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Special Issue on Health Systems Strengthening (Ljubljana Charter 1996–2016)



➤ Priorities for health systems strengthening in the WHO European Region

- Transforming health services to meet the health challenges of the 21st century
- Moving towards universal health coverage and a Europe free from impoverishing out-of-pocket payments
- Enhancing the health workforce
- Ensuring equitable access to cost-effective medicines and technology
- Improving health information and health information systems

EUROHEALTH

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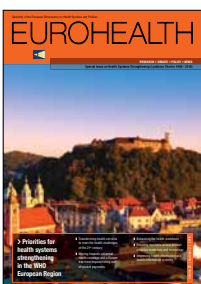
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INTRODUCING THE 20TH LJUBLJANA CHARTER ANNIVERSARY ISSUE



By: Zsuzsanna Jakab, Milojka Kolar Celarc and Jevgeni Ossinovski

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Introduction

We are delighted to offer our joint support to this publication, which looks at how Member States across the European Region are strengthening their health systems in line with the recently launched strategic document “*Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness*”.¹ The strategic document guides countries on how to implement the values outlined in two health systems charters – the *Ljubljana Charter on Reforming Health Care in Europe*² and *The Tallinn Charter: Health Systems for Health and Wealth*.³

In 2012, the European health policy framework *Health 2020*⁴ was adopted by the WHO Regional Committee. *Health 2020* builds upon both charters, taking a human rights approach and emphasizing the importance of solidarity, equity and participation at the heart of national health policy development and decision making. The main goals of *Health 2020* are the equitable improvement of health and well-being, and improvements in leadership and participatory governance for health. The strengthening of people-centred health systems and public health is one of its four policy priorities, alongside a life-course approach, tackling the

burden of non-communicable and communicable diseases, and promoting resilient communities and supportive environments.

It is in supporting the *Health 2020* policy priority of strengthening people-centred health systems and public health that the charters have made the greatest contribution. Implementation of the charters has led to important advances in the WHO European Region, giving a better understanding on how to invest in health systems for the benefit of the overall development of societies and establishing a mandate to invest in policies that respond to the needs of vulnerable groups.

The charters are relevant for all countries, promoting human rights and gender equality, where markets and economic interests may not. Together these documents remain of critical importance in guiding Ministers of Health towards the strengthening of health systems and public health, which lie at the heart of achieving our goals for population health.

The charters

The *Ljubljana Charter on Reforming Health Care in Europe* of 1996, whose 20th anniversary we are celebrating this year, was a milestone in thinking

about health systems. The Ljubljana Charter brought a health systems perspective to health care reform, emphasizing the importance of smooth linkages between health system functions and health care performance. It focused on the positive role of health within the development of societies, and the importance of intersectorality. Universal access, it was argued, should be assured, alongside sustainable financing and continuously striving for quality. The achievement of these aims was supported with the establishment of the European Observatory for Health Systems and Policies.⁵

The Ljubljana Charter emphasized the responsibility of governments exercising stewardship for the health system through legislation and governance, regulating health system performance and financing. A national health policy should be based on values, and aim to shape the performance of health care.

Health systems should focus on the role of public health and primary health care, and integrate disease management, including health promotion, disease prevention, treatment and rehabilitation. The Charter also emphasized respect for citizens’ voice and choice; moving away from acute hospital care to primary health care,

community care, day care, home care and informal care; and the coming together of health and social care.

The *Tallinn Charter: Health Systems for Health and Wealth* of 2008 built on these themes, with the added focus on health system-wide performance and accountability. The Tallinn Charter emphasizes that health systems should prioritize financial protection, consider the social determinants of health and actively influence other sectors with Health in All Policies.

The Tallinn Charter also emphasizes that health systems should guide other sectors to address the social determinants of health. This approach to consider the multiple determinants of health in addressing public health was taken further in *Health 2020*, with its focus on governance for health across all determinants, and its emphasis on whole-of-government, whole-of-society and Health in All Policies approaches to improvements in health and well-being.

Another focus of the Tallinn Charter is on financial accountability, and the fair and efficient use of resources. Vitaly, individuals should not become poor due to ill-health. Overall system financing should meet needs, reduce barriers, protect against financial risk, and be fiscally responsible. Throughout, care delivery should be integrated and coordinated, delivering people-centred care and integrated disease-specific management programs.

The importance of the charters

There are many similarities between the Ljubljana and Tallinn charters, which have provided frameworks for progress, now supported by *Health 2020*. Both charters emphasize that governments have an ultimate responsibility to sustain universality in access to timely and affordable services of good quality. Such an approach also clearly links with the United Nations' Sustainable Development Goals (SDGs).

This issue of *Eurohealth* looks at Member State examples of health systems strengthening as outlined in the strategic document. In Estonia, the Tallinn Charter

has provided a value-based foundation on which to build the health system in responses to a range of new and existing challenges for providing better health care, building on the themes of improving health system performance, and promoting transparency and accountability, particularly when these qualities were most needed due to the financial crisis. It also presented a forward-looking vision, covering issues such as health system responsiveness, patient-centredness and the ability to respond to crises. The values of solidarity, equity and participation also paved the way to Universal Health Coverage (UHC).

For both Estonia and Slovenia, the main values of the charters have been integrated into national health planning, focused on the equitable improvement of health and well-being and the further development of health care services. Based on these values Slovenia has recently launched a reform of its health system to assure patient-centredness. The reform aims to improve the integration of services, including public health and social services, along with strengthening primary health care. In Estonia, despite considerable overall budget cuts during the financial crisis, the health care budget was largely sustained as the charters helped to guide decision making to reduce the effects of the crisis.

In both countries, reforms have been based on evidence and analysis, through wide stakeholder engagement and the involvement of other sectors. The charters have helped guide decisions about investment in the health sector and the use of resources – human, pharmaceutical and technological – particularly during the recent financial crisis. Investments have been made in expanding the health care services available through primary care as well as developing health care at the local level, improving cooperation with the social welfare system. Investments have also been made in the training and development of the health professional workforce, as well as improvements in compensation, working environments and staff morale.

Across the European Region, Member States have been working towards implementing the main values of the charters, which have provided a high-

level political mandate to invest in health systems across the Region and have secured health systems strengthening at the top of the agenda in both Member States and WHO. Now reinforced by *Health 2020*, many countries in the Region are developing and implementing policies informed by these goals.

Now more work needs to be done, focusing particularly on the role of health systems in taking social determinants of health into account to reduce inequalities, achieving transformative change and improved health outcomes. This is the purpose of the strategic document *Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people-centredness*.

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- 5 European Observatory on Health Systems and Policies. Available at: <http://www.euro.who.int/en/about-us/partners/observatory>

PRIORITIES FOR STRENGTHENING PEOPLE- CENTRED HEALTH SYSTEMS



By: Hans Kluge

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The WHO Regional Office for Europe supports Member States in strengthening their health systems to become more people-centred in order to accelerate health gain, reduce health inequalities, guarantee financial protection and ensure an efficient use of societal resources. The goals of these efforts are entrenched in *Health 2020*, the health policy and framework for the WHO European Region^{1,2} stressing a value-based approach to health systems. These values are entrenched in the *Ljubljana Charter* on reforming health care and the *Tallinn Charter on Health Systems, Health and Wealth*^{3,4} which were signed by the countries of the WHO European Region in 1996 and 2008 respectively, and which are central to the health systems work of the WHO Regional Office.

This June, and through this Special Issue of *Eurohealth*, we are celebrating the 20th anniversary of the *Ljubljana Charter*. This anniversary offers us an important moment to reflect on the legacy of the Charter and what progress we have made in our health systems strengthening activities over the last twenty years.

In this vein, we have commissioned a series of articles from across the Region, which reflect specific initiatives or policy options pursued by countries in order to strengthen their health systems. They correspond to a series of priority

areas agreed on by all 53 Member States, and which find their inspiration in the Ljubljana and Tallinn charter commitments to strengthening health systems via a value-oriented approach.

Priorities for strengthening people-centred health systems

Following the 5th year anniversary of the Tallinn Charter, and a high level meeting to commemorate the event,⁵ the Division of Health Systems and Public Health began a process of consultations with Member States to map out the key strategic directions around the development of people-centred health systems under the third pillar of *Health 2020*. The result was a strategic document entitled *Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness*,⁶ which, in turn, was adopted by all Member States during the 65th WHO European Regional Committee held in Vilnius, Lithuania in 2015.

The sub-title of the document – *walking the talk on people centredness* – reflects the importance that the Regional Office attaches to ensuring that health systems in the European Region meet people's needs and live up to their expectations. In our view, this means providing an opportunity for people to voice their needs and contribute to systems which are

responsive and proactive in meeting them. It also involves providing the necessary tools to empower and engage with people and populations as co-producers of health and health services to ensure better and more equitable access to health. This is particularly important for the vulnerable, whose access to quality services will ultimately determine our success in promoting people-centred health systems that do not leave anyone behind and set us on the path to Universal Health Coverage (UHC) as called for under *Health 2020*.

It is clear that strengthening health systems in a manner that places people at the centre necessarily involves trade-offs, especially in times of economic hardship. And, while cost savings often occupy a central focus of governments, in Europe we need to ensure political and popular support for moving towards UHC remains a health system priority. This was an important message to come out of two meetings convened by the Division of Health Systems and Public Health on the impact of the Economic Crisis on Health and Health Systems in 2009 and 2013 in Oslo.^{7,8} The Division, in close collaboration with the European Observatory on Health Systems and Policies, evaluated the evidence from across Europe on policy responses to economic shocks, and set out a series of key messages to guide countries in making the right policy choices in times

of budgetary pressures; with a focus on addressing inefficiencies rather than strictly the balancing of books or cost containment.⁹ These resulted in a series of 10 policy lessons¹⁰ which were endorsed via Resolution by all Member States during the 53rd Regional Committee, held in Izmir, Turkey in September 2013*. Again, our overriding priority is to develop health systems which serve the needs of all our populations.

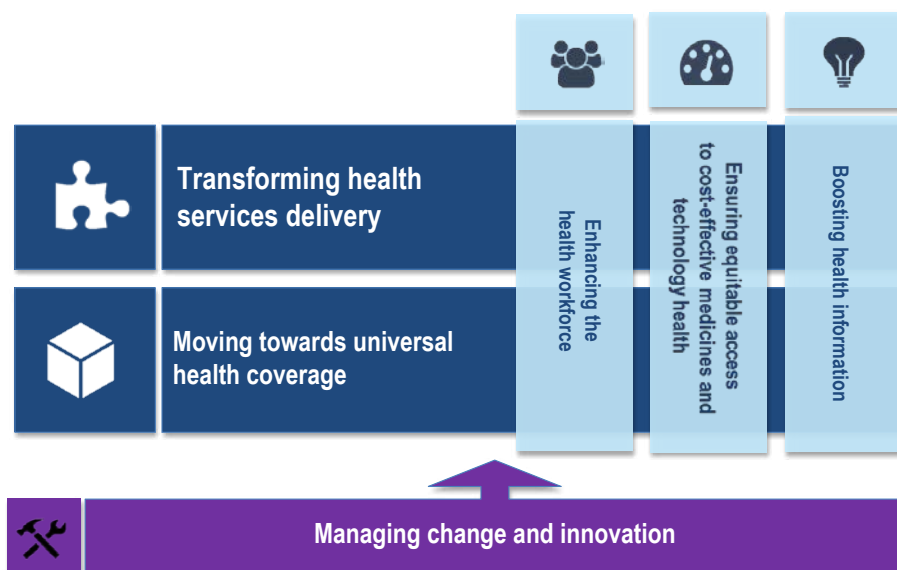
With the endorsement of the ‘walking the talk on people-centredness’ strategic document, the Regional Office and Member States have committed to work intensively together over the 2015–2020 period in two priority areas (Figure 1):

- 1) transforming health services to meet the health challenges of the 21st century;
- 2) moving towards universal health coverage for a Europe free of impoverishing out-of-pocket payments.

In focusing our efforts in these two main directions, we acknowledge that health needs in the 21st century require the transformation of health services away from traditional approaches based on disease-specific, reactive and fragmented interventions. Instead, we must move towards health systems with strong primary health care that delivers comprehensive, integrated and people-centered services coordinated with public health and multisectoral interventions to improve health outcomes and reduce inequalities. In parallel to promoting such a transformation of services is a need to rethink health financing. More specifically, policy-makers must ensure that individuals can afford the quality services they require and that health system financing has the ability to withstand economic or other shocks. Indeed, this is key to the promotion of resilience in health systems today. To make progress in these areas requires whole-of-society and whole-of-government efforts to embrace intersectoral actions,

* <http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/past-sessions/sixty-third-session/documentation/resolutions-and-decisions/eurrc63r5-health-systems-in-times-of-global-economic-crises-an-update-of-the-situation-in-the-who-european-region>

Figure 1: Priorities for health system strengthening in the European Region 2015–2020: walking the talk on people centredness



Source: Ref ⁶

while designing effective and evidence-informed policies on service delivery and health financing.

In addition, high-quality health system inputs make it possible to transform health services and away from impoverishing out-of-pocket payments. The availability, accessibility, acceptability and quality of the health workforce will be central to the transformation of service delivery and to translating the vision of universal health coverage into improved health services on the ground. Similarly, ensuring the availability of and equitable access to cost-effective medicines and technology is an important input into health systems. Finally, health information and research that strengthens health systems and health policy will include strengthening not only the information content but also the information systems themselves, including health information platforms, infrastructure and eHealth.

In this regard, three underpinning foundations that will need concerted support to achieve the two overarching directions have been set out in the strategic document as follows:

- a) Foundation 1: enhancing the health workforce

- b) Foundation 2: ensuring equitable access to cost-effective medicines and technology
- c) Foundation 3: improving health information and health information systems.

It is clear from the above, that the implementation of these strategic directions and underlying foundations requires leadership for managing change, the willingness and ability to embrace innovations, and an understanding of the need to ensure accountability for performance as part of good governance; in other words, an overall commitment to change management in the health system. To date, while the literature on specific reform measures and the evidence of their impact continues to grow, there is little evidence available to guide policy makers about the process of reform and methods for making a transition. In other words, while countries can learn how to implement a specific intervention or policy, there is less understanding on how to shape and reform their systems more fundamentally. As such, it is often left to judgment as to whether, when and how to transform.¹¹ As Figure 1 indicates, this is of course the overall impetus for change, and it is important that countries work together towards embracing the change management required.

WHO support to the Member States

In pursuit of these health system strengthening directions, the WHO Regional Office for Europe, through the Division of Health Systems and Public Health, is prioritizing its support to the Member States via a number of activity lines. These include:

- the provision of direct technical assistance to countries (e.g., Review of pharmaceutical sector reform in Ukraine[†], health financing reform in Georgia[‡], strengthening the response to ambulatory care sensitive conditions in Portugal[§] and improving midwifery education in Uzbekistan[¶]);
- the generation of information and evidence (often with the European Observatory) disseminated via various media (e.g., On access to new medicines^{**}, good practices in strengthening health systems for the prevention and care of tuberculosis and drug-resistant tuberculosis^{††}, developing the case for investing in public health^{‡‡} and good practices in nursing and midwifery^{§§});
- capacity building and providing an international platform for partnerships

† <http://www.euro.who.int/en/health-topics/Health-systems/health-technologies-and-medicines/country-work>

‡ <http://www.euro.who.int/en/health-topics/Health-systems/pages/news/news/2015/07/georgias-health-financing-reforms-show-tangible-benefits-for-the-population>

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‡‡ http://www.euro.who.int/..._data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf

§§ <http://www.euro.who.int/en/health-topics/Health-systems/nursing-and-midwifery/publications/2015/nurses-and-midwives-a-vital-resource-for-health.-european-compendium-of-good-practices-in-nursing-and-midwifery-towards-health-2020-goals>

and dialogue with provider and patient associations. (e.g., expert meeting for the health system response to non-communicable diseases work programme^{¶¶}, sub-regional meeting on antimicrobial consumption^{***}, subregional training course for the central Asian republics on public health leadership^{†††}, strengthening the coordination/integration in the delivery of services in the WHO European Region^{‡‡‡}, collaboration with the European Forum of National Nursing and Midwifery Associations (EFNMA)^{§§§}).

The work of the Regional Office and the Division has also been bolstered through the establishment of a new WHO Centre of Excellence on Primary Health Care based in Almaty, Kazakhstan. The work of this office, under the guidance of the Division, will be instrumental in assisting countries in the transformation of health service delivery. Additionally, change management represents a key area of future work for the Division of Health Systems and Public Health and here we have set up an important collaboration with the Deusto Business School and Durham University to establish a network of high-level policy-makers able to advise current decision-makers on how to initiate, accelerate, sustain or improve large scale health system reforms^{¶¶¶}.

¶¶ <http://www.euro.who.int/en/health-topics/Health-systems/pages/news/news/2015/12/third-expert-meeting-in-the-health-system-strengthening-ncd-work-programme>

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With these strategic priorities set, this is a good time for us to take the pulse of the Region in terms of what is happening and how these changes are being realized through this Special Issue of *Eurohealth*. The series of articles which follows will profile a select number of examples of progress currently being made in the European Region.

These articles describe the challenges and opportunities in managing processes for quality and better outcomes through effective intersectoral action and regular monitoring of performance in order to transform services to meet the health challenges of the 21st century and move towards a Europe free of impoverishing out-of-pocket payments.

As we celebrate the 20th anniversary of the *Ljubljana Charter*, and reflect on how far we have come in health systems strengthening, bolstered by the *Tallinn Charter* and *Health 2020*, we hope that this Special Issue will provide you with new insights into how the two priority areas and three foundations for health system strengthening are being enhanced in the WHO European Region. We still have a way to go, but such examples and stories can provide inspiration to us on the journey that lies ahead.

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PEOPLE-CENTRED POPULATION HEALTH MANAGEMENT IN GERMANY

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By: Oliver Groene, Helmut Hildebrandt, Lourdes Ferrer and K. Viktoria Stein

Summary: Since 2006 the *Gesundes Kinzigtal* (GK) model has demonstrated how a people-centred focus on population health management can lead to significant gains in achieving the Triple Aim of better population health, improved experience of care, and reduced per capita costs. Through a strong management organization, a sophisticated data management system, and a trusting relationship between network partners and the communities, the GK model has been able to provide better outcomes for all partners involved.

Keywords: *People-Centred Care, Population Health Management, Integrated Care Outcomes, Germany*

Background

In Europe, cardiovascular diseases, cancer, diabetes, obesity, and chronic respiratory diseases account for an estimated 77% of the disease burden as measured by disability-adjusted life years. Between 70% and 80% of health care costs in Europe are due to chronic disease management. In monetary terms, this corresponds to €700 billion and this figure is expected to increase substantially in coming years.^{1,2} This represents a major challenge for health systems across Europe and has profound social and economic implications, as patients with chronic conditions often require treatment and care from different practitioners in multiple institutions and settings over time. However fragmented governance and funding mechanisms, misaligned incentives, and vested interests

often impede a continuum of care. Not surprisingly, poorly integrated systems are frequently associated with inefficiencies, consumer dissatisfaction, and restricted access to and poor quality of health care services.³

Given the evidence and experience of the past 15 years, it is now widely accepted that in order to achieve a safe, effective, patient-centred, timely, efficient, and equitable health care system, we need to overcome the fragmentation of care and strengthen the focus on population health.^{4,5} To tackle these challenges, the call for a transformation of health services to strengthen people-centred care has been taken up by policy makers and managers and has led to the adoption of

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population health management and the Triple Aim approach as the underlying guiding principle.

Tackling the challenges of the 21st century in Germany

The German health system is characterized by federalization, whereby the ‘Laender’ (federal state) is in charge of implementing national health policies. Key stakeholders in the operationalization, delivery and design of health services at the regional and local level are the health insurance companies and sickness funds, of which there are non-for profit and private ones, all competing for potential insurees. German citizens have (in principle) free choice between the public, non-profit and private insurances, but they are obliged by law to be insured (i.e., one cannot opt-out of the system). As the birth place of the Bismarck system, the German health (insurance) system is a highly competitive but also highly regulated system. It is characterized by frequent national health reforms, resulting in constant adjustments but maintaining the key features of a publicly funded health system, including: strong stakeholder organizations and decentralized governance, clear accountability pathways and funding structures.

In tackling the challenges of the 21st century, a decisive stimulant for change came in 2000 and increased in 2004, with the introduction of a national health reform regulating that henceforth health insurances and provider coalitions could offer integrated care options to patients. The initiative also provided seed money for the development and implementation of integrated care projects. One well-researched – and successful – example of an integrated care system is the *Integrierte Versorgung Gesundes Kinzigtal* model, referred to hereafter as the GK model. The model is designed around the Triple Aim approach⁸ and based on promoting a governance model that prioritizes strong stakeholder consensus building towards achieving population health. An independent management organization acts as the regional integrator, brings together the stakeholders involved in service provision and systematically

monitors the implementation of the GK model. Based on a dynamic and well developed data management system, the GK model features a continuous learning environment, which also serves to inform further development and innovation of the services and programmes.

The GK model is based on a population health management approach, identifying the patients and the community as key partners in care. Population health management is an integral part of people-centred care, by using the needs of the people as the prerequisite for the planning of services. These then need to be addressed on two levels. First, these person- or patient-centred care services develop individual care plans through shared decision-making. Secondly, strong community engagement and increased health literacy leads to informed choice and co-design of services.⁹

“population health management is an integral part of people-centred care”

The three targets of the Triple Aim model are: 1) better population health; 2) improved experience of care; and 3) reduced per capita costs. The model was built on substantial evidence from research and practice related to success factors for health care integration.^{8 9 10 11 12} This accumulated evidence helped identify several necessary components for attaining the Triple Aim. These are: developing a clear (regionally defined) reference population; external policy constraints (such as a total budget limit, assumption of financial responsibility for the population, or the requirement that all groups should be treated equitably); and the presence of a regional integrator to take responsibility for the three aims. The integrator plays a crucial role in establishing partnerships with individuals and families, redesigning

health and care services, managing population health, achieving system integration at the management level, and implementing tailored solutions with the involvement of stakeholders.

Strengthening people and communities to improve population health

The GK model adopted these key principles and since 2006 has taken up the role of regional integrator for the population of the area. Set up as an accountable care organization between a network of physicians and a management company, GK holds long-term contracts with two German non-profit sickness funds to integrate health and care services for their insured populations in Kinzigtal. Currently, they have enrolled approximately half of the 71,000 inhabitants in their programmes. Since 2006, GK has held ‘virtual accountability’ for the health care budget of this population, and since January 2016, a new contract assigns the GK management company full financial accountability. If the sickness funds spend less on health care for this group than standardized, risk-adjusted costs, GK shares the benefits with the sickness funds and reinvests the savings into the extension and improvement of the model. Thus, a shared health savings account is created.

In order to achieve the Triple Aim, the GK model focussed on improving population health in the region from the very beginning, and targeted programmes for people with chronic illness. Thus, a patient-centred care approach is embedded at three levels: at the structural level by including patients in biannually elected patient-advisory boards, and giving patients opportunities to contribute to identifying and developing new programs; at the level of intervention, by embedding a strong focus on shared-decision making and supported self-management in design and development; and at the level of individual doctor-patient interactions, by providing patients a comprehensive health-check (including a self-assessment questionnaire), based on which the appropriate programmes and services are offered. Patients are also given the

Figure 1: Achieving the Triple Aim in Gesundes Kinzigtal

Source: Authors' own.

opportunity to set health-related goals (i.e., doing more exercise, giving up smoking, reducing alcohol consumption, or losing weight), which are then discussed with the physician and monitored, accompanied by individual support and participation in patient education and self-care programmes on an as-needed basis. Programmes to support families and caregivers complement the services offered to the patients.

On the population level, programmes to strengthen health literacy and primary prevention are offered through the “Healthy Kinzigtal Academy” and lectures on health and self-management for a whole variety of diseases and health issues. A magazine and TV channel, available in 22 GP practices or health centres, inform people about upcoming activities, courses, classes and health improvement programmes on a continuous basis. Health festivals are also held to provide people with a fun and relaxed setting in which they can try out different types of physical activity. Furthermore, GK developed a specific employee health management programme targeting small and medium-sized enterprises, which normally would not have the resources to provide such programmes in-house.

Another success factor lies in a strong network of service providers, many of which do not belong to the health sector. GK has established cooperation

with 38 community organizations like local sports clubs, associations for people with disabilities, dancing and hiking clubs, women’s groups, and kids clubs, in addition to closely collaborating with ten local self-help groups. In cooperation with 14 local community councils, GK has designed a wide variety of activities to engage local inhabitants, strengthen local networks, and incentivize people to engage in social activities. GK established two walking trails for memory training, hiking trails for children and their parents, and developed a joint community centre with nurses and housing options in development.

Improving outcomes for all partners involved: demonstrating impact

The impact of all activities is evaluated in terms of implementing the Triple Aim approach has been supported by two independent, scientific evaluation studies.¹⁵ The first involves conducting a biannual random survey with insurees regarding their perceived health, satisfaction, changes in health behaviour, and health-related quality-of-life and levels of activation. The results of the survey demonstrated very high levels of overall satisfaction: 92.1% state they would recommend joining GK and 19.7% state that, overall, they have lived a healthier life since joining GK (with 0.4% stating the contrary and 79.9% stating no change). Among insurees who had

developed a health-related goal, 45.4% stated they now live a healthier life (compared to 0.6% stating the contrary and 54% stating no change, $p > 0.001$). The second is a quasi-experimental study comparing the intervention population to a matched random sample of around 500,000 insurance members from neighbouring regions.

The financial results have been assessed in relation to the development of the contribution margin described above.¹⁶ Routine data analysis has shown a decrease in the overuse of health services for the prescription of anxiolytics, antibiotics for higher respiratory tract infections, non-steroidal anti-rheumatics, non-recommended prescription for vascular dementia, non-recommended prescription for Alzheimer dementia, and an increase in the prescription of antiplatelet drugs and statin (where appropriate) for patients with chronic coronary heart disease (CHD), prescriptions of statins for patients with an acute myocardial infarct (AMI), cardiology referrals for patients diagnosed with heart insufficiency.

“ 45.4% stated they now live a healthier life

According to routine data, there are still a number of indicators that haven’t yet shown a significant change, perhaps due to insufficient observational time. For two indicators – AMI patients on beta blockers and osteoporosis patients with indicated medication – the analysis suggests a deterioration. Overall, a propensity score matched control group suggests an increase in life expectancy by 1.4 years, and ten years since inception of the project.¹⁵ Overall costs have developed favourably compared to expected costs, with annual savings amounting to €5.5 million in 2013. This difference is expected to further increase in the coming years as some of the health programmes will start paying off years after the initial intervention. The reasons for the observed effects are not yet fully understood and

further, long-term evaluation is needed to assess whether, and to what extent, these results can be further enhanced through improving quality and greater citizen and provider engagement.

Conclusions

The GK model demonstrates that a focus on population health management and providing a continuum of care, including health promotion and primary prevention, can lead to cost-effective solutions, while also strengthening communities and healthier people. The model also underlines the importance of taking an inter-sectoral approach even when working at the local and regional level, since so many determinants outside the health system influence the health and wellbeing of people. Establishing lasting, trusting and respectful relationships with and between health service providers, social and community services, private enterprises and local councils was another factor in developing these successful people-centred services. Finally, long-term and sustainable change can only be achieved with the help of a strong evaluation and monitoring framework in order to understand the impact of the interventions, identify risk factors early on, and design and improve the services based on evidence and predictive modelling. Looking more closely at health inequalities and strengthening patient-related outcomes and experience measures are also essential.

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Lessons from transforming health services delivery: Compendium of initiatives in the WHO European Region

Copenhagen: WHO Regional Office for Europe, 2016

Available for download at: <http://www.euro.who.int/en/health-topics/Health-systems/health-service-delivery/publications/2016/lessons-from-transforming-health-services-delivery-compendium-of-initiatives-in-the-who-european-region-2016>

In order for health services delivery to accelerate gains in health outcomes it must continuously adapt and evolve according to the changing health landscape. At present, the case for change

is compelling. In the context of both new challenges and opportunities, initiatives to transform services delivery across the WHO European Region has emerged.

This Compendium demonstrates the diversity in activity, describing examples of health services delivery transformations from each Member State in the Region. The initiatives vary greatly in their scope and stages of implementation, from early changes to initiatives at-scale. When taken together, these examples offer unique insights for setting-up, implementing and sustaining transformations. A summary of 10 lessons learned attempts to synthesize key findings and consolidate insights derived from experiences.

DEVELOPING INTEGRATED HEALTH AND SOCIAL CARE MODELS IN SCOTLAND

By: Toni Dedeu

Summary: Across Europe demographic and epidemiological changes are challenging Member States' health systems. Scotland is no exception. The Scottish government is integrating health and social services to improve their quality and consistency, thereby improving health outcomes in Scotland. A clear vision, strong political commitment, extensive partnerships, and a health systems approach to integrating services have all enabled integration that promotes strong accountability arrangements, transparent joint planning, and a clear outcomes framework. The government has provided funds to facilitate the reform and has established clear communication mechanisms for managing the transformational change that is needed.

Keywords: Health and Social Care, Integration, Scotland

Introduction

The configuration of Scottish society is changing as are the health and social care needs of its communities. Over the next ten years, the number of people in Scotland aged over 75 is likely to increase by over 25%. Over the same time period, it is estimated that nearly two-thirds of the population will have developed long-term conditions by the age of 65. Public services will need to adapt to these changes and be reconfigured to respond to these emerging health and social care needs. Since 1999, successive Scottish Governments have been exploring ways to anticipate and tackle these demographic and epidemiological challenges. The result has been the transformation of health and social care services.¹

A step wise and participatory approach

The transformation has involved several phases. The transformation began in 1999, when 79 local health care cooperatives were established across Scotland to bring together health and social care practitioners to deliver a range of primary and community health services and promote joint working with local authorities and the voluntary sector. In 2000, the Joint Futures Group, a collection of senior figures from the National Health Service (NHS) and local government, recommended that shared assessment procedures, information sharing, joint commissioning, and joint management of services must be developed throughout the country. By 2002, the Community Care and Health (Scotland) Act included powers, but not duties, for NHS boards and

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Table 1: A brief history of integration in Scotland

1999	Seventy-nine Local Health Care Cooperatives (LHCCs) established, bringing together GPs and other primary health care professionals in an effort to increase partnership working between the NHS, social work and the voluntary sector.
2002	Community Care and Health (Scotland) Act introduced powers, but not duties, for NHS boards and councils to work together more effectively.
2004	NHS Reform (Scotland) Act required health boards to establish CHPs, replacing LHCCs. This was a further attempt to bridge gaps between community-based care, such as GPs, and secondary health care, such as hospital services, and between health and social care.
2005	Building a Health Service Fit for the Future: National Framework for Service Change. This set out a new approach for the NHS that focused on more preventative health care, with a key role for CHPs in shifting the balance of care from acute hospitals to community settings.
2007	Better Health, Better Care set out the Scottish Government's five-year action plan, giving the NHS lead responsibility for working with partners to move care out of hospitals and into the community.
2010	Reshaping Care for Older People Programme launched by the Scottish Government. It introduced the Change Fund to encourage closer collaboration between NHS boards, councils and the voluntary sector.
2014	Public Bodies (Joint Working) (Scotland) Act introduced a statutory duty for NHS boards and councils to integrate the planning and delivery of health and social care services.
2016	All integration arrangements set out in the 2014 Act must be in place by 1 April 2016.

Source: Ref ⁵

local authorities to work together more effectively.⁵ An overview of reforms is provided in **Table 1** but in summary they resulted in the 2013 report on the Public Bodies (Joint Working) (Scotland) Bill which proposed to replace the 79 local health care cooperatives with 32 partnership arrangements – one for each area – between the NHS and local council care services.

The step wise and participatory transformation has achieved a high level of consensus between key stakeholders and was formalised with the Public Bodies (Joint Working) (Scotland) Act 2014 which received Royal Assent on 1 April 2014.⁵ The Act now allows for better anticipatory and preventative care and strengthened community-based care and provides a legislative framework for the integration of health and social care services in Scotland.

Key features of the Public Bodies (Joint Working) (Scotland) Act 2014

National outcomes for health and wellbeing apply equally to health boards, local authorities and integration

authorities*. Health boards and local authorities are required to establish *integrated partnership arrangements*. The purpose of the partnership arrangements is to establish an integration scheme, an integration authority and ultimately oversee the implementation of the integration of health care and social care in the area. Statutory partners (health boards and local authorities) decide locally whether to include children's health and social care services, criminal justice, social work and housing support services in their integrated partnership arrangements.

Based on how health boards and local authorities develop their integrated partnership arrangements they will choose different integration authorities. Two models exist: a) delegation of functions and resources between health boards and local authorities (referred to as a *lead agency*); or b) delegation of functions and resources by health boards and local authorities to a corporate

* Integration authorities are the single agency ultimately accountable for the implementation of a statistical data integration project.

body (referred to as an *integrated joint board*).⁵ Both authorities are key to ensuring accountability for integration.

An integrated budget is established by each integration authority to support delivery of integrated functions, which must cover adult social care, adult community health care, and aspects of adult hospital care and aim to support prevention and improved outcomes.

Each integration authority (lead agency or integrated joint board) establishes locality planning arrangements which engage a forum for local professional leadership and innovation in service planning. Localities correspond to the more recognisable towns and cities of Scotland which can be found within settlements (of 500 or more people).

Each integration authority puts in place a strategic commissioning plan for functions and budgets under its control. The joint strategic commissioning plan will be widely consulted upon with non-statutory partners, patient and service-user representatives, among others.

Where an integrated joint body is introduced, a Chief Officer must be appointed by the integrated partnership to provide a single point of management for the integrated budget and integrated service delivery. For the delegation between partners model, this single point of management falls to the Chief Executive of the Lead Agency (i.e., the partner to whom functions and resources are delegated).

Principles of integration

There are five key principles promoted by the Scottish model for integration.⁵ The principles inspire change in culture and services to improve outcomes and deliver these reforms successfully. The integration model: respects the rights of service-users; protects and improves the safety of service-users; improves the quality of the service; best anticipates needs and prevents them from arising; and makes the best use of the available facilities, people and other resources.

Integrated services must be integrated from the point of view of service-users, but also planned and led locally in a way

Box 1: Integration Scheme components

- Engagement of stakeholders
- Clinical and care governance arrangements
- Workforce and organizational development
- Data sharing
- Financial management
- Dispute resolution
- Local arrangements for the Integration Joint Board
- Local arrangements for operational delivery
- Liability arrangements
- Complaints handling

Source: Ref ⁵

that is engaged with the community, those who look after service-users, and those who are involved in the provision of health or social care. Furthermore, the services must take into account the needs of different service-users; the communities in which they live; their dignity; the particular needs of service users as they vary across the country; and the particular characteristics and circumstances of different service users.⁷

Integrated partnership arrangements

Each integrated partnership arrangement (i.e., each of Scotland's 32 areas) must propose an *Integration Scheme* that facilitates ten key components, as presented in **Box 1**.

Currently, 22 *joint integration schemes* have been approved by the Cabinet Secretary for Health, Wellbeing and Sport and established across Scotland. Ten joint integration schemes are still currently undergoing internal review. A number of policy leaders, financial officers and solicitors are also involved to ensure that the integration schemes comply with legislation.

Table 2: Integrated partnership arrangements in Scotland

Project Name	Description
<i>Community Links Project, Midlothian</i>	The project aims to provide support for older people (over 65 years), who are isolated and living in the Midlothian area. It works to enable them to stay connected with their local community and maintain or build on existing social networks and opportunities.
<i>Sustaining tenancy, sustaining wellbeing, Muirhouse Housing Association</i>	This initiative strives to provide practical assistance to tenants through an enhanced management service. Run by Muirhouse, it aims to help people maintain their tenancy, enable them to improve their quality of life, and create the conditions in which people can address aspects of their health and wellbeing. This initiative illustrates how housing associations – through extra services – can have a positive impact on their tenants' quality of life, health and wellbeing.
<i>Edinburgh Joint Carers' Strategy</i>	The City of Edinburgh Council and NHS Lothian have been working collaboratively with carer organizations and carers themselves to develop a strategic approach to commission support services for carers. The development of its three year Joint Carers Strategy for 2014–2017 included a logic model that promotes consultation with carers on priorities and support required.

Source: Ref ⁷

Implementation of integration in Perth & Kinross

The recent integration of two services – the Reablement Service and hospitals – in Perth and Kinross is one example of how the reform described above is translating into the integration of health and social services. Other examples are provided in **Table 2**.

The *Reablement Service*⁸ is a social service that was launched in 2010 in Perth to help patients over the age of 65[†] regain their independence upon discharge from hospital and return home. The service offers individuals six weeks of support to plan and implement measures that promote independence focusing on the things they would like to be able to do for themselves. This can include anything from washing and dressing to preparing meals. The amount of care and support someone receives varies depending on individual needs and if individuals cannot achieve full independence after the six week period, on-going care is arranged. Until 2010, this service was engaged upon referral by the local authority, independently from any health care service or provider.

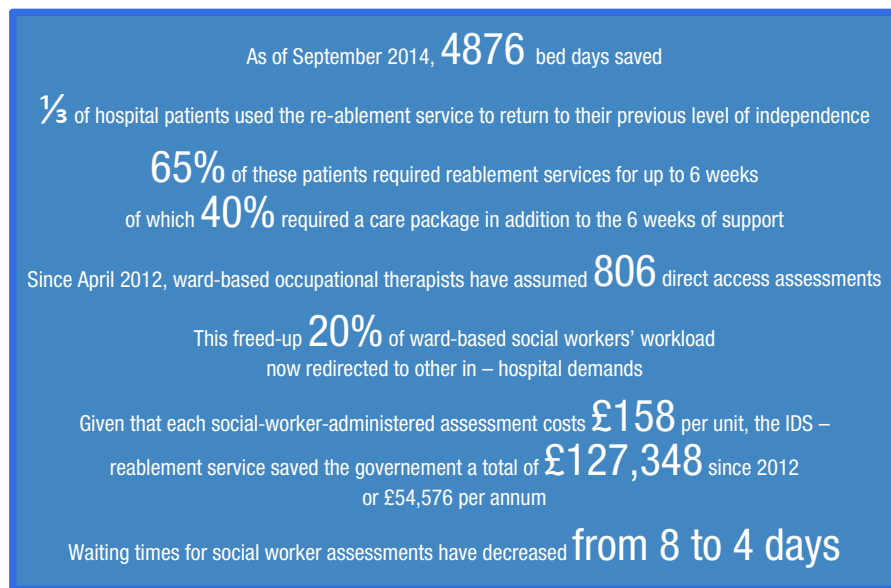
In 2011, as a means of reducing bureaucracy and accelerating patient access to *Reablement Service* the locality introduced the Immediate Discharge

Service (IDS). The IDS was convened to directly assist hospital staff to ensure patients preparing for discharge are connected with the *Reablement Service*. The IDS team consists of a Reablement Coordinator, twelve new Reablement Assistants, an occupational therapist support assistant and a clerical officer.

Achievements

Since the introduction of IDS and by November 2012, Perth and Kinross have successfully reduced the number of hospital bed days for patients over 65 by 50%. The ability of hospital staff to directly connect with the *Reablement Service* though the IDS has also allowed hospital-based social workers to direct non-complex cases to the *Reablement Services* and redirect hospital social services to more complicated cases. Direct collaboration between hospital and *Reablement Service* staff has resulted in improved communication and collaboration. This is in large part due to having dedicated clerical staff to assume administrative and logistical communication responsibilities allowing clinicians to focus on clinical discussions and care plans with patients and the *Reablement Service* staff. Such a review and redesign of the discharge pathway has led to a robust, efficient multi-disciplinary approach to assist with building community capacity, reduced duplication and increased efficiency. Direct access to the *Reablement Service*

[†] The number of people aged over 65 living in Perth and Kinross is expected to increase by 74% by 2031.

Figure 1: Quantifying the benefits of the IDS-Reablement ServiceSource: Ref ¹⁰

by health workers has reduced the waiting time for assessments. See **Figure 1** for more quantified gains from this initiative.

Monitoring outcomes

A national framework for measuring the impact of integrated health and social care on the health and wellbeing of individuals is being developed based on a series of desired outcomes of the Health and Social Care Integration model. The outcomes emphasize quality and consistency of services for individuals, carers, their families, and those who work in health and social care. All health boards, local authorities and integration authorities are jointly responsible and accountable for achieving these outcomes. The desired outcomes are listed in **Box 2**. Indicators have been developed and linked to outcomes in consultation with a wide range of stakeholders across all sectors, with significant input from the Convention of Scottish Local Authorities (COSLA). They have also been approved by a Ministerial Steering Group. The indicators are still being piloted, however, and will need to be tested before their usefulness can be assessed both in terms of reporting and strategic planning. Integration Authorities will then be required to publish annual performance reports that monitor progress on these indicators along with any information on the local setting that can help contextualize local performance.

Conclusions

In March 2013, the Scottish Government launched its 2020 Vision. The vision aspires to the goal that by 2020 everyone is able to live longer healthier lives at home or in a homely setting. Thanks to the development of the integrated health and social care system in Scotland the foundations for achieving that vision are in place in most Scottish territories. Interventions ranging from hard regulation to detailed integration schemes, have ensured this transformation is tailored to the specificities of each territory. By 2020, Scotland will have a health care system that fully integrates health and social care and focuses on prevention, anticipation and supported self-management. Day care treatment will become the norm where traditionally individuals have been hospitalized. Whatever the setting, care will be provided at the highest standards of quality and safety, with the person at the centre of all decisions. The focus will be on ensuring that people get back to their home or community environments as soon as appropriate, with minimal risk of re-admission⁷. Scotland's integrated health and social care model, is at the forefront of transformational change in Europe. Close monitoring of the implementation and impact of the Scottish model will be important for scaling up and knowledge exchange.

Box 2: National health and wellbeing outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7. People who use health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

Source: Ref ¹¹

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TRANSFORMING THE MODEL OF CARE FOR TREATING TUBERCULOSIS IN THE REPUBLIC OF ARMENIA

By: Saro Tsaturyan and Armen Hayrapetyan

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Summary: Reforms to treat tuberculosis (TB) patients undertaken in Armenia have actively moved away from traditional modalities of service delivery, and are rather based on modern service delivery models informed by evidence-based guidelines, with clearly developed pathways, more appropriate use of resources (human and physical), and revised roles for hospitals. In the context of limited public resources, measures were introduced to change the model of care to deal with the growing burden of multidrug-resistant and extensively drug-resistant forms of TB. These measures included changing the hospitalization and discharge criteria for TB patients and reorganizing TB services while aligning provider payment mechanisms.

Keywords: Tuberculosis, Health Services Delivery, Health Financing, Armenia

Introduction

Although ongoing reforms have resulted in large reductions in tuberculosis (TB), morbidity and mortality rates over the past years* TB remains a major public health threat in Armenia. The TB incidence rate (including HIV+TB) per 100 000

population in 2014 was 45,³ compared to 62.4 in 2005.⁴ TB services, including outpatient and hospital services for the entire population, are fully covered by the Basic Benefits Package (BBP), which is funded from the public budget. However, the rise in the number of multidrug-resistant and extensively drug-resistant forms (M/XDR) forms of TB poses serious public health and social challenges for the country.

* TB morbidity was 34.7 per 100 000 inhabitants in 2014, compared with 62.4 in 2005. The TB mortality rate for the same period was reduced from 5.2 to 1.6 (1).

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“public funding for TB services was increased

Prior to the 2013 TB infrastructure optimization reform described here, there were 72 outpatient and 9 inpatient TB care facilities in Armenia, of which 21 outpatient and 2 inpatient facilities were located in the capital city Yerevan[†]. More than 65% of TB patients in Armenia were diagnosed at inpatient TB care facilities, where around 95% of all TB patients received their intensive course of treatment. In 2013, 82% of public funding was allocated for hospital facilities and the remaining 18% for outpatient services.⁴

An evaluation of the ongoing TB reforms, conducted by a team of WHO experts in 2014, identified both achievements and existing shortcomings, such as the need to emphasize the role of intersectoral cooperation for successful implementation of health sector reforms, to adopt a strategy for the integration of vertical programmes (including TB) into primary health care, development of a unified health information system and reform of hospital infrastructure. More specific recommendations with regard to TB were to improve training of TB providers, to increase their awareness about performance-based incentives at the primary care level and to ensure more flexibility for the Ministry of Health in managing budget allocations by consolidating numerous budget programs.⁵ While some of those recommendations are not yet fully implemented and need further consideration by the Ministry of Health and other stakeholders, others were addressed with specific steps described below.

Transforming the TB model of care

Prior to 2014 most hospitalized TB patients did not meet the WHO criteria for hospitalization, undermining the

potential role of outpatient facilities in diagnosing, treating and preventing TB. The reorganization that followed the 2013 reform included all aspects of TB services: human resource management; administrative procedures and financing mechanisms.

In 2014, new criteria for admission and discharge of patients with TB were implemented in line with the WHO recommendations. The introduction of specific hospitalization and discharge criteria directed clinicians to avoid hospitalization except for diagnostic purposes or smear negative TB patients.⁶ To further increase the efficiency of the system, a recommendation was made by the Ministry of Health working group to close inpatient facilities that were serving only a limited number of patients annually and to revise the structure of outpatient TB facilities in Yerevan.⁷

This resulted in the reduction of the number of outpatient TB facilities in Yerevan from 21 to 9 in 2014 (the number of facilities in the regions remained the same – 51), while their human resources and technical capabilities were further strengthened. With the support of the Project “Strengthening tuberculosis control in Armenia” (funded by a grant from the Global Fund), all TB providers in Yerevan (i.e., doctors, nurses, lab technicians) were involved in training opportunities. Premises providing TB services in two Yerevan polyclinics were also renovated. Three regional-level inpatient facilities were closed due to low workloads bringing the total number of inpatient TB facilities to six – two in Yerevan and four in the regions.

Alignment of financing mechanisms to transform TB care

It is important to mention that public funding for TB services (both outpatient and inpatient) was increased during the same period. In Armenia, the medical services covered by the BBP are funded from the public budget through the State Health Agency (SHA) of the Ministry of Health which acts as a single purchaser of services. Prior to the 2013 reform, payment mechanisms included “per capita” payments for outpatient and

“fee per case” payments for hospital services. However, some types of inpatient services, including the treatment of TB patients prior to 2014, were reimbursed through a combination of fee per case and fee per bed/day mechanisms, such that hospitals would receive a fixed fee per case for each discharged patient for a pre-defined length of stay. If the actual length-of-stay was less than the normative number of days, then the reimbursement was calculated according to the actual number of bed/days multiplied by the fee per day.

During 2012–2013, the National Tuberculosis Control Office, in collaboration with SHA, conducted a comprehensive evaluation of TB service delivery and financing in the country. Based on the findings, recommendations were to modify the financing mechanism for outpatient services from being based purely on per capita calculations and to introduce financing mechanisms that were based on a combination of per capita and performance based payments. For inpatient services recommendations included shifting from the previously mentioned mix of fee per case and bed/day approach and introduce a combination of guaranteed funds for facility maintenance (fixed) costs plus remuneration for variable costs (drugs, other medicine and food). Measures aimed to implement financial incentives for health care providers to incentivize early interventions, successfully treat TB cases, reduce the number of unnecessary hospitalizations and average length of stay, and overall, promote higher productivity and cost effectiveness.

Armenia has had a performance-based financing (PBF) mechanism for primary care providers in place since 2010. In 2014, two additional indicators related to early detection of TB (one for adults and another for children) were added to the existing set of PBF indicators.⁸ New financing mechanisms for inpatient TB services were introduced in October, 2014.⁹ While 2014 was marked by a transitional period for the implementation of new financing mechanisms, 2015 saw the first full-scale post-reform reporting period. Further data comparisons will be drawn between 2013 (the baseline year)

[†] The largest inpatient TB facility in the country, the National Anti-Tuberculosis Dispensary, is geographically located in the Kotayk region, near the capital city Yerevan, and is directly managed by the Ministry of Health.

Table 1: Financing TB services in Armenia, 2013–2015

	2013			2015		
	Number of cases	Number of bed/days	Funding (AMD millions)	Number of cases	Number of bed/days	Funding (AMD millions)
Hospital TB services	6 513	144 582	1 249.9	4 382	99 193	1 425.0
Outpatient TB services	n.a.	n.a.	270.2	n.a.	n.a.	347.6
Total			1 520.1			1 772.6

Source: Database of State Health Agency, Ministry of Health, Armenia.

Notes: AMD – Armenian Dram; n.a. – data not available.

and 2015. During the 2013–2015 period, total public funding for TB services increased by 16.6%. **Table 1** shows that public funding for outpatient TB services increased by 28.6% while funding for inpatient TB services increased by 14.0%. This is also reflected in the increased outpatient/inpatient ratio of public funding (80% for inpatient services in 2015 and 20% for outpatient).

“Improved quality of care and higher satisfaction”

The total number of hospital TB cases dropped by 32.7% from 2013 to 2015 while the number of bed/days was reduced by 31.4%. These changes resulted in an increase in the average cost per discharged patient by 69.4%, while total funding of inpatient services increased only by 14% during the same period, as mentioned above. This, in turn, has led to improved quality of care and higher satisfaction of both providers and patients, since TB facilities received additional resources to invest in improvement of both service delivery and working conditions for their staff. At the National Anti-Tuberculosis Dispensary, which manages approximately 80% of all hospital cases, average monthly salaries increased by 20–25% in 2015 compared to 2013; this represents a 21.5% increase for doctor salaries, and a 26.7% increase for nurses salaries.⁶

Preliminary findings

While assessing the impact of comprehensive reforms will require a longer term perspective than is currently available, initial achievements have been encouraging. Continuous annual monitoring and evaluation of the outcomes in order to identify necessary adjustments in a timely manner is ensured through a set of 33 indicators covering inputs, processes and outputs (some indicators also will be monitored on a quarterly basis). First assessment results are expected by May 2016 (after this article was sent to press). Overall, the success of the reform on TB care in Armenia seems to have hinged on the clarity of definitions for models of care and the alignment of the incentives and financing mechanisms to underpin those changes towards a more sustained transformation.

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UNIVERSAL HEALTH COVERAGE AND THE ECONOMIC CRISIS IN EUROPE

By: Sarah Thomson, Tamás Evetovits and Hans Kluge

Summary: As the concept of universal health coverage (UHC) has gained prominence internationally, some have questioned its relevance for high-income countries, especially for countries that already offer universal (or near-universal) population coverage. This line of questioning is misguided because it limits UHC to population coverage and assumes that past achievements cannot be undone. In the years following the economic crisis, many people in EU member states experienced an erosion of health coverage. Before the crisis, unmet need for health services was falling across the EU, but by 2014 it had once again reached the level of 2007.

Keywords: Economic Crisis, Universal Health Coverage, Health System Performance

What does UHC mean for high-income countries?

UHC means everyone can use effective health services when they need them without experiencing financial hardship. Moving towards UHC involves meeting three distinct health system goals: access to needed health services; the provision of services of sufficient quality to be effective; and financial protection, with equity being central to each goal. This in turn requires a focus on all three dimensions of health coverage, as shown in the cube in **Figure 1** and not looking solely at the share of the population that is covered, but also thinking about the range, quality and timeliness of covered services and the presence and magnitude of co-payments people are required to pay when they use health services (user charges).

During the 20th century, European Union (EU) countries led the way in moving towards UHC, providing a model for

others to follow. Yet few policy makers in EU member states would claim to be fully satisfied with their country's progress in meeting all three UHC goals. And in the wake of the economic crisis, few would argue that movement around UHC is inexorably in one direction.

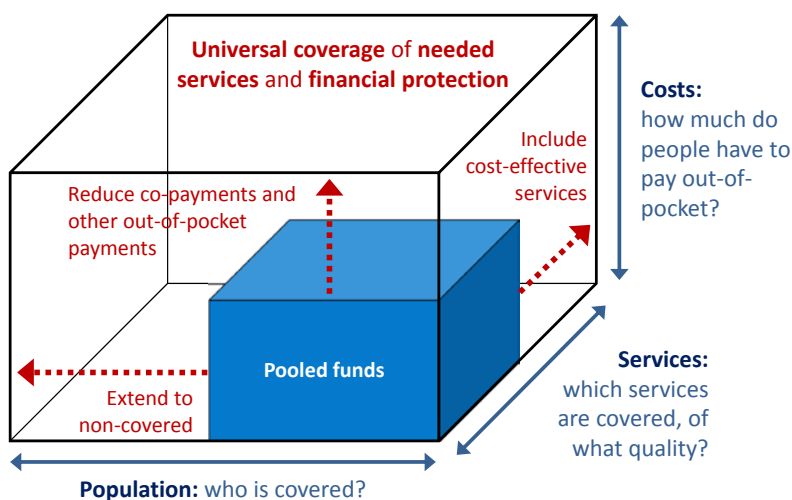
The impact of the crisis on UHC: theory

An economic shock can undermine progress towards UHC through the following pathways:

- failure to address existing gaps in health coverage may add to financial pressure, especially for households at risk of poverty, unemployment and ill health
- growing unemployment and poverty may increase people's need for health care or lead people to save money by using publicly rather than privately financed treatment; increased need for

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Figure 1: Three dimensions of health coverage



Source: Adapted from Ref 1

Note: In almost every country in the world, the vast majority of pooled funds are considered to be public because they are generated through compulsory forms of pre-payment and are not linked to individual risk of ill health.

health care and increased use of publicly financed treatment may put pressure on publicly financed health services

- reductions in public spending on health and restrictions of health coverage are likely to shift health care costs onto households, increasing the out-of-pocket share of total spending on health and leading to financial hardship, access barriers and unmet need, particularly among vulnerable groups of people.

Evidence from previous shocks indicates that *countercyclical* public spending on health and other social services during an economic downturn – that is, public spending that rises as gross domestic product (GDP) is falling – is important for protecting health and health system performance.

The impact of the crisis on UHC: practice

To assess the impact of the crisis on UHC in EU countries, we look first at trends in public spending on health and trends in out-of-pocket payments, to see if reductions in public spending shifted health care costs onto households. We then review health system responses to the crisis, focusing on changes to the three dimensions of health coverage.

Finally, we consider data on two key UHC outcome indicators: unmet need and financial protection.

The information we draw on comes from a study on the impact of the crisis on health and health systems in Europe carried out jointly by the European Observatory on Health Systems and Policies and the WHO Regional Office for Europe. The study looked at policy responses to the crisis between the end of 2008 and the beginning of 2013.

Many countries shifted health care costs onto households

Changes in public spending on health and out-of-pocket payments can be used as simple proxy indicators of potentially negative effects on UHC. Evidence from previous economic shocks clearly highlights the importance of countercyclical public spending in minimising risks to health and health system performance.

Figure 2 shows how public spending on health has been pro-cyclical – that is, falling as GDP falls – rather than countercyclical in nearly half of all EU countries in the years since the crisis, with several countries experiencing substantial and sustained declines. Public spending

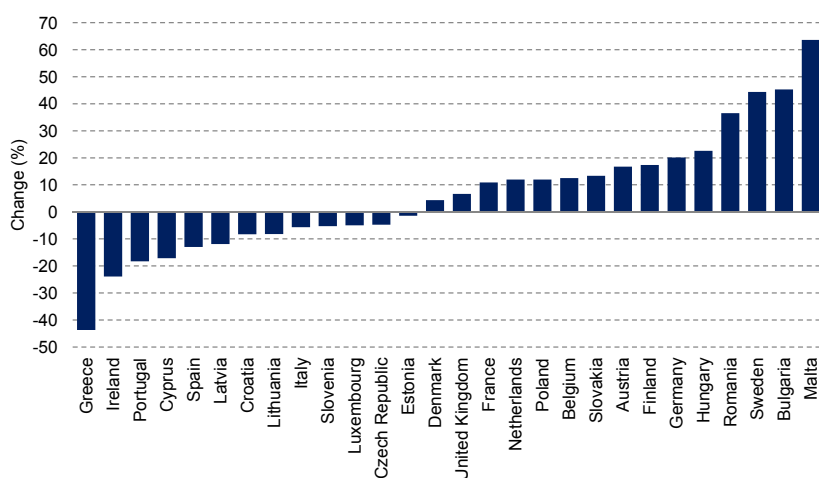
on health fell to such an extent that the level of spending per person in 2013/14 was around the level of 2007/08 in Croatia, Cyprus, Italy, Latvia, Luxembourg, Slovenia and Spain, and around the level of 2003/04 in Greece, Ireland and Portugal.

Between 2008 and 2014, out-of-pocket payments per person rose steadily in all except a handful of countries (Croatia, Cyprus, France, Greece and Slovakia, where they were lower in 2014 than they had been in 2008). Out-of-pocket payments rose as a share of total spending on health in just over half of all EU countries (Figure 3). In several countries heavily affected by reductions in public spending on health, the increase in the out-of-pocket share has been large. For example, in Ireland, Portugal and Spain, the out-of-pocket share in 2014 was higher than in any year since 1995. In Greece, the out-of-pocket share fell dramatically in 2009, but grew rapidly in 2013 and 2014. Changes of this magnitude indicate a substantial shifting of health care costs from governments to households at a time when many households were facing additional financial pressure.

“spending cuts were large enough to limit access”

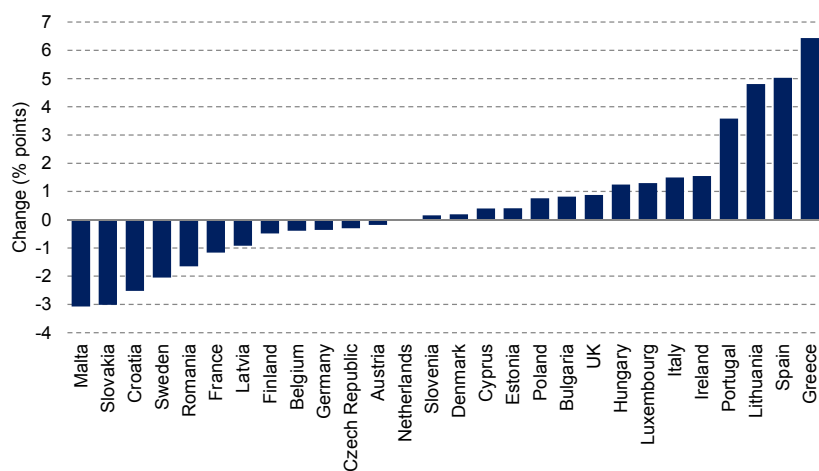
Relatively vulnerable people lost entitlement to publicly financed health coverage

People who are not entitled to publicly financed health coverage will face significant barriers to access unless they are able to buy private insurance. Extending population entitlement is therefore a critical first step in moving towards UHC. The decade before the crisis saw important changes to population entitlement in EU countries – for example, coverage expansions in Belgium for self-employed people, in Ireland for older

Figure 2: Change in public spending on health per person during the crisis, EU28

Source: Authors using WHO data on per person public spending on health in national currency units ⁷

Note: Negative changes are between the year *before* public spending on health fell and the *last* year in which public spending on health fell (so for Greece it is between 2009 and 2014, for Ireland between 2008 and 2013 etc). Positive changes are between 2009 and 2014.

Figure 3: Change in the out-of-pocket share of total spending on health during the crisis, EU28

Source: Authors using WHO data ⁷

Note: The change is between 2009 and 2014 for all except Estonia and Romania (2008 and 2014). Data for the Netherlands are not internationally comparable because they systematically understate out-of-pocket payments. ⁸

people and in the Netherlands for richer people previously excluded from publicly financed coverage.

During the crisis, six EU countries reported reductions in population entitlement. Almost all of the reductions affected relatively poor households (Cyprus, Ireland, Slovenia) and non-citizens (the Czech Republic, Spain). In Cyprus, Ireland and Slovenia, the targeting of poorer households was the result of a change in the means-test threshold,

making it more difficult for households to qualify for entitlement. Spain restricted access for adult undocumented migrants, but the measures were not implemented by all regions and, in 2015, the central government announced it would partially reverse the policy. ⁹

Unemployed people are highly vulnerable in countries where entitlement to a comprehensive package of publicly funded health services does not extend beyond a fixed period of unemployment. The

policy response to this problem varied across countries. Early on in the crisis (2009), Estonia extended health coverage to people registered as unemployed for more than nine months, on the condition that they were actively seeking work. As a result, a high share of the long-term unemployed now benefit from improved financial protection, although they still do not have publicly financed access to non-emergency secondary care. ⁵ In contrast, in Greece action to protect unemployed people has been slow and ineffective. ⁶ Estimates suggest that around a fifth of the Greek population no longer has entitlement to comprehensive health coverage due to unemployment or inability to pay contributions – an alarming situation that has as yet to be resolved. ⁵

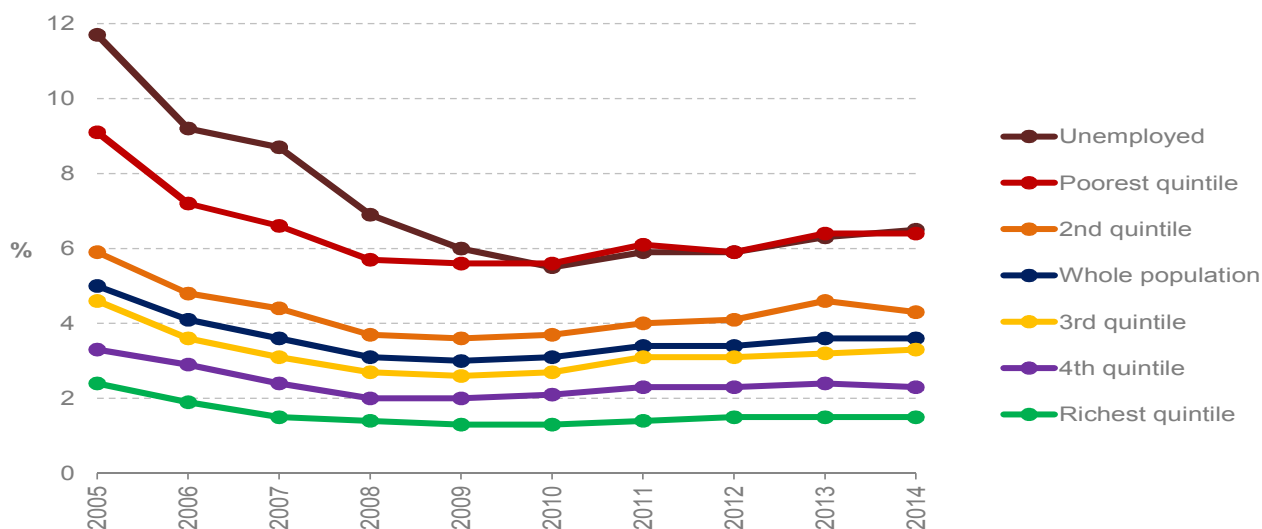
The crisis has clearly shown the limitations of basing population entitlement on income or employment (often a proxy for income) and demonstrated the merits of basing entitlement on residence.

Very few countries selectively de-listed non-cost-effective benefits

Using health technology assessment (HTA) to identify and de-list (remove from coverage) non-cost-effective services, medicines and patterns of use can save money and enhance efficiency. It would therefore be an appropriate response to fiscal pressure if the infrastructure required were already in place. However, HTA was not in fact widely used to inform coverage decisions during the crisis. Only four EU countries reported using HTA for disinvestment, while eleven reported restricting benefits on an ad hoc basis. This is a cause for concern, especially where countries restricted access to primary care – for example, Romania introduced a cap on the number of covered visits to a general practitioner for the same condition, initially set at five visits a year in 2010 and further restricted to three visits a year in 2011.

In some countries, spending cuts were large enough to limit access to needed health services. Cuts to hospital budgets in Latvia are reported to have pushed up waiting times for elective surgical procedures to such an extent that these services were de facto no longer publicly

Figure 4: Unmet need for health care due to cost, distance or waiting time, 2005–2014, EU28



Source: Authors using data from EU-SILC²⁴ available from 2005 to 2014.

financed; those who needed them had to use private hospitals and pay out of pocket.²⁵

Many countries increased co-payments; a few understood the risks

When faced with fiscal pressure, some countries will consider introducing or increasing co-payments. This is likely to undermine access and financial protection unless co-payments are applied with great care, in a highly selective way: (a) targeting non-cost-effective care only; or (b) targeting rich households only. However, option (a) would probably not lead to more efficient patterns of use because people will generally continue to use services and medicines if instructed to do so by a physician or other health worker; removing non-cost-effective care from coverage would be more likely to have the desired effect, if accompanied by strong signals to care providers. Option (b) might succeed in shifting some costs onto households without increasing access barriers or financial hardship, but the administrative costs incurred could mean the net revenue gained is small.

Twelve EU member states reported introducing new or higher co-payments in response to the crisis, suggesting many countries found this to be a relatively easy policy lever to employ. Eight countries

reported reducing co-payments or trying to strengthen protection against co-payments. Economic adjustment programs negotiated with the European Commission required a blanket increase in co-payments in Cyprus, Greece and Portugal, without selectivity or protection for poorer people. In this respect, the programs were not in line with international evidence or best practice.

Some countries tried to address fiscal pressure through efficiency gains rather than coverage restrictions. For example, reductions in medicine prices in countries where co-payments are set as a share of medicine costs have lowered the financial burden on patients and enabled a wider range of medicines to be publicly financed.

Impact on UHC outcomes

Assessing changes in two UHC outcomes (unmet need and financial protection) requires data on the use of health services, estimates of the incidence of impoverishing and catastrophic out-of-pocket payments, and data on unmet need, all disaggregated by income and other individual characteristics to allow analysis of impact on equity.

Across the EU, only data on unmet need are routinely available and disaggregated*. These data show how, on average, unmet need due to cost, distance or waiting time had fallen substantially before the crisis began, but has risen steadily since 2009. In 2014, unmet need for these three reasons was back at the level it had been in 2007 (Figure 4). As a result, over 3 million more people reported unmet need for health care in 2014 than in 2009.

“unmet need has risen in 22 out of 28 EU member states”

Since the onset of the crisis, unmet need due to cost, distance and waiting time has risen across the whole population in 22 out of 28 EU member states and was higher in 2014 than in 2009 among the poorest quintile in 21 out of 28 countries.²⁶ The highest rises in unmet need among the

* Through the EU Survey on Income and Living Conditions (EU-SILC) covering the EU28 countries, Iceland, Norway and Switzerland.

poorest quintile – a doubling or more, an increase of more than three percentage points or increases in each of three or more years – have occurred in Belgium, Cyprus, Finland, France, Greece, Ireland, Italy, Latvia, Luxembourg, the Netherlands, Poland, Portugal, Spain and the United Kingdom.

Until recently, financial protection was not systematically monitored in Europe. To address this gap, the WHO Regional Office for Europe has initiated a study to collect and analyse data on the incidence of impoverishing and catastrophic out-of-pocket payments across a range of EU countries (see the article by Thomson, Evetovits, Cylus and Jakab in this issue). Preliminary results for countries in which pre- and post-crisis data are available indicate an increase in financial hardship over time in most countries.

What lessons for the future?

In assessing the effects of the crisis on UHC, we identify three important lessons for policy. First, for a robust assessment, we need better data on patterns of health service use; more internationally comparable data on unmet need; and more regular analysis of catastrophic and impoverishing out-of-pocket payments. All of these data, and data on health spending trends, need to be made available much more quickly than at present.

Second, it is evident that the remarkable progress EU countries made in meeting UHC goals in the decade before the crisis has been partly undone as a result of the crisis. We see this in the widespread rise in unmet need across countries,

especially (but not only) among the poorest households. It is not easy to tell from the EU Survey on Income and Living Conditions data whether the increase in unmet need is driven by changes in households' financial status or changes in the health system (or both). However, identifying the precise source of the increase is probably not as important as understanding that, in any future downturn, the health system response must be to step up protection for poorer households as a priority. The fact that so many countries failed to prevent erosion of health coverage for the most vulnerable people should be a matter of concern to national and international policy makers in the EU.

Third, resilient health systems will take steps now to ensure that fiscal pressures do not undermine UHC achievements in the future. This includes establishing mechanisms to enable countercyclical public funding for the health system; abolishing links between population entitlement and employment or income, to ensure that relatively vulnerable people do not lose entitlement if they become unemployed or because a means-test threshold is raised; putting in place the infrastructure needed to make evidence-informed decisions about cost-effective investment and disinvestment; and bringing the design of co-payment policies in line with international evidence, so that there is effective protection for the poor and for regular users of health services and a cap on co-payments for everybody.

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Good practices in strengthening health systems for the prevention and care of tuberculosis and drug-resistant tuberculosis

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To improve the transfer of knowledge and experience among countries and their use of the health-system approach to tackle health problems, the WHO Regional Office for Europe has collected and disseminated good examples of the prevention, control and care of TB in the Region. In this second compendium, it presents 45 examples of good practice in strengthening health systems for the prevention and care of TB and drug-resistant TB from 21 countries.

GENERATING EVIDENCE FOR UHC: SYSTEMATIC MONITORING OF FINANCIAL PROTECTION IN EUROPEAN HEALTH SYSTEMS

By: Sarah Thomson, Tamás Evetovits, Jonathan Cylus and Melitta Jakab

Summary: High-performing health systems protect people from experiencing financial hardship when using needed health services. But what does financial hardship mean, how is it measured and what can policy makers learn through systematic monitoring? These are some of the questions the WHO Regional Office for Europe is addressing in a new study that uses a refined methodology to monitor financial protection across countries in Europe. The study will provide actionable information on a key indicator of universal health coverage (UHC) and an important dimension of health system performance.

Keywords: *Financial Protection, Universal Health Coverage, Health System Performance*

Why does financial protection matter?

Financial hardship is an outcome of using health services and having to pay for them ‘out of pocket’ at the point of use*. Out-of-pocket payments are unlikely to be a problem if they are small and paid by people who are well off. However, even small payments can cause financial hardship for poor people and those who need to pay on an ongoing basis – for example, to cover some or all of the cost of medicines for chronic conditions. Weak financial protection may prevent households from spending enough on health care and other basic needs like

food, housing and utilities. In the long run, this could lead to further deprivation and ill health.

Health systems that provide strong financial protection keep out-of-pocket payments to a minimum using a combination of strategies.¹ These include adequate and stable public funding for a broad spectrum of health services; limited use of co-payments (user charges); efforts to ensure equitable and timely access to good quality care delivered at least cost; and policies to protect vulnerable groups of people. Because outpatient medicines account for a large share of out-of-pocket payments, policies to expand publicly financed coverage of medicines, to reduce medicine prices and to ensure

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* Out-of-pocket payments refer to formal and informal payments made by people at the time of using any good or service delivered in the health system.

cost-effective prescribing, dispensing and use of medicines play a vital role in strengthening financial protection.

Why monitor financial protection in high-income countries?

Many people see lack of financial protection as a policy problem mainly affecting health systems in low- and middle-income countries. The assumption is that richer countries provide good financial protection through high levels of public spending on health and universal (or near-universal) population coverage. Although it is true that the incidence of financial hardship tends to be higher in poorer than in richer countries,² inadequate financial protection remains a pertinent issue in high-income countries.

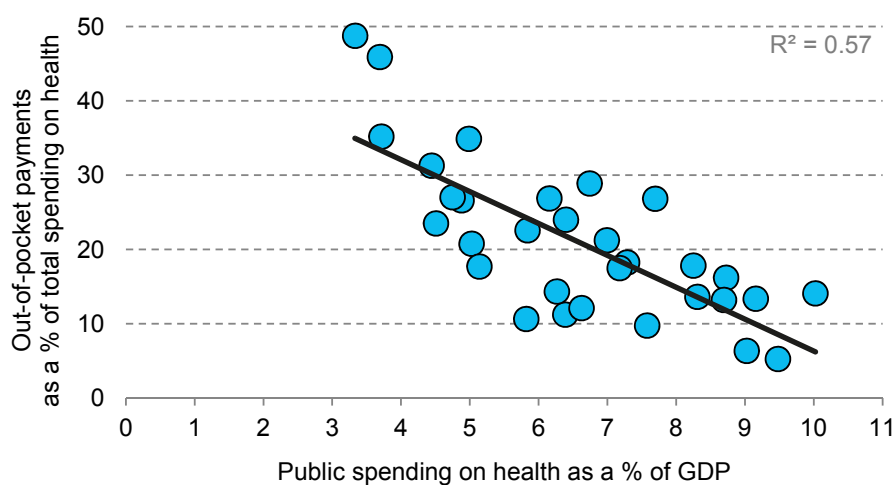
First, there is substantial variation across high-income countries in levels of public spending on health and of out-of-pocket payments, as shown in **Figure 1**. Across the 34 high-income countries in the WHO European Region, public spending on health ranges from 3.3% to 10.0% of GDP and out-of-pocket payments range from 6.3% to 48.7% of total spending on health.

Second, population coverage alone is not enough to secure financial protection. If publicly financed benefits do not include a broad range of good quality health services, or if co-payments are required, some people will experience financial hardship in spite of being covered.

Third, policy choices matter. Even high-income countries face fiscal constraints and must make trade-offs when allocating resources. They also have people who are poor or vulnerable in other ways. As a result, failure to spend limited resources efficiently and to provide effective protection for vulnerable groups (for example, through exemptions from co-payments) is likely to exacerbate financial hardship.

Finally, policy achievements can be undone. People in many EU member states have experienced an erosion of health coverage due to changes introduced during the economic crisis³ (see the article by Thomson, Evetovits and Kluge in this issue).

Figure 1: Public spending on health and out-of-pocket payments in high-income countries in the WHO European Region, 2014



Source: WHO data.

Note: The figure includes high-income countries in the WHO European Region with populations of more than 100,000 people.

The genuinely global relevance of financial protection is reflected in the inclusion of universal health coverage in the sustainable development goals (SDGs), to which all countries have committed. Because financial protection is a core health system objective, it should be a central component of health system performance assessment in rich and poor countries alike.

How is financial protection measured?

Financial protection is commonly measured using two indicators associated with the use of health services: so-called ‘impoverishing’ and ‘catastrophic’ out-of-pocket payments.^{4 5} Both indicators estimate the number of households in which out-of-pocket payments for health care exceed a pre-defined threshold.

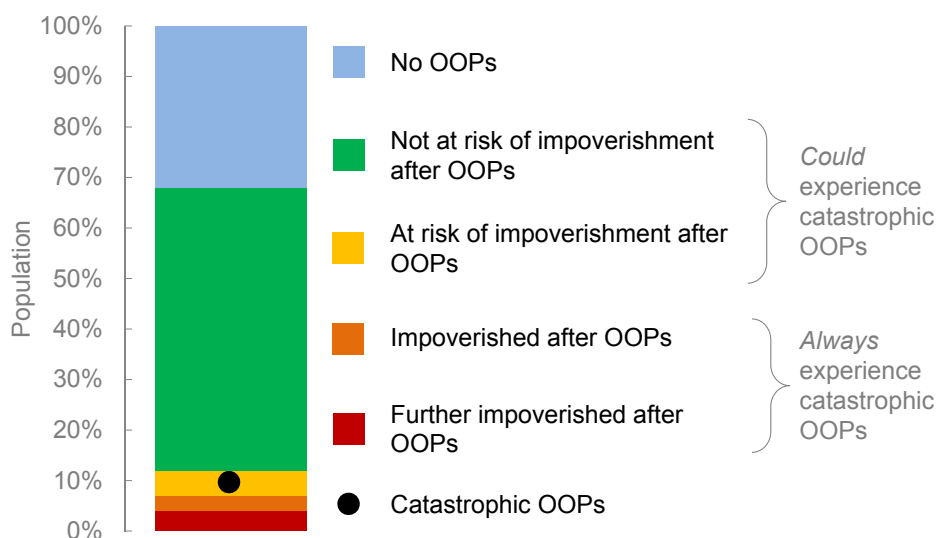
The threshold used to estimate the incidence of impoverishing out-of-pocket payments is a poverty line. Estimates involve identifying households initially above the poverty line (non-poor households) who find themselves below the poverty line after making out-of-pocket payments (now poor households). The poverty line can be defined in different ways.

For catastrophic out-of-pocket payments, the threshold is a share of a household’s budget or capacity to pay. A simple approach is to consider out-of-pocket payments to be catastrophic if they exceed a share of a household’s budget, with budget defined as total income or total consumption (that is, actual spending, often regarded as a more stable indicator of financial status than income, especially in contexts where incomes are irregular or partially in kind).

More refined approaches define out-of-pocket payments as catastrophic if they exceed a share of capacity to pay – that is, income or consumption remaining after deducting an amount to cover spending on basic needs. This amount could be normative – the same for all households of equivalent size – or reflect a household’s actual spending on basic needs. Studies that account for capacity to pay usually focus on food spending, but food may not be a good proxy for basic needs in all contexts.

In estimating either indicator, it is not the *absolute* amount spent out of pocket that is important, but rather the *impact* of this spending on a household’s financial status – so the amount *relative* to a household’s proximity to the poverty line (impoverishing out-of-pocket payments)

Figure 2: The incidence of impoverishing and catastrophic out-of-pocket payments for health services in a high-income country



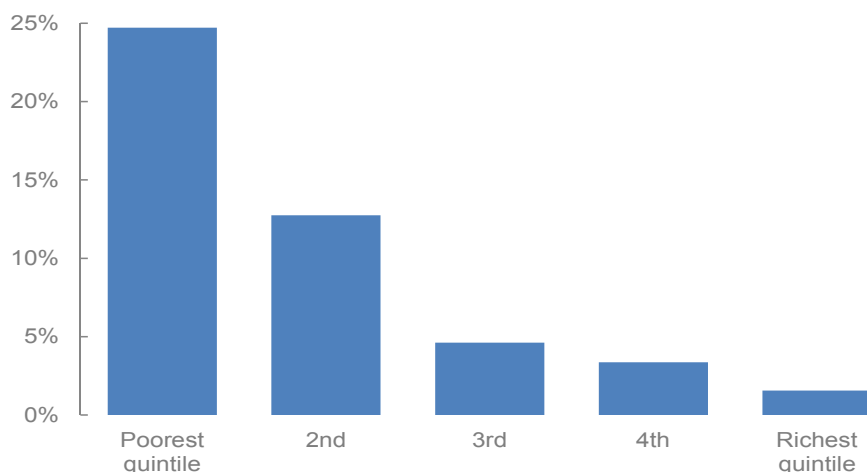
Source: Authors' modelling.

Note: Stylised example; OOPs = out-of-pocket payments.

is a normative amount based on spending on food, rent and utilities among relatively poor households[†].

We present the incidence of impoverishing and catastrophic out-of-pocket payments in a single chart (Figure 2). The chart also draws attention to other important groups of people, such as those 'at risk of impoverishment' because they come close to the basic needs line after making out-of-pocket payments; those who are 'further impoverished' because they are living below the basic needs line *before* incurring out-of-pocket payments; and people who do not incur any out-of-pocket payments at all, potentially raising questions about the magnitude of unmet need for health services.⁶ Highlighting out-of-pocket spending among already poor people is particularly valuable for policy makers given the emphasis many health systems place on protecting poorer households.

Figure 3: The distribution of impoverishing and catastrophic out-of-pocket payments across income groups in a high-income country



Source: Authors' modelling.

Note: Based on data from an EU country; income groups are based on household consumption quintiles.

What can policy makers learn from monitoring financial protection?

Analysis of financial protection provides policy makers with actionable information on an important dimension of health system performance and a key indicator of universal health coverage. At a national or sub-national level at one point in time, it sheds light on how many people experience financial hardship as a result of out-of-pocket payments (incidence, Figure 2); who these people are and whether some groups are systematically disadvantaged (distribution, Figure 3); and the role of different types of health service in causing financial hardship (drivers, Figure 4) – most datasets allow disaggregation by inpatient care, outpatient care, medicines, medical products, diagnostic tests and dental care.

or the amount *relative* to capacity to pay (catastrophic out-of-pocket payments). For both indicators, disaggregating results based on household characteristics (income, age, place of residence and so on) is central to the analysis.

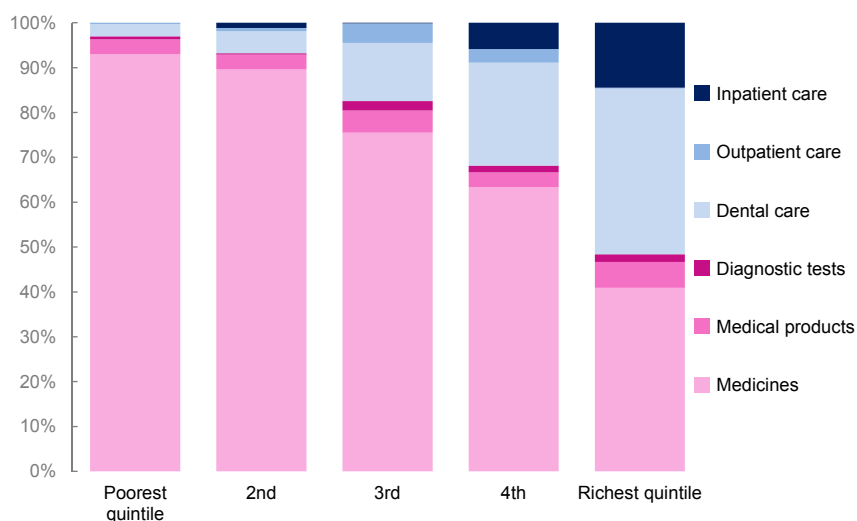
The WHO Regional Office for Europe has recently developed a further refined methodology that adapts these common indicators to address inconsistencies in measurement, to enhance clarity around

policy implications and to increase policy relevance in both high- and middle-income countries. Our approach extends the concept of basic needs to spending on housing (rent) and utilities (water, gas, electricity and heating) as well as spending on food. The poverty line we use – reflecting the costs of basic needs –

When analysis involves more than one year of data, it makes it easier to identify correlations between the incidence, distribution and drivers of financial hardship, the health system and the socio-economic environment. For example, it may be possible to link a change (or the absence of change) in financial hardship to

[†] Households between the 25th and 35th percentiles of the household consumption distribution.

Figure 4: The drivers of impoverishing and catastrophic out-of-pocket payments across income groups in a high-income country



Source: Authors' modelling.

Note: Based on data from an EU country; income groups are based on household consumption quintiles; OOPs = out-of-pocket payments.

changes (or the absence of change) in the health system and in policies beyond the health system.

Comparative analysis can generate even richer evidence for policy. Preliminary results from ten of the countries in our study show how financial hardship is consistently concentrated among the poorest 40% of the population and mainly driven by out-of-pocket spending on outpatient medicines, especially among poorer households. Early results also show that the incidence of financial hardship varies significantly across countries. While incidence is associated with out-of-pocket payments as a share of total spending on health, it is also influenced by policies to protect vulnerable groups of people. Differences in the way in which countries provide people with protection against co-payments appear to be important. This finding suggests that efforts to strengthen financial protection need to focus on policies, not just on levels of public spending on health.

A limitation of all indicators used to measure financial protection is that they do not capture unmet need due to cost – that is, instances in which people needed but did not use health care because they

could not afford to pay for it. In our study we try and address this by ensuring that each national report includes a discussion of data on unmet need. Highlighting people who do not incur any out-of-pocket payments also helps to make the issue of unmet need more visible, particularly in health systems that do not exempt people from co-payments, although most datasets do not allow us to say whether these people experience unmet need or not.

What does it take to monitor financial protection systematically?

Systematic monitoring of financial protection requires three things: survey data on household consumption; a standard approach to monitoring applied over time and across countries; and a good understanding of national health system and socio-economic contexts.

EU member states are required to carry out household budget surveys at least once every five years; some do this annually. Many non-EU countries in Europe also carry out regular household budget surveys. This means the statistical data needed to monitor financial protection are routinely available in almost all countries in Europe, although there is variation

across countries in the regularity of data collection and in the level of detail with which household spending on health services is assessed.

In the past 15 years, WHO and the World Bank have supported monitoring of financial protection in Europe and Central Asia. However, the analysis has been limited to a relatively small number of countries and at regional level we still lack a comprehensive set of comparable estimates. This new study initiated by the WHO Regional Office for Europe is the first to apply the same methodology to a large number of countries from across the whole region, including a significant number of western European countries and EU member states.

Previous multi-country analysis of financial protection has generated numbers on the incidence of impoverishing or catastrophic spending on health services without accompanying national analysis.^{2 7 8} In contrast, our study takes a bottom up approach. We have commissioned one or more national experts in over 20 countries to prepare a comprehensive national assessment of financial protection. Each national report will not only generate numbers using at least two data points, but also provide a detailed discussion of these numbers in the context of health system and broader socio-economic developments. National experts are using a standard template for reporting to facilitate comparison across countries. Their reports will feed into a regional overview and comparative analysis.

What will monitoring financial protection achieve?

Systematic monitoring of financial protection with in-depth national analysis will lead to a better understanding of the contextual factors and policies that drive financial hardship within and across countries. It will allow countries to identify ways of improving financial protection, especially for vulnerable groups of people. The WHO Regional Office for Europe is ready to work with member states to ensure that the evidence generated by our study raises awareness of financial hardship and, ultimately, results

in policy changes that strengthen financial protection. To this end, we seek to facilitate policy dialogue through national and international meetings to share results, foster cross-country learning and support evidence-informed policy development.

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A PEOPLE-CENTRED SYSTEM APPROACH IN WALES: PRUDENT HEALTHCARE

By: **Jean White, Ruth Hussey and Leighton Phillips**

Summary: The Ministry of Health of Wales has introduced the *Prudent healthcare* policy to transform service delivery towards empowering people through enhanced health literacy and engagement of patients in clinical decision-making, self-management and care planning. *Prudent healthcare* seeks to minimise interventions and maximise effectiveness. The policy places people at the centre of decision-making working in partnership with patients to co-produce a course of action with shared responsibility. Particular focus here has been devoted to the implications for the health workforce, the first foundation of “walking the talk on people-centredness”.

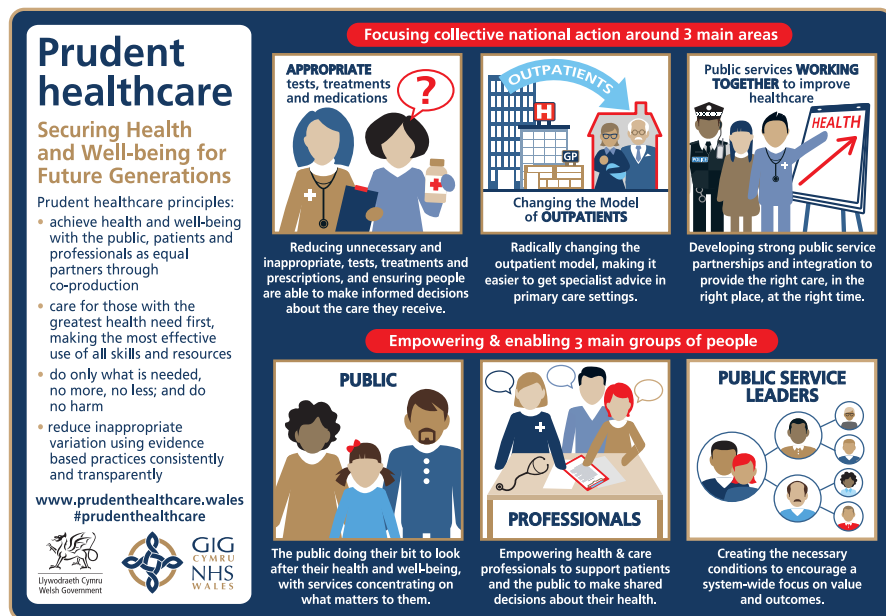
Keywords: *Health Literacy, Engagement, Co-production, People-centred, Wales*

Introduction

In the face of increasing demands for health care, many governments are considering how best to respond to ensure accessible and sustainable health services that are people-centred and value-based but also affordable. These aims are in line with those set out in the third pillar of the World Health Organization Regional Office for Europe’s overarching policy framework, *Health 2020*, dedicated to strengthening people-centred health systems and public health. As therapeutic medicines advance and technologies improve at a rapid pace, there is an inevitable temptation to engage with these developments and thereby increase the number of medical interventions, often driven by the public’s expectations. Without prudence and careful selection

of interventions, this is likely to lead to more, not less health inequality in society, will be unsustainable over the long term and will not necessarily achieve improved outcomes. Focusing improvement activity solely on access and patient flow is unlikely to ensure the affordable health improvements that all are seeking. A greater understanding of demand for services coupled with redesigned care pathways is now needed. Building on an international movement towards using health resources more wisely, Wales has developed a policy that sets out four guiding health care principles ensuring a person-centred approach to care that utilizes health resources intelligently to secure the desired outcome for individuals.¹ By applying this prudent policy to health care delivery, a new

Figure 1: The Prudent Healthcare policy, Wales



Source: Ref 1

system-wide policy is established that prioritizes activities that add value, contribute to improved patient outcomes as well as sustainability.

The *Prudent healthcare* policy helps implement aspirations outlined in existing legislations and ensures these aspirations are realised and synergised. For example, the Well-being of Future Generations Act (2015)² is cross sectoral legislation focusing on sustainable development with an emphasis on long term prevention, collaboration, involvement and integration of approaches that are needed to tackle the generational challenges like climate change, tackling poverty and health inequalities. Consequently, ensuring sustainable public services are responsive to patient needs, both immediately and for future generations, is a key government strategic priority, as this is a powerful driver to improve the health and well-being of the population. Furthermore, by focusing on working with individuals to reach their desired outcome, the *Prudent healthcare* policy also ensures that a more integrated and coordinated approach across services is delivered.

Part of an international movement

In recent years there has been a growing international movement to reduce harm

and poor outcomes from the excessive use of medical interventions. For example, the Choose Wisely campaigns in the US and Canada³ provide simple information which makes clear the advantages and disadvantages of different tests, treatments and medications, thus enabling patients to make better informed decisions with their clinicians. *The British Medical Journal* campaign ‘Too much medicine’⁴ highlights the threat to human health posed by over-diagnosis and the waste of resources on unnecessary care. Scotland has also recently advocated the concept of ‘Realistic Medicine’. There is some evidence that suggests that around 10% of all health care interventions contribute to some harm to patients,⁵ while an estimated 20% of health service activity has no effect on patient outcomes⁶ – suggesting this ‘imprudent’ use of resources is endemic in current health systems.

Principles and actions

The development of the *Prudent healthcare* policy for health services in Wales was initiated by the Bevan Commission in 2013.⁷ Following nationwide discussion, four guiding principles have been adopted (see left side of **Figure 1**). A *Prudent healthcare* website⁸ has been developed with a

wide range of resources that explores the principles in the context of health care delivery; as well as a number of conferences and other events providing fora of engagement at regular intervals. All health service organizations are now exploring and testing how these four principles can be used to drive service change and the remodelling of patient pathways.

The action plan for national health services in Wales, ‘*Prudent healthcare – Securing Health and Wellbeing for Future Generations*’, was published in February 2016. This sets out three priorities to focus collective national action by professionals, the public and public service leaders. The areas chosen for action in this plan are:

- reducing unnecessary and inappropriate tests, treatments and medication and ensuring people are able to make informed decisions about their care;
- changing the model of outpatients; and
- public services working together to improve health care.

Info-graphics are used where possible to help communicate the concept and help with engagement (**Figure 1**).

“CO-production focusses on empowering individuals to actively participate

The specific actions within the plan were selected because they touch the lives of many people and because coordinated action taken at both a national level and by provider organizations will have a significant impact on the way health services are delivered in Wales. For example, the number of outpatient appointments held in acute secondary care

hospitals each year is roughly equivalent to the number of people who live in Wales, 3.1 million. Many of these appointments would be more effective if they were held in health settings closer to the person's home or via tele-health. Streamlining follow-up for people with complex needs would save time for patients from having to attend multiple condition-specific clinics. Designing services around patient needs and life circumstances will both optimize the use of acute hospital facilities and improve the experience for service users, particularly for the large portion of the population who live in rural areas and have multiple chronic conditions.

A people-centred approach

Putting people at the centre of care is widely recognized as an essential component of modern health care. The first *Prudent healthcare* principle focuses on people, particularly in adjusting the power dynamic that currently exists between health professionals and the patient so that patients are equal partners in making decisions about their treatment. A simple illustration of what this means is that all health professionals should ask the patient "What matters to you and how can we work together to focus on this?" This discussion on priorities and an honest exploration of advantages and disadvantages of options may lead to more appropriate clinical pathways for the patient.⁹

This concept of co-production is now being applied widely within public service organizations in Wales. A new web portal has been created to offer case study examples, demonstrating how collaborative working can materially improve the economic, social and environmental well-being of people and communities.⁹

The principle of co-production focusses on empowering individuals to actively participate in achieving the outcomes that matter to them. Practically, this means engaging with the public specifically about what they can and should do to ensure their own health and well-being and that of their families. There is good evidence that the adoption of five healthy lifestyle activities (not smoking, consuming alcohol

in moderation, eating five or more portions of fruit and vegetables a day, taking regular exercise and maintaining a healthy weight) can reduce premature death and dramatically reduce the prevalence of conditions such as diabetes, heart disease, dementia and cancer.

Much attention is now focussed on how health professionals can work with members of the public to ensure that they have the information needed to make informed choices. An example of this is in maternity care, where early access to a midwife is seen as essential. In Wales, over 80% of women are seen by a midwife by the time they have completed twelve weeks of pregnancy. All health providers have been asked to organize care so that women are able to access local services by ten weeks of pregnancy. This ensures earlier access to advice on healthy lifestyles, referrals to support services (e.g., smoking-cessation services) and information on community services (e.g., specialized exercise classes and social support). Midwives, who already encourage and support women to give up smoking during pregnancy, are now equipped with carbon monoxide monitors to support mother's understanding of risk from smoking to their own and their baby's health. There is a strong interest in focusing on the first 1000 days of life as a means of maximising health service impact and ensuring these services are universally accessible to ensure all babies have the best start in life.¹⁰

Rethinking the roles of health workers and optimizing skill mix

Part of the wider implications for the health workforce in adopting a prudent approach is renewed configurations and roles of health professionals to deliver care in a timely manner. Pursuing *Prudent healthcare* may mean a change to some traditionally held roles and role adjustments within multidisciplinary teams. The 'prudent' concept here is that activities should be undertaken by the most appropriate person. This is particularly pertinent in primary care, which is the fundamental building block of a prudent health system. An example is the growth of pharmacy posts within general practice. A further manifestation

is the rapid expansion of advanced practice roles for nurses, midwives, paramedics and allied health professionals. Practitioners can advance their practice through various continuing professional development activities, either by developing specialist knowledge, acquiring prescriptive authority for medicines and tests and advancing clinical decision-making skills. For some professions, this advanced practice means leading delivery of care, previously the exclusive domain of the doctor. This has become a growing and essential practice in health services globally.¹¹

renewed
configurations
and roles of
health
professionals

Wales introduced a framework for advanced health professionals in 2010¹² which is framed around four core functions: clinical practice, research and development, clinical leadership and management and education. This framework has been accompanied by guidance on the safe delegation of tasks by health professionals to other health workers. The Welsh government has now committed to annually investing in providing education programmes to expand this cadre of workers within the national health care system.

A nurse-led prudent service is the development of leg ulcer clubs in Powys,¹³ a rural part of mid Wales, which typically serves around 3000 leg ulcer patients annually. Here drop-in clinics have been set up in non-clinical settings, where patients can show up without appointments for advice or other practical issues of their care, often involving group-based services and activities. Local volunteers have also been organized by the local health service providers to support patients with transportation and other access issues.

The community approach helps address social isolation and loneliness, which is frequently experienced by patients with leg ulcers and has proven to shorten recovery time. It has also been identified as a more cost efficient use of community nurse resources.¹⁴

Conclusion

Prudent healthcare in Wales is in its early stages, but it has already caught the imagination of those focused on improving the delivery of public services. Its success is predicated on strong leadership, not only at the top of organizations, but also at the clinical professional level. It provides an opportunity to reshape and base clinical care pathways on evidence and allows for a greater emphasis on primary and community services which are located closer to the individual. At its core, *Prudent healthcare* calls for new relationships between service providers, professionals and the public that centre on sharing power and challenging traditional practices and roles. People need to be equal partners in securing their health and well-being and must take responsibility for their own health. To do this they need information and support from knowledgeable health workers.

Mark Drakeford, Welsh Minister for Health and Social Services, sums up the urgency and need for reform by saying:

*“Our health services are under pressure; the people who work in the health service feel that pressure absolutely every day... So today in the challenges we face, I believe that the Prudent healthcare movement gives us an opportunity to recreate, reinvent and reimagine that most important of all our public services for the future...”*¹⁴

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Economic Crisis, Health Systems and Health in Europe: Impact and implications for policy

By: S Thomson, J Figueras, T Evetovits, M Jowett, P Mladovsky, A Maresso, J Cylus, M Karanikolos and H Kluge

Copenhagen: Open University Press, 2015

Freely available for download at: <http://www.euro.who.int/en/health-topics/Health-systems/public-health-services/publications/2015/the-case-for-investing-in-public-health>

Economic shocks pose a threat to health and health system performance by increasing people’s need for health care and making access to care more difficult – a situation compounded by cuts in public spending on health and other social services. But these negative effects can be avoided by timely public policy action. While important public policy levers lie outside the health sector, in the hands of those responsible for fiscal policy and social protection, the health system response is

critical. This book looks at how health systems in Europe reacted to pressure created by the financial and economic crisis that began in 2008. Drawing on the experience of over 45 countries, the authors:

- analyse health system responses to the crisis in three policy areas: public funding for the health system; health coverage; and health service planning, purchasing and delivery
- assess the impact of these responses on health systems and population health
- identify policies most likely to sustain the performance of health systems facing financial pressure
- explore the political economy of implementing reforms in a crisis.

The book is essential reading for anyone who wants to understand the choices available to policy-makers – and the implications of failing to protect population health or sustain health system performance – in the face of economic and other forms of shock.

BUILDING PUBLIC HEALTH LEADERSHIP SKILLS IN THE REPUBLIC OF KAZAKHSTAN

By: Zhanna A. Kalmatayeva, Saltanat A. Mamyrbekova, Gainel M. Ussatayeva and Regina Winter

Summary: Building capacity to restructure public health services is an important means of transforming health services to meet the health challenges of the 21st century. Several Member States have embarked on restructuring their public health services. The Republic of Kazakhstan is one such example. Its new State Policy for Public Health Development has set the course for reforming the country's public health services. Implementation of this policy will require well-trained public health professionals. This article describes how the Higher School of Public Health at the al-Farabi Kazakh National University Medical Faculty is leading the way by aligning curricula with contemporary public health needs and career trajectories.

Keywords: Public Health, Health Workforce, Education, Curricula Transformation

Introduction

Historically, management and the organization of public health services in the Central Asian Republics (CAR) have followed the Sanitary Epidemiological (san-epid) Service model, a model that was concerned more with hygiene, sanitation and communicable disease control than with health promotion and intersectoral action for health.¹ This has been attributed to the fact that the very concept of 'public health' has been difficult to translate into national languages. Previously, public health was hierarchically organized and the majority of public health services were provided in a context that prioritized centralized monitoring, inspection and mandatory sanitary services.² Health promotion, preventive programmes besides immunization, and to some extent environmental and occupational health or operational research, did not

figure prominently as an integral part of the public health system. Moreover, public health services were financed and operated in parallel to health care service structures, which remained predominately curative and disease-oriented. Advantages and disadvantages of the Semashko system continue to be the subject of extensive discussion in these countries.

The State Policy for Public Health Development

In order to address its contemporary public health challenges, the Republic of Kazakhstan recently launched the State Policy for Public Health Development for 2016–2019.³ The policy puts forward a transformative and novel vision for public health services in the country. These now include 1) empowering and educating the population in health

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promotion and disease prevention to avoid exposure to environmental, dietary and behavioural risks; 2) improving surveillance of communicable but also non-communicable diseases, including mental health disorders, road safety and injury prevention; 3) improving inter-sectoral communication; 4) strengthening public health legislation and regulation; and 5) optimizing long-term disease modelling to better forecast risks at the regional and national levels. Under this new public health policy, the Republic of Kazakhstan is prioritizing the integration of the aforementioned public health services with various sectors, primary care services, and various specialized medical research institutions. Implementation and integration has been planned for both the national and regional level.

At the national level, a network of public health organizations will perform the functions of monitoring risk factors for communicable and non-communicable diseases; developing public health policy and inter-sectoral programmes; conducting public health research; establishing and strengthening public health surveillance and warning systems; and improving quality of, and accessibility to, public health programmes.

At the regional level, development, planning, implementation and monitoring of communicable and non-communicable disease prevention activities will be conducted in collaboration with primary health care facilities, including screening and preventive medical examinations. An important emphasis has been placed on prioritizing the prevention and monitoring of the main burden of diseases in Kazakhstan (cardiovascular diseases, injuries, cancer, tuberculosis, diabetes).

Introducing a new public health curriculum

Health workforce training will have a central role in the implementation of the State Policy for Public Health. In order to implement the policy, the al-Farabi Kazakh National University Higher School of Public Health has launched innovative new courses and programmes to help prepare a public health workforce that is fit for purpose. The school's curriculum is

closely in line with the European Program of Core Competences for Public Health Professionals which defines a relatively wide range of competencies for public health professionals.^{4 5 6}

Currently, public health education in Kazakhstan is offered at bachelor degree level, through post-graduate programmes (master's and doctoral degree (PhD) programmes) as well as through continuing professional education (CPE) courses to provide supplementary, advanced and updated training for health professionals.

In 2016, the Republic of Kazakhstan's School of Public Health was moved to the Al-Farabi Kazakh National University (www.kaznu.kz) where it joined fifteen departments and 47 institutes and centres*. Moving the school into the Al-Farabi Kazakh National University was an important first step in the transformation of public health education as it provides an opportunity for the school, its faculty and students to interact with a range of disciplines, thus improving content and organization of the curricula to promote interdisciplinary and intersectoral collaboration.

Public health leadership and management

One emerging topic of discussion among Public Health experts across CAR countries and a topic of discussion during a workshop in 2015 with the WHO Regional Office for Europe[†] has been the perception of leadership in Public Health. Contemporary understandings of public health leadership based on collaboration and on horizontal, adaptive structures involving many actors and many sectors, as proposed by the WHO Regional Office for Europe's strategic document

* The University consists of 15 departments, 8 scientific-research institutes, 4 institutes, and 35 social-humanitarian scientific centers.

† The WHO Regional Office for Europe organized a subregional training course on public health leadership for the central Asian republics on 15–18 June 2015 in Tashkent, Uzbekistan. It brought together 30 participants from the four central Asian republics – Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan – and the Russian Federation. Participants included mid-to-senior-level public health policy-makers, administrators, public health programme managers and representatives of public health institutions.

on health systems strengthening, is still underdeveloped in CAR countries. This can in part be explained by the historical and political context of leadership in some of these countries. Another explanation could be that the definition of leadership is translated differently in these languages. For example, the word “leadership” alone can be translated in Russian as “leadership”, “management” and “guidance”. This has posed significant challenges for the preparation and training of public health leaders in CAR countries at the required quantities and quality.

The Higher School of Public Health includes modules on public health leadership and management in all of its courses. Every stream –described below–provides students with the basic concepts of public health leadership and management as well as applied topics on leadership and management that depend on specific features of the stream (e.g. management in lab diagnostics, or leadership in primary health care).

The Higher School of Public Health

When the newly named al-Farabi Kazakh National University Higher School of Public Health initially piloted its new courses their new content received a very positive response and demand has been increasing ever since. The Higher School of Public Health provides three streams for students: 1) medical and preventative care; 2) public health; and 3) health systems and health care management.

Medical and preventative stream

Students enrolled in this can take courses in three areas: 1) epidemiology and hygiene 2) consumers rights, and/or 3) laboratory diagnostics and infection control. All these streams represent priority areas in public health for Kazakhstan as much today as they did during the Soviet period. Today, however, the school distinguishes itself by preparing graduates with added content that emphasizes the importance of developing advanced leadership skills, ability to work in interdisciplinary teams, dealing with ethical issues, and embracing emotional intelligence over and above basic public health knowledge and skills. These will all

be important skills for graduates as they begin to work with the new public health services in the country.

The courses will focus not only on basic theory of epidemiology and hygiene but will also include biomedical statistics, research methods, applied and field-based epidemiology, health protection, health promotion and prevention of diseases, law bioethics, and management.

The courses on consumer rights protection teach students about international practice in consumers rights protection (i.e., definitions, development, legislation, and various approaches to protecting consumers rights etc). The courses also address EurAsEC Regulatory Compliance in the Republic of Kazakhstan (e.g. food safety, toys safety and etc.). This focus is an important one given the increasing role of requirements and technical regulations set by the Eurasian Economic Commission.⁷

The third set of courses allows students to focus on lab test errors. In Kazakhstan, 2.7% in clinical settings and 12% of lab errors result in inappropriate treatment choices for patients.⁸ Courses therefore address unsafe lab practice, and clinical practice by nurses, physicians, pharmaceutical workers and lab workers. In order to systematically address these errors, courses have been introduced to teach students about bioethics, patients' safety, organizational behaviour, personal accountability and legislation literacy. The main emphasis is on improving training programmes on biosafety, biosecurity, patient and sample identification, relevant information technologies, and quality management systems for laboratories.

Public health stream

The public health stream, alongside traditional topics, provides students with tools to measure the interactions and relationships between social-behaviours, the environment, genetics, and biology along with internal and external risks, point and cumulative effects for health. For this stream in particular, the School has decided to expand its student body to be more inclusive of students with diverse backgrounds. This means not only recruiting students with medical science

degrees but also targeting students with a background in economics, law, history, sociology, biology and other specialties. This will not only benefit the students to learn from diverse perspectives but can also help to prepare leaders in public health to work in other sectors (education, finance, transportation, social care).

Health systems and health care management

This stream provides students with theory and practice to work in health care organizations. This is the newest of the three streams and offers specializations in strategic management in public health, management of human resources for health, and a combined specialization in public health economics, financing and law. This stream provides students with various leadership and management skills. The focus has been on building leadership, effective communication, social marketing, and oral presentation skills. The stream takes a perspective that leaders learn by doing and that they need to develop specific leadership qualities that are important to maintain organizations' focus and motivation on specific interests, technical areas and visions for public health. This is important in a context where administrators and heads of health care institutions cannot always do so given the changing nature of their portfolios.

Conclusion

As a result of this new approach to public health education, experts across the Republic of Kazakhstan are increasingly more confident that they are securing the country's capacity to respond to its public health needs and implement the new State Policy for Public Health Development for 2016–2019. Through programmes like those offered at the Al-Farabi Kazakh National University School of Public Health the country is effectively equipping itself with a group of public health professionals that are fit for purpose to take on the health challenges of the 21st century.

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TRANSFORMING HEALTH PROFESSIONAL EDUCATION AND TRAINING IN MALTA

By: Maria Cordina

Summary: Enhancing the health workforce will be critical to transforming health services delivery to better respond to the changing needs and realities of the 21st century. This article describes new methods and approaches for facilitating interprofessional education and training during initial, graduate and continuous professional education and training of health professionals in Malta. By embracing the principles of transformative education and training, Malta is moving towards breaking down boundaries across levels of care and settings, thereby developing a health workforce that is fit-for-purpose to address contemporary health challenges.

Keywords: Education, Training, Cooperation, Collaboration, Multidisciplinary Teams, People-centred

Introduction

The health needs and priorities of the 21st century for the World Health Organization (WHO) European Region, documented in Health 2020, aim to 'significantly improve the health and well-being of populations, reduce inequalities strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality'.¹ The European Region has placed non-communicable diseases, chronic conditions, multi-morbidity and other conditions requiring long-term management at the top of its European health policy agenda.² Successful management leading to positive patient outcomes of these conditions will require coordinated and integrated inputs across disciplines throughout the individual's life course rather than through episodic management and isolated services. This also calls for more active participation

of the individuals, their families, and communities affected. A health workforce that is focused on facilitating this will be fundamental to improving health outcomes. Transformative models of education and training for the health workforce will be key to achieving these goals.³ This is by no means a trivial task. It demands dramatic shifts in mind-set both among clinicians and academics. Over the past ten years, leaders in Malta have been embracing transformative education and training in several areas, including the area of safe and effective use of medicines.

Transformative education and training

The goal of transformative education and training is to foster greater alignment between educational and training institutions and health services.⁴ These goals are also important in securing

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the pursuit of Universal Health Coverage (UHC) and were endorsed by Member States in Resolution WHA66.23 *Transforming Health Workforce Education in Support of Universal Health Coverage*. In response to the Resolution, WHO has convened a technical working group on Health Workforce Education and Assessment Tools 'to enable countries to identify and measure their progress towards developing a transformative approach to health workforce education that will promote and support universal health coverage'.⁴

The WHO Regional Office for Europe's own Expert Group on Health Professionals' Education and Training also recognised that education and training institutions are often disconnected from the needs of health services, especially when faculty is mainly composed of development of academics theoretically oriented academics with minimal exposure to practice. The working group has discussed development programmes of academics, addressing the evolving health care needs, utilizing a variety of approaches to support the selection of the most suitable methods of health professional education and training.⁵ These methods aim to lessen the 'theory-practice gap'⁶ by engaging experienced clinicians from hospitals and primary care who possess the necessary skills to teach in initial education and training institutions and contribute to continuing education and training.

Bridging the gaps at the University of Malta

The University of Malta is the highest publicly funded health professional education and training institution in Malta. While the university is overseen by the Ministry of Education, that ministry shares close ties with the Ministry of Health and supports the Ministry of Health's goals and objectives: to provide education and training that is relevant to population health needs. The university has applied guidance produced by the above-mentioned steering groups.

For example, at the University of Malta the vast number of academics involved in teaching in the Faculties of Medicine and

Surgery, Dentistry and Health Sciences are also practitioners in Malta's state teaching hospitals. The experience and insights they possess help to ensure that health professional education and training is up to date and delivered by academics who are skilful and aware of the most current needs of health services and the patients and populations they serve. A number of these academics are also involved in professional organizations and unions. In Malta, these teachers have been instrumental in introducing modifications and new methods of teaching to better overcome barriers and obstacles faced by services. This places them in a strategic position to promote necessary changes to education and training, but also to services.

Interprofessional education and training

One means of transforming health professional education and training is through the introduction of interprofessional education and training in both undergraduate and post graduate programmes.⁷ Interprofessional education and training and collaborative practice can help to address fragmentation of health care services and the unmet needs of the system.⁸ Interprofessional education and training however, can also be quite challenging. A significant amount of coordination between academics and programme developers from different professions/disciplines is necessary to implement it.⁹ All academics must be convinced of the need to implement such programmes and must then invest a lot of time in re-designing curricula which can effectively promote teamwork and team learning.

Safe and effective use of medicines

The Department of Clinical Pharmacology and Therapeutics oversees all teaching related to pharmacology and therapeutics for health professional students at the University of Malta. A core group of people in the Department is responsible for coordinating, overseeing and participating in the teaching of all courses. Teaching is provided by clinical pharmacologists, specialised practicing medics and practicing clinical pharmacists and is

based on current recommendations.^{7 8 9 10} This facilitates the introduction of the same key and general concepts related to safe and effective use of medicines for all health professional students. While all health professional students receive education and training on this topic, traditionally the focus of this education and training has varied depending on the group of students, e.g. medical students tend to focus on prescribing issues, pharmacy students on dispensing and identifying errors, and nursing students focus on administration. This led to a situation where the individual health professions are not able to fully appreciate the entire medicines use process and the contributions of different professions to the process.

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methods that
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Since 2010, the Department of Clinical Pharmacology introduced new methods that foster more interprofessional learning. This approach allows all health professional students to continue receiving uniform and consistent knowledge about the safe and effective use of medicines while also allowing them to gain a better appreciation of the entire medicines use process, to identify their place in the process, and to realise how their practice can contribute positively and negatively to the safe and effective use of medicines. Students also get the chance to learn, reflect and improve their skills and work in teams well before entering practice, thereby accelerating their ability to work in teams once they have graduated. It also promotes the use of a common language which enhances effective communication between different professions.

The topics addressed are discussed in the context of practice, through both lectures and tutorials, using examples and cases from teaching hospitals and

the community. At times the classes are multidisciplinary and at times, due to logistical restraints, they are taught by discipline. Even when taught to a single discipline of students, discussions on the contribution of other professions to the medicines use process are prioritized. Explicit efforts are made to also give students hands on training in clinical settings, both in hospitals and the community where they will eventually work. The department has received positive feedback, both from the students following the courses as well as from the different faculties. The environment created has been deemed very constructive and the curriculum has been made dynamic through the interactions of experts from various disciplines, academics and students.

The Department also offers a Master's course in Clinical Pharmacology. Individuals from different professions are encouraged to enrol, which provides a very healthy environment for the exchange of ideas and methods for increased collaboration. These individuals then proceed to act as key leaders in their own professions to champion and disseminate the principles of interprofessional work for the safe and effective use of medicines.

Student engagement and participation

The university also actively encourages student driven activities that can serve to promote interprofessional learning. Student groups are encouraged to collaborate across disciplines in integrated public health activities as a means for better understanding of each other's contribution to various conditions. In Malta, health professional student organizations are very active and regularly collaborate in a number of initiatives as well as organize joint educational seminars. For example, recently student health care associations organised a conference entitled, *The Multidisciplinary Approach to Health Care*, with the aim of promoting communication and teamwork between all health care professionals.¹¹ The Maltese health care student associations also hosted the first World Medicine and Pharmacy Students Joint symposium.¹² Here again, they learn from an early stage how to engage

with each other and appreciate the health-related needs of the community. This effort has been an important means of better positioning students – future clinicians – to understand the meaning of, and contribute to, a people-centred health system.

“ instill a culture of engaging in CPD in students

Continuing professional development

A fit-for-purpose workforce also needs to be continuously updated with information on emerging new evidence-based practice, innovative technological approaches, knowledge regarding new treatment modalities and various skills. Continuing professional development (CPD), like university-based education and training, can benefit from transformative education and training principles. In Malta, CPD for health care professionals is not mandatory nor is it linked to licensing. It is the individual professional associations, such as the Malta College of Pharmacy Practice, the Malta College of Family Doctors, the Malta Association of Hospital Pharmacists to mention a few, who have undertaken initiatives to provide CPD to their members. In the absence of a national accrediting body, the associations are self-accrediting. Meetings are national and are held in various locations, such as the University of Malta, the main public acute hospital, and various private locations.

It is important to instil culture of engaging in CPD in students while they are still studying at the undergraduate level. This can increase the probability that they will identify with, master and engage in desirable practices. Various methods of CPD are in use in Malta. Most importantly, what is offered should be responsive to the current and changing health challenges faced by clinicians;¹³ for example, the management of a number of chronic diseases, such as diabetes, cardiovascular disease, and dealing with obesity, all of

which are highly prevalent in Malta. These are approached from different angles and would include academic updates and practical information, such as efficient ways to access patient services and collaborating with different disciplines to achieve the best possible patient outcomes. Methods of decreasing the burden on the system and the patient are also usually highly debated.

Towards this end, various professional organizations organise CPD for their professions. It is not unusual for CPD sessions to be organized jointly by various associations. CPD sessions organized by all professional organizations are sometimes open to undergraduate health professional students, as a means of introducing them to the concept of CPD. In addition, professional associations habitually invite members from other professions to address their educational sessions. For example, the Malta College of Pharmacy Practice regularly invites medical doctors who have specialized in relevant fields to address management of respiratory, cardiovascular and endocrine conditions; nutritionists to address obesity and provide updates on healthy eating practices; and psychiatrists and psychologists to address management of mental health.¹⁴ CPD is offered in the form of in-service training, interactive workshops, seminars, and as a series of talks. Therefore, there has been a very interesting and diverse mix of approaches and methods to give health professionals the opportunity to reflect and improve their team practice.

Conclusion

Due to the varying structures that exist in different countries, there is no single solution to effectively train undergraduate and postgraduate students to practice efficiently as a team. Multiple modalities need to be used to produce a health workforce that is flexible, multi-skilled, and team-oriented. Academics from different disciplines could shift from the comfort of their traditional approach to education and training and break down barriers between different professions. Collaborations between academics from the different disciplines has been key to drawing on the strengths, identify gaps,

and together build effective programmes to deliver a health workforce that is fit-for-purpose to successfully transform health services and respond to the demanding needs to the 21st century.

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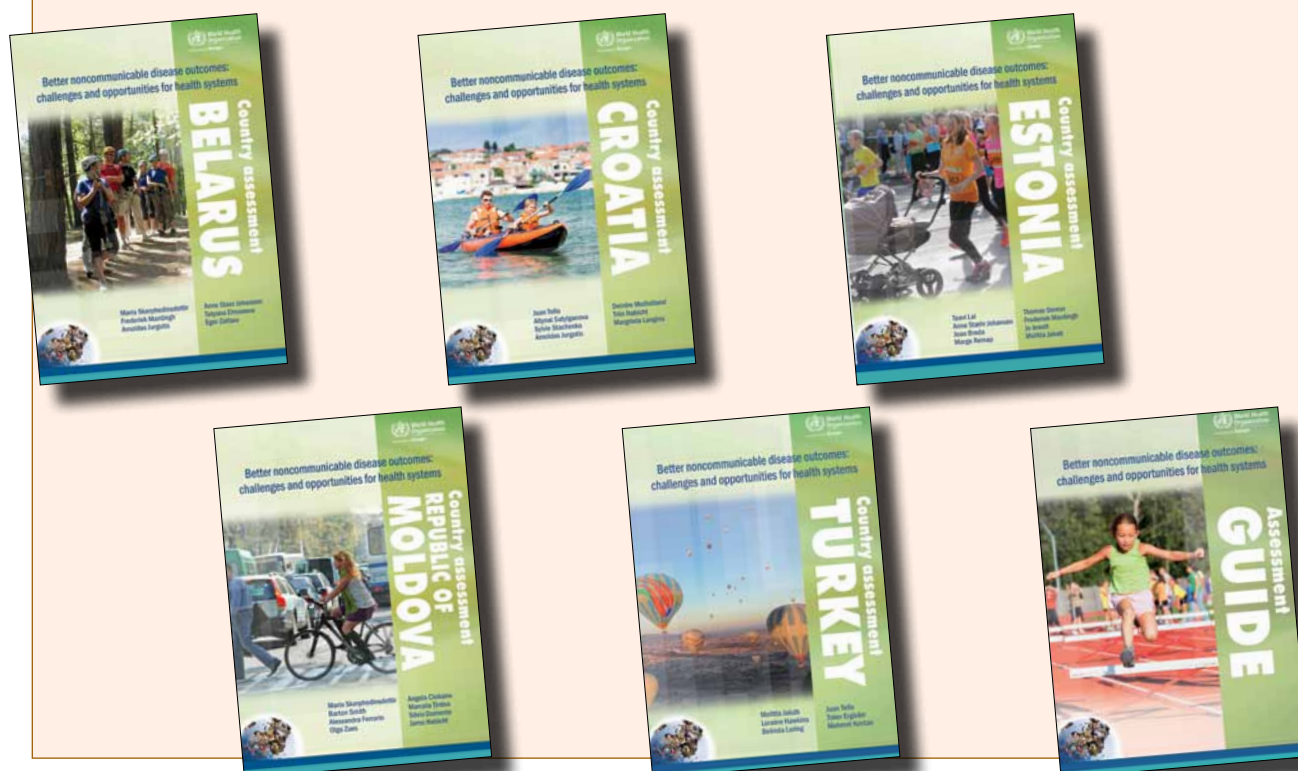
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ADDRESSING HEALTH WORKFORCE OUTFLOW IN HUNGARY THROUGH A SCHOLARSHIP PROGRAMME

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Summary: Evidence-based interventions are key to ensuring a sufficient and sustainable health workforce and thereby ensuring a workforce available for transforming health service delivery. As health professional retention strategies are among the top priorities of the country's national health policy agenda, Hungary has introduced a scholarship programme for resident doctors. This evidence-informed strategy appears to be reducing the outflow of Hungarian doctors. While evaluation is still pending, the country's high level commitment to securing a sustainable health workforce is offering new graduates the opportunity to stay and practice in Hungary.

Keywords: *Human Resources for Health, International Health Workforce Migration, Retention Policies, HWF Data, Scholarship Programme, Hungary*

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Introduction

The impact of health workforce shortages and health professional mobility on governments' abilities to respond to patient and population health needs is high on national, European and global health policy agendas. Higher wages and better working conditions in more economically developed countries attract qualified health professionals from less developed countries. The resulting shortages of qualified health professionals and the rapidly changing dynamics of health professional mobility (i.e., changing individual motivations, legal and economic circumstances, working arrangements, and policy frameworks) have added a layer of complexity to securing a sustainable health workforce.^{1 2}

Over the past decade, Hungary has become a source country for health professionals in the European Union (EU). Estimates show that a significant proportion of health professionals have migrated to other EU countries since Hungary's accession to the EU (on 1 May 2004).^{3 4} Doctors in particular – who obtained their academic medical qualification as “general” medical doctors in the Hungarian graduate health education system – have expressed intentions to leave and work abroad.⁵ Although proxy indicators are available on outflow, precise numbers are hard to define, due to difficulties in follow-up with those who actually have left Hungary. It is important to understand the potential volume and reasons for outflow to secure a sustainable health workforce and develop responsive policies.

Table 1: Age distribution and total numbers of active doctors

Age	2011	2012	2013	2014
–24	104	108	94	113
25–29	2 050	2 380	2 736	3 096
30–34	2 483	2 460	2 455	2 468
35–39	2 656	2 762	2 742	2 881
40–44	3 036	2 968	2 792	2 820
45–49	3 391	3 385	3 353	3 378
50–54	3 908	3 872	3 757	3 725
55–59	4 276	4 371	4 426	4 318
60–64	3 258	3 452	3 603	3 913
65–69	2 349	2 535	2 747	2 855
70–	1 951	2 236	2 749	3 234
Total	29 462	30 529	31 454	32 801

Source: Ref ⁶

Specific issues and concerns

Since accession to the EU, tensions have been rising in Hungary over the public health sector budget. Salaries have been below those of the EU and Central and Eastern Europe averages ^{7,8} and by 2012, salaries had not risen for ten years. In 2014, the net salary of doctors working full time in the Hungarian public health care sector was 310,770 HUF (approximately €1,002) per person per month. ⁹ In 2011, the European Federation of Salaried Doctors rated Hungary's salaries as the second worst in the 27 EU countries. ⁷ In June 2011, Hungary's resident doctors' monthly take-home pay was between HUF 80,000 (€258) and HUF 100,000 (€323). Financial pressures and austerity measures further strained health workforce expenditures. ⁹ Despite

the significant increases in wages in 2012 and 2013, Hungary still struggles to compete with higher western EU wages. ⁶

Since Hungary's accession to the EU, recruitment has also become easier for destination countries through various strategies, i.e., direct advertizing. Licenced and practising doctors, including senior specialists, have received offers of employment from abroad without having proactively sought such opportunities. The 36/2005 EU directive on mutual recognition of medical diplomas, ¹⁰ amended by 55/2013 has further eased the mobility of specialists on a legal and practical basis.

Centralized monitoring of medical doctors in Hungary

In 2004, Hungary established a central health authorization office – the Health Registration and Training Center (*Egészségügyi Nyilvántartási és Képzési Központ*, ENKK) – to collect, manage and analyse all health workforce related data (including graduate and postgraduate health workforce specialization training data, licencing data, etc.). ENKK is also responsible for maintaining and updating national registers of health professionals and overseeing continuing professional development (CPD). In Hungary, renewal of licenses is compulsory every five years and the process is regulated. A specified number of credits – obtained for practise

in health care and participation in training courses – must be collected to obtain a renewal.

ENKK also provides publicly available annual health workforce status reports to the government. Between 2012 and 2014, a national IT project was dedicated especially to health workforce monitoring development. The project was led by ENKK, and its sustainability has been supported by this authority, running and updating the health workforce monitoring system. The system enables data linkages in compliance with individual data protection.

In 2014, based on ENKK data (see Table 1) 21 413, i.e., 65.3% of doctors with active licenses were over the age of 45, while 1002, i.e., 30.5% were over 60 years old. Young doctors between the ages of 25 to 29, numbering 3096 in total, only accounted for approximately 9.4% of the doctors' workforce. ⁶

Monitoring health workforce outflows

ENKK also issues verification certificates to health professionals intending to work abroad. This allows ENKK to monitor the age, professional background and preferred destination country of applicants. These data can be used as proxy indicators for outflow, albeit with acknowledged limitations. This data cannot capture

Table 2: Number of all doctors who applied for a verification certificate between 2011 and 2014

Year	All applicants (including doctors with foreign nationality)
2011	1200
2012	1108
2013	955
2014	948

Source: Ref ⁶

actual outflow, or confirm how long, if at all, the health professional settles to work in the destination country. Data also include foreign nationals who obtain their medical degree in Hungary, but does not distinguish outflow of domestic medical doctors in their case. **Table 2** shows the number of applications received by ENKK from 2011 to 2014.

Semmelweis University Health Services Management Training Centre (HSMTC) has also played a key role in assessing mobility of the health workforce in Hungary. Back in 2003, the Centre and the Association of Hungarian Resident Doctors (doctors in postgraduate specialization training) initiated a survey for resident doctors. The annual survey studied the potential and motivations for residential doctors to migrate.⁵ Based on these surveys migration potential was high, between 60% and 70%, with around 10% (average rate) taking active steps to realize this intention among respondents.⁵ The analysis also identified a potential “marginal migration decision threshold point” for remuneration. According to the analysis, medical doctors “would not consider migration and not take on a second job and/or accept informal payment” if salaries for resident doctors in their first two years, non-specialists and specialists were increased to 200,000 HUF (€645 Euro); 300,000 HUF (€970); and 450,000 HUF (€1450), per month, respectively.

Migration as a top policy priority

Despite these available data, by 2010, no comprehensive retention strategy had been implemented. This changed when the State Secretariat for Healthcare declared that the international mobility of doctors,

especially outflow among new graduates,¹¹ is a top priority of the country’s health policy agenda. This political commitment resulted in concrete efforts to address the issue in a comprehensive way. One of the interventions implemented to secure the health workforce was a scholarship programme.

The scholarship programme and implementation

The programme was introduced in 2011 with a scholarship for resident doctors. In 2012 and 2013, two additional scholarships were introduced (see **Box 1**). These three scholarships are only available for resident doctors entering postgraduate training to obtain their first specialization or who have at least one year remaining prior to completing their ongoing first specialization training*. As compensation, the recipients must provide the equivalent number of years of service in a specified health care setting (settings vary depending on scholarship) after obtaining the specialization, typically amounting to five years of service. All three scholarships award doctors a tax-free net sum for the period of their postgraduate specialist training, in addition to their monthly salary. The *marginal migration decision threshold point* served to determine the monetary value of these scholarships.

Based on a recorded decrease in the number of applications for verification certificates to work abroad by new graduates, the scholarships have been important in retaining newly graduated doctors – the main target group.¹²

The entire process (application, contracting, payment, monitoring) is coordinated and managed by ENKK. Announcements of recipients and rules are available on the ENKK website.¹²

Results

Since the introduction of this programme applications have exceeded the amount of awards that the government was able to fund, indicating great interest among the target group. The total number of

* Specialists who enter a new postgraduate resident training program to obtain a second or third specialization are not eligible to apply for the scholarship.

Box 1: Scholarships[#]

1. Markusovszky Lajos Scholarship Program

Introduced in 2011, this scholarship is available to all resident doctors who are enrolled in their first specialization training, regardless of speciality. The scholarship stipulates that graduates must work in the public health care system upon completion of the specialty training. The monthly net sum of this scholarship is 100,000 HUF (approx. €320).

2. Méhes Károly Scholarship Program

Introduced in 2012, this scholarship is available to paediatric resident doctors. Upon completion of the specialization training, graduates are appointed to a service post in underserved areas in primary care* practices that have been left vacant for a prolonged period. The monthly net sum of this scholarship is 200,000 HUF (approx. €640).

3. Gábor Aurél Scholarship Program

Introduced in 2013, this scholarship responds to acute shortages in emergency medicine. The Gábor Aurél Scholarship is available to emergency medicine resident doctors. Recipients must work at a Hungarian Ambulance Service assigned post upon completion of the specialization. The monthly net sum of it is 200,000 HUF (approx. €640).

Note:

[#] Resident doctors can apply for more than one scholarship, but they can only accept one scholarship.

* Primary care for children is characteristically provided by paediatrician specialists in Hungary.

Table 3: Annual number of Markusovszky scholarships between 2011 and 2013

Year	Number of granted scholarships
2011	584
2012	486
2013	547
Total	1614

Source: Ref ⁵

scholarships granted for the Markusovszky scholarship alone has increased three fold since its introduction (see **Table 3**).

The number of resident doctors applying for postgraduate specialist training is also monitored annually, together with the number of graduating doctors. These data allow further observations. Since doctors, who apply for the aforementioned scholarship programmes, have to enter postgraduate specialization training, they also have to apply for a postgraduate

Table 4: Number of applications for subsidized postgraduate training positions compared to the number of graduate doctors annually, 2010–2014

	2010	2011	2012	2013	2014	Total
Graduate doctors with Hungarian citizenship	705	750	905	876	864	4 100
Applications for subsidized resident doctor positions	421	705	712	794	884	3 516
Proportion	60%	94%	79%	91%	102%	86%

Source: Ref ⁶

training position. Changes in the numbers of applicants reflect how the scholarship programmes influence the number of entries into the postgraduate training program for specialists. **Table 4** shows that the number of applications has increased since 2011.

Conclusion

The three scholarships seem to have been effective in retaining the health workforce and demonstrate the importance of targeted evidence-based interventions. The scholarship programme appears to also be shifting the dynamics of health professional migration among young doctors. While it is too early to draw any solid conclusions – the average specialization training programme lasts for five years – preliminary evaluations point to an increase in available doctors in Hungary and to a decrease in outflow of doctors. Sophisticated evaluation criteria for the scholarship programme are still needed to evaluate the effects of the programme over the long run.

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The case for investing in public health

Copenhagen: WHO Regional Office for Europe, 2015

Available for download at: <http://www.euro.who.int/en/health-topics/Health-systems/public-health-services/publications/2015/the-case-for-investing-in-public-health>

The economic crisis has led to increased demand and reduced resources for health sectors. The trend for increasing health care costs to individuals, the health sector and wider society is significant. Public health can be part of the solution to this challenge. The evidence shows that prevention can be cost-



effective, provide value for money and give returns on investment in both the short and longer terms. This report gives examples of interventions with early returns on investment for health and other sectors. Population-level approaches are estimated to cost on average five times less than individual interventions. Investing in cost-effective interventions

to reduce costs to the health sector and other sectors can help create sustainable health systems and economies for the future.

CENTRALIZING PROCUREMENT OF MEDICINES TO SAVE COSTS FOR DENMARK

By: Dorthe Bartels

Summary: An important foundation of the WHO Regional Office for Europe's health systems strengthening strategy is to ensure equitable access to cost-effective medicines and technology. Denmark has taken important measures that have not only helped to save costs but also ensured higher quality and more equitable use of expensive medicines. Two initiatives are central: 1) a centralized structure, in this case a public sector organization—Amgros—that carries out the tendering procedures and bulk purchasing for all hospitals in Denmark; and 2) the Danish Council for the Use of Expensive Hospital Medicines that assesses the clinical costs and benefits of expensive medicines and helps guide the selection of medicines by Amgros and clinicians. By investing in and combining these two processes the Danish government saved approximately €314 million in 2015.

Keywords: Procurement, Medicines, Equitable Access, Amgros, Denmark

Introduction

Concerns about containing health costs touch all governments. Pharmaceuticals are among the highest expenses for many governments and their population, regardless of who picks up the cost of medicines. Meanwhile, they are also vital to improving health outcomes. Decreasing costs of pharmaceuticals have a direct impact on ensuring that the right medicines reach patients at the right time. Ministries of health or their delegated authorities can play an important role in negotiating prices so that the cost of medicines is decreased, out-of-pocket payments are reduced and the population does not experience an onerous financial burden. In Denmark, pharmaceuticals

account for 12.6% of the national health budget and 55.6% of these costs are incurred in hospitals.

Amgros ensures price and supply

Amgros* is the pharmaceutical procurement service for the five regional authorities in Denmark. It is a public-sector organization owned by the regions. Before establishing Amgros, each region handled their own procurement of pharmaceuticals; therefore, Amgros was established in 1990 to create economies of scale and to achieve administrative savings by centralizing the procurement of pharmaceuticals.

* <http://www.amgros.dk/en/areas-of-work/tenders-and-procurement/>

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Ninety-five percent of Amgros' business is pharmaceuticals for Danish hospitals while the remaining 5% of business procures medical devices. The primary task of Amgros is to ensure that Danish public hospitals are always equipped with the medicines they need at the best possible price. In so doing, Amgros can adjust tendering according to the current market situation, thereby optimizing competition. In addition to carrying out tendering procedures, Amgros manages registration and coordination of all pharmaceuticals produced in hospital pharmacies in Denmark. Hospital consumption of pharmaceuticals accounts for more than 55% of the market.[†]

As a result of this centralized process the five Danish regions saved €314 million in 2015.[†] **Figure 1** shows the difference between the market price of the medicine, also known as the pharmacy purchasing price (PPP) and the negotiated price by Amgros after the tender process (HPPP). The difference between these two values represents the savings for the health system. Moreover, a recent analysis by the consultancy KPMG concluded that Amgros is highly cost-efficient in purchasing pharmaceuticals.[‡] The process of involving an external evaluation company is only one of several continuous improvement activities that Amgros is engaged in. In order to remain responsive the organization looks at the experiences of other countries, and actively engages in various subregional and regional networks, e.g. a Nordic Forum and different European networks.

Tender structures

During the last few years, Amgros has made several changes to their tender structures in order to optimize the balance between negotiating good prices, ensuring patient safety and safeguarding the availability of necessary drugs. The goal is to create favourable conditions that allow all potential suppliers – whether big or small – to participate in the tender process. To achieve this Amgros uses four different

Figure 1: Pharmaceutical turnover in Amgros (million Euros) 2008–2015



Source: Department of Business Analysis, Amgros.

Note: PPP – Pharmacy purchasing price; HPPP – Amgros negotiated price.

types of tender contracts: framework contracts, fixed volume tender contracts, regional tender contracts and contracts for new products (with tailored criteria like confidential prices).

Framework contracts

Framework contracts are the most common form of tender used by Amgros. Because treatment guidelines change, this form of tender allows hospitals the degree of flexibility they need. The framework contract gives Amgros the right, but not the obligation, to buy the amount of products included in the tender. When special medical reasons or issues regarding patient safety dictate, it is possible to use another supplier. Through a thorough preparation of the tenders and the involvement of all relevant parties, including clinicians and regional representatives, Amgros strives to create consensus and support for its recommendations for treatment.

Fixed volume tender contracts

Over the past few years, Amgros has introduced other types of tenders in order to create a more dynamic market and to ensure both small and large suppliers have the possibility to bid for tenders. The advantage of the fixed volume tender is to give suppliers the security of selling a certain amount of product. However, these contracts typically expire after a short

period of time (a few months). Therefore, this means that product availability changes frequently and can potentially place patient safety at risk if the patient needs to change “product” frequently. The number of product changes must be weighed carefully against potential cost savings. Moreover, needs over short periods cannot always be estimated very precisely. The amount of required medicine can vary depending on the number of patients undergoing a certain treatment. Hence, only certain products with very stable consumption patterns are suitable to be negotiated using fixed volume tenders, such as Paracetamol. It should be noted that fixed volume tenders appeal more to suppliers of parallel imported pharmaceutical products.

Regional tenders and tenders for new products

Regional tender contracts allow suppliers more flexibility as they can bid to supply either one or all regions, depending on their ability to deliver. Since 2007, Amgros has entered into many region-specific tender contracts. However, there has not been a trend of more suppliers bidding for these smaller tenders, most likely because they are more difficult to administer. In most cases, one supplier wins the tender in all regions.

For new products, Amgros has created a new model of agreement (with new

[†] In 2014, KPMG estimated that Amgros could still save an additional €8–13 million (or (DKK 60–95 million) by implementing KPMG's recommendations, all of which lie within Amgros' control. In 2014, Amgros' total annual revenue was €966 million.

anatomical therapeutic chemical -ATC-code). This involves price volume agreements whereby prices decrease as volume increase and all discounts are confidential. These agreements can be terminated with three months' notice, which can then be used in the case of parallel imports.

Assessing expensive medicines

Another important initiative in Denmark that has benefited the centralized procurement work of Amgro is the Danish Council for the Use of Expensive Hospital Medicines (RADS council), established in 2010. The RADS council consists of representatives from each region, the National Health Board, the Danish Association of Clinical Pharmacology and the Patients' Association. The Council's objective is to ensure that all patients have access to the best possible treatment no matter where they live and which hospital they visit. To achieve this, the RADS council set up smaller professional councils consisting of leading experts within the different specialties. Each professional council evaluates the clinical benefits of expensive medicines that have been selected for evaluation. The evaluation is based on dossiers submitted by the industry and an analysis of the literature of the therapeutic area. RADS uses the Grading of Recommendations Assessment (GRADE) methodology[‡]. After a thorough assessment, the professional council publishes recommendations for treatment. Amgro uses these recommendations for treatment to determine which medicines it will hold tenders for. The RADS council then prepares a priority list showing which generic substances hospitals should choose first, then second and so forth. After the tender, the recommendation includes the name of products.

The results of the tender are used to establish a list of medicines that hospitals should use for the treatment in question. The winner of the tender and their product is ranked first on the list which prescribers will then use unless they have a justification not to. It is important to underline that physicians maintain their prescription authority.

The system was originally received negatively as not respecting physician's autonomy. Over time, however, many physicians have started to regard the system as helpful[§], and instead now see the treatment recommendations as a useful tool for decision making; the system is also reported to alleviate physicians' workloads.

Prioritizing quality

The RADS council has made it possible for Amgro to negotiate better prices. While an evaluation of the process to assess cost savings from engaging the RADS council is still pending and will depend on hospitals' implementation of the tool, what is clear is that the RADS process has improved quality of treatment in Denmark.[¶] Preliminary estimates suggest that the RADS council and its recommendations has given the country €42 million added value at an expense of approximately €22 million since 2010.[¶]

Prioritizing cost-effective processes

Over the 25 years that Amgro has existed, billions of Euros have been saved for Danish public hospitals.[¶] Although the objective remains the same- to save costs in pharmaceutical procurement – Amgro has become more than a trading company. In addition to ensuring savings, Amgro has been able to promote safety and quality of medicines used in hospitals across Denmark and has also engaged in research and development activities by promoting research collaborations with hospital pharmacies. It also provides administrative support to hospital pharmacies, allowing them to focus more on patient care and their core tasks.

Trading has been made easier for both suppliers and customers through Amgro. The specially tailored tender and Enterprise Resource Planning (ERP) systems support the business processes for hospital pharmacies, hearing clinics and suppliers. Hospital pharmacies and hearing clinics achieve considerable administrative savings by having Amgro organize supply, and fully integrating order management systems. The efficient

ERP systems also mean that Amgro does not have to manage and run stocks of medicines. Hospital pharmacies order drugs directly from the supplier-once approved through the tender process-through an online ERP system.

billions
of Euros have
been saved

As a purchaser Amgro is constantly on the lookout for cheaper alternatives to existing medicines that are also of equivalent quality. Pharmacists in its tendering unit are employed to scan the market, make decisions about new products and explore possibilities for substitution or parallel import. Suppliers can benefit from the unique internet-based tendering system, which ensures easy workflows, transparency and equal treatment for everyone submitting a tender.

Next steps

Amgro will continue to play an important role in the centralized procurement for hospital medicines in Denmark. It continues to meet the regions' expectations and reduces costs by working in close and constructive dialogue with all stakeholders. Amgro is driving an efficient business when it comes to buying pharmaceuticals. Centralized procurement has resulted in savings for Denmark and Amgro is now working on becoming a strategic procurement business partner. Being a *strategic* partner means being able to forecast market trends but also scanning the market for new products and innovations, known as horizon scanning.

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IMPROVING ACCESS TO ESSENTIAL MEDICINES IN THE REPUBLIC OF MOLDOVA

By: Zinaida Bezverhni, Vladimir Safta, Elena Chitan, Alessandra Ferrario and Jarno Habicht

Summary: The Republic of Moldova is one of the former Soviet Union countries being widely documented as a reformer in terms of successful health financing policy and introducing mandatory health insurance. The benefit package covers the majority of hospital medicines but is limited in how much it covers outpatient pharmaceuticals. Policy responses have sought to increase coverage through higher budget allocations for pharmaceuticals and positive list extensions. However, with low affordability of medicines and limited public budgets, implementing universal health coverage is still facing significant challenges.

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Keywords: Essential Medicines, Universal Health Coverage, Access, Reimbursement, Moldova

Introduction

Since independence, the Republic of Moldova has made significant strides towards improving the performance of its health system through several important health reforms. Implementation of family medicine in the late 1990s and decentralization of both primary and hospital care^{*} significantly improved patients' access to health services.¹ The introduction of mandatory health insurance in 2004 has led to many positive improvements in financing of health services. Since 2009 the main focus of health reforms has shifted towards universal health coverage with the primary health care benefit package being extended to all citizens irrespective of their insurance status. In addition,

several legislative amendments have extended benefits to the most vulnerable and poorest citizens.² The Government vision on future policy developments is clearly described in the National Health Policy 2007–2021 and the Health System Development Strategy 2008–2017. These documents set out three overarching goals for the health system: improved health, financial risk-protection and responsiveness to changing population needs.

The need to make medicines affordable

While resource allocations from the insurance fund to medicines have been increasing and the positive list has been gradually extended over time, a number of essential out-patient pharmaceuticals are not included in benefit package in the Republic of Moldova. The majority of in-

* The policy initiative was partially supported by the European Union/WHO joint initiative to support policy dialogue and universal health coverage.

patient medicines are covered. Medicines are the main driver of out-of-pocket (OOP) payments and a key source of catastrophic health expenditures and impoverishment in most transition countries. Moldova is no exception. In 2014, nearly 94% of total expenditures on medicines were borne by patients as direct OOP payments.⁸ The Government has taken steps towards securing timely and equitable access to medicines by developing and implementing national programmes for the main non-communicable diseases (NCDs) (diabetes, mental health, cancer, cardiovascular diseases), communicable diseases (tuberculosis, HIV/AIDS, hepatitis, immunizations), rare diseases, transplantations, congenital pathology, blood products security and emergency care. In 2013, access to insulin was improved by including it in the positive list of medicines eligible for reimbursement (previously insulin was only procured through a separately funded national programme). While adding it to the positive list of medicines seemed to improve access to antidiabetic treatments for patients, the additional cost, due to distribution through pharmacies and insulin now subject to retail mark-ups, had a negative impact on the budget. Increased expenditure is also likely to have been due to improved access. Considering the growing prevalence of chronic diseases and only partial health coverage, the main burden of medicine expenditures remains with patients and their families.⁹ In this context, efficient use of limited resources, smart selection of medicines and responsible use of medicines become important tools to improve financial protection and meet population needs.

“
increase

expenditure on
medicines from
4.3% to 10% of
total NHIC
expenditure

Essential Medicines List

The essential medicines list (EML) is a list of medicines deemed necessary to meet priority health care needs of the population. These medicines should be available in health systems at all times, in adequate amounts, in the appropriate dosages, with assured quality, and at a price the individual and the community can afford.¹⁰ Moldova started to implement the EML and to promote its rational use in the public and private health sector in the mid-1990s.¹¹ The national list was developed in 2002 and it was intended to be regularly updated every two years. However, the EML has only been revised three times since its launch. During these revisions, the number of medicines listed has gradually increased from 506 international non-proprietary names (INN) in 2007 to 585 INNs in 2009 and 650 INNs in 2011. The next revision of the EML is expected in 2016.

Pricing of medicines

High prices of medicines substantially affect patient access to medicines, especially in low and middle-income countries. The Republic of Moldova introduced its first price control policies in 1995.¹² All levels of medicines prices have been subject to regulation in a step-wise manner. Manufacturer prices for all medicines (including over-the-counter medicines, or OTCs) have been fixed using external price referencing, based on a basket including eleven countries. The wholesale mark-up has been limited to a maximum of 15% of the ex-factory procurement price and the retail mark-up to 25% of the wholesaler procurement price. All medicines are subject to 8% value added tax, which is less than the normal VAT rate of 20%.

Access to medicines

Despite all efforts and policy changes, total health expenditure has increased over the last ten years, including OOP expenditure on medicines and medical supplies.¹³ Affordability of partially reimbursed medicines for the treatment of NCDs has improved since the introduction of the first reimbursement list in 2006 for all income and expenditure quintiles.¹⁴ However, this improvement

was mainly driven by higher income and expenditure by households rather than an actual increase in coverage of the reimbursement list.¹⁵

New policy initiative

Several policy options can be considered to increase coverage for essential medicines. Depending on its design, a price reduction policy can have a wide reaching effect on medicines affordability, beyond reimbursed medicines. On the demand side, the National Health Insurance Company has set the objective to increase expenditure on medicines from 4.3% to 10% of its total expenditure in 2017. The available budget for medicines has grown by almost 140% since 2010.¹⁶ Another objective is to reduce OOP expenditures (not just medicine-related expenditure) from the baseline of 72% to 65% of total OOP expenditures by 2017. Reducing medicine prices will reduce household expenditure provided consumption does not increase. Besides regulating ex-factory prices, it is important to reduce excessive charges being added to medicines as they move through the supply chain. Moldova is already regulating the maximum levels of distribution mark-ups, so the next step was to introduce a regressive mark-up scheme. This policy option has been widely used globally in low and middle-income, as well as high-income countries.¹⁷ ¹⁸

Significant variability exists in the methods for calculating and controlling the size of mark-ups. A single model does not fit all settings. Early in 2015, an initiative to increase financial protection for the population was developed by the Parliament and subsequently underwent intensive rounds of consultation led by the Ministry of Health with technical support from the World Health Organization. Two main models were considered, one based on three price segments (less than 50 lei (€2.40); 51–150 lei (€7.20); more than 151 lei) and the second based on five price segments (less than 30 lei (€1.40); 31–60 lei (€2.90); 61–120 lei (€5.70); 121–240 lei (€11.5); more than 241 lei). Other country's experiences – such as the Baltic countries and Romania – were explored and adapted to the Moldovan context. A simulation model based on five price segments was designed using

the National Catalogue of manufacturers' prices[†]. Mark-ups are regressively defined starting from 15% to 5% for wholesale mark-ups and from 25% to 11% retail. Simulations showed that, if applied, the proposed regressive mark-up structure would lead to a reduction of wholesale median prices by 6% and retail median prices by 12%. Around 80% of medicines will experience a price reduction from 2% to 10% in the wholesale sector and from 7% to 20% in the retail sector. The Government introduced these changes in the Summer of 2015 with gradual implementation from October 2015 for wholesalers and April 2016 for retailers.

“policy initiatives were a result of intensive inter-sectoral dialogue”

Lessons learned

While international evidence is important in defining the vision and directions of pharmaceutical policies, contextualized situation analysis through a participatory process in consultation with stakeholders is crucial for acceptance of new policies. The policy initiatives described here were a result of intensive inter-sectoral dialogue in 2015, including academic partners, health authorities, private sector partners and parliamentary officials. Over the short-term regulation of mark-ups, will probably lead to reduced medicine prices. In the medium and long-term, the new regulation on regressive mark-ups may have an effect on the viability of some actors in the pharmaceutical supply chain and may adversely affect operations in more remote areas. However, there is no evidence on the expected and actual impact to date: incentives and disincentives need to be mapped out and unexpected effects anticipated to ensure viability of the supply chain and access to medicines in all regional areas. Continued open constructive dialogue with all

stakeholders will help create transparency and accountability of the new amendments to legislation. There is a need to develop a reliable mechanism for monitoring prices and sales of medicines in order to assess the intended and unintended effects of price regulations on affordability and access to medicines. Trying to balance public and private interests without jeopardising access to medicines can be achieved by regulating only priority areas (e.g. reimbursed medicines) and provide some flexibility in non-priority areas (e.g. exempting OTCs from price regulation).

As this initiative covers only a part of the procurement and supply management chain – namely margins – further efforts to improve other areas of relevance to improve access to medicines, such as selection, financing, supply and rational use of medicines, are needed.

Steps forward

Ensuring long-term sustainability of and access to medicines is one of the greatest challenges for health systems in Europe and worldwide. One of several important requirements is an overall review of procurement and supply management processes to bring efficiency into all steps of the supply chain. Clear criteria for including and excluding medicines and medical devices are needed, together with capacity building on health technology assessment. Decision-makers are increasingly faced with difficult choices due to budget constraints and pressure from different stakeholders. Health systems must adapt and be responsive to changing environments, new priorities and innovations while also managing limited financial resources. The pharmaceutical market is highly regulated and particularly sensitive to the introduction of new policy measures. Regular monitoring of market data, business intelligence tools and projections of market response have yet to be implemented in Moldova, nor have efficient supply management processes. Their implementation will be key to informed policy-making. Extension of the positive list based on sound selection criteria (cost-efficiency, budget impact, evidence based), awareness campaigns for consumers about responsible use of medicines, with special focus on cost-

efficient generics and antimicrobials, and resource generation by improving public procurement processes are already included in the country's newly approved Action Plan for Pharmaceuticals for 2016.

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IMPROVING THE MORTALITY INFORMATION SYSTEM IN PORTUGAL

By: Cátia Sousa Pinto, Robert N. Anderson, Cristiano Marques, Cristiana Maia, Henrique Martins and Maria do Carmo Borralho

Summary: The inability to invest in and develop mortality information systems has been considered the single most critical failure in health information systems. Health information systems are an integral part of health systems. This includes strengthening not only the information content but also the information systems themselves, health information platforms and infrastructure. In this article, particular focus has been placed on the regional and inter-sectoral approach to implementation adopted in Portugal. The article shows how legal and operational barriers have been overcome and focuses on the potential of the new system to improve the quality and timeliness of mortality statistics.

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Keywords: *Electronic Death Certificate, Mortality Information System, Mortality Statistics, Mortality Surveillance, Portugal*

Introduction

Mortality information is a critical cornerstone of public health surveillance and is at the core of health policy decision making. Inability to invest in and develop mortality information systems has been considered the single most critical failure in health information systems and there is a recognized urgent need to improve mortality statistics and cause-of-death information.^{1,2} Even where complete coverage has been achieved, the quality of mortality statistics and cause-of-death information remains suboptimal.³ Although there have been major developments in information technology with the potential to improve public health information systems,⁴ mortality data collection has remained

largely unchanged in most countries, mainly due to legal and operational barriers. Transition to electronic mortality information systems often requires changing laws and regulations (e.g., electronic signatures, data protection and confidentiality). In addition, for the optimal application of these systems there is a need to invest in ensuring that these systems are made user-friendly for health professionals and the range of professionals outside the health care sector who will provide information to the system.

Electronic registration of death certificates can improve the quality and timeliness of mortality statistics.⁵ There are two approaches to developing electronic

mortality information systems: 1) death certificates are registered electronically using information from paper records (e-death registration) or, 2) all institutions involved in the death certification process enter information directly into an electronic system without relying at all on paper records (e-death certification). The latter – e-death certification – is a more efficient means of synchronizing data from various institutions and ensuring a more complete and accurate record.

“ 100%
e-death
certification was
achieved

Death Registration and Certification in Portugal

Mandatory civil registration of deaths in Portugal was instituted in 1911, along with the closing of church registries.⁸ Until now, The Mortality Information System in Portugal has been based primarily on paper-based death certification with cause-of-death information registered in accordance with World Health Organization recommended guidelines.⁹ In Portugal, cause-of-death certification was, and still is, performed by a qualified medical doctor and is mandatory for all deaths including foetal deaths (of more than 22 weeks of gestational age).

A national mortality database was created by combining civil registry information with cause-of-death coding performed manually at the Directorate-General of Health (DGS) in accordance with the International Statistical Classification of Diseases and Related Health Problems (ICD). This system did not allow for timely epidemiological surveillance and depended on paper death certificates being collected centrally, a process that usually took several months, followed by time needed to retrieve and code cause of death. Another challenge was the accuracy and completeness of the information obtained from paper death certificates because of difficulties with reading handwriting,

Table 1: E-death certification implementation period in Portugal, by region of the country

Region	E-death certification implementation period	
	Start date	End Date
Center	15 November 2012	15 June 2013
Madeira	18 February 2013	15 October 2013
North	1 March 2013	1 September 2013
Algarve	5 June 2013	1 July 2013
Lisbon and Tagus Valley	5 June 2013	15 November 2013
Alentejo	10 June 2013	5 September 2013
Azores	1 July 2013	4 November 2013

Source: Authors' own.

Note: E-death certification implementation period for NHS institutions in each Portuguese region. The private health sector was included on 1 January 2014, except in the autonomous region of Azores (on 4 November 2014).

improper cause-of-death certification, poor descriptions of cause of death, an inability to collect and use cause-of-death information from autopsy reports available after death certification, and an inability to register multiple causes of death. This resulted in a high proportion of ill-defined causes of death, or so-called “garbage codes” (>20%).¹⁰

To improve timeliness, accuracy and overall quality of information the Portuguese DGS implemented electronic death certification as the basis of the mortality information system.¹¹

Development of the electronic mortality information system

Between 2007 and 2013, DGS coordinated a joint working group involving the Portuguese Ministries of Health, Justice and Internal Administration (including the Shared Services of Ministry of Health, the Institute of Civil Registries, Public Prosecution Services, Police Authorities, National Institute of Legal Medicine and Forensic sciences, National Institute of Medical Emergency and the National Institute of Statistics) and the National Medical Board. Their aim was to review the legal framework and operational procedures for death certification in Portugal and to develop a new legal framework to guide e-death certification and web-based software to support the electronic mortality information system.

The development of the legal framework to guide the digitisation of death certificates was concluded in 2012 with publication of a law and four decrees in the Portuguese Official Journal^{8 9 10 11 12} and the approval of the Portuguese Data Protection Authority. The new legal framework requires certification of all deaths in Portugal through an electronic registry and the electronic transmission of death certificates for civil registration purposes. Additionally, it requires that an integrated electronic system is set up to synchronize and link electronic clinical and circumstantial information forms, electronic forensic autopsy reports, and electronic clinical autopsies.

Web-based software, SICO (*Sistema de Informação dos Certificados de Óbito*), was developed by the Shared Services of the Ministry of Health to support the system described above (available through <https://servicos.min-saude.pt/sico>). This software is accessed by all doctors in Portugal through a high security password validated by the Portuguese Medical Association. It is also accessed by the Public Prosecution Service and Police Authorities through a high security password provided by the Ministries of Internal Affairs and Justice.

Upon completion, death certificates registered by medical doctors are forwarded to a central database maintained by the Institute of Civil Registries and

made available to local civil registry offices. Death certificates for suspected violent deaths and deaths of uncertain cause are first processed by the Public Prosecution Service and the Institute of Legal Medicine and Forensic Sciences in order to allow for a legally required forensic autopsy before they are forwarded to the central database.

Portuguese legislation requires that a clinical and circumstantial information form be completed by the certifying doctor for deaths of unknown cause and suspected violent death. Once this form is registered in SICO it can be made available to the Public Prosecution Service for investigation.

Causes of death reported on death certificates and registered in SICO are available to the DGS (Ministry of Health) in real time for mortality surveillance and cause-of-death coding. Once information is received and coded, it is sent through a web service to the National Institute of Statistics.

SICO also allows for queries to the National Medical Emergency Institute database in all situations where emergency care was provided directly prior to the death of an individual. This information is then made available to the certifying doctor and also for cause-of-death coding performed at DGS.

A secondary but nonetheless important function of SICO is to update the National Health Service (NHS) Users Registry to remove decedents from the health insurance coverage plan. The NHS Users Registry is the national registry of people insured by the NHS, which is used as the basis for planning and evaluation of several disease prevention programs and provision of health services.

Implementation

A strategic multi-step and multi-sectoral approach, across the country, was taken to implement the system. It included a pilot phase; training in software use for public and private doctors, forensic medical pathologists, the Public Prosecution Services and Police Authorities; and a national stepwise rollout. A regional

framework for the implementation was crucial to achieving a coherent force for change, and a multi-organizational transition to the electronic system. The regional approach allowed for institutions across the country to be prepared simultaneously for change but also allowed for closer monitoring and support.

The pilot phase started in Coimbra University Hospital Centers in November 2012. During the one month trial phase the software was tested and adjusted to correct system errors and to respond to the end-users' feedback. Adjustments mainly included resolving difficulties in using the software, application errors, operational needs not identified in preliminary testing and web service data flow.

The national stepwise roll-out started in December 2012. During this period a national training plan was implemented by a core team based at DGS and by regional teams (Regional Health Administrations) responsible for training. Each region started using the system on a specific date agreed upon by the Regional Health and Justice Administrations and approved by the Ministry of Health. **Table 1** shows when each region initiated and finalized the transition to the new mortality information system.

Implementation across the country was completed in December 2013 and 100% e-death certification was achieved at the beginning of January 2014.

Improved data quality and cause-of-death coding

The transition to e-death certification in Portugal has resulted in both operational and epidemiological improvements in mortality surveillance, as well as improvements in the quality of data collected. From an operational point of view, e-death certification allows for more efficient communication as participants interact electronically and can minimize confidentiality breaches with the elimination of paper records of personal information. This improves the legal and administrative process of death certification. It also ensures that doctors do not have to disclose more sensitive

health or personal data information that can stigmatize the deceased or their family as was reported to occur with paper-based death certification.

From an epidemiologic perspective, e-death certificates have substantially improved the timeliness of access to mortality data. While previously this information was only available after six months it is now available as soon as the death is registered. Electronic certification has also improved the completeness and quality of data through the use of automatic form-filling of demographic data drawn from the civil registry and based on a national identification number, automatic error checking and the use of mandatory field features. Corrections and amendments can be made directly in the database. The need to decipher handwritten entries is avoided and the use of mandatory fields can be used to ensure information that is frequently neglected is complete (e.g., pregnancy at time of death, date of labour and data regarding previous pregnancies and demographic information of the mother for foetal and neonatal deaths).

“operational and epidemiological improvements in mortality surveillance”

A preliminary analysis of improvements in data quality has shown that previously unavailable data has been made available in death certificates (e.g., whether the autopsy was performed; access to the autopsy report before coding). Also, a substantial amount of duplication of information from different sources has been minimized. Previous data collection methods required that different entities of the state register the same information. Now, for example, doctors do not need to write in the death certificate that a forensic

autopsy was performed as that information is already directly available from public prosecution services.

As a result of electronic interoperability between health software and civil registry software (e.g., between the institutions involved in death certification), additional information has been linked with the death certificate and can serve to validate, specify or rectify cause-of-death coding. In a sample of 40,039 e-death certificates registered in 2013, 16.4% had additional relevant information available on cause of death. National emergency forms were available in 6.9% of all deaths, autopsy reports and clinical and circumstantial information forms in 9.9% of all deaths (50% of suspected violent deaths and deaths of unknown cause in the sample used). Clinical and circumstantial information forms, and autopsy reports, are especially important for non-natural deaths as these often provide detail on the circumstances of death and nature of injury that can substantially improve the specificity of cause-of-death coding. Similarly, these may be used to identify the cause of deaths that are initially certified as unknown.

A more complete evaluation on the impact of this new mortality system on quality of cause-of-death coding will be conducted once a complete year of coded e-death certificates data (2014) is made available.

Conclusions and next steps

Transition to electronic, real-time mortality information systems in Portugal involved strong core leadership and inter-jurisdictional cooperation in both development and implementation from the DGS and the inter-jurisdictional group. The experience has also shown that a regional approach to implementation is an effective way of transitioning to electronic death certification. The transition in Portugal was completed in one year and 100% coverage was achieved in two years. These achievements were also due to an adequate legislative framework that defined a horizontal approach to the functions of the State in the vital registration system, good collaboration between all ministries involved and shared responsibility for implementation

of the system between central, regional and local levels of the Ministry of Health. The intersectoral stepwise approach allowed for input from a range of sectors (health institutions, public prosecution services, police authorities and civil registry services) that proved to be crucial for supporting the transition period in each region.

Implementation of e-death certification is the first step to improving mortality information in Portugal. Next steps will include: improving electronic error checking and alert functions for medical certifiers and coding staff; improving the registry of clinical and forensic autopsies; developing a process for epidemiological investigation of ill-defined deaths and deaths of unknown cause with local health authorities; developing an integrated automatic coding functionality; and electronic integration with other relevant health information systems.

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EVIDENCE-INFORMED POLICY-MAKING IN SLOVENIA

By: Mircha Poldrugovac, Tit Albreht, Tanja Kuchenmüller, Marijan Ivanuša, Tatjana Buzeti and Vesna Kerstin Petrič

Summary: Health information and research are important foundations for health systems strengthening (HSS). This includes strengthening the information systems themselves such that they are up-to-date, inclusive of all relevant stakeholders and tailored to local contexts. Evidence-informed policy-making (EIP) is a major priority for Slovenia. This article shows how Slovenia applied the principles of EIP to two complementary initiatives contributing to the reform process: 1) a large-scale health system review and 2) an evidence brief for policy on provider payments in primary care. As a result, both are contributing to the transformation of the Slovenian health system.

Keywords: Health Systems Strengthening; Evidence-Informed Policy-Making; Provider Payment; Primary Care; Slovenia

Introduction

Strengthening evidence-informed policy-making (EIP) has gained increasing attention across the European region over the past few years. On the eve of the 20th anniversary of the *Ljubljana Charter on Reforming Health Care in Europe*, it is important to mention that EIP was already recognized as a key contributor to effective reform when Ministers of Health signed the Charter in 1996. To manage the reform of health care effectively, the Charter urged that "...decisions on [the] development of the health care system should be based on evidence, where available."¹ At the same time, the Charter stressed that "governments must raise value-related issues for public debate..."² Although seemingly contradictory, decision makers need to reconcile these two dimensions – the need for evidence and the need to consider values – in order to identify policy actions that promote the health of the population. No country, including Slovenia, is exempt

from the challenges that balancing these two dimensions of high-level policy-making present for decision makers.

In 2015, a comprehensive, large-scale, evidence-informed health system review was commissioned by the Ministry of Health to support the development of a new national health plan in Slovenia. Simultaneously, the Ministry supported activities to establish a Knowledge Translation Platform (KTP) to strengthen the role of systematic evidence in important areas not covered by large health system evidence – they tested this in the area of primary care.

The Slovenian health system review

At the start of 2015, Slovenia was in need of a new national health plan to guide medium- and long-term policy priorities. The previous national health plan had expired at the end of 2013 and new austerity measures had been put

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in place with the 2012 adoption of the Fiscal Balance Act. The Fiscal Balance Act influenced as many as 30 legal acts in different sectors. In addition, the Health Insurance Institute of Slovenia (HIIS), which governs the country's single-fund, compulsory social health insurance system, had had to significantly cut its budgets for hospitals. According to the HIIS, the unit cost of health services reimbursed to health care providers declined cumulatively by 8.5% between 2009 and 2013. Despite rising stakeholder pressures for the speedy development of a reform agenda, the Ministry of Health decided to pursue the more time-consuming but also more evidence-based approach of a large scale health systems review.

To better understand the complexities of a broad spectrum of health system issues, the Ministry of Health engaged the technical assistance of the World Health Organization (WHO) Regional Office for Europe and the European Observatory on Health Systems and Policies. Together, WHO experts, external consultants and national experts conducted an extensive analysis to inform a new national health plan. In order to strengthen the analysis, the Ministry of Health invited key health sector stakeholders—the HIIS, the National Institute of Public Health (NIPH), professional associations and chambers, provider organizations, and patient representatives. In order to ensure that a broader and more intersectoral approach was achieved, the Ministry of Health also invited representatives from non-health sectors, including the Ministry of Labour, Family, Social Affairs and Equal Opportunities, the Ministry of Finance and the Institute of Macroeconomic Analysis and Development. These stakeholders were involved from the very beginning of the analysis and provided not only evidence, but also diverse views to help address challenges faced by the health system.

The health system review explored six thematic areas, resulting in six reports: *Health system expenditure review*, *Evaluating health financing*, *Long-term care*, *Making sense of complementary health insurance*, *Purchasing and payment review* and *Optimizing service*

delivery. The drafts of the reports served to guide a series of policy workshops held in autumn 2015. Some of the reports addressed issues already high on the policy agenda, i.e., the role of complementary health insurance, while others addressed issues requiring more and immediate attention based on long-term forecasts and international experiences, i.e., the overreliance on payroll funding of the compulsory health insurance system. The findings of the review were then used to inform the new national health plan approved by the Slovenian government in December 2015.

The Minister of Health's novel and explicit approach towards evidence-informed health system reform in Slovenia gained national as well as international attention.² On the occasion of the presentation of the final reports on the health system review, the Minister of Health urged: "The time for reflection and strategic planning is drawing to a close; the next two years will be the time for concrete actions in all priority areas."³

EVIPNet in Slovenia

In order to implement the priorities set out in the national health plan, transformation and systematic scale-up into practice will be required. An institutionalized knowledge translation platform (KTP)* can help identify policies and a range of possible actions using scientific research and local experiences in a systematic and comprehensive way.

The Evidence-Informed Policy Network (EVIPNet) is a WHO-sponsored initiative, aiming to build and institutionalize national capacities to strengthen EIP through a systematic, transparent and broad stakeholder approach. In 2012, the WHO Regional Office for Europe launched EVIPNet Europe and selected Slovenia as a pilot country for implementation of the EVIPNet methodology.⁴ Aware of its potential, in 2014 the Ministry appointed two experts from the NIPH to participate in the pilot project. Throughout 2014, the experts

conducted an EIP situation analysis, informed by a stakeholder consultation with the participation of the WHO Country Office, the EVIPNet Europe Secretariat at WHO and the Ministry of Health. This resulted in a proposal to the Ministry of Health to institutionalize EIP through the establishment of a KTP in collaboration with key health system stakeholders.⁵ Stakeholders included the HIIS, professional associations and chambers, academia and NGOs, in addition to the Ministry of Health and the NIPH.

Primary care in Slovenia

Primary care is considered a fundamental building block of the Slovenian health care system. It is currently being challenged by an ageing population and an increase in multi- and co-morbidities requiring increased capacity in managing patients and integrating care, particularly for those with chronic conditions. Despite several changes taking place in primary care, a report in 2013⁶ called for clear targets to understand the extent of primary care provider networks in Slovenia. Two factors were deemed as important to focus on: the health workforce (availability), and the nature of financing (including the extent and method of financing).

Developing a KTP in Slovenia

As an initial trial to test the KTP, the Ministry of Health requested the group of stakeholders to: 1) prepare an evidence brief for policy (EBP), and 2) organize a policy dialogue. Using the EVIPNet methodology, an EBP aims to summarize and analyze the evidence while also providing three policy options for decision makers to choose from. The policy dialogue should ideally follow a process that allows the EBP to be considered among the real-world factors influencing the policy-making process.⁷ This is achieved by convening a dialogue of the key stakeholders in the policy area in question. Both the EBP and the policy dialogue are fundamental to the KTP proposed by EVIPNet and have proven to be successful mechanisms by which to translate evidence into policy in a systematic and transparent manner elsewhere.^{4 8}

* A knowledge translation platform is a formal organization, department or network, focusing on bringing actors together, synthesizing explicit and tacit knowledge, and leading networking in knowledge translation.⁷

The EVIPNet country team, which worked on the situation analysis described earlier, a representative of the Ministry of Health and the WHO Country Office decided that the first EBP should focus on the payment model for personal physicians (general practitioners or paediatricians)[†]. The EBP would help guide the Ministry to implement the national health plan. A team was formed to prepare this specific EBP. The group consisted of experts and practitioners, including a family medicine specialist, the director of a health care centre, a community nurse, an expert from the providers' association, a representative from the HIIS, and the EVIPNet country team. The process involved several iterations before the draft EBP was reviewed by both national and international experts. The preparation of the EBP was then presented and discussed at the health system review policy dialogue on primary care held in December 2015.

Lessons learned

Slovenia's experience with both the health systems review and developing a KTP using the EVIPNet methodology have been fundamental to equipping the government with evidence-based and inclusive decision-making processes that are up-to-date, tailored and relevant to the local context. Both the processes of drafting the health system review reports and the EVIPNet-guided EBP and policy dialogues should continue to be employed in the future.

The two approaches to EIP are complementary. While both approaches served to summarize and analyze available evidence and information, the EBP to be used for informing primary care reform provides decision makers with three detailed policy options to choose from. The EIP processes used to inform the health system review, on the other hand, resulted, with a few exceptions, in identifying the broader areas of required action.

The credibility of any document that synthesises evidence depends on the consistency of the methods used to combine and appraise the evidence, considering locally specific circumstances and the involvement of stakeholders. It is clear that both the health system review and the development of the EVIPNet-informed KTP effectively involved a broad range of stakeholders. For both processes these were valuable opportunities to acquire direct experience and unpublished information (or tacit knowledge) that help strengthen the scientific evidence. With such a large group of interests around the table it is possible to cross check scientific evidence and minimize the monopoly of one single set of interests or agendas. Both processes required time and continuous consultation to address all stakeholders, interests and priorities. Both processes also require continuously clarifying roles and responsibilities among the diverse groups of stakeholders to plan for successful implementation.

Finally, an important lesson learned is that a strong convening power, such as that from the Ministry of Health, is necessary. This was particularly evident in the case of the health system review where important backing from the Ministry of Health was in place. As the focus shifts towards implementation of the new national health plan, the Ministry will need to sustain and create additional capacities to ensure the ongoing, systematic and targeted use of evidence in policy-making. This is a primary focus and strength of the EVIPNet methodology.

Conclusion

The two approaches to EIP clearly responded to different policy-making needs and should be seen along a continuum of EIP. Both approaches set out to "synthesize, exchange and apply knowledge by relevant stakeholders to accelerate the benefits of global and local innovation in strengthening health systems and improving people's health."[‡] The Slovenian Ministry of Health is clearly committed to engaging EIP processes for health reforms. Without such government support, evidence-based policy-making initiatives would not attract the attention, the expertise, or the involvement of

stakeholders that it needs to maintain its integrity and strength. This political support, however, must be matched with ongoing, appropriate local capacity, financial and non-financial resources as well as systematic approaches.

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[†] Personal physicians are primary care providers (particularly general practitioners) in the public health care system, chosen by insured people (or their guardians) as their first port of call for health related services. They also act as gatekeepers to specialist and hospital care.

THE EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES: KNOWLEDGE BROKERING FOR HEALTH SYSTEMS STRENGTHENING

By: Suszy Lessof, Josep Figueras and Willy Palm

Summary: The European Observatory on Health Systems and Policies (Observatory) is a partnership hosted by the WHO Regional Office for Europe. It emerged from the preparatory work for the Ljubljana Charter and in response to the focus on people centred, quality health systems shaped by values and evidence. Over the last 20 years it has generated and communicated evidence explicitly to inform policy makers, developing a range of innovative approaches to knowledge brokering. The key lessons for bringing evidence into the processes of health systems strengthening revolve around the understanding that knowledge brokering is a dynamic process with three phases: identifying what the evidence need is; pulling together the right evidence; and unpacking and sharing that evidence so that policy makers can use it.

Keywords: *Observatory, Health Systems, Health Policy, Knowledge Brokering*

The legacy of Ljubljana

The Ljubljana Charter, adopted 20 years ago, was a remarkable achievement. It was rooted in the belief that health cannot be separated from the wider society or economy and articulated a set of principles for health system reform, which understood that people's experiences of health systems are central to improving them. It went on to inform the Tallinn Charter and the WHO Regional Office for Europe commitment on walking the talk on people centeredness.

The Observatory follows from the commitment that all the big decisions on health system development should be "based on evidence where available".¹ Its founding Partners recognized the lack of health systems evidence and, perhaps more importantly, the significant gap between what academic researchers were producing and what decision makers needed to shape policy. They designed the Observatory to bridge that gap, and to support evidence-based policy making through the rigorous analysis of the dynamics of health care systems.

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Box 1: Observatory Partners at May 2016**Governments**

- Austria
- Belgium
- Finland
- Ireland
- Norway
- Slovenia
- Sweden
- United Kingdom
- Veneto Region

International organizations

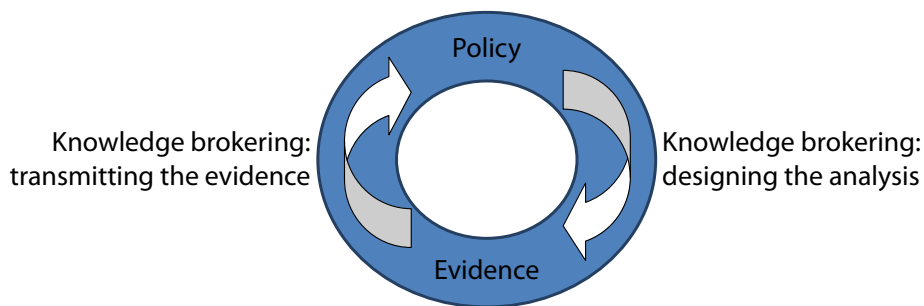
- WHO Regional Office for Europe (host and Partner)
- European Commission
- World Bank

Other organizations

- Union nationale des caisses d'assurance maladie (UNCAM), France

Academic organizations

- London School of Economics and Political Science
- London School of Hygiene and Tropical Medicine

Figure 1: Knowledge brokering as the dynamic between evidence and policy

Source: Authors' own.

A partnership to broker knowledge

The Observatory brings together different stakeholders – international organizations, governments, and academics (see Box 1) who insist that ‘generating evidence’ must be tied to policy relevance. They also place huge emphasis on disseminating the findings – that is, on packaging and sharing evidence so policy makers can use it. As advocates of evidence, they also draw on it so the Observatory uses research on knowledge transfer to enrich and improve the way it connects researchers and policy makers; builds trust; signals quality and credibility; and makes its outputs ‘interpretable’, ‘applicable’ and, above all, accessible.

The evidence interacts with health systems strengthening through the dynamic of knowledge brokering. The Observatory works with decision makers and key counterparts like the WHO Division of

Health Systems and Public Health (DSP) to understand what policy makers need; assemble the right evidence; and share it in ways that are useful – with all phases feeding into each in an iterative cycle.

Evidence products and the lessons learned

A wide range of evidence products have evolved to reflect this experience and to bring decision makers and the evidence together in ways that work. These include published outputs (studies, policy briefs, Eurohealth); face to face work (policy dialogues, flagship courses, Summer School) and on-line platforms (see Box 2).

The way that these evidence products support policy in practice can best be explained through ‘real’ examples. WHO’s ‘walking the talk’ strategic priorities² provides a framework for strengthening

health systems. Table 1 (over the page) matches an example of the Observatory’s recent work with each heading and lists the knowledge brokering lessons. It demonstrates that knowledge brokering is not simply about explaining the evidence. It needs to tackle a much broader set of questions around who defines the ‘right’ question, where the evidence can be found, which country comparisons are illuminating, how national context is understood, and who is involved in taking a policy agenda forward.

Knowledge brokering for health systems strengthening: some conclusions

To support policy makers in strengthening their health systems means managing the dynamic inter-relationship between the three phases of knowledge brokering:

Identifying what the evidence need is:

this means working with policy makers, their advisers, experts and academics to pin down what the real policy question is. This holds true whether a major study or a policy dialogue is being planned. There needs to be a ‘drilling down’ to understand the situation that prompts the question; to check that the way the question is described means the same things to everyone involved; and to ensure that the evidence the team plan to assemble will properly and directly speak to the question.

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evidence to
support policy in
practice

Pulling together the right evidence:

this does not imply huge amounts of primary research; it requires knowledge of what has already been done and by whom so that existing work is not duplicated and existing expertise can be co-opted. It means working across boundaries, so health economists working with epidemiologists or Spanish specialists collaborating with Latvian ones. It also

Box 2: Observatory evidence products

- **HiTs** (Health Systems in Transition series): a set of reviews that describe how each country's health system works, using the same structure and terms to support comparison.
- **HSPM** (Health Systems and Policy Monitor): an on-line platform and network whose members provide health systems news and updates and reflections on policy developments.
- **Case studies**: tailored reviews of how a particular issue is being addressed in different countries using a standard questionnaire and a network of national experts.
- **Analytic studies**: detailed explorations of an issue that bring together existing primary research and different disciplines to develop a rounded understanding of current policy challenges.
- **Performance studies**: looking at a particular domain and how the indicators available can be used (and misused) in addressing health system performance.
- **HFCM** (Health and Financial Crisis Monitor): a web platform and twitter feed that provides updates on emerging evidence on the health system impacts of the financial crisis.
- **Policy briefs**: concise reviews of evidence around a clearly (and narrowly) defined policy question with a format that emphasizes key messages and demonstrates the strength of the evidence underpinning them.
- **Eurohealth**: a quarterly journal aimed at both the scientific and the policy-making communities which shares syntheses of evidence, news, and debate.
- **Health Reform Monitor**: an open access series of articles in the journal *Health Policy* that draws on the HSPM network to discuss reform issues across Europe.
- **Policy dialogues**: carefully facilitated meetings that allow small groups of senior policy makers to discuss a specific, current policy decision in a confidential environment with key evidence and expert inputs.
- **Presentations**: at conferences, meetings and seminars which ensure the Observatory's evidence contributes to the wider European public health and health policy debate.
- **Summer School**: an intensive one-week course for policy makers, planners and practitioners which this year addresses primary care innovation and integration.

means transparent and explicit terms of reference, methods and review as well as a strong focus on context, comparability and trends over time.

Sharing the evidence so that policy makers can use it: this requires clear, timely, and understandable messages that are demonstrably trustworthy and backed by high quality evidence and expertise. It means tailoring messages to the issue and the specific audience, and, when possible, tapping into an entry point – a key moment when there is the will to take evidence on board. It also means engaging policy makers and ensuring that they feel ownership, creating the momentum for them to follow through.

Factors that confer success

The Observatory tries to combine these elements and tools to bring policy makers the right evidence at the right point in the decision making cycle, so that they can make informed choices. It could not begin to do so without the extraordinary network of academics, policy makers and practitioners who contribute to its work; its staff team who combine academic rigour with a commitment to evidence for policy; its colleagues in DSP; and its Partners who know what it is like to try to put evidence into practice.

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Table 1: Evidence products and knowledge brokering lessons

Observatory evidence product	Knowledge brokering lessons
<p><i>Walking the talk: strategic priority 1: Transforming health services</i></p> <p>Slovenia – health system review: a comprehensive review in conjunction with WHO Europe's DSP, assessing expenditure, funding, purchasing, payment and service delivery including long term care. Experiences and evidence from other European health systems illuminated possible choices for Slovenia.</p> <p>The Review delivered a set of interlinked reports⁶ that were welcomed by the Minister and discussed in Parliament. DSP will work with Slovenia to use the evidence and the ownership created to improve health system performance.</p>	<ul style="list-style-type: none"> • Link with national experts: working closely with the Slovenian Institute of Public Health, Health Insurance Institute, academics, managers and other stakeholders was central to understanding what was really happening and building trust. • Work across silos: bringing different experts together who could connect hospitals payment to referral patterns to multi-morbidity turned the analysis from an abstract exercise into something practical. • Tap into political will: it was a Slovenian decision to explore the evidence and to use it. Without (senior) engagement evidence has little power.
<p><i>Walking the talk: strategic priority 2: Moving towards universal health coverage</i></p> <p>Financial crisis case studies: these case studies (a response to the pressures of the economic crisis on health systems), were carried out in close collaboration with DSP and its Barcelona team. They reviewed in detail policy responses in the areas of public funding, health coverage and health service planning, purchasing and delivery in nine countries.⁸ The studies provided the evidence for policy dialogues in member states, demonstrating that securing universal coverage was an appropriate response in the face of the crisis. They also fed into an overview volume analysing the policy responses in 47 countries.⁵</p>	<ul style="list-style-type: none"> • Cultivate extensive academic networks: the case studies were only possible because they drew on the knowledge and insights of dozens of experts across the Region. • Make methods and review transparent: the significant investment in developing a country questionnaire paid dividends in demonstrating validity and building trust. • Release results early: timeliness is crucial for policy makers and although the case studies took time to publish they were circulated and used in policy dialogues, and by DSP, to support practitioners and implementation, as soon as they were quality controlled.
<p><i>Walking the talk: foundation 1: Enhancing the health workforce</i></p> <p>Health workforce policy briefs: Developed to support the Belgian European Union Presidency, the briefs addressed very specific themes (workforce needs, skills, audit for quality and work environment) reviewing the evidence and generating evidence-informed policy options.^{6 7}</p>	<ul style="list-style-type: none"> • Write explicit terms of reference: these policy briefs had to fit closely into a wider agenda – they worked because a lot of thought was given to the commissioning process and to ensuring that the evidence collected would address the policy need. • Highlight key messages: the policy briefs are structured in the understanding that decision makers have little time. They offer one page of easy access key messages and a brief summary (all underpinned by a fuller iteration of the evidence). • Use entry points: in this case the Belgian government used the EU Presidency to push forward thinking on workforce issues. Having an opening when policy makers are willing to address an issue makes a real difference to evidence uptake.
<p><i>Walking the talk: foundation 2: Ensuring equitable access to medicines and technologies</i></p> <p>Central European Policy Dialogue: A policy dialogue in Bratislava on pricing and reimbursing pharmaceuticals in Central-Europe, bringing together Bulgaria, Croatia, Czech Republic, Hungary, Poland, Romania, Slovakia and Slovenia, and key experts to consider the challenges and options.</p> <p>Summer School: the 2014 OBS Venice Summer School was on rethinking pharmaceutical policy and looked at pricing, procurement and innovation. Summer Schools are not policy dialogues but many of the same lessons apply to their design and delivery. See: http://theobservatorysummerschool.org/</p>	<ul style="list-style-type: none"> • Define the question: policy dialogues bring evidence together for a particular group to meet a particular need. Therefore, getting the question right is imperative. A lot of work went into understanding the central Europe context and what would be useful. • Bring the right experts together: this policy dialogue involved two leading academics and experts from WHO, the European Commission and the OECD. The Observatory facilitator helped line up their different strengths and perspectives to provide the right evidence for the participants. • Create a safe space for discussion: the dialogue worked because participants could try out different ideas and ask any questions in a secure and confidential setting.

Observatory evidence product	Knowledge brokering lessons
<p><i>Walking the talk: foundation 3: Improving health information</i></p> <p>HiTs: give a clear, analytic description of how a country's health system is organized and paid for and what it delivers. They detail reform and policy initiatives and capture the challenges, which helps countries to assess what is happening in their own system and explain it to others. See: http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits</p> <p>The Health Systems and Policy Monitor: puts HiTs on-line and updates them using a network of leading national experts to capture news and policy developments. See: http://www.hspm.org/mainpage.aspx</p> <p>The Health Reform Monitor: a series of open access articles in Health Policy written by network members. See: http://www.hspm.org/hpi.aspx</p>	<ul style="list-style-type: none"> • Build in comparability: policy makers want to be able to set their national system in a European context and to learn from other countries' experiences. HiTs use the same template to ensure 'read-across' from one to another. • Address trends over time: a snap shot of what is happening is useful, but a sense of how a picture is evolving over time tells policy makers much more about the underlying issues and allows them to understand performance evaluations in context. • Update regularly: HSPM network members are an invaluable source of in-depth knowledge and are able to bring a sense of the changes taking place in real time and with real insight.
<p><i>Walking the talk: governance: managing change and innovation</i></p> <p>Governance study: This Observatory study ⁸ develops a framework for understanding governance and explores how it works in different situations and countries. It concludes that transparency, accountability, participation, integrity and capacity are the crucial aspects of health governance.</p>	<ul style="list-style-type: none"> • Offer practical tools: not all analysis leads directly to something 'applicable' but the governance study was able to extract from the literature and practice a five- point framework that will allow policy makers to 'check' the health of their system's governance and focus efforts to implement change. • Identify champions to take ideas forward: the Observatory generates evidence for policy makers but does not support policy development or implementation. The WHO Regional Office for Europe's Policy and Governance for Health and Well-being programme will make the study's evidence operational and use it with countries. • Unpack the evidence: the study is rich in detail so the research team are extracting key messages and making them available to different audiences in appropriate formats. They have launched the book, will present at conferences and publish articles to facilitate access.

Israel: Health System Review

By: Bruce Rosen, Ruth Waitzberg, Sherry Merkur

Copenhagen: World Health Organization 2015 (on behalf of the Observatory)

Pages: xxv + 212; ISSN 1817-6127

Freely available for download at:
<http://tinyurl.com/IsraelHiT2015>

The Israeli health system is considered quite efficient. At the same time reform initiatives are being taken to tackle certain problems: the benefit package is further expanded to include mental health care and dental care for children; health inequalities are reduced through a multipronged effort; national projects are set up to measure and improve the

quality of hospital care and reduce surgical waiting times, along with greater public dissemination of comparative performance data. Due to the growing reliance on private financing

with potentially deleterious effects for equity and efficiency, action is taken to expand public financing, improve the efficiency of the public system and constrain the growth of the private sector. Finally, major steps are being taken to address projected shortages of physicians and nurses.



PUBLICATIONS

Health services delivery: a concept note

By: J Tello and E Barbazza

Copenhagen: WHO Regional Office for Europe, 2015

Available for download at: <http://www.euro.who.int/en/health-topics/Health-systems/health-service-delivery/publications/2015/health-services-delivery-a-concept-note-2015>

This paper takes stock of the developments in the literature on health services delivery and lessons from the firsthand experiences of countries, viewing clarity on the performance, processes and system dynamics of health services delivery a



prerequisite for the rollout, scale-up and sustainability of reforms. Through a mixed-methods approach, evidence from existing frameworks

and tools for measuring services delivery, country case examples and commissioned papers have been reviewed around three key questions:

- what are the outcomes of health services delivery?
- How can the health services delivery function be defined? And,
- how do other health system functions enable the conditions for health services delivery?

Contents: Preface; About this document; Section 1 Performance outcomes for measuring health services delivery; Section 2 Health services delivery; Section 3 Enabling health system conditions for services delivery; Final remarks; Annex 1 Frameworks, tools and strategies reviewed; Glossary of key terms; References

European strategic directions for strengthening nursing and midwifery towards *Health 2020* goals

Copenhagen: WHO Regional Office for Europe, 2015

Available for download at: <http://www.euro.who.int/en/health-topics/Health-systems/nursing-and-midwifery/publications/2015/european-strategic-directions-for-strengthening-nursing-and-midwifery-towards-health-2020-goals>

The European strategic directions for strengthening nursing and midwifery towards *Health 2020* goals, the first such document produced in the European Region, was developed as a result of extensive collaboration with senior nurse



and midwife leaders and consultation with policy makers. The document aims to guide Member States in enabling and enhancing the

contribution of nurses and midwives to achieving the *Health 2020* goals of improving the health and well-being of populations, reducing health inequalities, strengthening public health and ensuring sustainable, people-centred health systems.

Contents: Foreword; Introduction; Health trends and challenges in the Region; Towards a new era; European strategic directions for nursing and midwifery; Implementing and monitoring the framework; References; Annex 1 Priority action areas and proposed action lines; Annex 2 Enabling mechanisms and proposed action lines.

Access to new medicines in Europe: technical review of policy initiatives and opportunities for collaboration and research

Copenhagen: WHO Regional Office for Europe, 2015

Available for download at: <http://www.euro.who.int/en/health-topics/Health-systems/health-technologies-and-medicines/publications/2015/access-to-new-medicines-in-europe-technical-review-of-policy-initiatives-and-opportunities-for-collaboration-and-research-2015>

This report, with a focus on sustainable access to new medicines, reviews policies that affect medicines throughout their lifecycle (from research and development to disinvestment), examining the current evidence base across Europe. While many



European countries have not traditionally required active priority-setting for access to medicines, appraising new

medicines using pharmacoeconomics is increasingly seen as critical in order to improve efficiency in spending while maintaining an appropriate balance between access and cost-effectiveness.

The study features findings from 27 countries and explores different ways that health authorities in European countries are dealing with high spending on new medicines, including methods such as restrictive treatment guidelines, target levels for use of generics, and limitations on the use of particularly expensive drugs. It also outlines possible policy directions and choices that may help governments to reduce high prices when introducing new drugs.



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65TH SESSION

Vilnius, Lithuania, 14–17 September 2015



Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness



Available at: <http://tinyurl.com/healthsystemstrengthening>