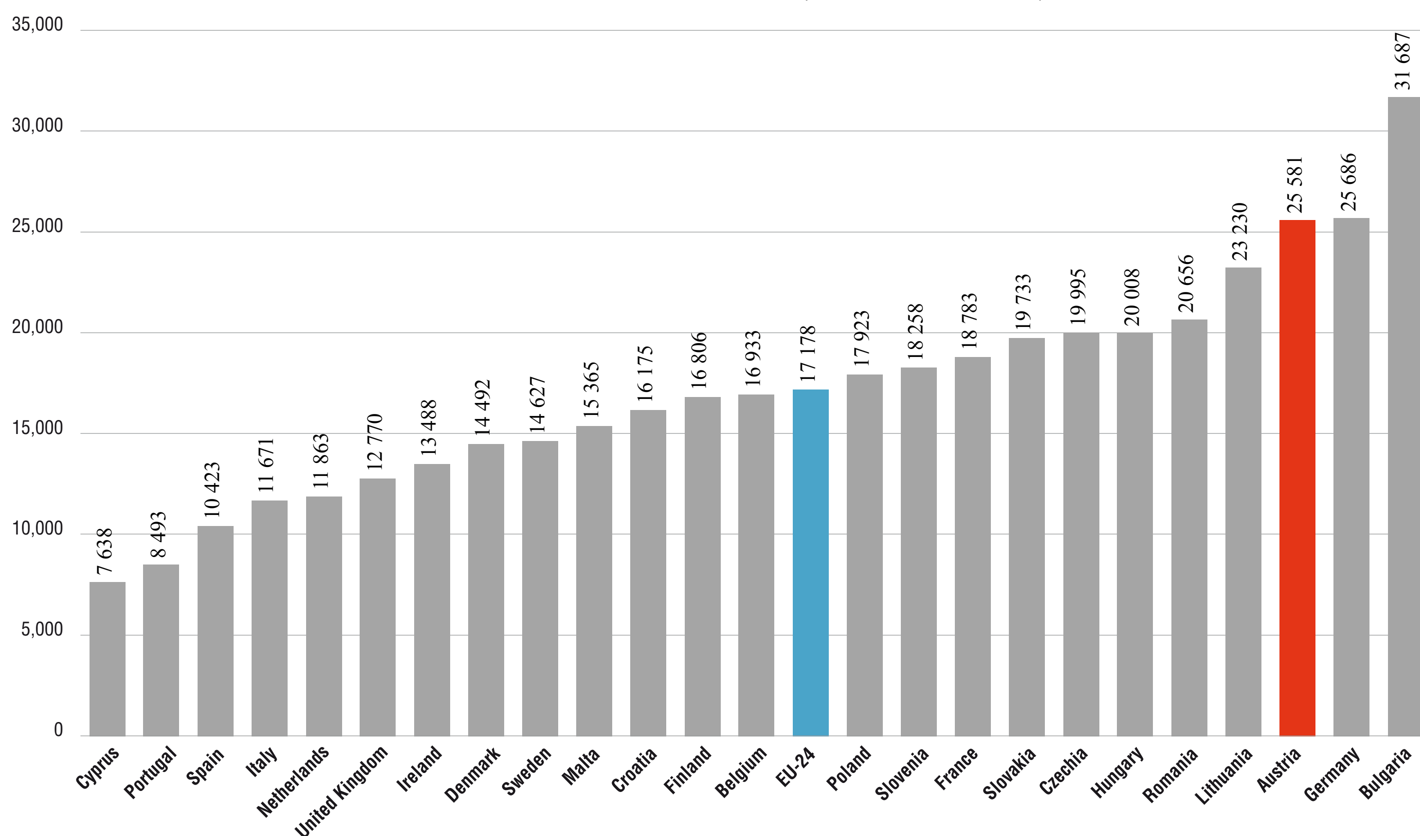
Background

Policymakers in Europe (and beyond) struggle to control rising health care expenditures. One approach that many countries have adopted with the aim of reducing costs is to shift patients away from the costly impatient sector towards ambulatory care or day-care settings. In Austria, a major reform was initiated in 2012 that is interesting from an international perspective because it has created a new governance system in order to better control rising health care expenditures. In addition, the country has made some progress with shifting care to the ambulatory sector.[1] This article describes the Austrian health care system's current challenges, outlines the ongoing reform process, and concludes with an intermediary assessment of what has been achieved so far and what future challenges await.

Figure 1: Hospital discharges per 100 000 population in the EU, 2016 (or latest available year)



Source: Eurostat data

Overreliance on acute care in hospitals is Austria's top health care challenge

Too much reliance on the acute care inpatient sector is a major cause of high health care expenditures in Austria. Hospital discharge rates are among the highest in the European Union, exceeded only by Bulgaria, Lithuania and Germany (**see Figure 1**), and hospitals accounted for around 40% of public health care expenditure in 2015.[2] Health spending in Austria (US$ 5138 per capita) is considerably above the EU average (US$ 3310). While virtually all of the population is covered by social health insurance (SHI), with a broad benefit basket and good access to health care, moderate performance on health outcomes put above-average spending in question.[1]

There are two major explanations for Austria's focus on hospital care. First, there is relatively unrestricted access to all levels of care, including hospitals, without a formal gatekeeping system in place. For ambulatory care, patients can choose between independently practising physicians, group practices, hospital outpatient departments and outpatient clinics.[1]

> The new governance system relies on cooperation and coordination of the different stakeholders

Second, there is a 'passing-the-buck' problem implicit in the way health care financing and service provision are organized. The federal constitution assigns responsibilities for financing and service provision of inpatient and ambulatory care to different actors: The federal and state *(Länder)* governments are responsible for inpatient care, while SHI is responsible for ambulatory care. This results in fragmentation and poor care coordination for people with chronic diseases[3] and at the same time hampers shifting of service provision to ambulatory (extramural) care as this would increase the expenditure of SHI funds.

The new governance system is based on a common vision for all stakeholders

In the past, numerous reform attempts were aimed at reducing the fragmentation between inpatient and ambulatory care and improving cooperation and coordination in the health care system. Former and recurring recommendations by national and international institutions had focused on streamlining the constitutional competences in the health sector. However, this was difficult to achieve because it would have required a constitutional majority (two-third majority) in parliament. Major political parties did not commit to the daunting task of constitutional reform because they expected considerable public resistance.[1]

Therefore, in 2012, the federal government (i.e. the Ministry of Health and the Ministry of Finance), the SHI funds and the state governments jointly initiated a fundamental reform of the health system. Their primary aim was to increase joint planning, joint governance and (partially) joint financing. The result was the development of a new "target-based health governance" system, which could potentially achieve the overall aim of improved coordination in the health system while leaving the constitutional division of powers and responsibilities unchanged.

The new governance system is based on a common vision for the future development of the health system and relies on cooperation and coordination of the different stakeholders who agreed to set their own interests aside for the benefit of achieving jointly agreed goals or targets. In 2013, the new governance system was institutionalised through the setting up of the Federal Target-Based Governance Commission (*Bundes-Zielsteuerungskommission,* B-ZK). In the B-ZK, representatives of the federal government, the states, and the SHI funds agreed on common goals or targets for the health system. As a result, the B-ZK has become the supreme decision-making body of the Austrian health system, defining the common vision for the future development of the system.

The jointly agreed goals and targets are specified in a Target-Based Governance Agreement *(Bundes-Zielsteuerungsvertrag)*, which is a legally binding contract concluded between the members of the B-ZK. This agreement provides the basis for State Target-Based Governance Agreements *(Landes-Zielsteuerungsverträge)*, which operationalise the implementation of federal targets, and which are approved by the State Target-Based Governance Commissions *(Landes-Zielsteuerungskommissionen).*

Agreement on cost containment and strengthening primary health care

The first Federal Target-Based Governance Agreement was concluded in 2013 and outlined a reform agenda for the period 2013–2016. It defined financial* and health targets together with specific measures for achieving them. This included a cost containment path, combined with a transparent monitoring mechanism. Furthermore, a shift of activities and resources to less costly settings was meant to contribute to attenuating the strong focus on hospital inpatient care. One of the most important reform elements with regard to health care structures was the development of a new concept for the provision of primary health care, which ultimately led to the adoption of the Primary Health Care Act (2017).

> Establishing a strong primary health care system

In 2017, the B-ZK concluded the second Target-Based Governance Agreement, which defined goals for the next 5-year reform period (2017–2021). This agreement, together with the Primary Health Care Act, provides the legal framework for the planned establishment of 75 primary health care units by 2021. Primary health care units are required to consist of multi-professional and interdisciplinary teams and are intended to reduce the overreliance on hospitals.[1]

Procedures performed in day-care settings are increasing

The ongoing reforms lay an important foundation for establishing a strong primary health care system, while reducing the country's focus on hospital care. This could only be achieved because the new governance system contributed to better alignment among the goals of the three main financing agents (federal government, *Länder* governments, SHI). A common understanding between these stakeholders is crucial in implementing reforms in the health care sector that affect different levels of service provision, governed by different decision-makers. One perceived weaknesses of the new governance system is that the health service providers are, to a large extent, not involved in the decision-making process. Decisions are only taken by the three main financing agents. Yet, reforms aimed at establishing strong primary health care may well cause so-called 'ripple effects', which require changes in the regulation and scope of practice, adaptation of payment systems, changes in medical education and changes in governance structures.[5]

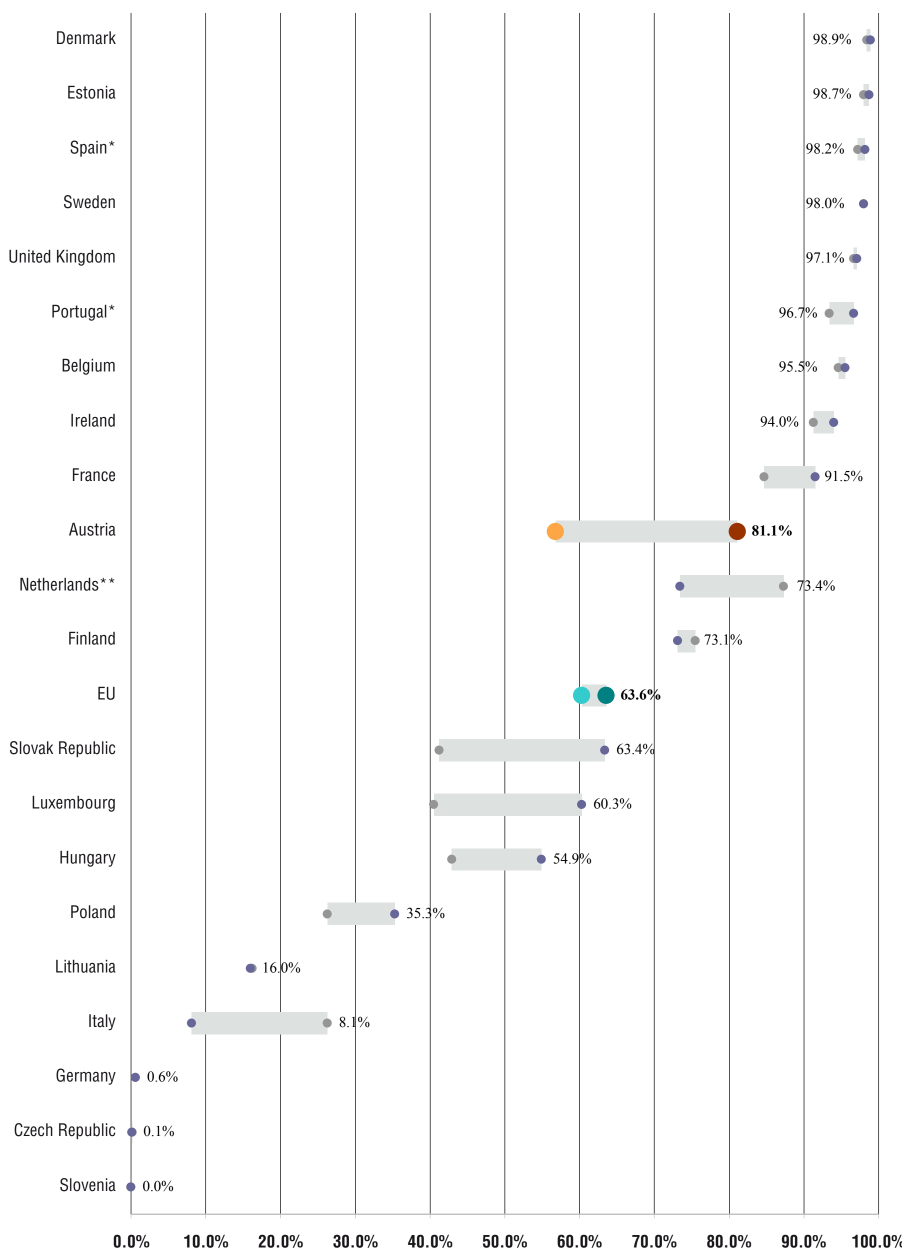
An important achievement of the reforms has been that the share of procedures performed in a day-care setting has increased over recent years, thus avoiding overnight stays (e.g. for cataract surgeries (**see Figure 2**). In addition, the number of hospital admissions for conditions that could usually be treated in an ambulatory setting (avoidable hospital admissions) is decreasing. However, large variations exist across hospitals,[6] and it is difficult to evaluate how much of the reduction is attributable to the reforms themselves.

Overcoming fragmentation of financing and service provision remains challenging

The planned roll-out of multi-professional and interdisciplinary primary health care units is one important step in strengthening primary health care. This can potentially further reduce avoidable hospital admissions, as well as the country's overreliance on inpatient care. At the same time, when it comes to shifting provision from the inpatient sector to the ambulatory care sector, a number of problems remain unresolved.[3] The reform efforts lead to more coordination, but disincentives and the "passing-the-buck" problem remain. Despite the establishment of joint planning and governance, fragmentation in the organisational and financial structures is still evident. Structural change envisaged by the reforms is occurring incrementally

* The ongoing health care reforms also focus on rising public health expenditure. Average expenditure growth in the health care sector has been consistently higher than GDP growth since 2012. To contain public spending on health, the first Federal Target-Based Governance Agreement concluded in 2013 introduced a global budget cap for federal, sectoral and regional health budgets aligned with GDP growth, which was further extended throughout the 2017 health reform package.

Figure 2: Share of cataract surgeries carried out as day cases, 2012 and 2016 (or nearest year)



Source: OECD data [7]

Notes: EU-21 refers to the unweighted average, *2012 and 2015, **2012 and 2014.

rather than in a transformative manner, as constitutional responsibilities remain unchanged, particularly for financing.[1]

Finally, expenditure caps might contribute to reducing expenditure growth if stakeholders continue to abide by the rules of the new governance system. However, expenditure caps will not necessarily lead to shifting service provision away from the inpatient sector. Rather, this requires further structural reforms and improved access to strengthened SHI-funded ambulatory care. In addition, reductions in hospital care should go hand in hand with expansion in the ambulatory care sector so as to ensure high-quality accessibility of health services in the future.

Conclusions

The Austrian reform experience highlights the importance of institutional factors when it comes to health reforms aimed at strengthening primary health care, particularly in countries with a social insurance-based welfare model. The ongoing reforms have contributed to strengthening the primary health care system, while reducing the country's focus on hospital care. This could only be achieved because the new governance system has better aligned the goals among the three main financing agents. An important aspect of the reform has been the agreement on financial and health targets among these three stakeholders. The share of procedures carried out in a day-care setting has increased over the past years, thus reducing the country's focus on hospital inpatient care. Yet, fragmentation in organisational and financial structures remains problematic. Further structural reforms are needed to tackle fragmentation and to further shift service provision away from the inpatient sector, while expanding ambulatory care.

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OVER-UTILISING INPATIENT CARE: DEVELOPMENT AND REFORMS TO THE BULGARIAN HOSPITAL SECTOR

By: Anne Spranger, Antoniya Dimova, Maria Rohova, Stefka Koeva, Elka Atanasova, Lubomira Koeva-Dimitrova and Todorka Kostadinova

Summary: Bulgaria has the second highest level of acute care bed density in the European Union after Germany and the highest number of hospital discharges. And yet, the current national payment and regulation scheme offers limited possibility to reduce over-utilisation of hospital care. This article sheds light on attempted reforms to contain hospital activity in Bulgaria since 2010 and outlines some of the current and future problems of financial sustainability and inequity in inpatient care.

Keywords: *Hospital Care, Provision of Care, Private Sector, Reforms, Bulgaria*

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Introduction

The hospital sector in Bulgaria is remarkable for its size, activities and growth trends, which are at odds with the general European trend. First, Bulgaria had some 51 000 beds in total, and the majority (43 000 beds or 83%) are allocated for curative care.[1] [2] In 2016, the ratio of acute care hospital beds in Bulgaria stood at 6.03 beds per 1000 population, which is second only to Germany (6.06 beds).[3] While there were cuts to the number of publicly-owned acute care beds in 2006 and 2011, these cuts have been offset by a more dynamic increase in the private sector (with a 106% increase in beds between 2010 and 2016). In contrast, according to OECD data, the number of hospital beds per population decreased in all EU Member States between 2000 and 2014.[4]

Bulgaria also has the highest rate of hospital discharges in the European Union (EU): in 2016, three out of every ten Bulgarians was discharged from an inpatient treatment of more than 24 hours. Here too, the trend in hospital discharges has dropped in other EU Member States such as Denmark, Hungary and Romania since 2010, but it has increased in Bulgaria (on par with Germany and Austria).[3]

In consideration of these trends, this article sheds light on the general payment and regulation schemes for hospitals and current reform efforts to contain the inpatient sector in Bulgaria.

Several failed attempts to strengthen regulation of hospital care

The overcapacity of acute care beds is a widely acknowledged fact in Bulgaria

and there have been several reduction plans which aimed to lower the number of curative beds. Between 2000 and 2016, the number of publicly-owned hospital beds decreased by 33% (also partly due to policies of the single payer organisation, the National Health Insurance Fund (NHIF)). In the private sector, however, an increase in hospitals and beds has occurred. Between 2015 and 2016 alone, three new private hospitals with a total of 799 beds entered the hospital market, while the public sector decreased further. This is due to the fact that the NHIF is required to contract with hospitals once they meet formal requirements.

At the same time, all hospitals, both public and private, have registered an increase in total hospital discharges, although private hospitals are the main driver. In total, Bulgarian hospital discharges increased from 25.7 hospital discharges per 100 inhabitants in 2010 to 31.7 in 2016, which is far above any other European country (with Germany ranking second with 25.7 discharges). Moreover, there is an ongoing trend of market concentration of private hospitals. Past reforms have attempted to introduce selective contracting of providers by the NHIF based on (regional) health needs but with limited success (**see Box 1**).

Box 1: The National Health Map as a tool for selective contracting

The idea of a "National Health Map" dates back to the very beginnings of the Bulgarian social health insurance system and was enshrined in the Law on Health Care Establishments (1999). Originally, the National Health Map was intended to be used as a planning tool where implementation should guarantee both accessibility of health services and efficient resource allocation. The first National Health Map was enacted in 1999, but was never used as a planning instrument. This was realised only in 2011.

In 2015 and 2016, the newly enacted National Health Map (due to be enacted every five years) was accompanied by regulations defining the rules and criteria for selective contracting. A specific feature of the 2015 National Health Map was that it was based on regional health maps, established by representatives of local health authorities, municipalities, physicians and patients. However, in 2017, the Supreme Administrative Court repealed both, on a number of formal grounds. In 2018, the Ministry of Health once again published a new draft legislation on selective contracting in a further attempt to curb public spending on hospital care.

Hospitals are paid based on clinical pathways

Since 2001, hospitals receive funding mostly through case-based payments– called "clinical pathways"–which differentiate between 292 flat rates according to performed procedures. These rates are subject to negotiation between the NHIF and the Bulgarian Physicians Union.

Rates are calculated based on the cost of medical activities, auxiliary services provided to patients and up to two outpatient medical examinations and consultations after the patient has been discharged from hospital. Furthermore, user fees are paid by patients directly to hospitals at the point of care delivery (although there are some groups such as children, patients suffering from chronic diseases and pregnant women who are exempt from user fees). User fees are fixed at BGN 5.80 (€2.96) for each day of stay (up to ten days per year). Additionally, patients may opt for above-standard hospital services, such as a single room. The extra billing is based on the hospital's price list and the maximum has been regulated since 2011. For instance, the choice of physician may be billed up to BGN 700 (€357) and for a patient who wishes to choose a physician team, up to BGN 950 (€485).

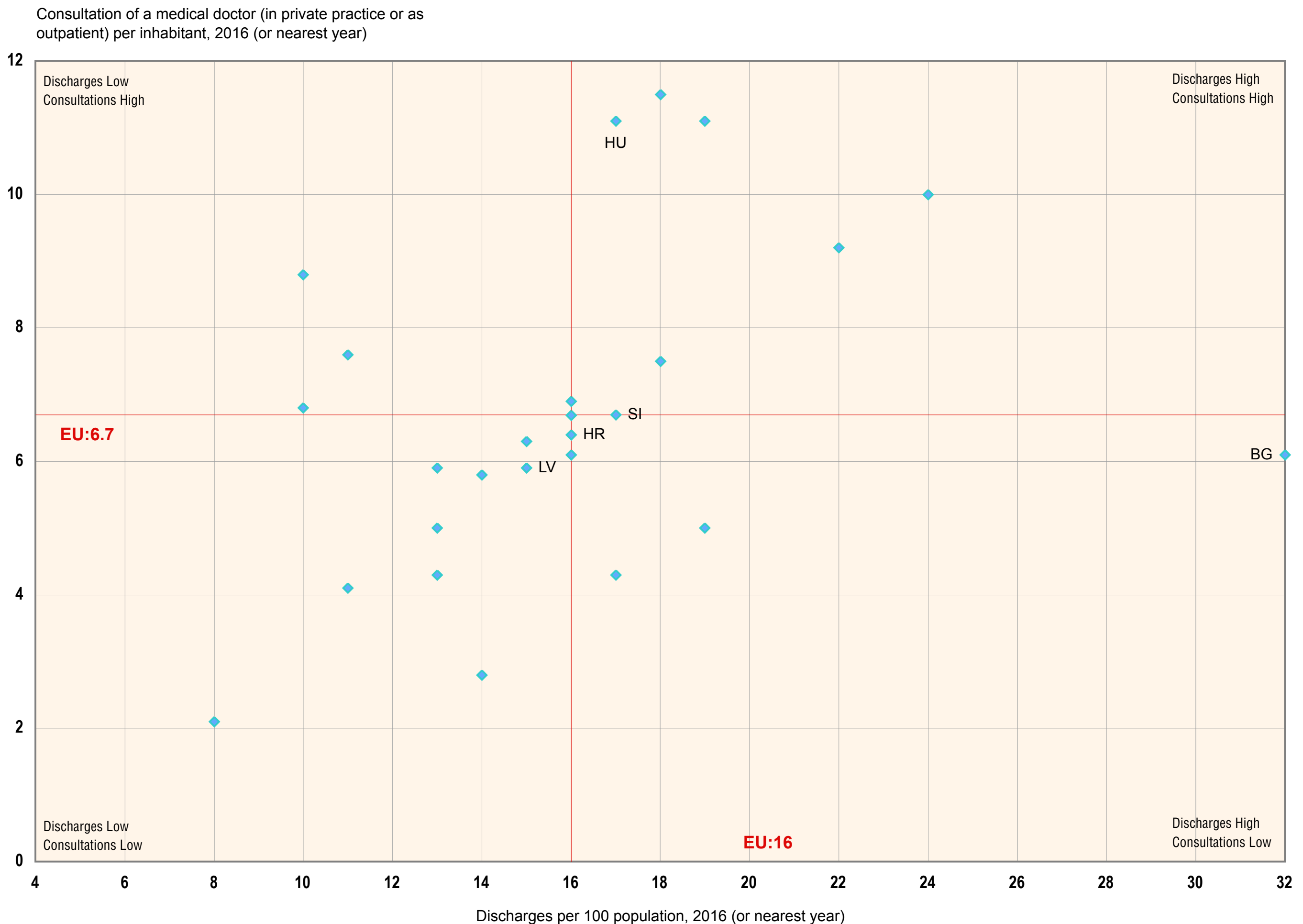
Selected reform efforts have attempted to curb hospital spending with little success. In 2015, in an attempt to reduce unnecessary hospitalisations, ceilings on hospital admissions were introduced for each hospital and clinical pathway. Complying with these new payment schemes, the NHIF should not pay for hospitalisations that exceeded the set ceilings. In practice, however, hospitals continued to provide services – even after the allocated budget was spent – and petitioned the NHIF for additional funding as emergency cases, which are not subject to the hospital ceilings. In 2018, the Supreme Administrative Court repealed the 2015 hospital ceilings altogether.

Overreliance on hospital care needs more attention

Bulgaria had the highest hospital discharges rates for heart failure (1342 per 100 000 population), diabetes mellitus (721.6 per 100 000 population), and asthma (189.9 per 100 000 population) among all EU countries in 2016.[2] High hospital discharge rates point to an overall weak primary care system, a fact which is also exacerbated by the generally low number of outpatient contacts of 6.1 per person in 2016 (**see Figure 1**). However, this utilisation pattern also points to several interrelated factors:

- There is a general imbalance between general practitioners (GP) and specialists in Bulgaria. What is more, the number of generalist physicians decreased by 21.6% between 2000 and 2015, while the number of specialist physicians increased by 11.8%. The share of generalists to the total physician workforce has consistently been shrinking from 21% in 2000 to 16.6% in 2015, which is the second lowest ratio in the EU after Greece and far below the EU25 weighted average of 30.2%.
- Besides a generally low GP density, there are also geographical distortions in health care labour supply throughout the country. The districts with medical universities and university hospitals concentrate the largest numbers of physicians and more health professionals on average per 1000 population than other districts. For example, in 2016, in Pleven district there were 5.63 physicians per 1000 population, whereas the national average was 4.16 per 1000 population. One-fifth of all physicians works in the capital, Sofia,

Figure 1: Outpatient visits per inhabitant and hospital discharges per 100 patients, 2016 (or nearest year)



Notes: BG: Bulgaria; HU: Hungary; SI: Slovenia; HR: Croatia; LV: Latvia

Sources: Ref.[3]

with 5.03 per 1000 population. This puts rural areas at a disadvantage and erodes accessibility.

- Additionally, other factors are contributing to the overall high levels of hospital discharges. For instance, the significant proportion of the population who are uninsured (roughly 12 %) is still prone to forgoing care and rely, in cases of a quick deterioration of their health status, on emergency services in local hospitals.

Disparities between types of hospital beds and regions persist

The overall high level of hospital beds and their activity come with a high price. In 2016, Bulgaria spent one-third of its current health expenditure on hospitals. Furthermore, general and multi-profile hospitals accounted for 51% of total beds and 26% of current health expenditure in 2016.[1] In contrast to acute care beds, the numbers of hospitals for long-term treatment and for psychiatric treatment remain constant at a very low level: a total of 12 psychiatric hospitals account for only 0.6% of current health expenditure. Long-term care beds are even scarcer with only 0.2 long term beds available per 1000 population in 2016.

Additionally, there is also considerable regional variation across all examined inpatient establishments and beds. The south-western region still has the highest number of hospitals (103 in 2016 or roughly one-third of all hospitals), mostly driven by the capital city Sofia.[5] This high concentration of hospitals is not necessarily driven by demographic indicators, because some districts with a comparable population have far lower numbers of hospitals.[6]

Conclusions

The hospital sector in Bulgaria with its current level of activity poses a potential threat to the financial sustainability of the health system. Inpatient care accounts for a third of current health expenditure, but does not yield optimal results in terms of population health indicators. Additionally, current challenges like strengthening capacities in primary care still have to be faced and financed. Over-utilisation of hospital services is evidenced by recording the highest number of hospital discharges in Europe, the tendency for more private hospitals, the absence of effective

purchasing arrangements (such as selective contracting) and the failure of reform efforts in the hospital sector.

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THE 'TO AND FRO' OF **SPANISH HEALTH CARE COVERAGE** AFTER THE ECONOMIC CRISIS

By: Cristina Hernández-Quevedo, Dolores Jiménez-Rubio and Enrique Bernal-Delgado

Summary: Despite the principle of universal health coverage underlying the Spanish health system, the breadth of coverage has been affected by the implementation of reforms ostensibly aimed at securing the sustainability of the health system. Specifically, the 2012 reform which followed the economic crisis excluded undocumented migrants from coverage. This group has suffered access barriers even for services that were exempt from the legislation, e.g. health care for mothers and children. Recent reform introduced in July 2018, which guarantees universal health care coverage for the whole population in the country, will need to be carefully monitored.

Keywords: *Universal Health Care, Migrants, Health Coverage, Spain*

Introduction

While most countries in Europe have achieved universal or quasi-universal health care coverage, some countries have implemented measures that mainly reconsider the breadth of coverage, which ostensibly aimed to improve the sustainability of the health system in the aftermath of the economic crisis. The Spanish case is one example. Given the budget and debt constraints imposed by successive Stability Pacts, in 2012 the ruling party in the country initiated a series of policies intended to reform the breadth, depth and cost-sharing mechanisms of the Spanish National Health System (SNS) coverage. The decision on the breath of population coverage focused on limiting entitlement rights which, as a matter of fact, predominantly affected undocumented migrants.[1]

At the time of writing, however, the Spanish Parliament has passed a new universal coverage regulation following a change in the Spanish Government. The new Royal Decree Law (RDL) re-establishes the universality of the health system, after the Ministry of Health opened a dialogue process with the regions and civil society.[2] The new RDL[3] on access to the universal health system, was

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enacted in Parliament in September 2018, and aims for homogenous implementation across the regions. This article reviews the Spanish legislation on universal health care coverage over the past 20 years and analyses the associated costs of these measures.

Universal health care coverage was restricted during the economic crisis

The Spanish National Health System (SNS) is designed as a universal health system, which is tax funded and that mainly operates within the public sector. Competences in this field have been totally devolved to the regions since 2002.[1] Until 2012, SNS population coverage was almost universal (99.5%) and was designed to guarantee a comprehensive package of benefits to all citizens. Entitlement was independent of the working status of the individual as well as socioeconomic status, with only a negligible 0.5% of the population without any health coverage.[4]

At this time, coverage of foreign residents was regulated mainly by Organic Law 4/2000, of 11 January 2000, on the rights and freedoms of foreigners in Spain and their social integration.[5] This regulation introduced one of the main reforms in the last 20 years in the health system, granting full access to health services for all individuals regardless of their nationality and legal status. In order to access health services, migrants were requested to enrol in the municipal population register. In spite of this, there is substantial evidence that migrants were experiencing barriers to access to care, as they were accessing the health system mainly through emergency care.[6]

In parallel, Spain witnessed an unprecedented increase in its foreign population. According to the 2007 National Immigrant Survey, 2.6 million Spanish households contained at least one person born abroad, although as a result of the recent economic downturn, the figures remained stable: in 2011, Spain received 457 650 immigrants, a slightly lower number than in 2010 (465 169).[7]

In the context of implementing costs-cutting measures due to the economic crisis, the government introduced legislation (RDL 16/2012, of 20 April 2012) on 'urgent measures to guarantee the sustainability of the National Health System', which changed the scope, depth and breadth of SNS benefits.[8] This new legislation resulted in undocumented migrants being excluded from health coverage, posing some challenges to public health. In particular, those individuals from countries other than EU Member States or nationals from countries with bilateral agreements, were only entitled to emergency care for serious illness or accidents until discharge (regardless of the cause), and to obstetric care and services for children (i.e. those under 18).[1] The RDL 16/2012 reform was largely criticised by many health professionals and the wider civil population: the entitlement modification was approved without the required agreement of the governing body for the SNS, i.e. the Inter-territorial Council of the SNS, nor did it receive the desirable consensus of the Spanish Parliament. In fact, the new legislation was introduced through a RDL, which is a legal formula issued by the government that just requires parliamentary validation.

At the time of implementation of RDL 16/2012, the government announced alternative health care plans for undocumented immigrants. The new regulation foresaw annual premiums covering the basic package of benefits to be €710 per year for those aged under 65, and €1900 per year for those who are 65 and older. However, these plans have since proven to be unaffordable and even more expensive than existing private insurance plans in Spain.[9]

Quantifying the number of migrants who lost their health care entitlement after 2012 is a great challenge. Official figures point to around 900 000 individuals losing access to health care. Moreover, there is evidence that the immigrant population continues to face access barriers compared to the national population.[10] Further, recent reports have documented the existence of obstacles to accessing health services by population groups that, in theory, are unaffected by the law, such as mothers and children, and in some cases even impediments to access to emergency care by undocumented individuals.[9]

Not all regions implemented the reform

Implementation of the legislative changes was uneven across Spanish regions (or Autonomous Communities). Some refused to apply the new law on the basis that there was no credible rationale backing the decision, i.e. the undocumented migrant population group is younger than the native population, with lower utilisation rates and they still contribute to the economy and society via the payment of indirect taxes. These regions were also concerned about the risk of widening health inequalities and the potential negative consequences on the health of the population. Instead they introduced regional legislation granting access to the health system for undocumented immigrants who have been living in the region for a certain time (variable, depending on the region). For example, the Canary Islands, Andalusia and the Basque Country all introduced such counterbalancing regional laws.[11] In fact, only one region fully applied the nationwide regulations without restrictions while five introduced the national law with some minor exceptions.[12]

> "The economic crisis impacted the scope, depth and breadth of SNS benefits

The remaining regions introduced alternative health programmes for undocumented immigrants, which differ on the timing and access details, and other aspects specific to each region. Furthermore, the Ministry of Health ended up relaxing the measures for the sake of reducing hospital emergency departments' workloads and due to public health issues.[1]

The reform was also accompanied by great confusion about the terms of the restrictions, not only among the targeted population but also among doctors and

other stakeholders in the health system. Moreover, even in regions granting full access to the entire population, no health campaigns were launched to inform the population on the access rules.

Equity in access for migrants, the major impact of the reform

Until 2012, immigrants living in Spain, despite having the same health care coverage as nationals, were less likely to visit a specialist and more likely to access emergency services. Potential access barriers were likely to be either demand related, or driven by culture, language ability, socioeconomic context or legal status, or created by supply-related factors such as accessibility or staff attitudes.[6]

Evidence provided so far on the effects of the 2012 reform shows important reductions in planned care, which do not seem to be fully compensated by higher emergency care use by the affected population.[11] In fact, a recent study suggests that mortality among this population group increased by 15% during the first three years of implementation of the reform.[13] In addition, restricting access to health care for undocumented immigrants in 2012 considerably reduced the probability of this group visiting a specialist doctor, and in particular, the probability of them making a scheduled hospital visit.[11]

It is difficult to determine the potential long-term health impacts of denying access to the health system to undocumented migrants; many migrants have left the country, so the exposure was short-term and the consequences unpredictable. Many health professionals in primary care opposed the measure because they wanted to avoid the unintended consequences of introducing access barriers, in particular losing continuity of care of migrants' clinical conditions.[9]

The new legislation brings some redress but assessment is necessary

One of the first measures of the new government that took office in July 2018 was to restore universal health coverage. Under new legislation, Regional Health Authorities are in charge of issuing specific health insurance cards for those undocumented migrants that prove to have lived for more than 90 days in the country. In cases where an individual requires health assistance within those 90 days, social services must first submit a favourable report.

The new legislation grants undocumented migrants access to benefits in the SNS general scheme free of charge at the point of use, with the exception that the pharmaceutical co-payment threshold has been set at 40% of the retail price for this population, irrespective of their income level. This co-payment scheme is similar to that one for Spanish active workers with annual income lower than €18 000. Likewise, they cannot benefit from monthly payment caps either.[1]

> Assessing the potential long-term health impact of the reform remains challenging

Although no formal procedure has been established to assess the impact of this new policy, the Inter-territorial Council held on 28 June 2018 agreed to create a joint committee, made up of representatives from the organisations defending universal coverage, whose role will be to monitor compliance with the new measure. Such monitoring is important as persistent barriers to accessing the health system for undocumented migrants may result in significant health impacts in the long-term and may impose other substantial health and social costs (for example, in terms of the impacts of domestic violence, which is usually detected in primary care or reproductive health). More importantly, with the re-establishment of universal health care, continued assessment of the long-term consequences of access barriers constitutes good practice by policymakers.

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Spain: Health system review

By: E Bernal-Delgado, S García-Armesto, J Oliva, et al.

Copenhagen: World Health Organization, 2018 (on behalf of the Observatory)

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The underlying principles and goals of the Spanish national health system continue to focus on universality, free access, equity and fairness of financing. The evolution of performance measures over the last decade shows the resilience of the health system to macroeconomic conditions, although some structural reforms may be required to improve chronic-care management and the reallocation of resources to high-value interventions.

Life expectancy in Spain is the highest in the EU. Inequalities in self-reported health have also declined in the last decade, although long-standing disability and chronic conditions are increasing due to an ageing population. After decreasing in 2009–2015, public health-care spending is on the rise with public sources accounting for over 71.1% of total health financing. Yet private spending, mainly related to out-of-pocket payments, has increased over time, and it is now above the EU average.

Primary care remains the core element of the health system. Public health efforts over the last decade have focused on increasing health system coordination and providing guidance on addressing chronic conditions and lifestyle factors such as obesity. Health system-specific measures to maintain the sustainability of the Spanish health system were implemented in the last decade, with no short-term impact on health outcomes. Structural measures, however, are needed to improve resource allocation and technical efficiency as well as patients' participation in decisions on their care.

WORKING **TOWARDS UNIVERSAL HEALTH COVERAGE:** LESSONS FROM **GEORGIA**

By: Erica Richardson and Nino Berdzuli

Summary: In 2012, the newly elected government in Georgia sought to make good on their promises of improving access to health care by making clear political commitments to achieving universal health coverage (UHC). Progress has been made in improving access to health care, protecting the population from financial risks of inpatient care and reducing inequalities. Consolidating and developing these gains will require further government investment in population health and broadening coverage for outpatient pharmaceuticals.

Keywords: *Universal Health Coverage; Georgia (Republic); Benefits Package Design, Single Payer*

Introduction

Since 2013, Georgia has been striving to provide UHC through a tightly defined package of publicly funded benefits. Reforms have fundamentally altered health system financing through the introduction of a single purchaser for the government's package of benefits. This replaced the previous system where competing private insurance companies provided a state-funded package of benefits to a tightly defined group of recipients who lived below the poverty line. Under the old system, although the lowest income households were covered, most of the population remained uninsured. However, the introduction of the Universal Health Care Programme extended the breadth of coverage to almost the whole population.[1]

What is the Universal Health Care Programme?

The government that came to power in 2012 was committed to higher social spending. The state budget for health in 2013 increased dramatically (from 388 million to 662 million GEL (US$235 million to US$401 million), steadily growing to over 1bn GEL (US$416 million) in 2017) as the new government sought to refocus on spending in the social sphere. All citizens were to receive a universal basic package of high-quality health services, protection from financial risks, prevention of diseases and coverage of emergency care using globally approved mechanisms. The ultimate aim is to increase the population's life expectancy and improve its overall health.

Package of benefits

The first phase of reforms introduced the Basic Package of Benefits in February 2013 and the whole uninsured population were eligible. Over 90% of the resident population became entitled to a tightly defined package of state-funded benefits in 2013. The package of benefits covered primary care services

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(including many basic diagnostic tests) and emergency medical care – both inpatient and outpatient services. This was then expanded in July 2013, when the Universal Health Care Programme was implemented, to include elective surgery, oncology and childbirth (all with variable limits and co-payments). All those uninsured in July 2013 could apply for cover.

> the depth of coverage is greater for lower income households

Within the package of benefits under the Universal Health Care Programme, the depth of coverage is greater for lower income households. More comprehensive cover is provided to pensioners, children aged five years and under, and households registered as living below the poverty line. Basic primary care and some diagnostic services, as well as urgent outpatient and inpatient care (with a cost ceiling), elective surgery (with 10–30% co-payments), oncological services and obstetric care, are available for those above the poverty line but earning less than the highest income bracket.

In March 2017, the next wave of health care reforms was announced and this brought further differentiated packages for those covered under the Universal Health Care Programme. The highest income group of around 43, 000 people was excluded from the Universal Health Care Programme from July 2017, as they are expected to purchase voluntary health insurance. The savings accrued from no longer covering this group are intended to be used to cover an expanded package of pharmaceutical benefits for the lowest income 'target' group. The impact of this policy on solidarity and risk pooling in health financing is yet to be seen.

Single payer

The Social Services Agency (SSA), which conducts means testing and access to social assistance programmes, is now the single payer in the health system for different levels of government-funded cover under the Universal Health Care Programme. The purchasing function was consolidated to the SSA and moved from the private health insurance industry in order to improve efficiency and reduce the high administrative costs of the previous model. The vertical programme covering high-risk maternal and newborn care was integrated into the Universal Health Care Programme to be purchased by the SSA and the Ministry of Labour, Health and Social Affairs (MoLHSA) is working on the integration of the diabetes programme. The gradual incorporation of vertical programmes should help to reduce fragmentation in the system and consolidate funding flows.

Why was it introduced?

The nature of the health system in place in 2012 has fundamentally shaped the Universal Health Care Programme, as it was put in place to address the shortcomings the previous Medical Assistance for the Poor (MAP) programme. MAP was part of an approach to the health system driven by the aim of complete marketisation of the health sector: private provision, private purchasing, liberal regulation and minimum supervision. From 2008 to 2012, most government spending on health was channelled through private health insurance companies, which were paid to provide a standard package of benefits for households living below the poverty line – MAP.

Studies have shown that the targeting of MAP was robust in that it did cover the most vulnerable population with very little 'leakage' to higher-income groups. MAP also improved access to inpatient services. However, although access to and utilisation of acute care improved for those covered by MAP, there was no improvement in access and utilisation for those with chronic conditions. This is important because chronic conditions dominate the disease burden in Georgia. This also highlighted a very significant gap in the scope of coverage even for the lowest income households – outpatient pharmaceuticals.[1]

The limitations of the MAP programme meant that out-of-pocket (OOP) payments were almost three-quarters of total health expenditure in 2010. The narrow targeting of MAP also meant that the leading causes of household impoverishment in Georgia were related to health care costs.[2] In 2010, only 27% of the population had health insurance, and households on the cusp of eligibility for MAP were at most risk of being pushed into poverty by catastrophic health spending.[3]

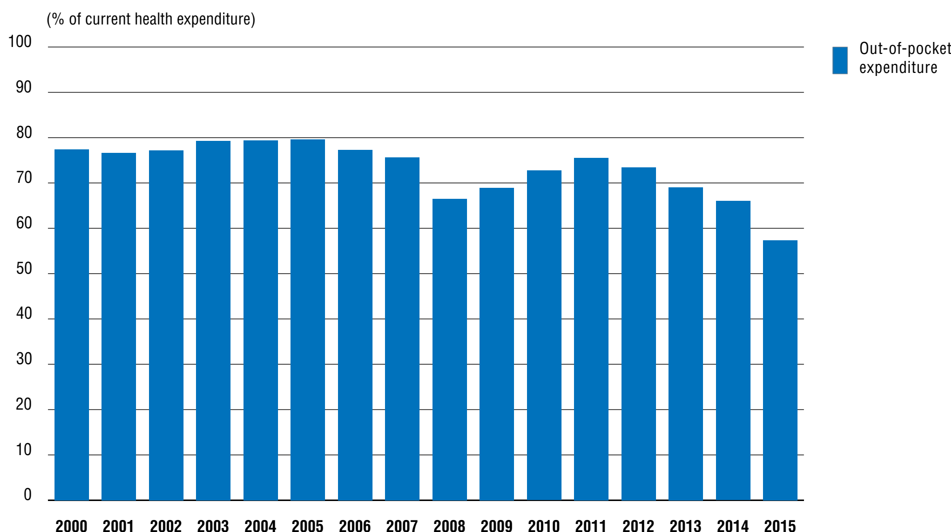
As elections approached in 2012, access to health care became an increasingly important political issue and the government of the time committed to quite radical expansions of the MAP programme in September 2012 to cover all broader population categories, not just those below the poverty line, but also pensioners, people with disabilities, children aged six years of age and under, and students. With these changes, coverage was extended to about 45% of the population, but the elections in October 2012 ushered in the new government which was committed to much higher social spending and universal health care.

What has been the outcome?

Financial protection

Since independence in 1991, one of the key financing issues faced by the Georgian health system has been the lack of political will to prioritise health for national development and fund the health sector accordingly. The expansion of coverage under the Universal Health Care Programme was made possible by a substantial increase in budgetary funding for health, although government health expenditure remains low in international comparisons. Current government per capita spending on health in Georgia was $278 (PPP) in 2015, which was below the average for the Europe and Central Asia Region as a whole ($1 997 PPP) and well below the average for EU28 countries ($2 942 PPP); even in an EU Member State such as Latvia, which has a relatively low

Figure 1: Out-of-pocket expenditure in Georgia



Source: Ref.[2]

share of government spending in current health expenditure (CHE), government per capita health expenditure was $821 (PPP).[2]

> The role of the SSA as a single purchaser has significantly improved efficiency

An increase in government health expenditure is consistent with the experience of other countries when they have moved towards universal coverage from less equitable systems, as it goes hand-in-hand with reducing the financial barriers to care. Since 2014, the Universal Health Care Programme has consistently overspent its budgeted amount. This was largely due to the rapidly growing demand for health services among those who were previously uninsured or lacked coverage for certain treatments.

Georgia still has some of the lowest utilisation rates for outpatient care in Europe, but utilisation of outpatient and inpatient care has more than doubled since the introduction of the Universal Health Care Programme. Utilisation of inpatient care is relatively high, but this is indicative of a strong preference in the system for care-seeking and treatment at more specialised levels of the system. Despite primary care being made free at the point of use for all, most of the Universal Health Care Programme budget is spent on inpatient services.

Increased government expenditure has also reduced levels of OOP spending, although OOP expenditure still dominates health system financing in Georgia. Although they remain among the highest in the European Region, OOP payments fell from 73% of CHE in 2012 to 57% in 2015.[2] Outpatient pharmaceuticals are the largest driver of OOP spending on health as they represent one of the biggest gaps in coverage and pharmaceutical costs can be impoverishing for low-income households. This has serious implications for overall equity and financial protection in the system. Formal co-payments are also an important component of OOP spending. Although co-payments are fixed at 10–30% of the official price of an elective procedure, the benefits are capped at this price and hospitals often charge more, with patients covering these extra bills themselves. An increase in public spending on health is needed to help further lower OOP spending on health.

Efficiency

The role of the SSA as a single purchaser has significantly reduced fragmentation in the system and improved efficiency. In 2016, the Universal Health Care Programme was spending less per person than the MAP programme – approximately 166 Georgian lari (GEL) ($72) compared with 180 GEL ($78), even though the benefits offered were more extensive. This demonstrates a big decline in spending on administration; prior to 2013, Georgia's public spending on health administration was considerably higher than most high income countries, including Switzerland.[1]

Nevertheless, incentives in the system for patients and providers still strongly favour emergency and inpatient care. Even though the per capita cost of coverage has fallen with the implementation of the Universal Health Care Programme, more than half of the funding went on emergency inpatient care. It has been difficult for the SSA to control costs with the reformed payment system, and incentives in place encourage providers to treat patients as urgent cases. As a result, the SSA introduced standardisation of tariff-rule setting, which has already led to cost savings at the system level. However, any savings in health expenditure are accrued to the central government budget rather than the health system.

Satisfaction

Overall satisfaction with the health system has increased and grown since the introduction of the Universal Health Care Programme in 2013. Survey data show that patients appreciate the level of choice in the system and the improved access to specialist services, but dislike making co-payments and the restrictions on the services covered – particularly for pharmaceuticals and dental care.[4]

Future reform directions

Ongoing reform plans focus on strengthening governance and the role of the SSA as a strategic purchaser, ensuring the quality of medical services, improving the training and regulation of the health workforce, strengthening primary care and public health services, and increasing financial protection – particularly around

outpatient medicines, which account for around two-thirds of OOP spending in Georgia. This is recognised as being one of the main barriers to UHC in Georgia as medicines are expensive and generally not covered if prescribed in primary care.

> expansion of coverage was made possible by a substantial increase in funding

In July 2017, the government introduced essential medicines coverage for four common types of chronic disease – cardiovascular (including hypertension), chronic obstructive pulmonary disease, type 2 diabetes and thyroid conditions – for households below the poverty line. From September 2018, this was expanded to all pensioners and people with disabilities to reduce financial hardship among these groups as they tend to be at higher risk of living in poverty and have greater health needs. The goal is to provide coverage for up to 40 essential medicines required for evidence-based management of chronic conditions. Further reforms are needed to encourage physicians, pharmacists and patients to prescribe, dispense and use generic and cheapest alternative medicines.

The challenges faced as part of expanding coverage in Georgia are common to many countries around the globe and policy lessons could be particularly valuable for other middle-income countries in Europe. The Georgian experience also highlights how moving towards universal health care requires increased public spending and improved health system performance.

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Georgia: Health system review

By: E Richardson, N Berdzuli

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Since 2012, political commitment to improving access to health care, to protecting the population from the financial risks of health-care costs and to reducing inequalities has led to the introduction of reforms to provide universal health coverage. Considerable progress has been made such that over 90% of the resident population became entitled to a tightly defined package of state-funded benefits in 2013; previously, only 45% of the population had been eligible. To finance this broader coverage, the government increased health spending significantly, although it remains low in international comparisons.

Out-of-pocket (OOP) payments have fallen as public spending has increased. Nevertheless, current health expenditure is still dominated by OOP payments (57% in 2015), two-thirds of which are for outpatient pharmaceuticals. For this reason, in July 2017, the package of benefits was expanded for the most vulnerable households to cover essential medicines for four common chronic conditions. The system has retained extensive infrastructure with strong geographical coverage. Incentives in the system for patients and providers favour emergency and inpatient care over primary care. Also, financial incentives to improve the quality of care are limited and disincentives are lacking to inhibit poor quality of care. Future reform plans focus on ensuring universal access to high-quality medical services, strengthening primary care and public health services, and increasing financial protection.

KEY LESSONS FROM PREPARING THE HEALTH STRATEGY IN THE KYRGYZ REPUBLIC

By: Nigel Edwards, Aigul Sydykova, Nazgul Tashpaeva, Hans Kluge and Jarno Habicht

Summary: Strategic planning for health systems is an important policy tool. The skills to do this need to be assembled and significant investment in the process is required. In addition to technical expertise, success requires the effective involvement of stakeholders, skilful management of relationships with other ministries and the recruitment of political support at all levels. Being part of a wider national planning process is helpful. Attention to prioritisation of goals and to the development of effective implementation machinery is important. These exercises take time to do properly and while a sense of urgency is helpful, it is important to ensure that there is sufficient time for the task.

Keywords: *Health Strategy, Intersectoral Action, Implementation Plan, Universal Health Coverage, Sustainable Development Goals, Development Partners, Kyrgyz Republic*

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Introduction

Landlocked and largely mountainous, the Kyrgyz Republic adopted a parliamentary system in 2011 and is one of the few countries classified as "lower-middle-income" in the Europe and Central Asia region.[1]

In 2017, the leaders of the Kyrgyz Republic decided to develop a long term national development strategy looking forward to 2030 and even as far ahead as 2040. Health and health care were to be an important part of this programme. This decision coincided with the need to renew the strategy for the health sector although this required a shorter-term focus. This was needed to address the limited progress and some reversal of the key health system performance indicators. During the process there have been changes after elections for the President, Prime Minister and key ministers, but this has not halted the development of a new health strategy, which was approved by the relevant Kyrgyz Republic Parliament Committee and government in autumn 2018 following wide consultation. This article looks at some of the lessons learned in developing the strategy over the last two years.

Using national programmes to guide long term health reforms

With a total population of 6.2 million people, life expectancy at birth is 68 years for men and 75 years for women. In 2014, the Kyrgyz Republic spent 6.5% of GDP

on health with a per capita expenditure of US$ 215.[2] The Kyrgyz Republic has a track record of using national programmes to guide long term health reforms. These include the Manas National Health Reform Programme (1996–2005), Manas Taalimi Programme (2006–2011) and the Den Sooluk Programme (2012–2018). From the outset, the focus was on the structural reforms needed to move from specialist–oriented care to family practice; finance reforms to introduce a single-payer system; the creation of a split between provider and purchasing functions and the introduction of a state guaranteed benefits package. The latest programme, the Den Sooluk health sector programme, builds on the achievements of the two previous programmes. Over the past decade, the Kyrgyz Republic has achieved several significant improvements in health outcomes, notably reductions in maternal and infant mortality and in deaths from cardiovascular disease. There have also been important gains in equity through reducing the gap between urban and rural health care use.[3]

Personal, out-of-pocket expenditure was significantly reduced during the Manas and Manas Taalimi programmes, but has gone up again recently. Spending on pharmaceuticals contributed significantly to this trend reversal.[4]

Development partners support both health policy and service delivery through the Sector Wide Approach mechanism and effective coordination as well as policy dialogue which has been well established in health sector over the last decade. Total Official Development Aid (ODA) to Kyrgyzstan rose from US$ 267 million in 2000 to US$ 769 million in 2015. In the health sector, aid contributes more than 20% of public health expenditure, with a significant proportion pooled and earmarked to support the Den Sooluk health programme.[5]

In 2014, Kyrgyzstan moved from low income country status to being a Low Middle Income Country. This ‘transition’ signals a reduction in external resources for the health sector with domestic resources now constituting more than 90% of total health expenditure.[6]

Table 1: Timeline and key milestones

October 2016	Health strategy process was discussed at a policy dialogue event (“Den Sooluk” Thematic Week with objective to plan the process until end of 2017 for the preparation of the 4th generation health programme)
October 2016	Request to WHO to support the process and development of 4th generation health programme
February 2017	The Ministry of Health consulted with national stakeholders and development partners the agreement on initial process description, principles and agreement of working groups (WG)
April 2017	“Den Sooluk” Joint Annual Review and launch of the strategy drafting process and changing development landscape (SDGs, universal health coverage (UHC) and national development strategy)
June 2017	“Den Sooluk” Thematic Week to discuss the conceptual process of the strategy with national and international stakeholders
July 2017	High level policy dialogue on health and economic development
October 2017	1st round of local level consultations conducted by Ministry of Health
November 2017	1st round of consultation process of the draft document and inputs from all development partners supporting the health sector
December 2017	Thematic Week of “Den Sooluk” and dialogue on next strategy with particular focus on health service delivery
December 2017	Intersectoral WG on strategy development to address intersectoral development
March 2018	2nd round of consultation process of the draft document and inputs from all development partners supporting health sector
April 2018	Expert group delivers full package of programme documents after consolidating inputs
May 2018	Joint Annual Review of “Den Sooluk” and meeting of the Intersectoral WG on strategy development to endorse latest draft
June–July 2018	2nd round of local level consultations conducted by Ministry of Health and Members of Parliament, and with NGOs, members of Intersectoral WG
June 2018	Parliament Social and Budget and Finance Committees endorsement
Summer 2018	Expert Group consultations with stakeholders to finalise documents, focus group meetings with the state agencies and municipal governing bodies, independent experts
July 2018	The Joint Financiers (World Bank, KfW, SDC) package for 2019–2023 preparation starts under WB leadership
August 2018	Government of Kyrgyz Republic meeting on the next health strategy development and agreed the documents for final public agencies consultation (around 40 agencies)
September 2018	Kyrgyz Republic joining the UHC2030 compendium
October 2018	Thematic Week of “Den Sooluk” and dialogue on next strategy with particular focus on programme budgeting and 5-year action-plan
November 2018	Final approval of health programme “Healthy Person – Prosperous Country 2019–2030” and its 5-year action-plan for 2019–2023

Source: Ref.[2]

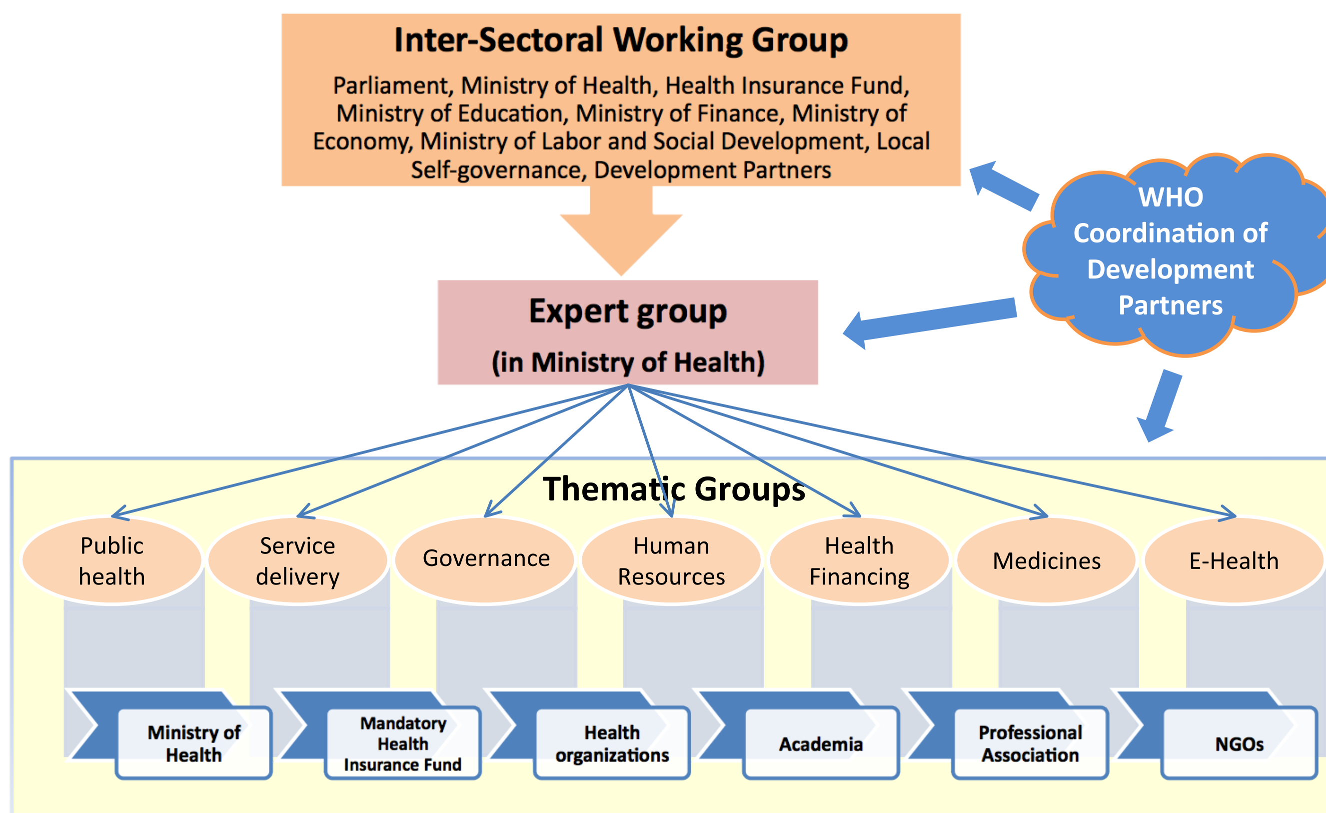
Seven Lessons

Over the last two years (since late 2016) in developing the strategy, a number of lessons were learned and seven of these are discussed in detail below.

Being part of a national planning process is helpful

The government, Ministry of Health and Development Partners jointly decided to extend the Den-Sooluk Programme through to the end of 2018 and began developing a new Strategy/Plan in 2017

Figure 1: Working groups structure



Source: Authors

(**see Table 1** on timeline). This new plan was to be part of a larger cross government exercise to develop a 20 year strategy for the Republic and to adapt to the Sustainable Development Goals (SDGs) agenda. This approach had two clear advantages. It made it easier to create the links required for intersectoral action, and by setting out a long term implementation plan there has been a better focus on long term policies that will create more systemic change in public health and health care. Unpopular but important reforms to the health system can be promoted more successfully in the context of a national development strategy. Making health a priority in the overall development strategy will help support implementation across the board since the 2030 health sector strategy aims to strengthen the dialogue between different sectors of the economy and to take action to address wider determinants of health.

Planning takes time

The ambition to develop a comprehensive plan with strong links to other sectors meant that there were elements of the timescale that could not be easily compressed. Initially a very short, one year timescale was set but it quickly became clear that this was not enough. It is easy to make over-optimistic assumptions about the time required to bring together the right information, assemble the team and to arrange stakeholder consultations. However, ambitious timescales did create a sense of urgency and purpose which helped the team make quick and agile progress once they were established.

The team, structure and consistency matters

Assembling a multidisciplinary and multi-agency expert group (**see Figure 1** on the working groups structure) at national level which could dedicate its full attention to the development of the plan was very important. The fact that the Ministry of Health delegated authority for coordination and day to day management of the process to the expert group, provided continuity and consistency throughout the planning process. The commitment ensured neutrality and the ability to adapt the process during a two-year period in which the President, Prime Minister, governments as well the Minister of Health changed.

The wider intersectoral working group consists of parliamentarians, government structures, public health experts, the Ministry of Health, the Mandatory Health Insurance Fund, NGOs, and a wide range of international, national, regional and municipal representatives and experts. Intersectoral and thematic groups were created at national level. For each region, public health support groups and representatives of local government were brought together in an attempt to form an expert community. The national expert group acted as a link between all levels of the process.

Experience elsewhere shows that staff who have to combine planning with their everyday duties can easily get diverted by operational issues and find it hard to focus on the long term. The individuals selected

included experts with a wide knowledge of their own and other health systems. They had a high level of credibility and the group leader was well regarded by important stakeholders. Skills in costing, implementation planning, modelling and an understanding of the wider macroeconomic and political context were more difficult to acquire, and it is an important lesson that countries need to build capacity in these technical areas. An issue here is that continued progress is very dependent on the continued funding of the expert group.

Technical advice from WHO (as well other international organisations) to the team included coaching, expert review and sometimes provocation to help move an argument forward and to back up arguments being made by the team to other stakeholders.

Stakeholders matter

The team put a great deal of effort into consultation and stakeholder engagement especially with politicians at national and local level.

Consensus was developed from the bottom up with stakeholders. This gave legitimacy to the proposals which was key to overcoming resistance from some politicians and interest groups. The process of developing the strategy involved components of convening, listening to opinions and sharing evidence so that stakeholders were convinced that the reforms were necessary and that their support would be important. The strategy development process was covered by the media.

A key lesson is the importance of development partner and donor input which requires expert coordination and having high-quality processes and senior leadership. The development partners' constant involvement is important for future engagement in strategy implementation and to create pre-conditions for aid effectiveness. However, it is important for local experts and leaders to retain ownership of the strategy, especially as a number of donors and national stakeholders were keen to see a continued focus on vertical programmes or particular issues. Experience had shown that this had come at the expense of more general strengthening of the system and the desired move towards universal health coverage. A judicious balance between targeted programmes and system strengthening is required.

making health a priority in the overall development strategy

Kyrgyzstan joined the Universal Health Coverage 2030 platform[7] and signed the compendium in 2018. This action was taken to inspire national stakeholders and development partners to continue the coordination that has developed so well in recent decades.

Relationships with ministries need managing

Establishing good relationships between the Ministries of Health, Finance and other ministries, as well as the Mandatory Health Insurance Fund is very important to secure links to the budget process and broader cross sectoral government plans. During this period the Ministry of Finance had also been developing its policy capability which helped the process.

Top level interest from government, Parliament and the President helped to deal with some resistance and created an environment in which other ministries became increasingly interested in how health could contribute to the achievement of their objectives. This is also where the evidence linking health to national wealth and economic growth was able to be deployed to good effect.

The Ministry of Health has a large amount of operational work but has less capacity for policy and regulation to support execution. As a result, the plan was not always the highest priority nor can it be assumed that Ministries of Health have a united view on important strategic issues. Some of the tensions associated with this can be difficult to manage. There are occasions where the intervention of the minister to overcome problems, reinforce the direction of travel and even confront difficult behaviour is very important. The work demonstrated the need to strengthen the Ministry of Health as a good governor and effective regulator with enhanced skills in analysis, forecasting, planning and management.

There was a need to change significant elements of undergraduate and postgraduate training of doctors and other health professionals. This made cooperation from the Ministry of Education immensely important. One lesson is that ministries of health need a strong voice in specifying the content and type of education provided for health care staff. Likewise, good cooperation has been required with the Ministry of Agriculture to conduct an analysis of the regulatory framework for the supervision of antibiotic resistance.

Developing capacity for strategic purchasing and steering the health system

The concept of strategic purchasing is a key health policy idea but the process revealed that it is poorly understood and difficult to articulate. In countries like Kyrgyz Republic with a National Health Insurance Fund (HIF), a clear understanding and agreement is needed of the role the Fund will play in formulating and implementing the purchasing strategy. It is important to develop the institutional strategy for the HIF in parallel with the main health strategy as there will inevitably be difficult purchasing decisions to be implemented. The HIF needs to be willing and able to execute difficult decisions for the contracting of services according to needs.

A key part of the strategy is about the shape of public health and health care services delivery. A gradual transition from managing health infrastructure to managing the whole health system is crucial for this and requires new skills and systems in planning, organizing, financing and delivery.

In the Kyrgyzstan context, market mechanisms were not sufficiently

developed to achieve this and so a master planning exercise is required. Initially, the intention was to look only at hospital services but, with support from the World Bank and other partners, the scope has been broadened to include primary care reform and emergency services. The master planning exercise will need to consider all available health care resources regardless of ownership – private sector provision and facilities operated by other ministries or bodies tend to be excluded from these types of plans. It would have been better for the plan had this exercise been commissioned much earlier.

Governance of implementation

As part of the planning process thought was given to the measures needed to ensure a strong system for implementation. A lesson is that perhaps even more attention should have been given to this and to identifying priorities – there is a danger in this process of priorities multiplying.

The personal responsibility of managers of state bodies, local providers and other bodies is key to delivering the plan. Instilling the view that strategy execution is the everyday business of health sector institutions and is supported by the management unit at the Ministry of Health is a key element of implementation that needs to be established early in the process.

A significant and new approach compared to past strategies is the review of the domestic budget as a key source of financing. The country has a shift towards programme budgeting as a cornerstone of the strategy implementation and the health sector is one of the first sectors from 2019 onwards. This is to be complemented by development assistance to support catalytic change. Taking a more holistic approach to financing and looking beyond primarily development assistance to support strategy provides a precondition for alignment and reform implementation.

Significant effort needs to be put into a sustainable monitoring and evaluation system at national, regional and departmental levels. The system should be developed with wide engagement and consultation in parallel with the strategy. It is a significant task to develop leadership and management capability – particularly for middle managers.

Conclusions

The ability to develop long term and intersectoral plans is a key ability that all mature health systems need. The nature of the work and the need for a wide range of skills, knowledge and abilities means that it will be necessary to create specialist teams to carry this out. There also needs to be a highly sophisticated approach to engaging all types of national stakeholders. In resource limited and middle-income countries the coordination of development partners gains special importance. The development of implementation plans and the governance to support them is equally demanding. A key theme running through many of the lessons is the importance of investing in high quality communications and coordination that keep all the stakeholders properly involved.

A very significant investment of time and resources is required and the work needs to be seen as a major project rather than just an extension of business as usual.

Top level support from the top of government is essential to make the process work. However, the biggest threat to this sort of work is relatively underdeveloped capacity in middle management across the whole system and other parts of the implementation machinery required to execute complex change management. This is where the next set of investments will need to be directed.

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NEW SWEDISH SUBSIDY ON SPECTACLES FOR CHILDREN AND ADOLESCENTS

By: Sharareh Akhavan and Elisabeth Wärnberg Gerdin

Summary: Over the last decade there has been an increase in health system reforms aimed at equity. The Swedish government initiated a national reform to provide a subsidy for spectacles for all children and adolescents aged 8–19 years old. One year after the reform some improvements are needed as follows: refining the subsidy administration process to increase uptake; achieving an appropriate balance between population-based needs and subsidy access criteria; and improving institutional arrangements for the regulation and delivery of services by focusing on issues of quality assurance and efficiency.

Keywords: *Spectacles, Children and Adolescents, Health Sector Reform, Sweden*

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Introduction

Over the last decade, concern has grown regarding health system reforms aimed at achieving greater equity. Countries at all levels of economic development are engaged in finding better ways of organizing and financing health care, while promoting the goals of equity, effectiveness, and efficiency. One crucial health system reform is in the area of children's and adolescents' health.

A national reform

Starting in March 2016, the Swedish Government initiated a national reform to provide a subsidy for spectacles for children and adolescents. The objective of the reform is that all children and adolescents aged 8–19 years who are in need of spectacles can receive a spectacles subsidy each year. The law's background documentation specifically mentions that this law will contribute to equity: stating that more equal access to spectacles prevents children and adolescents living in families with financial vulnerability from being excluded.[1] The actors involved in the reform are the 21 county councils which are responsible for distributing the subsidy. All county councils have previously provided a spectacles subsidy to children under the age of seven or children with more complex vision needs and/or certain rapidly progressing eye conditions. Therefore, the government decided that contribution management should take place through county councils, which already had an established system.

The subsidy expenditure is approx. €80. To be allowed to access the subsidy, the target group must meet the following eligibility criteria: aged 8–19 years at the date of assessment and have defective vision identified by an optician. A licensed

Table 1: Households who waited or refrained from purchasing glasses or contact lenses for their child/children in the last 12 months (%)

(Base n= 508)	Civil status		Household income			Education			Country of birth	
	Single parent	Cohabitant parent	Low	Average	High	Low	Middle	High	Sweden	Other
Waited (n=92)	26 *	16	39 **	17 ***	7	39 ****	22 ****	10	17	33 *****
Refrained (n=52)	13	9	29 **	9 ***	2	31	12	7	9	26 *****

* Statistically significant 95% (P value 0.05) compared to cohabitant parent

** Statistically significant 95% (P value 0.05) compared to household with average/high income

*** Statistically significant 95% (P value 0.05) compared to household with high income

**** Statistically significant 95% (P value 0.05) compared to respondents with high education level

***** Statistically significant 95% (P value 0.05) compared to respondents born in Sweden

Source: Household survey

optician performs eye examinations and tests glasses and contact lenses. The most common setting in which these tests take place is an optical store.

The idea behind the reform was multifold. Firstly, medical evidence shows that eyesight plays a critical role in children's health and in their achieving a good quality of life. Throughout the life course, vision affects a child's cognitive development, mental health and integration into society in areas such as education and employment.[2] In addition, the number of children and adolescents with short-sightedness is expected to increase in the coming decades.[3] [4] Secondly, an NGO (the May Flower Association which has been the largest children's charity organisation in Sweden since 1907) raised the alarm that the number of families who apply for donations for spectacles have increased significantly. Thirdly, members of the Left Party in the Swedish parliament raised the issue of a spectacles subsidy as a way of reducing disparities between different socioeconomic groups in society.

The Swedish reform to provide a subsidy for spectacles differs from those of other countries[5–7] in four ways. Firstly, it is focused on children and adolescents aged between 8 and 19 and not on the whole population, unlike in Turkey[5] and New Zealand.[6] Secondly, it is paid annually, which is in contrast to Turkey[5] where it is paid every three years or in some provinces of Canada where it is paid every two or three years.[7] Thirdly, it is for all children and not only children in low-income families, unlike in New Zealand[6] and Canada.[7] Finally, it is unique as it also includes children and adolescents who are asylum seekers or who are living in Sweden without the necessary residency permission.

In order to address and assess the impact of the reform after one year, the Swedish National Board of Health and Welfare commissioned by the government conducted a follow-up study in two settings:

1) County council survey – A questionnaire consisting of 20 questions was sent to all county councils in the country.

2) Household survey – A web-panel survey which consisted of 17 questions and one open-ended question was used for data collection.

Four policy levels

Sweden is one of the few countries that has introduced the reform of a spectacles subsidy for children and adolescents. The reform is thus new and probably needs more time before it is fully implemented. Previous research indicates that health system reform operates at four policy levels: systematic, organisational, instrumental and programmatic.[8] The spectacle subsidy reform results can be discussed within the framework of these levels.

Systematic level

The spectacle reform can be improved at a systemic level, which deals with the institutional arrangements for regulation and delivery of services between county councils. There were differences in regulations and delivery of services among county councils, such as in: the possibilities of receiving the spectacle subsidy several times a year if the amount does not exceed approx. €80 whether the applicant needs to make a financial contribution; inclusion of the eye examination; criteria for collaboration with opticians; and finally, whether there is a specified minimum visual acuity for receiving the spectacle subsidy. There is also a difference in the length of decision time in different county councils.

Organisational level

The spectacle reform needs to progress at an organisational level, which is concerned with the production of services by focusing on issues of quality assurance and technical efficiency. The World Health Organization (WHO) also recommends building institutional capacity for health policy reforms and development.[9] As the results of this study show, although web-based administrative systems can

facilitate the management of a contribution and shorten decision-making time, some county councils still use a manual administrative system.

Instrumental level

The spectacles reform can develop at an instrumental level, which refers to policies for collection and use of research. WHO supports the idea of collection and analysis of health evidence and translating it into policies.[9] There is a need for more knowledge about the balance between population-based needs and subsidy access criteria to make the reform more efficient and sustainable.[6] [7] In total, 6.5% of children and adolescents aged 8–19 years received spectacles in accordance with the reform in Sweden but the proportion of children and adolescents aged 8–19 who have a visual impairment and are in need of eye glasses or contact lenses is not known. This knowledge is needed in order to be able to compare the proportion of children who received the spectacles subsidy with the needs of the target group.

“differences in regulations and delivery of services among county councils

The programmatic level

The programmatic level specifies the priorities of the system, determines the efficiency strategies, and uses the method of cost-effectiveness analysis. Policies should aim at minimising the economic cost of an intervention. Cost-effectiveness allows the minimisation of aggregate costs and the setting of more ambitious targets in the future.[10] There are no studies on the cost-effectiveness of the spectacles subsidy for children, but two previous research projects show that screening of schoolchildren for refractive errors is economically attractive in all regions in the world.[11] The cost effectiveness of this reform should be measured taking a lifelong perspective and by considering children's and adolescents' progress in physical/mental health, education, work and career opportunities.

The Swedish Government has ordered cost-effectiveness reports for the spectacles reform and will analyse the results over the coming years. The issues of quality, supply, distribution, cost and acceptance all need to be examined.

Awareness and information

Reform implies not only action, but also information. The household survey shows that a third of respondents had no knowledge of the spectacles subsidy, or thought it was difficult to apply for. Furthermore, the information is only available mainly via the internet and for Swedish-speaking citizens. Lack of awareness of the subsidy was a major cause of not applying for it. Information about the subsidy to the target group needs to be improved in order to reach a larger population. For example, active communication between schools and optometrists may also improve delivery of spectacles.[3]

Equity perspective

One of the main aims of health sector reform is to add benefits for the underserved. Previous research shows that inequities in health are substantially socially determined, arising from differences in life circumstances and inequities in opportunities to lead a full and meaningful life. Understanding the effects of these social determinants and working toward reducing inequities should be prioritised in order to improve health and wellbeing.[12]

Like the New Zealand evaluation study,[7] the results of this study show that the spectacles subsidy reform is particularly necessary for households belonging to vulnerable groups in society and may reduce unjust practices and inequities. As Table 1 shows, some of the respondents (18%) state that they have been waiting, and some others (10%) state that they refrained from buying glasses or contact lenses for their children in the last 12 months because they have not been able to afford them. It shows significant differences between single and cohabitant households. Significant differences were also found between low/average income households in comparison with high-income ones, between low/middle educated individuals in comparison with highly educated ones and between foreign-born residents in comparison with native Swedes. Due to the household's lack of economic resources, foreign-born residents refrain from buying glasses or contact lenses for their children to a greater extent than do native Swedes. That difference is significant.

Concluding comments and future considerations

There is no single strategy for health sector reform. There are many opportunities for mutual exchange and learning. In this context, the following recommendations can be highlighted for achieving a sustainable spectacles subsidy for children and adolescents:

- Aim for an appropriate balance between population-based needs and subsidy access criteria.
- Improve subsidy administration processes to increase the efficiency of update and response times. This could, for example, include moving administrative systems to process submissions completely online.
- Review subsidy data collection to ensure it meets monitoring and evaluation requirements. This could include developing a monitoring and evaluation framework, with indicators to monitor future subsidy performance.
- Disseminate information about the subsidy to the target group through a number of channels e.g. opticians, school nurses, primary health care centres and health navigators.

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NEW PUBLICATIONS

The role of public health organizations in addressing public health problems in Europe: The case of obesity, alcohol and antimicrobial resistance

Edited by: B Rechel, A Maresso, A Sagan, C Hernández-Quevedo, E Richardson, E Jakubowski, M McKee, E Nolte

Copenhagen: World Health Organization 2018 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies), 2018

Number of pages: xiii + 104 pages; **ISBN:** 978 92 890 5171 2

Available at: http://www.euro.who.int/__data/assets/pdf_file/0011/383546/hp-series-51-eng.pdf?ua=1

Growing levels of obesity, continued harmful consumption of alcohol, and the growing threat of antimicrobial resistance (AMR) are some of the greatest contemporary challenges to the health of European populations. While their magnitude varies from country to country, all are looking for policy options to contain these threats to population health. It is clear that public health organisations must play a part in any response, and that intersectoral action beyond the health system is needed. What is less clear, however, is what role public health organisations currently play in addressing these problems.

This volume provides detailed country reports from nine European countries (England, France, Germany, Italy, the Republic of Moldova, the Netherlands, Poland, Slovenia and Sweden) on the involvement of public health organisations in addressing obesity, alcohol and antimicrobial resistance. These reports explore the power and influence of public health organisations vis-a-vis other key actors in each of the stages of the policy cycle (problem identification and issue recognition, policy formulation, decision-making, implementation, and monitoring and evaluation).

A cross-country comparison assesses the involvement of public health organisations in the nine countries covered. It outlines the scale of the problem, describes the policy responses, and explores the role of public health organisations in addressing these three public health challenges.

Contents: *Cross-country analysis: Introduction, Obesity, Alcohol, Antimicrobial resistance, Key policy lessons; Country reports.*

The organization and delivery of vaccination services in the European Union

Edited by: B Rechel, E Richardson, M McKee

United Kingdom: World Health Organization 2018 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies), 2018

Number of pages: xv + 183 pages; **ISBN:** 978 92 890 5173 6

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In recent years, the EU has been facing serious outbreaks of vaccine-preventable diseases, with an increasing number of cases and deaths. This study, undertaken at the request of the European Commission, collates information on the organisation and delivery of vaccination services in the EU, with a focus on childhood vaccinations against measles and adult vaccinations against influenza. It provides a systematic review of health system related factors, a comparative analysis of country experiences and a suite of fiches that describe the organisation and delivery of vaccination programmes in EU Member States.

The report finds that there are substantial differences in the governance, provision and financing of vaccination services across EU member states. The report also notes that childhood vaccination against measles is mandatory in nine EU member states but free at the point of delivery in all EU member states, whilst adult vaccination against influenza is voluntary in almost all EU member states, but in seven countries adults targeted by influenza vaccinations have to pay at least part of the costs of vaccination.

The report calls attention to the fact that, despite some challenges in the governance, provision and financing of vaccination services, vaccine hesitancy and lack of awareness are the greatest barriers to improving vaccination coverage.

Contents: *Executive summary, Acknowledgements, Introduction, Vaccine update and vaccine-preventable disease in the EU, Health system barriers, Comparative analysis of country fiches, Discussion, Conclusion, References; Appendix: Country fiches.*

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