

*Reinhard Busse,
Sophia Schlette (eds.)*

Health Policy Developments

Issue 2: Focus on Health and Aging,
Pharmaceutical Policy and Human Resources

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Editorial

The Bertelsmann Foundation has a tradition of comparative policy research and international benchmarking. In Germany, it has established a reputation for providing advice and innovative problem-solving in the field of economic and social politics.

The International Reform Monitor (www.reformmonitor.org), initiated in 1999 and now in its sixth year, is one example of this benchmark expertise. It primarily covers social and labor market issues. An example of the Foundation's experience in comparative health system analysis is the eight-country study "Reforming the Health Sector," edited by Esche, Böcken and Butzlaff (Gütersloh 2000). The success of both projects underscored the need and the potential demand for timely and regular information on health policy issues in countries with similar socioeconomic patterns. To this end, the Foundation established a separate monitoring tool, the International Network Health Policy & Reform.

The International Network Health Policy and Reform

Since 2002, the International Network has brought together health policy experts of 16 countries from around the world to report on current health reform issues and health policy developments in their countries. Geared toward implementation, the purpose of the Network is to narrow the gap between research and policy, providing timely information on what works and what doesn't work in health policy reform.

Participating countries were chosen from a German perspective; we specifically looked at countries with relevant reform experience to enrich the debate in this country.

Partner institutions were selected taking into account their expertise in health policy and management, health economics, or public health. Our network is interdisciplinary; our experts are economists, political scientists, physicians or lawyers. Many of them have considerable experience as policy advisers, others in international comparative research.

Australia	Centre for Health Economics, Research and Evaluation (CHERE), University of Technology, Sydney
Austria	Institute for Advanced Studies (Institut für Höhere Studien; IHS), Vienna
Canada	Canadian Policy Research Networks (CPRN), Ottawa
Denmark	Institute of Public Health, Health Economics, University of Southern Denmark, Odense
Finland	STAKES, National Research and Development Center for Welfare and Health, Helsinki
France	CREDES, Centre de Recherche d'Etude et de Documentation en Economie de la Santé, Paris
Germany	Bertelsmann Stiftung, Gütersloh Department Health Care Management, Berlin University of Technology (TUB)
Japan	National Institute of Population and Social Security Research (IPSS), Tokyo
Netherlands	Institute of Health Policy and Management (iBMG), Erasmus University Rotterdam
New Zealand	Centre for Health Services, Research and Policy, University of Auckland
Republic of Korea	Seoul National University
Singapore	Department of Community, Occupational & Family Medicine, National University of Singapore (NUS)
Spain	Research Centre for Health and Economics (Centre de Recerca en Economia i Salut; CRES), University Pompeu Fabra, Barcelona
Switzerland	Until 2003: Centre for Economic Sciences (Wirtschaftswissenschaftliches Zentrum; WWZ), University of Basel From 2004: Università della Svizzera Italiana, Lugano

UK	LSE Health & Social Care, London School of Economics and Political Science (LSE)
USA	The Commonwealth Fund, New York
	Institute for Global Health (IGH), University of California Berkeley/San Francisco

Survey preparation and proceedings

Issues for reporting were determined jointly based on what the network partners identified as the most pressing issues for reform. Subsequently, the issues were arranged into clusters:

- Sustainable financing of health care systems (funding and pooling of funds, remuneration and paying providers)
- Human resources
- Quality issues
- Benefit basket and priority setting
- Access
- Responsiveness and empowerment of patients
- Political context, decentralization and public administration
- Health system organization/integration across sectors
- Long-term care
- Role of private sector
- New technology

If an issue did not fit into one of the clusters, participants could create an additional category to report the topic. To respond to the new issues that were brought up during the first round, we added three more categories for the second survey:

- Pharmaceutical policy
- Prevention
- Public health

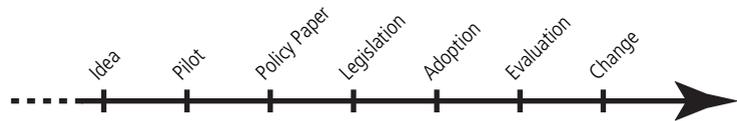
Reporting criteria

For each survey, partner institutes select up to five health policy issues according to the following criteria:

- Relevance and scope
- Impact on status quo
- Degree of innovation (based against national and international standards)
- Media coverage/public attention

For each issue, partner institutions fill out a questionnaire aimed at describing and analyzing the dynamics or processes of the idea or policy under review.¹ At the end of the questionnaire, our correspondents give their expert opinion regarding the expected outcome of the reported policy. Finally, they also rate the policy in terms of system dependency/transferability of a reform approach.

The *process stage* of a health policy development is illustrated with an arrow showing the phase(s) a reform is in. A policy paper or idea does not necessarily have to evolve step by step. Also, depending on the dynamics of discussion in a given situation, a health policy issue may well pass through several stages during the time observed:



“Idea” refers to new and newly raised approaches voiced or discussed in different fora. Idea could also mean “early stage”: any idea floating but not anywhere near formal inception.² That way, a “stock of health policy ideas-in-development” is established, permitting the observation of ideas appearing and disappearing through time and “space.”

- 1 Detailed definitions of health policy issues, criteria for selection and rating, process stages and groups of actors form part of the questionnaire included in the annex.
- 2 For the first survey, this notion was widened to capture (1) ideas that have only recently surfaced and (2) ideas that have been in the pipeline for more than six months (retrospective view). For the second survey, experts were invited to particularly look into health policy challenges related to demographic change and aging.

“Pilot” characterizes any innovation or model experiment implemented at a local or institutional level.

“Policy” means any formal written statement or policy paper short of a draft bill. Included under this heading is also a growing degree of acceptance of an idea within a relevant professional community.

“Legislation” covers all steps of the legislative process from the formal introduction of a bill/draft piece of legislation through parliamentary hearings, driving forces, the influence of professional lobbyists in the process, up to the effective enactment or rejection of the proposal.

“Adoption”: This stage is about all measures taken towards legal and professional implementation. Adoption does not necessarily result from legislation; it may also follow the evidence of best practice tried out in model or pilot projects.

“Evaluation” refers to all health policy issues scrutinized for their impact during the period observed. Any review mechanism, internal or external, mid-term or final, is reported under this heading.

“Change” may be a result of evaluation or abandonment of development.

Policy ratings

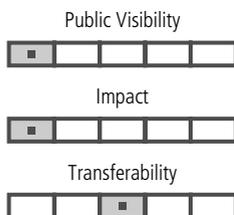
A second figure is used to give the reader an indication of the character of the policy. For this purpose, three criteria are shown: visibility, impact and transferability.

“Visibility” refers to the public awareness and discussion of the reform, e.g., demonstrated by media coverage or public hearings. The ratings range from “very low” (on the left) to “very high” (on the right).

“Impact”: Ranging from “marginal” to “fundamental,” this rating criterion illustrates the structural or systemic scope and relevance of a reform given the country’s current health care system.

“Transferability”: This rating indicates whether a reform approach could be adapted to other health care systems. Our experts assess the degree to which a policy or reform is system neutral (transferable) or strongly context dependent.

The figure below illustrates a policy that scores low on visibility and impact but medium on transferability.



Project management

The Bertelsmann Foundation's Health Program organizes and implements the half-yearly surveys. The Department of Health Care Management, Berlin University of Technology (TUB), assisted with the development of the semi-standardized questionnaire (see Annex) and produced and edited this summarizing report. We owe special thanks to Susanne Weinbrenner and Annette Zentner at the University of Technology for producing the English and German summaries respectively, to Celia Bohannon for an excellent proof-reading job and to Christina Brickenkamp for her technical and editorial support at the Bertelsmann Foundation.

The results from the second biannual survey, covering the period April to November 2003, are presented in this booklet. Out of 68 reforms reported, 39 were selected.

Reform reports from the first and second survey rounds can be looked up and researched on the network's Web site, www.healthpolicymonitor.org. Both the detailed description on the Web and this brochure draw upon the partner institution's reports and do not necessarily reflect the Bertelsmann Foundation's point of view.

Thanks of course go to all experts from our partner institutions: Rob Anderson, Toni Ashton, Mickael Bech, Wim Buiten, David Casado, Terkel Christiansen, Agnès Couffinhal, Luca Crivelli, J.K. van Dijk, Cathy Fooks, Michel Grignon, Tom van der Grinten, Marion Haas, Jane Hall, Jan-Kees Helderma, Maria M.

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Comments and suggestions on the second half-yearly report are more than welcome and can be addressed to the editors. This series will continue to evolve, change, and, as we hope, improve. That is why any input will be helpful.

Reinhard Busse

Sophia Schlette

Introduction

This second issue of “Health Policy Developments” pays special attention to three concurrent health policy topics, all of them high on health policy agendas in a variety of developed countries:

- Health and aging
- Pharmaceutical policies
- Human resources and health

While we describe current developments from the reporting period April through November 2003 in detail on our Web site, www.healthpolicymonitor.org, we chose a somewhat different approach to present the findings from the second survey in Issue 2. Criteria for selection were scope, continuity and presence in public debate during and beyond the reporting period proper. With this in mind, we looked at topics from the first and the second survey independently of their present stage of development or implementation. Some of the case studies—drawn, for example, from Germany, France, the United States, Australia and Canada—may offer test cases or model solutions for the same debates elsewhere.

Finally, in line with the Health Policy Network’s news and monitoring function, the last chapter follows up on developments reported in Issue 1/2003, particularly on funding, quality and coordination of health care services. The Newsflash also gives a brief overview of key health policy reform in our new network member country, the Republic of Korea.

The very success of increasingly large numbers of people living to a respectable seniority raises challenging questions for communities and policy makers. Throughout the world, the proportion of older people (65 years or older), and especially that of

Health and aging

the oldest old (80 years or older), is growing faster than that of any other age group. This increase results not only from prolonged life expectancy but also from decreasing fertility rates.

Aging societies face important economic and social changes that require a timely and adequate response. International organizations, governments and civil society must enact proactive aging policies and programs that enable older citizens to enhance their health, participation and security.

**LTC: Variety of
concepts and
definitions**

Some countries have concentrated on providing coverage for services needed by persons who can no longer manage their daily lives independently. Policies directed at providing and financing such services are often summarized under the term “long-term care” (LTC). However, this notion does not follow per se a common definition: In some countries, long-term care includes both nursing care and personal care. In others, LTC means nursing care only. As an umbrella term, LTC covers all age groups; that is, LTC is not just provided to the elderly, but can also reach younger people, the disabled and the chronically ill.

**Beneficiaries,
quality, eligibility,
funding**

The provision of care is also a major issue of political debate. Most societies must rely on care provided by family members or, more generally, laypersons instead of professionals.

Moreover, both eligibility for financial support and the definition of neediness are bones of contention in the current debate. Last but not least, quality deficits and poor coordination of services in and between sectors also need to be addressed.

Reforms on these issues are high on the agenda in the Netherlands, in Spain, in the United Kingdom and elsewhere. Australia has established a Ministry for the Aging and addresses the broad spectrum of policies on aging through a comprehensive strategy. This approach is still more the exception than the rule.

Regarding the financing of long-term care, countries face a choice between social insurance contributions and taxes on the funding side and between the insurance principle and means-testing on the eligibility side. Countries such as Austria and Germany have introduced insurance coverage in the last decade and are now in the process of discussing or introducing reforms of their schemes. Other countries such as Singapore, Spain, Switzerland and France are just beginning to introduce such coverage. New Zealand and the United Kingdom are discussing

the extent to which private financing should contribute to the financing of long-term care.

Pharmaceutical expenditures are rising steeply in many countries. The difficult tradeoff between health policy objectives and competitive market objectives makes any regulation of pharmaceutical markets a complex issue. Policymakers in European Union countries must also consider supranational regulation.

**Pharmaceutical
policy**

Those who seek to regulate the pharmaceutical industry must take into account an array of contradictory factors. The stimulation of production, research and development can lead to positive effects on employment and trade balance-important economic goals. On the other hand, the road to affordable health care may call for restricting certain behaviors of the industry.

Standard measures during the past years mainly comprise cost-containment policies concerning pricing, reimbursement or increased private responsibilities. Some reforms establish effectiveness criteria and/or cost-effectiveness assessment as the basis for drug pricing, as reported from Austria, Finland and France. Others feature the introduction or promotion of generic drugs, as in Finland and Spain. Information strategies addressing providers or patients constitute another pattern of reform options, as in Finland and New Zealand. Recent policy discussions have devoted greater attention to quality aspects. Thus, England created the National Institute for Clinical Excellence (NICE), and Finland established a Development Center for Drug Therapy.

**Human resources
and health**

During the past decades, while financing issues and structural health policy reform drew much attention, the health care workforce stood comparatively low on the reform agenda even though the knowledge and skills of health care professionals hold the key to delivering high-quality services in a rapidly changing health care environment. Health challenges of aging societies, quality management, integrated care and evidence-based medicine—to name just a few of the relevant issues—all require specialized training. When it comes to meeting the needs of tomorrow's health care systems, the constant adaptation of medical and nonmedical professional training, both primary and advanced, ranks among the most important health policy tasks. Governments and decision-makers have only recently begun to address these challenges.

Newsflash

The last chapter follows up on developments reported in Issue 1/2003. For instance, what has happened in France since the much-contested *Chadelat Report* was made public? What's new on discussions about portability of private health insurance in the US and in Singapore? Germany is likely to face this issue as well, as the debate about "citizens' insurance" will redefine the roles and function of private versus social health insurance systems. Legislation on quality management has also progressed. The Dutch government finally decided to mandate quality assurance throughout the health care system. In Canada, the national government followed the steps of Saskatchewan, a Canadian province that in 2002 established an independent council on health care quality. Similarly, New Zealand is introducing a participatory approach to quality improvement. A new regional cancer institute in Australia pursues an ambitious concept for cancer prevention and treatment. In the US, the burden of medical malpractice awards resonates on the political agenda and in the headlines. Also on health insurance, in October 2003 outgoing governor Gray Davis of California passed a highly visible piece of legislation requiring large employers to provide health insurance.

**New network
member: South
Korea**

Last but not least, this chapter spotlights a major reform passed a few years back in the Republic of Korea, a new member of the Health Policy Network. In 2000, more than 20 years after introducing a Bismarckian type of social health insurance provided by many small insurance societies, Korean health politicians came to the conclusion that a single payer system could do the job just as well, spreading risks more evenly, avoiding insolvencies, and increasing equity and efficiency.

Health and Aging

Long life expectancy is one of the 20th century's greatest achievements. Yet the very success of increasingly large numbers of people living to a respectable seniority raises challenging questions for communities and policy makers (cf. table 1). Throughout the world, the proportion of older people (65 years or older), and especially that of the oldest old (aged 80 or older), is growing faster than that of any other age group. This increase does not only result from prolonged life expectancy but also from decreasing fertility rates—a double effect from economic growth, improved living conditions and female education not confined to developed countries.

Table 1: Percentage of old and oldest old in population, Health Policy Network countries, 2000

Country	Persons > 65 years (x 1000)	> 65 as percentage of total population	Persons > 80 years (x 1000)	> 80 as percentage of total population
Australia	2,379	12.4	562	2.9
Austria	1,257	15.5	287	3.5
Canada	3,854	12.5	910	2.9
Denmark	791	14.8	211	4.1
Finland	772	14.9	174	3.4
France	9,466	16.1	2,206	3.7
Germany	13,523	16.4	3,011	3.7
Japan	22,043	17.4	4,856	3.8

Republic of Korea	3,395	7.2	483	1.0
The Netherlands	2,163	13.4	508	3.2
New Zealand	453	11.7	108	2.8
Spain	6,730	16.9	1,501	3.8
Switzerland	1,102	15.3	287	4.0
United Kingdom	9,295	15.9	2,362	4.0
United States	33,835	12.0	8,916	3.5

Source: OECD Health Data 2003

Aging societies face important economic and social changes that require a timely and adequate response. International organizations, governments and civil society must enact proactive aging policies and programs that enable older citizens to enhance their health, participation and security. Such policies and programs should center on the rights, needs, priorities and abilities of older people, addressed from perspectives that take the entire lifecycle into account. The World Health Organization suggests key policies in each of the following areas (www.who.int/hpr/ageing/ActiveAgeingPolicyFrame.pdf):

- Prevention of diseases and premature mortality
- Reduction of risk factors
- Continuum of high quality health care throughout the life course
- Provision of education and learning opportunities throughout the life course
- Participation of people in all areas of public and private life, according to their individual needs, preferences and capacities
- Protection, safety and dignity
- Reduction of inequities in the security rights and needs of women

To address such a broad spectrum of policy areas through a similarly comprehensive strategy, as Australia does, is still more the exception than the rule.

Other countries have concentrated on providing coverage of services for persons who can no longer independently perform the activities of daily living, i.e., those who require care for extended periods of time, often for the rest of their lives. Policies directed at providing and financing such services are often summarized under the term “long-term care” (LTC). However, this concept is not based on a common understanding of beneficiaries and coverage of services and providers:

- As an umbrella term LTC covers all age groups; that is, LTC is not just provided to the elderly, but also to reach younger people, the disabled and the chronically ill.
- The definition of long-term care varies widely. Some countries have a very broad understanding and reimbursement of LTC, subsuming personal care as well as nursing care. For others, LTC means nursing care only.
- The provision of care—place and caregiver—is also a major issue of political debate. Most societies must rely on care provided by family members or, more generally, laypersons instead of professionals.
- Eligibility for financial support often depends on the individual’s or his/her family’s ability to pay. Both financial eligibility and the definition of criteria of need for long-term care are bones of contention in the current debate.
- The quality of services provided and the coordination of services within and between sectors are often insufficient.

Long-term care

What age groups?

Which services?

Who provides care?

Who is eligible?

What is quality LTC?

From this perspective, the definition of “requiring care” and the associated criteria for LTC eligibility have become important health policy issues. Others include the institutionalization of LTC, the professionalization of care, quality standards and requirements for curriculum development, and human resources development.

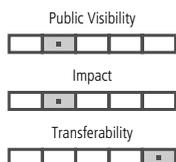
Reforms on these issues are high on the agenda in the Netherlands, in Spain, in the United Kingdom and elsewhere.

Regarding the financing of LTC, countries face a choice between social insurance contributions and taxes on the funding

side and between the insurance principle and means-testing on the eligibility side. Countries such as Austria and Germany have introduced insurance coverage in the last decade and are now in the process of discussing or introducing reforms of their schemes. Other countries such as Singapore, Spain, Switzerland and France are just beginning to introduce such coverage. New Zealand and the United Kingdom are discussing the extent to which private financing should contribute to the financing of long-term care. In the United States, expansion of Medicare coverage to prescription drugs is planned in order to reduce the private financial burden of pensioners.

Aging: Rising on the policy agenda

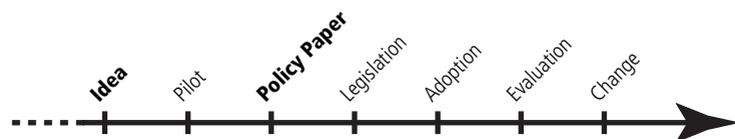
Australia: National Strategy for an Ageing Australia



The Australian social security system is regarded as a comprehensive system. However, 12 percent of the Australian population is 65 years old or older, and this proportion is projected to grow to 18 percent by 2023. More importantly, the number of those 80 years old or older is expected to double by 2023.

Ministry of Ageing

In 2001 a ministerial area of operations was created within the Department for Health and Ageing, and the first federal minister for ageing was nominated. Inspired by the Second World Assembly on Ageing, he issued a “National Strategy for an Ageing Australia.”



Joint search for solutions

Core themes of the “National Strategy for an Ageing Australia” provided a basis for community consultations, carried out to collect practical solutions and to connect to all potential stakeholders. Community consultations drew participants from a wide range of community groups, local businesses, local government and the health industry.

The “National Strategy for an Ageing Australia” report summarizes the results of the consultations, focusing on

- Retirement income
- Employment for mature age workers
- Attitude, lifestyle and community support, and
- “World class care.”

One of the key recommendations for healthy aging was that laypersons and professionals be educated about healthy lifestyles and related activities in their own communities and workplaces.

The Australian government did not formally respond to the consultation exercise. However, this initiative, a catalyst for several reviews in the residential and community aged-care sectors, laid the groundwork for state-level policy initiatives (e.g., the State Aged Care Plan in Western Australia). The consultations also stimulated joint activities among stakeholder and consumer groups.

Measures to Build Ageing Research Capacity (BARC) recently also gained momentum via two national fora. Build Ageing Research Capacity is a collaborative venture between the Australian Institute of Health and Welfare and the Office for an Ageing Australia within the Federal Department of Health and Ageing.

**Wellness,
not illness**

**Consultations as
catalyst for review
and research**

**Public research on
aging**

Sources and further reading:

www.ageing.health.gov.au/fofa/documents/pdf/nsaobook.pdf

www.health.gov.au/acc/fofa/agepolicy/index.htm

www.health.gov.au/acc/fofa/healthcare/currentsys.htm

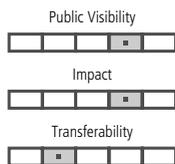
www.curtin.edu.au/health/research/cracs

www.ageingsymposium.com.au/index.html

www.health.wa.gov.au/publications

Aging: Integrated care and quality issues

The Netherlands: Compulsory health insurance (AWBZ) and long-term care

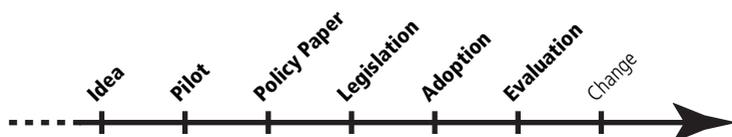


**Benefits to
fit citizens’
preferences**

In the Netherlands, long-term care is financed by the AWBZ (“Algemene Wet Bijzondere Ziektekosten”), the compulsory national health insurance scheme. Under AWBZ, long-term care services are provided as benefits in kind. Currently, a reform of the AWBZ is underway, especially as people claim services according to their preferences and needs, which means that older citizens are actively lobbying for changes in long-term care.

Care providers and providers of nursing homes search for opportunities to diversify their arrangements and politicians see a possibility of cutting collective costs. New legislation is underway, as prevailing laws and rules pose obstacles to major reform directions. The discussion addresses three different elements:

- More flexibility for claims of medical health insurance
- Separation of housing and caring; integration of health care with other relevant policy areas
- Introduction of personal budgets



More flexible purchasing arrangements are expected to increase quality of services, particularly efficiency and continuity of care. One approach comprises laws and regulations focusing on inpatient and ambulatory care for the elderly. Another seeks to overcome a division between housing and caring and to better integrate health care with other relevant policies.

**Community care
and individual
responsibility**

Implementing this strategy, the Dutch hope to improve community care and enhance responsibility of consumers. Common goals and collective funding are yet to be defined. The reform is expected to yield improved quality of care, better living and housing conditions for the elderly and more possibilities for independent living.

Finally, the reform introduces personal budgets for patients. Under this system, services are not provided in kind; rather, the insured receive a certain amount, based on need, to purchase services according to their preferences. The objectives are consumer empowerment, increased purchasing power for consumers and more consumer choices. The expectation is that care will be better adapted to the patient’s needs. The measure also aims to stimulate proper use of services, more competition between providers of care and greater efficiency.

In an inbuilt review process, changes are constantly monitored to avoid undesirable side effects, such as differences in care provided to rich and poor people.

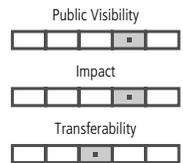
The Netherlands: Integrated care for the elderly

Despite numerous efforts to strengthen integrated care in the Netherlands, Dutch health care remains fragmented. During past decades, the idea of integrated care has evolved along the main purpose—continuity of care. Various proposals to redesign the care process sought to create a client-friendly effective workflow that fit with the overall requirements of the care process and involved aspects of curing, caring and social support.

In the 1990s, tight budget controls and capacity regulation led to waiting lists in the Dutch home care sector. After growing public pressure, private organizations were allowed to enter this market. Due to cream skinning and monopolist behavior, further entry was blocked and waiting lists again grew long.

In 2000, a ruling clarified that rationing of care is contradictory to the legal entitlement to AWBZ service benefits. Therefore, the government decided to lift the budgetary constraints, permitting reimbursement of all services needed, not just those calculated into the budget. Waiting times for home health care and nursing homes were to be halved by 2003.

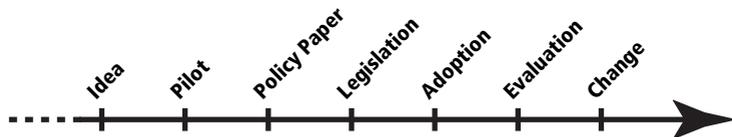
A focused integration policy exists only in long-term care for the elderly. In this area, cooperation and integration across traditional boundaries is subject to specific policies and support from government and private organizations. The Dutch government currently applies various measures to advance this policy. An



Private caregivers reduce home-care waiting lists

Integrated LTC for the elderly

interdepartmental committee oversees the endeavor; pilot projects on integrated care receive subsidies; budgets can include special arrangements or care products based on integrated care. The boundaries within the health care sector and between different sectors are increasingly permeable, thanks to new combinations and arrangements of care that involve elements from all necessary providers and sectors.

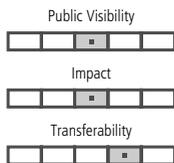


Integrated care triggering private service monopolies?

As the plan took effect and private service organizations developed, a wave of merger euphoria occurred. The Dutch Competition Authority (“Nederlandse Mededingingsautoriteit,” NMA) controls monopoly positions that are tantamount to mergers even though they were presented as integrated care. However, this regulation has not yet had an effect.

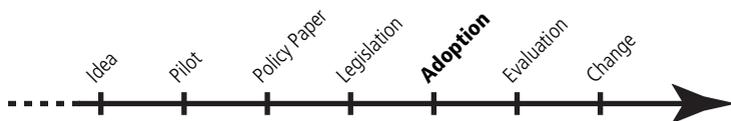
Integrated care is an incremental process; the Dutch health care system is still in the process of evaluating and improving the more detailed provisions of integrated care for the elderly.

Spain: Second plan for integrating health and social care in Castilla y León



In the autonomous region of Castilla y León, a more ambitious second plan for integrating health and social care (building on one approved in 1998) took shape when the region assumed control of its health care system in 2003. Castilla y León has some characteristics that facilitate implementation of the measures to improve integration of health and social care:

- Castilla y León has the highest share of elderly in the Spanish population (22.3 percent aged 65 or older, compared with 18 percent in Spain as a whole).
- Social service provision is more generous than in the rest of Spain.
- There is a single Ministry for Health and Social Welfare.



The plan is based on the assumption that many inefficiencies result from the lack of integration within the health care sector and between health care and social care.

**Integrating
primary care and
social services**

During the operation period of the program (2003–2007), four specific measures will be carried out:

1. In each health care/social care area, a Base Coordination Team (BCT), consisting of members from the primary care team and the social service center, will be established.
2. The BCT will develop a work methodology based on case management.
3. A shared information system allowing social and health care professionals to access each other's databases will be established.
4. Professionals of each sector will be educated in the coordination of social and health care.

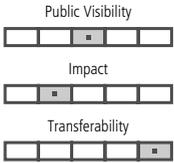
The plan, though very ambitious, does not take into account additional costs. Another challenge is the coordination of a variety of services managed at different jurisdictions. Health care is managed on a regional level, while social care is managed on a regional or local level. Not all administrations are likely to cooperate. Additionally, entitlements and financing differs: Social care is means-tested and requires co-payments, while health care is provided under a universal coverage scheme.

**Funds and
regulation
neglected**

Moreover, professional cultures and skills may not be adequate to face the specific requirements of integrated care and specialized care such as geriatrics. Some medical areas have severe personnel shortages.

Two evaluations are planned for this ambitious project, with good results expected.

England: National service framework for older people



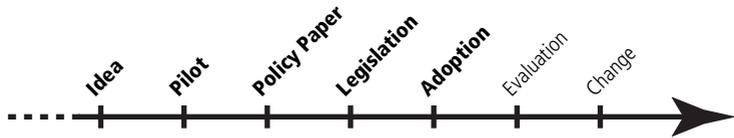
England faces enormous challenges associated with an aging population. The number of people aged 80 or over is increasing rapidly. Reports on services and cooperation have repeatedly identified poor practices and ageism. Quite obviously, the challenges of organizing health and social care and coordinating services among different sectors for this age group are particularly high.

Labour initiative against poor practice and ageism

In March 2001, the Labour government introduced a National Service Framework (NSF) to address a variety of problems. After widespread consultations with health professionals, social service professionals, older people's organizations and members of the public, the NSF was put together as part of a national management strategy. It comprises guidelines and protocols on best practice.

Conflicting policy goals: NSF vs. NHS

A major impetus for the NSF was the demand to better coordinate health and social care and improve interagency cooperation between the professions.



Implementation of the NSF has been very slow, mainly because its goals interfere with and in part contradict other goals of the National Health Service (NHS). For example, if the elderly received timely services, others would have to wait longer; hence, overall waiting times would exceed the established maximum.

On the whole, the NSF provides an example of taking a regulatory approach when service standards are lacking and quality is at stake. Guidelines and protocols on best practice are commendable, but when they interfere with other policy goals, success is jeopardized.

Sources and further reading:

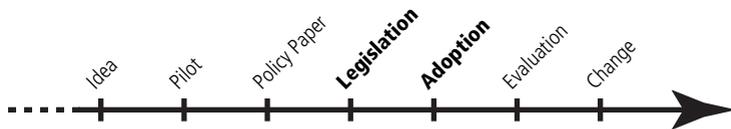
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Denmark: Free choice of provider of personal and practical help

In Denmark long-term care services are financed by the general social insurance system, which is tax-funded. Municipalities are responsible for the provision of in-kind services.

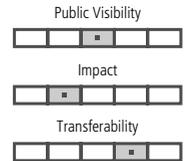
The “Law on free choice of provider of personal and practical help,” enacted in January 2003, focuses service provision on the needs of citizens. It aims to create and improve care for the elderly, based on the concepts of continuity, self-determination, dignity and respect. Furthermore, the consumer’s focus on price and quality will tend to engender and increase competition in the delivery of home care services.



The legislation took shape in a very consensual process after a change in government in 2001. It must be considered within the context of New Public Management, an approach that introduces market-type reforms (e.g., measuring performance, decentralization, introduction of private-sector management styles and focus on service and client orientation) into the social service system.

The key objectives of the new legislation embrace

- Expanding the choice of services for elderly citizens,
- Breaking the municipal monopoly in providing home care services, and
- Clarifying the responsibility of municipalities to provide services to citizens and strengthening the right of citizens to receive the care they have been granted.



Patient empowerment

The legislation requires each municipality to provide the elderly with information about private suppliers.

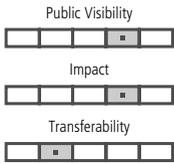
Municipalities as information brokers

Municipalities are required to secure a choice between competing providers. They can either sign contracts with private providers who agree to deliver according to a municipal price list or approve private providers for the particular purpose. These providers must meet well-defined quality criteria.

The law will be revised within two years. In this period, efficiency and quality are expected to improve.

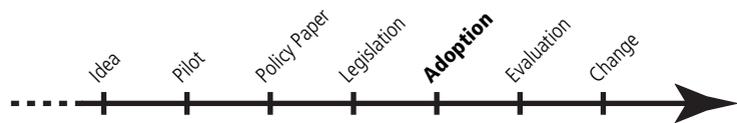
About 5,000 persons opted for a private provider in 2003. This number is estimated to rise to as much as 10,000 in 2004 (Association of Municipalities, December 2003).

Austria: Family Hospice Sabbatical



Frill or trendsetter?

The Family Hospice Sabbatical scheme is unique in Europe, but it may very well set a trend. Similar to the Austrian approach in providing long-term care benefits, the main purpose of this policy is to allocate resources—time and funds—to private households, thereby alleviating the burden on public facilities to provide acute inpatient care.



Family care for terminally ill relatives

The law enacted in July 2002 provides employees with the possibility to care for terminally ill relatives at home. Family caregivers can choose from three options:

- Uncompensated reduction of work time
- Change of work time
- Uncompensated sabbatical

People cared for can be spouses, partners, parents, grandparents, children, stepchildren, foster children, siblings, and stepparents. Options are provided for a period of three months but may be extended to six months. During this time the employee is protected against dismissal and is provided with health and pension

insurance. An employee who requests an uncompensated sabbatical has two options for gaining financial support:

- S/he may apply for financial support at the Ministry of Social Security and Generations and Consumer Protection. The so-called hardship compensation fund (“Härteausgleichsfonds”) provides up to €500/month.
- S/he may choose to apply for long-term care benefits. In urgent cases advance payments are granted within the limits of long-term care category 3 (€413 per month, corresponding to 120 hours of care per month). If long-term care benefits are already paid to this extent, category 4 is granted (€620 per month or 160 hours of care).

The program will be evaluated after two years. However, there already is some evidence that utilization of the program is low. Since its introduction only 535 persons made use of the options when 15,000 people were expected to apply. Furthermore the average length of absence was quite short—55 days instead of the possible six months in Lower Austria. The main reason for the low response rates is seen in the lack of financial compensation. The case-of-hardship compensation fund (Ministry of Social Security and Generations and Consumer Protection) effectively reimbursed €116,000 to 91 recipients in 2003.

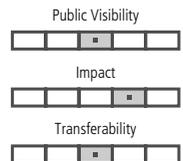
Low benefits-low utilization

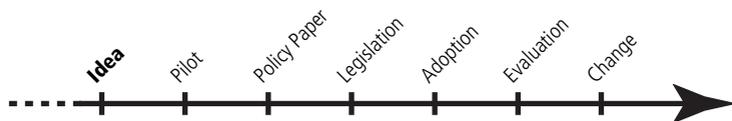
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Introduction of long-term care insurance

Spain: Toledo Agreement and LTC insurance

Spain has an even higher share of people aged 65 or older (16.9 percent), and of very old citizens (80 years or older—3.8 percent) than other European countries. The number of elderly dependents is expected to double within the next ten years.





Non-party agreement on dependency insurance

A new convention within the Toledo Agreement aiming at the introduction of reforms (e.g., for sustainable funding of the social security system) was reached in early October 2003.

The Toledo Agreement (“Pacto de Toledo”) of 1995 is a convention about public pension schemes within the Spanish social security system. It is a non-party agreement on the gradual reform of certain old-age benefits to ensure sustainable financing. With respect to dependency insurance, the Toledo Agreement does not recommend specific procedures. However, it recognizes the need for a comprehensive coverage system covering physical as well as mental disorders and an integrated approach to the delivery of health care and social care.

No comprehensive approach

Spain has yet to define a comprehensive, multidisciplinary approach to these challenges. Regional authorities provide health services on a universal coverage basis, while either municipalities or regional governments provide dependency coverage on a means-tested basis combined with co-payments.

The public system basically covers individuals with low incomes and little or no social support. Middle-income people are not eligible for public assistance although they may not be able to afford private services either. Moreover public institutions and public services are unable to provide a satisfactory number of care facilities.

All social sectors involved

Proposals to effectively address the problems of an aging population in Spain come from a variety of social sectors: academics, politicians, private institutions and foundations, medical associations, consumer associations, trade unions. All sectors of society are demanding sustainable solutions for enhanced public coverage of the needs of older citizens. Financing of public coverage will be the main challenge, possibly answered by a sound mixture of public and private commitments. Another issue is the integration of health and social care with respect to funding and supply.

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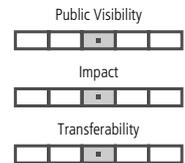
Recommendation R(98)9 of the European Council (<http://cm.coe.int/ta/rec/1998/98r9.htm>)
www.ijic.org

France: Towards long-term care reform

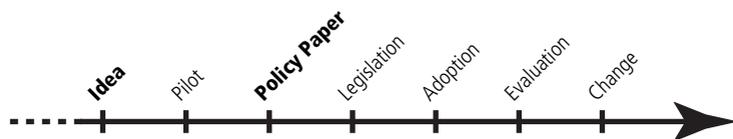
During the summer 2003 heat wave, 15,000 people died in France, many of whom were elderly people. The subsequent political crisis compelled the government to bring the issue of long-term care to the center of the political debates in the fall of 2003. A much needed and fairly consensual reform of large scope is in the process of being drawn. The organization and financing of long-term care in France are known to be very compartmentalized.

A person in need of long-term care can fall into a series of administrative categories, depending on whether s/he is physically or mentally disabled, dependent, elderly, suffering from a listed disease or in need of long-term psychiatric care. While a person can belong to more than one category at a time, there may also be gaps for certain categories of individuals. Each of these administrative categories opens a different array of rights in terms of provision or financing of care, benefits, or allowances.

The institutions involved in the provision of care are numerous, not specialized in most cases, and their coordination is notoriously insufficient. Moreover, long-term care services are paid for by various third-party payers that operate under different logics: medical care is funded through sickness funds (open-ended benefits and ear-marked contributions), while social and ancillary care is funded through social assistance budgets (fixed budget out of general revenue, sometimes locally funded).



**Fragmented
system of
assistance for
those in need**



2003: Reform proposal grants rights for those needing care

In November 2003, the Prime Minister presented the main lines of the future reform, labeled “solidarity reform for the dependent,” grouped under three headings:

- Acknowledgment of new rights. These rights are not as clearly defined for the elderly which should benefit from “better living conditions” as they are for the handicapped: the agenda clearly states that they will be compensated for the additional expenses caused by the handicap, which is new in France;
- Improved access to these rights. For the elderly, a series of measures will aim at helping them to live longer at home (tax rebates for equipment of the house, better remuneration of nursing care) and at increasing medical assistance in retirement and nursing homes (more staff, an air-conditioned room in each facility). For the handicapped, the compensation mentioned above is included in a wider reform, presented to the press by deputy minister Marie-Thérèse Boisseau at the end of January 2004, whose purpose is to update a 1975 law and to improve the integration of the handicapped in society.

Easier admission and administration

The plan foresees the creation of one-stop centers to improve access to services, decentralization of the administration of some services, simplification of the pricing of services in nursing homes at the department level.

Controversy about proposed new social security pillar

- Reshaping and consolidation of funding. The government has set to create a fifth branch of social security (in addition to health insurance, family benefits, pensions and a fourth branch which collects contributions). This aspect of the reform has so far been the only one to raise a public debate.

Pooled fund for dependency risks

This new Caisse Nationale de Solidarité pour l’Autonomie (solidarity fund for autonomy), would focus on a specific risk, dependency, and consequently would cover both the handicapped and the elderly. It would pool existing resources including the APA (Allocation Personnalisée d’Autonomie or Benefit for an

independent life), an in-kind benefit to the frail elderly created in 2002, and allocate the funds to the decentralized department-level administrations who would manage them. Additional funding would come from the abolishment of a public holiday. Serious reservations were expressed on whether such a measure would in fact raise revenues (Timbeau 2003).

Many other questions remain to be addressed. First, the status of an additional social security branch is not clear, and the split of responsibilities between that new branch and health insurance will undoubtedly be complex to draw. Second, the open-ended characteristic of this branch’s funding as well as its sustainability remain to be discussed. The financial components of the reform will be submitted to the parliament in spring 2004. In May 2004, a commissioned report will be published on the other aspects.

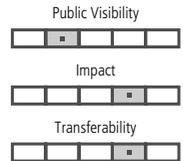
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“Une réforme de solidarité et de fraternité pour les personnes dépendantes” (Prime Minister’s Web site: www.premier-ministre.gouv.fr/fr/p.cfm?ref=41376)
 Timbeau, Xavier: “Impact de la suppression d’un jour férié.” Lettre de l’OFCE n 244, October 20, 2003 (www.ofce.sciences-po.fr/pdf/lettres/244.pdf).

Switzerland: Long-term care insurance not (yet) in sight

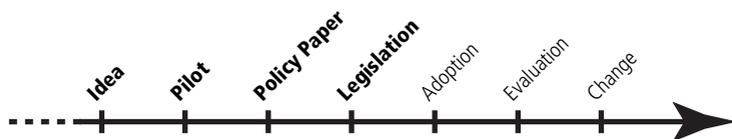
In Switzerland, three different sources finance long-term care services for the elderly: Health insurance, individuals, and taxes. In 2003, government and parliament started a debate about new financing systems for long-term care for the elderly, with emphasis on the definition and organization of new financial sources. The primary aim is to ensure sustainable and transparent financing of long-term services.

Sustainable and transparent financing systems for long-term care have been major topics of debate for quite some time. In early 2003, a new regulation following the (not yet passed) second revision of the health insurance law (KVG), changed the reimbursement of nursing care and long-term care institutions.



Despite high cost increases, no new legislation

Health insurances now must pay real costs instead of rates. This measure is expected to raise health care expenditure by about €640 million. This considerable increase thrust the issue onto the agenda again. So far, however, controversy over funding sources has blocked passage of any legislation on the financing of long-term care.



**Santésuisse
suggests
separate LTCI**

One proposal relevant to the issue of financing called for separate long-term care insurance for people older than 50 years of age. Introduced by the National Association of Health Insurance Funds (“santésuisse”), this proposal would “spin off” financing and reimbursement for long-term care from other health care insurance.

The proposal, part of the discussion around the second revision of the 1996 health insurance law, was completely rejected in December 2003. The Swiss Parliament stopped the second revision of the health insurance law and asked the government to present a new proposal on funding of LTCI within 2004.

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Reform of long-term care coverage

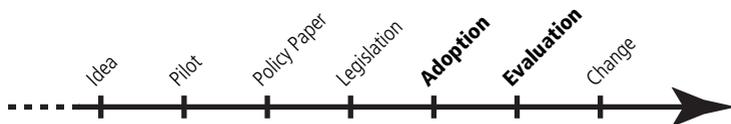
Austria: Ten years of LTC coverage

Austria was one of the first European countries to respond to the challenge of an aging society. In 1993, the Federal Law on Constant Attendance Allowance (“Bundespflegegeldgesetz,” BPGG) implemented a separate, tax-funded long-term care insurance scheme (LTCI). The amount of benefits depends on need, classified according to seven different categories of care. Over time, these categories were more clearly delineated, making it possible to target benefits more closely to needs. All persons who need long-term care are eligible, regardless of income.

At the time of implementation, all stakeholders welcomed the law as an important step to timely social policy. Primary objectives of the law are:

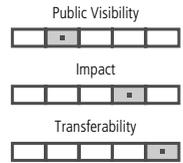
- To grant needs-based access to LTC services
- To enable people to purchase services according to their needs
- To promote independence
- To secure staying at home as long as possible

Between 1995 and 2000, employment in the health and social care sector grew at a much faster pace than the average growth over all economic sectors. Nevertheless, the shortage of caregivers remains a constant concern of institutional providers.



Since the law was passed, two evaluations took place. In a representative sample, the 2002 evaluation revealed that 90 percent of beneficiaries were very satisfied with the care delivered at home and another nine percent were satisfied.

Despite the reported satisfaction, other severe problems will have to be tackled in the near future. Real benefits have decreased, because cash benefits have not been increased or adjusted to inflation since 1995. Moreover, a recent report fueled the debate



Austrian LTCI—a model for timely social policy

Care market: a job machine

Proven high satisfaction with quality of care

Quality, benefits and funding

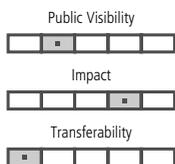
about the quality of care provided in nursing homes: An investigation in a large nursing home in Vienna revealed poor nursing practices, mainly attributed to the shortage of nurses. Other observers have raised concerns about the increase of expenditures.

Consequently, benefits should be adjusted to inflation. Also, more emphasis should be put on quality measures to achieve long-lasting benefits from LTCI for all Austrian citizens.

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Germany: Proposals to achieve financial sustainability of LTCI

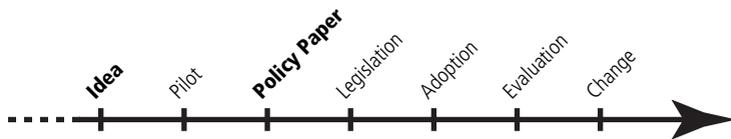


**More
commissions—
better
solutions?**

Germany introduced long-term care insurance (LTCI) in 1995 as the fifth pillar of its social security system. Since 2000, expenditures have exceeded revenue at an accelerating pace, and shortfalls are expected to increase further given the pattern of demographic change.

Following the elections, a huge financial gap in the pension fund was “discovered” in November 2002. In response, both the minister of health and social security and the opposition in parliament appointed expert commissions on sustainable funding of the German social security system.

The so-called Rürup Commission was nominated by the minister of health and social security (Social Democratic Party); the opposition in parliament (Christian Democratic Party) appointed the Herzog Commission.



Both commissions issued reports elaborating their proposals in the summer of 2003. Regarding LTCI reform, they presented similar recommendations:

- LTCI should be maintained as a social insurance financed by contributions from employers and employees.
- LTCI should continue to provide benefits up to a limited amount only.
- These upper limits should be equal regardless of whether the recipient receives ambulatory or inpatient care (thus replacing the currently higher limits for inpatient care).
- Benefits should be adjusted to inflation and changes in labor costs.
- Persons with mental disorders should qualify equally for benefits.

Both commissions suggested building a capital stock to achieve sustainable funding. The Rürup Commission proposed charging pensioners an extra contribution. The Herzog Commission, however, suggested an increased employer contribution, with employers compensated by the elimination of another public holiday. In addition the Herzog Commission wanted to extend the funding base to all types of income.

Capital stock as sustainable base for social insurance

An April 2001 ruling of the Federal Constitutional Court that called for a consideration of childrearing periods complicated the reform of the LTCI's funding base. The Court suggested that this might be achieved by reduced LTCI contribution rates, though this would further erode the funding base. Another option would exact an extra contribution from those without children, but Chancellor Schröder views this as politically difficult to sell. However, the court ruling calls for reform by the end of 2004.

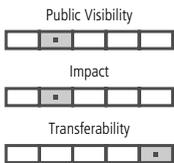
Recognition of childrearing

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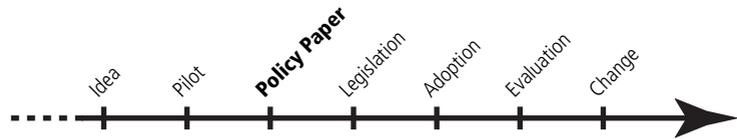
Private Financing

New Zealand: Removal of assets test for older people in long-term residential care



The proportion of elderly in New Zealand is not as high as in Europe, but the trend is heading in the same direction and expected to accelerate from 2010 on.

Currently, government subsidies for long-term residential care for New Zealand's elderly are subject to an assets test. In April 2003, the government announced its intention to remove this test by progressively increasing the threshold for assets exempted from the test.



Removal of assets test: increased equity or campaign maneuver?

The plan to remove the assets test was included in the Labour Party's election manifesto in 1999. Having won the elections, the Labour Party set the plan aside, probably because of very high cost estimates. After an internal review, the issue was put back on the agenda, but—strikingly—only to become effective just before the next elections to parliament.

Replacing one inequity with another?

By eliminating discrepancies between younger and older citizens concerning residential care, the policy aims to balance human rights issues against the substantial cost increases asso-

ciated with removing assets testing. However, the removal of asset tests will generate new differences between singles and couples.

Even though the policy may improve access to long-term care for some people, it does not address some of the inherent inequities in current funding arrangements and is seen to favor wealthier people. It also introduces a number of additional inequities into the system.

No good value for taxpayer's money

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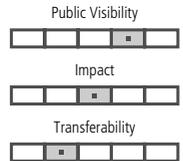
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United Kingdom: Recent reforms of policy on long-term care for elderly people

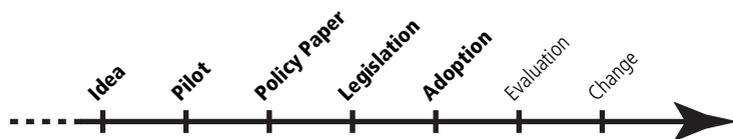
Together with Denmark and Switzerland, the United Kingdom has the highest share of citizens aged 80 years or older (4 percent). The total proportion of the population aged 65 or over is 15.9 percent.

The 1990s saw very active lobbying against the charging regime for long-term care. Under the prevailing system, assessment through the local social services department identified individuals as needing nursing home or residential care. Eligibility for financial assistance for either type of care depended on individual income and capital assets (including home equity). People with sufficiently high income were expected to pay the full fees.

Widespread criticism and corresponding media coverage in the 1990s led to the appointment of a Royal Commission on Long Term Care for the Elderly. Most of its recommendations (1998) entered the Health and Social Care Act 2001.



New charging regime not questioned



England retains inequities between physically and mentally ill

England and Scotland apply the new funding system differently. In England, eligibility for payments distinguishes between nursing care and personal care. Long-term nursing care is free of charge to users, but personal care is subject to means testing and user charges. Scotland implemented a more generous system, with personal care also free of charge.

The English approach made it necessary to define nursing care and establish procedures to assess the need for it. The program defines three levels of nursing care. Nursing homes receive payments to cover the costs of needed care.

Distinction between personal and nursing care criticized

The decision to distinguish between personal care, i.e., assistance with daily life activities, and nursing care has triggered substantial criticism. For example, people who need personal care because they have Alzheimer’s disease are heavily disadvantaged compared to people who need nursing care because they have cancer.

Affordability beats equity

The government did not fully implement the commission’s recommendations, largely because of affordability. There is little likelihood that the discussion will resume soon, even though the solution is neither fundamental nor sustainable. Indeed, increasing strains on the budget have made the situation worse.

New arrangements on monitoring and regulating quality

The Care Standards Act 2000 initiated new measures for monitoring and regulating the quality of long-term care standards. A new body for ensuring high standards, the National Care Standards Commission, was established in 2001. This body will soon merge with the Social Services Inspectorate to form a new Commission for Social Care Inspection. Its responsibilities will include inspecting care providers and social services, rating social services and reporting the results to parliament.

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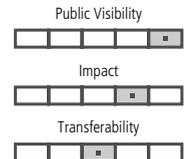
USA: Expansion of prescription drug coverage for the elderly

In November 2003, Congress passed the Medicare Modernization Act, the largest single change in Medicare since its creation in 1965.

Medicare, the federal program providing universal health care coverage for people aged 65 years or older, has not previously covered outpatient prescription drugs. The new law's main objective is the expansion of Medicare to provide drug coverage to the 40 million elderly in the United States. The age group 65 and older accounts for 14 percent of the population and for one third of drug expenditure.

Nearly 25 percent of the elderly have no drug coverage; 75 percent have at least some kind of assistance, though the extent of coverage varies broadly. In 2001, out-of-pocket spending for prescription drugs among Medicare beneficiaries was estimated to average €666 annually, with 27 percent paying more than €783.

From 2006 on, the elderly will have several options for drug coverage. These include employer-sponsored retiree plans, a stand-alone prescription drug plan and comprehensive plans that integrate enhanced Medicare Part A and B benefits for hospital and outpatient service.



25 percent of the elderly without any drug coverage

Increased privatization of Medicare

As emphasis is put on increased privatization of Medicare and increased competition in the Medicare program, another possibility consists of a private health plan. Incentives such as tax credits or reduced premiums encourage individuals to choose this type of coverage.

The full drug benefit does not take effect until 2006. To bridge the gap, from 2004 to 2006 Medicare beneficiaries may purchase a drug discount card that is projected to provide savings of about 15 percent on the price of medications.

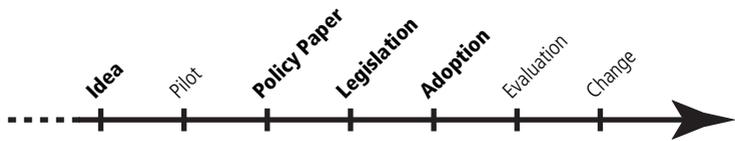
The "doughnut hole"

Under extended Medicare coverage, seniors would pay an estimated annual deductible of €196 and monthly premiums of €27. Medicare would cover 75 percent of annual drug costs between €196 and €1,762 and then provide catastrophic coverage (95 percent paid by Medicare) for drug costs above €3,994. For drug expenditures between €1,762 and €3,994—the so called doughnut hole—individuals must cover 100 percent of the cost.

Private plans, retiree plans and the new Medicare Advantage plans offer an array of different conditions with financial incentives for the supplier, the customer or both.

Low-income seniors and seniors with high drug expenditure will benefit

The legislation includes subsidies for low-income seniors, competition between traditional fee-for-service Medicare and private health plans, incentives for private health plans and employer plans, and tax-preferred health savings accounts. People with very low income or very high drug costs are expected to benefit from the reform bill. For others, the bill is more or less disappointing.



Bipartisan issue

The issue of modernizing Medicare to include a prescription drug benefit has been on the agenda for years. It is a bipartisan issue; both parties have put forth plans. Many other stakeholders such as advocacy groups for the elderly, academics, health policy experts and the pharmaceutical industry, have been involved in shaping proposals.

The plan initially proposed by President Bush, which extended

coverage only to seniors enrolled in private managed-care plans, drew harsh criticism from Republicans and Democrats alike. In response, the proposal was revised to provide catastrophic coverage under traditional Medicare.

As the bill moved through Congress, the president, congressional Democrats and Republicans, advocacy groups, health policy experts and academics and various lobbyists participated in the debate and staked out their positions. In the end, perhaps because so many stakeholders were involved, Commonwealth Fund President Karen Davis commented, “Despite [the] Medicare bill’s passage, Congress’ work [remains] unfinished.”

“Despite Medicare bill’s passage, Congress’ work unfinished”

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Pharmaceutical Policies

Pharmaceutical expenditures are rising steeply in many countries. The delicate tradeoff between health policy objectives and competitive market objectives makes any regulation of pharmaceutical markets a complex issue. Policymakers in European Union countries must also consider and comply with supranational regulation.

Those who seek to regulate the pharmaceutical industry must take into account an array of contradictory factors. On the one hand, the stimulation of production, research and development can lead to positive effects on employment and trade balance-important economic goals. On the other hand, the road to affordable health care may call for measures that restrict certain behaviors of the industry.

Economic versus health goals

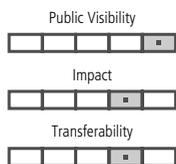
Standard measures during the past years mainly comprise cost-containment policies concerning pricing, reimbursement or increased private responsibilities.

Policy options for drug pricing

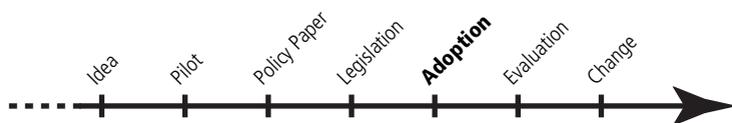
Some reforms establish effectiveness criteria and/or cost-effectiveness assessment as the basis for drug pricing, as reported from Austria, Finland and France. Others feature the introduction or promotion of generic drugs, as in Finland and Spain. Information strategies addressing providers or patients constitute another pattern of reform options, as in Finland and New Zealand. Recent policy discussions have devoted greater attention to quality aspects. Thus, England created the National Institute for Clinical Excellence (NICE) and Finland established a Development Center for Drug Therapy.

However, any given pharmaceutical policy reform can be rated only against the background of the other health policy tools in use.

France: Lower reimbursement rates and delisting of pharmaceuticals



France presents an interesting example of the dichotomy in pharmaceutical policy. On the one hand, the French government is seeking to contain costs; public expenditure on pharmaceuticals, as a percentage of total public expenditure on health care, has increased by more than 5 percentage points in recent years. On the other hand, the government is also trying to stimulate the industry (see next item).



1999 reimbursement scheme

The current French reimbursement plan was introduced in 1999, when the Ministry of Health (MoH) decreed that pharmaceuticals were to be reimbursed according to their medical effectiveness (Service Médical Rendu, SMR). The major aim was to establish an objective basis for the classification and reimbursement of pharmaceuticals.

Criteria for the SMR classification:

- Effectiveness and possible side effects
- Therapeutic value compared with alternative therapies
- Severity and duration of illness
- Curative, preventive or symptomatic characteristics
- Public health aspects.

Three groups of reimbursable drugs

The evaluation process categorizes pharmaceuticals into four categories, three of which qualify for reimbursement:

- Category A is reserved for essential or particularly expensive drugs used to treat severe conditions, for instance AIDS or diabetes, with important or major SMR. These drugs are fully reimbursed by the sickness funds.
- Category B comprises other drugs with important or major SMR (e.g., antibiotics); 65 percent of the cost is reimbursed.
- Category C comprises drugs with moderate or low SMR; the

reimbursement rate is 35 percent. Most drugs belong to this category.

- The remainder, drugs with an insufficient SMR, is not reimbursed; the patient or the patient's supplemental insurance pays the full cost.

The "Commission de Transparence," a commission of physicians, pharmacists, members of the health insurance association and representatives from the pharmaceutical industry, issues recommendations based on this classification. Between 1999 and 2001, the commission evaluated all of the 4,200 listed pharmaceuticals with respect to each possible indication. Based on its findings, the commission recommended reducing the reimbursement for 840 drugs from 65 percent to 35 percent and excluding another 835 drugs from the list of reimbursable drugs altogether. Until 2003, however, only a few drugs were actually delisted or moved to a lower reimbursement category.

Evaluations to little effect

In April 2003, the MoH implemented a new system, reducing the reimbursement rates for 617 drugs. Pharmaceutical companies raised an outcry, criticizing the criteria for reimbursement and reevaluation of the drugs and accusing the "Commission de Transparence" of inconsistency. Taking their case to court, on the grounds of breach of procedural rules and insufficient justification for reducing the rate, some of the affected companies won rulings that reversed the decreased reimbursement for 12 drugs.

Drug companies fight further reimbursement cuts

Some scientists criticize the SMR criteria as too narrow in scope. They argue that the criteria should consider not just efficacy, but also benefit-risk-ratios, social dimensions and equity aspects. Furthermore they argue that the consequences of this policy have not been evaluated.

Delisting criteria lack equity dimension

In response to these criticisms, the MoH decided to implement the delisting in three waves spread out over three years. In the first wave, 84 drugs were delisted in summer 2003. The MoH also reorganized the "Commission de Transparence" in September 2003, changing the composition of its membership.

MoH speeds up delisting in response to critics

**Drug price reform
with reverse
effects**

The reform will probably lead to cost increases, at least for the patients. While supplementary insurance usually covers the difference for drugs with lower reimbursement rates, delisted products will have to be paid entirely out of pocket. Physicians who stop prescribing the delisted drugs may shift to more expensive alternatives. Whether the overall effect on health care expenditures will be a decrease is therefore difficult to estimate.

**More private
insurance claims**

Smaller companies fear reduced profits and argue that jobs are at stake. Insurance companies offering supplementary insurance anticipate a steep rise in the number of claims.

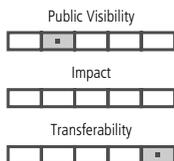
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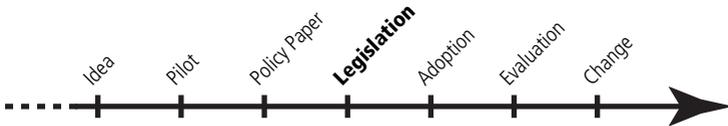
France: Liberalization of prices for innovative medicines



As of 2003, new innovative drugs are excluded from price negotiations between manufacturers and public institutions if they show an added value over drugs already on the market. The "Commission de Transparence" makes this determination according to the drug's ASMR (Amélioration du Service Médical Rendu, additional medical service rendered) classification. The purpose of the reform was to remove barriers to the development of new drugs and to facilitate access to new products.

From 1994 to 2003, prices for all pharmaceuticals were negotiated between the manufacturers' LEEM (Les Entreprises de Médicament) and the CEPS (Comité économique des produits de santé), the economic committee on health products. Negotiations were based on a medical assessment of the drug (by the "Commission de Transparence" according to the six-tiered ASMR system) and on expected sales, research and marketing costs as well as available funds.

New products excluded from price negotiations



The bill on liberalization of prices sought to exclude from this negotiation process those pharmaceuticals demonstrated to have a major added medical value. These drugs were to be defined by ministerial order according to the ASMR determined by the "Commission de Transparence." After intensive industry lobbying, the definition of the drugs in question was made part of the negotiations between CEPS and LEEM. CEPS merely retains the right to veto the price in the weeks after the drug is introduced to the market.

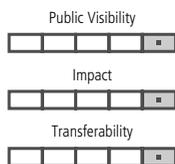
Intransparent negotiation process

The only independent journal on pharmaceuticals in France, "Prescrire," has accused the "Commission de Transparence" of inconsistent decisions. Furthermore, the French Court of Account strongly criticized the negotiation process for lack of transparency and inability to regulate the pharmaceutical market. CEPS was suspected of favoring industry goals over health policy goals.

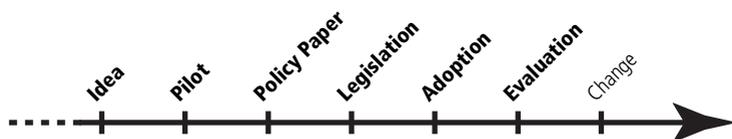
As a result of the reform on liberalization of prices for innovative drugs, pharmaceutical companies can define prices for new innovative drugs without negotiation through public institutions. Such a policy is completely new to France. The primary aim was to advance the development and market entry of innovative medications and to accelerate patients' access to such drugs. Whether this policy will effectively promote the development of innovative products and speed access to these drugs remains to be seen.

New product prices no longer negotiated

England and Wales: Health technology assessment and the National Institute for Clinical Excellence



In 2003, the WHO Regional Office for Europe reviewed the NICE Technical Appraisal Programme. It concluded that, “NICE (the National Institute for Clinical Excellence) has developed a well-deserved reputation for innovation and methodological developments that represent an important model for technology appraisals internationally.” On the other hand, the WHO experts criticized the close relationship between NICE and the pharmaceutical industry. They recommend excluding physicians employed by pharmaceutical companies from assessment boards and involving them by way of separate consultation procedures instead.



Post code prescribing

NICE was established in 1999 as an official health authority for England and Wales. It may be viewed as a response to variations in the quality of care offered by the National Health Service (NHS) and to rising costs caused by the introduction of new technologies and medicines. Its main role is to produce and disseminate clinical guidelines based on evidence of clinical and cost effectiveness.

The overall strategy was set out in the NHS Plan, which established National Service Frameworks and the Commission for Health Care Inspection as important national initiatives alongside NICE.

Guidelines for primary care trusts

Since 2001, NHS organizations must follow NICE recommendations that the secretary of state for health has approved. The main organizations expected to respond to NICE guidelines are primary care trusts, which have the responsibility for deciding whether particular treatments will be funded through the local NHS.

Of the 62 technologies assessed by NICE in the first four years of its operations, the majority have dealt with pharmaceuticals. To

keep products eligible for reimbursement, the pharmaceutical industry provides comprehensive studies on efficacy and cost-effectiveness. Some concerns currently center on the confidentiality of pharmaceutical industry evidence, which sits uneasily with the desired transparency of the NICE appraisal process.

**Focus on drugs
assessment**

Also actively lobbying are associations representing people with special illnesses, who may be particularly affected by NICE recommendations. For example, people with multiple sclerosis may not be covered for interferon therapy. Critics point out that NICE, essentially a scientific committee, failed to take the social context of recommendations into account as much as necessary. Meanwhile, an advisory group comprising members of the public has been established.

**Social context
neglected**

Some problems may arise. The requirement to fund positive NICE decisions may distort priorities; even more effective treatments (not assessed by NICE) may be displaced to fund treatments it has assessed.

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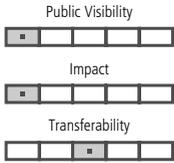
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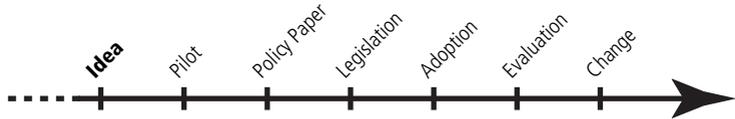
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Denmark: Emphasis on economic evaluation of new pharmaceuticals



In recent years, drug prices in Denmark have been higher than the European average. From 2001 to 2002, the pharmaceutical expenditure of Denmark’s National Health Service again increased by about 14.2 percent.



Economic evaluation of new pharmaceuticals

As a consequence, early in 2003 the chairman of the Health Committee of the Association of Counties proposed to limit further price increases, particularly for new pharmaceutical products with only marginal improvement. To do this, the National Board of Health (“Laegemiddelstyrelsen”) would give greater weight to economic evaluation when deciding on reimbursability.

Regional drug budgets

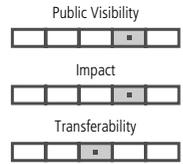
Health care budgets in Denmark are managed by the counties. The Association of Counties negotiates the budgets with the national government in an annual process—a high-pressure undertaking, because health care accounts for two thirds of the total budget. Therefore, this proposal wins support from leading politicians, the counties and the government. Patients appreciate the potential improvement in the quality of reimbursable drugs but may fear restricted access to innovative products. The pharmaceutical companies may fear loss of profit.

Since 2002, reimbursement of pharmaceuticals through health authorities has varied according to the patient’s annual expenditures on drugs. The percentage reimbursed increases gradually with the amount spent on pharmaceuticals. Some population groups (e.g., the terminally ill) receive their medication at no cost.

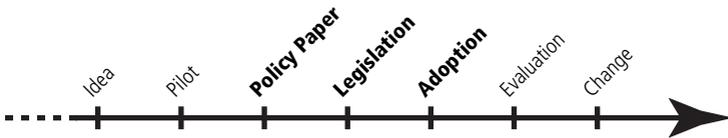
Austria: Criteria for reimbursable drugs and promotion of generics

During the 1990s, the cost of pharmaceuticals in Austria rose by an average of 7 to 9 percent annually. Three main factors drove the increase: an aging society, pharmaceutical innovations and a biased authorization process under which “chief physicians” employed by the sickness funds approved new, expensive drugs. The latter alone accounted for 64 percent of the increase.

The new pharmaceutical policy is part of the more comprehensive Austrian Health Reform 2003/2004, which took effect on January 1, 2004.



New pharmaceutical policy



It consists of two major procedures: a new classification and pricing procedure for reimbursable drugs and a campaign to encourage the prescription of generics. A newly established pharmaceutical evaluation commission, whose 20 members represent the social insurance system and the scientific community, will oversee the drug classification procedure. Guidelines for the evaluation process are to be established in March 2004.

Pharmaceuticals are now classified according to three “boxes” named after the traffic light colors.

Three classification boxes

All new pharmaceuticals start out in the Red Box, where they undergo a timed evaluation procedure before being assigned to the other boxes. As long as they are in the Red Box, the Austrian Social Insurance must authorize their use and the prescription volume is controlled. Prices of these new pharmaceuticals may not exceed the European average price. After being assessed, the drugs move to the Yellow Box or the Green Box.

The Yellow Box contains drugs for specific indications or patient groups. These drugs must have an essential additional therapeutic effect. The yellow-box drugs are also subject to authorization and quantity control through the Austrian Social Insurance. (In the past, patients had to apply to a “chief physician” employed

by the sickness fund for authorization of innovative or expensive drugs assigned to the Red Box or the Yellow Box.)

Finally, the Green Box contains all drugs that are freely prescribable. Thus, it replaces the former “Heilmittelverzeichnis.” Pharmaceuticals not assigned to one of the three boxes are not reimbursable. Within the Green Box, prices are regulated according to four criteria:

- Prices for brand products are reduced by 30 percent when patent protection expires.
- Prices for the first generic must be at least 25 percent lower than the (off-patent) brand product.
- Prices for other generics must be reduced further.
- If there is no generic, the Federation of Austrian Social Security Institutions may announce the pharmacologic active ingredient.

**Use of generics
encouraged**

Because the share of generics from the Austrian pharmaceutical market is rather small compared to the European average, the policy includes some measures to foster the use of generic drugs.

- It increased (from 10 to 15 percent to 25 percent) the difference between the price of brand products and generic products.
- It increased the difference between the prices of brand products and generic products by reducing the price of brand products about 30 percent and of the first available generic product about 45 percent as soon as they are accepted for the Green Box.
- It reduced the prescription charges for generics (from €4.25 to €2.82 per package).

Nevertheless, sales tax (savings of about €20 million), decrease of wholesale margin (savings of about €20 million), decrease of pharmacy markup (savings of about €21 million) and industry rebates and fees (another €24 million) are expected to have the main cost-curbing effects. If the overall policy is successful, the increment in pharmaceutical expenditure is expected to decrease to 3 to 4 percent annually and the share of generic prescription is expected to increase to 20 percent.

The Austrian pharmaceutical reform is based on a broadly based consensus among the Ministry of Health and Women, the

Federation of Austrian Social Security Institutions, economic associations, the pharmaceutical association and wholesalers. The Medical Association also supported the reform.

The Austrian Generic Association criticizes the measures as too weak to achieve the goal of 20 percent market share. The Federation of Austrian Social Security Institutions demands a reduction of the value-added tax for pharmaceuticals.

Overall, probably due to the broadly based negotiation process, the policy seems rather balanced and beyond controversy.

Consensual negotiations beyond controversy

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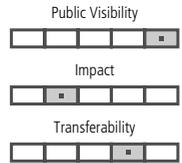
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Finland: Generic substitution of prescription drugs

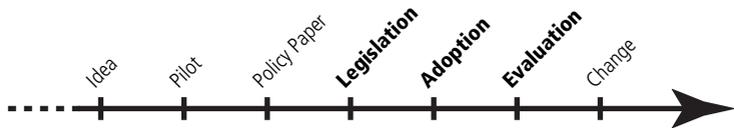
In Finland, as in other countries, expenditure on pharmaceuticals has been the fastest growing item, rising by 10-12 percent annually during the past decade. Previous legislation concerning the advancement of generic drugs had only a marginal effect; just 3 percent of prescribed drugs were generics.

As of April 2003, pharmacies in Finland must replace prescription drugs with a product whose price differs by no more than €2 to 3 from the price of the cheapest drug of the same active agent category. The 1900 drugs subject to this requirement are specified in a list issued by the Social Insurance Institution, which manages the National Health Insurance. Substitution can be refused either by physicians (for medical reasons) or by patients (for any reason).

Despite protests from pharmaceutical companies, pharmacists, physicians and some consumer associations, the law was passed nearly unmodified in December 2002.



Sweeping measures to cap drug prices



Generic substitution: Savings beyond expectations

This policy has met with unexpected success. According to a preliminary analysis, the savings during the first year were nearly twice as high as estimated. Reduced co-payments for patients made up 44 percent of the total savings, while the Social Insurance Institution saved 56 percent due to reduced reimbursement costs. More than two thirds of these savings can be attributed to the remarkable decrease in manufacturers' prices since the reform was introduced.

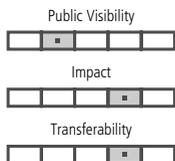
The reform affected the pharmaceutical industry, particularly the only Finnish manufacturer specializing in the production of relatively expensive brand-name drugs whose patents have expired. Consequently, the pharmaceutical industry may shift its focus to the production of patent-protected drugs. Up to now, prices for these drugs have risen only slightly.

High acceptance of generics

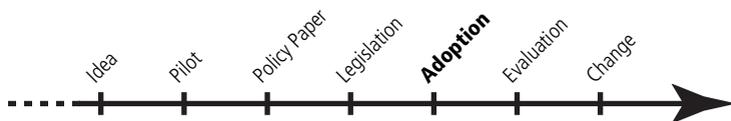
Amazingly, physicians refused substitution only in very rare cases (0.4 percent). In 70 percent of all prescriptions, they specified products whose prices were already satisfactorily low. On average, 89 percent of patients also accepted the low-price products, probably because their co-payments depend on the price of the pharmaceutical.

On the whole, the experiences are quite similar to those in Sweden, whose policies served as a model for the Finnish reform.

Finland: New Development Center for Drug Therapy



Different reports and various government commissions in Finland have called for another important tool to reduce pharmaceutical expenditure: an independent drug information system for physicians. In response, a new government agency, the Development Center for Drug Therapy, was established in July 2003.



The agency supersedes a preliminary program known as ROHTO (“Rationaalinen lääkehoito,” rational pharmacotherapy), which actually had the same goals. The main objective is to promote rational drug use in Finland by influencing the prescribing behavior of physicians. The agency provides independent education and information concerning drug therapies as well as feedback to physicians and health care units about prescription patterns.

Improving prescription through independent information

The program relies on information, education and communication (IEC): education in small groups, problem-based learning, extensive information activities and national support measures, procedures proven effective through an evaluation of ROHTO. The practical implementation of treatment guidelines and other evidence-based knowledge is a realistic goal for the agency’s education and information activities.

Effective IEC tools

The agency will coordinate activities within a network of providers and public institutions. Its key tool for training activities is collaboration with local contact persons in hospital districts, as the success of the reform depends on support from the main stakeholders.

Information network

One supportive stakeholder is Duodecim, the Finnish Medical Society, whose objectives include reinforcing the knowledge base physicians need in their medical practices, for example by promoting continuing education for physicians.

To ensure independence from the pharmaceutical industry, the Ministry of Social Affairs and Health provides funding for the Development Center. The ministry will also supervise and set targets for the operation of the agency. In addition, an advisory board representing relevant stakeholders will be formed to guide the work of the agency.

Independence from industry

On the whole, the political process has been quite quick and consensual, with almost no changes made to the draft bill. Even the pharmaceutical industry merely expressed concerns that the Center may focus solely on cost containment.

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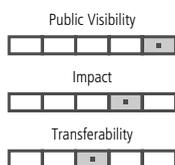
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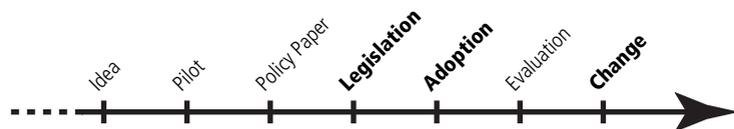
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Spain: Reference pricing system for generic medicines: update and extension



In response to mounting pharmaceutical expenditures (+11 per cent in 2003), Spain is radically altering its reference pricing system.



The reform of the reference pricing system must be assessed in the context of two important political goals. First, regarding pharmaceutical policy, it may be regarded as an attempt of the national government to gain back powers previously devolved to the regions under the Cohesion and Quality Act. Furthermore, the goal of realizing a 20-percent economization is situated in the context of upcoming regional and national elections. Probably due to the latter, the reform has been pushed through with very little consultation and discussion.

**Recentralization
politics and
elections as
drivers?**

**New reference
prices based on
lowest treatment
costs**

For the last three years, a reference price system has been in place that covers all pharmaceutical products without patent protection. The system is based on groups of pharmaceuticals with the same active agent. The reference price was calculated on the annually weighted average of the lowest priced products accounting for at least 20 percent of the market sales.

Spain has now introduced a variety of measures to curb pharmaceutical expenditure:

As of May 2003, criteria for the classification in particular groups of pharmaceuticals extend to all pharmaceutical preparations and dose rates. Reference prices are calculated on the basis of the three lowest treatment costs per day according to the WHO Daily Defined Dosis classification.

Since October 2003, if the price of a prescribed drug exceeds the reference price, the pharmacist must substitute the least expensive generic equivalent. If no less expensive generic drug is available, the prescribed drug must be delivered at the reference price. Generics cannot cost more than the average price.

The program offers physicians no incentives for cost-conscious prescription of drugs. In addition, the newly implemented measures may, in effect, cut prices instead of setting incentives for an autonomous regulation of prices.

Initially, the Spanish Economic and Social Council (CES) supported the reference price policy. However, these experts now raise concerns about the likelihood of adverse effects. They criticize the heterogeneous medication groups, arguing that this may favor high-dosage pharmaceutical preparations. Furthermore, they express concerns about supply problems, claiming that the reference price may be based on pharmaceuticals that are registered but possibly not available on the market.

Spanish manufacturers of generic drugs also fear that the reform may prevent them from investing in new off-patent products. Compared with brand products, they will not have sufficient leeway to compete with the big pharmaceutical corporate groups.

The expected savings for most of the pharmaceuticals range from 20 to 80 percent. As the reform affects only 20 percent of the drugs registered in Spain, the overall impact is not expected to be very high, especially as the reform excludes the main cost driver, the patent-protected drugs.

Substitution according to reference price

Experts worry about adverse reactions

Limited effect on expenditure—main cost driver excluded

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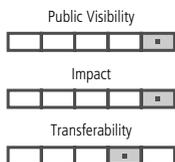
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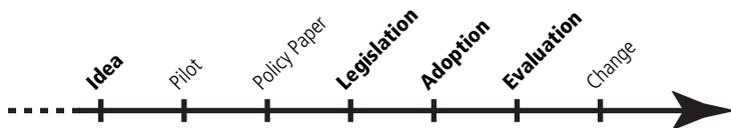
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Republic of Korea: Separation of drug prescribing and dispensing



Until the year 2000, physicians as well as pharmacists in South Korea could prescribe and dispense drugs. Both professions were inclined to prescribe and deliver large amounts of pharmaceuticals and expensive drugs, as they purchase drugs at much lower prices than the reimbursement prices. This contributed to a considerable part of their income and thereby maximized their profits. It also increased the public expenditure on pharmaceuticals and created a serious potential for drug misuse.



In 1998 a change in government opened a window of opportunity to realize this long-overdue reform of the South Korean health care system. Upon an initiative of progressive academics, the scientific community and to some extent civic groups, the government tackled the problem of separating the prescription of drugs from the dispensing of drugs.

Against the massive resistance of physicians and the much weaker opposition of pharmacists, the reform went through. Widespread strikes by physicians forced the government to amend the draft (e.g., by dropping measures promoting prescription of generics). As a result, the reform is expected to lead physicians to prescribe high-quality expensive drugs, thus reducing the potential savings.

Policy change:
Unique chance for cutting expenditure and drug misuse

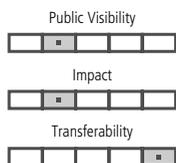
No generic prescription

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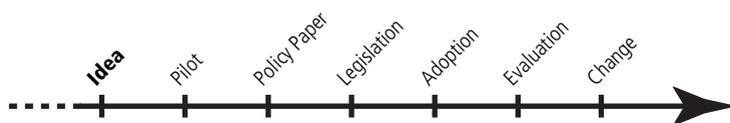
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New Zealand: Direct-to-consumer advertising of prescription medicines



In February 2003, a group of leading general practitioners prepared a report on direct-to-consumer advertising (DTCA) and presented it to the government. The flash point: Patients increasingly pressured their physicians to prescribe so-called “life-style pharmaceuticals,” such as drugs against obesity or male impotence. Data show that expenditure on these drugs has increased quite significantly.



However, there is little likelihood that this report will trigger any relevant response. When the DTCA policy was reviewed in 2000/2001, public consultations showed a slight majority in favor of DTCA. Therefore the government did not modify its policy. Instead, it encouraged the pharmaceutical industry to strengthen its rules and Code of Practice.

Except for the US, New Zealand is the only country in the world allowing direct-to-consumer advertising of prescription medicines. The European Parliament recently rejected a proposal that would have paved the way for DTCA in Europe.

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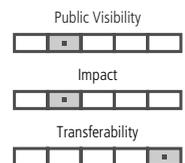
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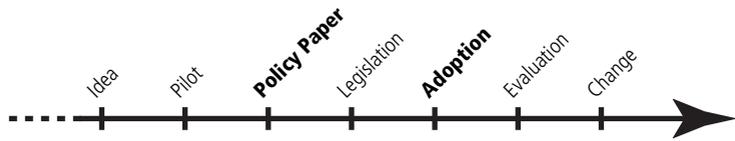
Human Resources for Health

The past decades have brought dramatic changes to health care systems in developed countries. Financing issues and structural health policy reform drew much attention. Meanwhile, the health workforce stood comparatively low on the reform agenda, even though the knowledge and skills of health care professionals are key to delivering high-quality services in a rapidly changing health care environment and crucial to implementing reform. Health challenges of aging societies, quality management, integrated care and evidence-based medicine—to name just a few of the relevant issues—all require specialized training. To meet the needs of tomorrow’s health care systems, the constant adaptation of medical and nonmedical professional training, both primary and advanced, ranks among the most important health policy tasks. Governments and decision-makers have only recently begun to address these challenges.

Australia: Policy responses to chronic and acute shortages in the nursing workforce

A shortage of nurses is apparent in all areas of the Australian health care system. In areas such as care for the elderly and mental health care, this shortage is particularly critical. An inquiry initiated by the Senate in 2002 yielded a comprehensive report on the key deficits along with recommendations on how to overcome them.





**Re-Connect:
Introducing adult
learning concepts**

Compared with traditional refresher courses, the New South Wales (NSW) Nursing Re-Connect strategy is innovative and well adapted to modern adult learning concepts. Each participant studies at a pace suited to his/her own professional background. Re-Connect aims to encourage nurses currently not working in the profession to return to the nursing workforce, thereby improving quality of care and access.

**Incentives and
retention
strategies**

Nurses quit their jobs for a variety of reasons: poor pay, inflexible working conditions, violence against nurses, mediocre professional image, family responsibilities and desire to retrain. Though strategies to “retain” are more likely to succeed than strategies to “recruit” for reentry, any strategy should address all these issues, as outlined in the Senate’s report.

The Re-Connect program provides refresher courses free of charge. It also offers fringe benefits such as increased payment, scholarships for postgraduate education and funding for continuing education. The support from health services, academic institutions and professional bodies that underpins the Re-Connect program is equally important to keep nurses from leaving their jobs.

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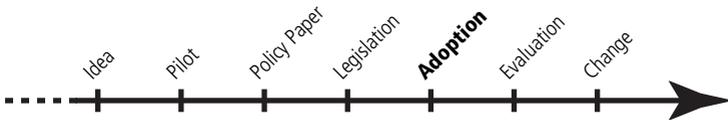
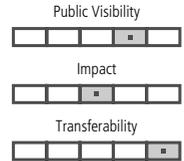
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Doiron, D. and G. Jones. “NSW Nursing Workforce Transitions.” Paper presented to the 25th Conference of the Australian Health Economics Society, Canberra, October 2003 (www.nsw.health.gov.au/nursing/refresher.html).

California: First-in-nation rules on nurse-to-patient ratios

In 2002, the Joint Commission on Accreditation of Health Care Organizations came to the conclusion that nearly one quarter of unanticipated incidents resulting in death or injury of patients are due to nursing shortage.

California's implementation of nurse-to-patient ratio rules—the first in the nation—marks an end to a lengthy administrative process. In 1999, based on concerns about working conditions for nurses, the quality of care patients receive and patients' safety, the California Association of Nurses drafted legislation on nurse-to-patient ratios that was signed into law that same year. It took three more years for the California Department of Health Services to release regulations and guidelines for implementation.



The new rules stipulate that starting in January 2004, all general wards in California must provide a ratio of one nurse for every six patients. That ratio must decrease to one nurse for every five patients in January 2005. The rules also set a deadline of January 2008. Additionally, a deadline is set for increasing the number of nurses in specialized health care units. These mandated ratios are expected to have a significant impact on:

- Improving working conditions for nurses, by keeping the number of patients manageable;
- Improving patients' safety, by allowing nurses to pay more attention to the individual patient; and on
- Increasing hospital costs, by forcing hospitals to increase their staffing.

Better nursing ratios—improved patient safety

Although the rules are regarded as a clear-cut victory for labor unions representing nurses, the unions themselves are divided on the details. The Service Employees International Union recommends different ratios (1:4) but also different qualification standards (not just registered nurses).

Victory for nursing unions

Kaiser Permanente, the largest health maintenance organization in California, is one of the few hospital systems backing the law.

The California HealthCare Association is very concerned about the costs (€337 to €794 million), especially because California already anticipates tremendous additional expenditures (about €11 billion) to care for the state's uninsured.

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 Institute of Medicine: "To Err is Human: Building a Better Health Care System." November 1999.

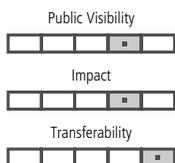
The Netherlands: Coping with prospective shortages in the medical workforce

The Netherlands is taking steps to forestall an anticipated shortage in several medical professions. A prognosis from 2002 estimates a deficit of nurses at about 10 percent in 2007 and a shortfall of general practitioners at about 11 percent in 2012. The estimated shortfalls for medical specialists range from 1 to 29 percent, depending on the specialization.

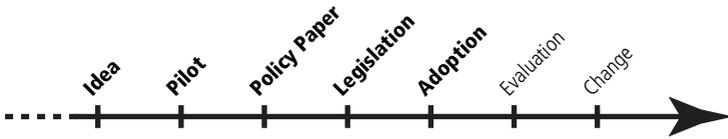
New professions to safeguard against personnel shortages

In an effort to address the imminent shortages by reorganizing and reallocating professional tasks, the Netherlands has undertaken initiatives to introduce two new professions: physician assistants and nurse practitioners.

Physician assistants



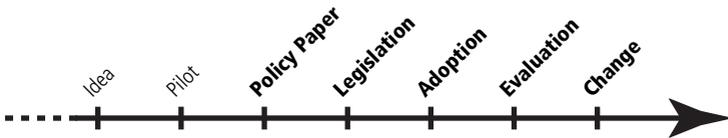
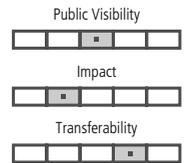
The model for physician assistants was imported and adapted from the US, where these professionals typically work under the supervision of physicians and have a broad scope of responsibilities governed by their individual work setting.



Two Dutch universities started pilot training projects for physician assistants: Utrecht in 2001 and Arnhem/Nijmegen in 2002.

Nurse practitioners

The profession of nurse practitioner, as adopted in the Netherlands, is based on developments in the United Kingdom and the US. Nurse practitioners can take on responsibilities and tasks formerly allocated to physicians, thereby helping to bridge the shortage of physicians.

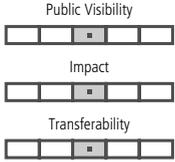


Nurse practitioners have enhanced responsibilities and tasks. Following an approach quite similar to Australia's Re-Connect strategy, the Dutch health planners expect to make this profession more attractive by offering new career opportunities and incentives.

**New incentives
for nurses**

In addition, the plans call for harmonizing all nurse-training programs nationwide.

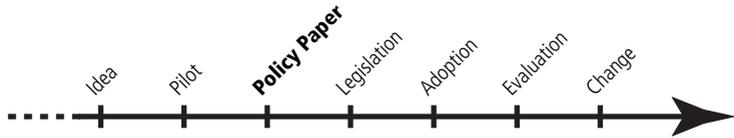
New Zealand: Workforce development



Health Workforce Advisory Committee

In New Zealand, too, the government has recently come to consider leadership in health human resources development a priority, recognizing emerging shortages in this field. Earlier efforts in health workforce planning had been abandoned in the 1990s in line with the government's more market-oriented approach to the economy in general.

In late 2000, New Zealand's Minister of Health established the Health Workforce Advisory Committee (HWAC) to evaluate national goals for the health care workforce and to recommend strategies for appropriate capacity development. The committee consists of ten members nominated by professional or consumer groups and then appointed by the minister.



Two reports published by the committee as discussion documents for public meetings identified the following issues as critical:

- Adaptation of workforce planning to the Primary Health Care Strategy (cf. HPD 1/2003)
- Education through lifelong learning for the workforce
- Building an adequate minority health workforce capacity (Maori, Pacific People)
- Building workforce capacity for the disability sector.

From disciplinary silo to interdisciplinary development

The HWAC departs from the traditionally narrow approach of the nursing profession to take a wider, more system-oriented view. The impact of the committee's recommendations remains to be seen.

Sources and further reading:

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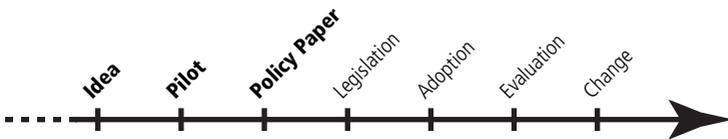
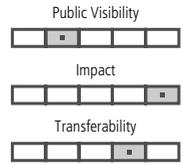
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Canada: A co-coordinated and comprehensive approach to health human resource planning

Health human resource planning in Canada differs from that of other industrialized countries. The issue of health human resources has been on the political agenda for quite some time. Frequent reports have dealt with quantitative assessments, from oversupply in the early 1990s to shortage in the late 1990s.

In 2001, the Canadian government assigned the Commission on the Future of Health Care in Canada to carry out consultations throughout the country and compile policy recommendations to shape the future of Canada’s public health care system. The aim was to ensure the sustainability of a universally accessible, publicly funded system that offers quality services, balancing prevention and health maintenance with care and treatment.

The commission also emphasized human resource planning. To this end, it assigned the Canadian Policy Research Network (CPRN), a social policy think-tank, to study the issue. In its 2002 report, CPRN recommended a national coordinating strategy with a focus on expertise, data analysis, best practice and public reporting.



Human resource management involves many actors at different health care and administration levels. Typically, every profession, jurisdiction and health care sector designs its own policy—the silo approach.

Overcoming the silo approach

As the commission suggested, a specialized agency could implement a more comprehensive strategy. As its key function, such an agency could monitor the health workforce with respect to current and future needs. Furthermore, the agency could act as a clearinghouse for best practice and bring together key players to recommend policy initiatives.

Best practice clearinghouse

Up to now, however, Canada has reached only very general agreements, such as to engage in a collaborative strategy and to

dispose of a budget of €54 million. Precise measures have yet to be defined and presented.

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Newsflash

In this section, we follow up on policies and developments reported in “Health Policy Developments” issue 1/2003 (HPD 1/2003). For instance, what has happened in France since the much-contested “Chadelat Report” was made public? What’s new on discussions about portability of private health insurance in the US and in Singapore? Germany is likely to face this issue as well, as the debate about “citizens’ insurance” will redefine the roles and function of private versus social health insurance systems.

Legislation on quality management has also progressed. The Dutch government finally decided to make quality assurance mandatory throughout the entire health care system. In Canada, the national government followed the steps of Saskatchewan, a Canadian province that in 2002 established an independent council on health care quality. Similarly, New Zealand is introducing a participatory approach to quality improvement.

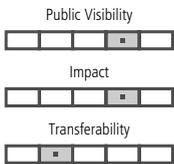
A new regional cancer institute in Australia pursues an ambitious concept for cancer prevention and treatment. In the United States, the burden of medical malpractice awards resonates on the political agenda and in the headlines. Also on health insurance, outgoing governor Gray Davis of California passed a highly visible piece of legislation in October 2003, requiring large companies to provide health insurance for their employees. For the United States as a whole, President George W. Bush and the Democratic presidential candidates propose different health insurance options to address the problem of 41 million uninsured citizens.

Last but not least, this chapter sheds light on a major health policy reform passed a few years back in the Republic of Korea, a new member of the Health Policy Network. In 2000, 23 years

after the introduction of a social health insurance system (as in continental Europe), Korean health politicians concluded that a single-payer system could do the job just as well. The merger of 350 health insurance societies into a monopsony system (with just one entity purchasing products and services from multiple providers) is expected to spread risks more evenly, avoid insolvencies of smaller insurers and increase equity and efficiency—although at the expense of leaving no choice for the insured.

Financing

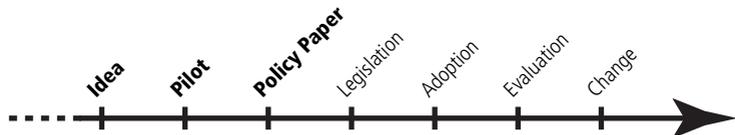
France: Health insurance reform



The current French health insurance reimbursement scheme is regarded as inefficient (high expenditures) and inequitable (higher burden for low-income people). As a result, France is now discussing comprehensive health insurance reform.

The Ministry of Health (MoH) commissioned Jean-Francois Chadelat, an expert on social security issues, to compile a report on reform proposals. The “Chadelat Report” recommended a three-tier structure, starting with basic insurance coverage for a minimum benefits “basket” of services to be partly reimbursed (from zero to 100 percent, depending on the service). At the next level, a highly regulated public co-insurance system would cover standardized services. The third level, neither regulated nor standardized, would allow individuals and families to take out totally optional insurance to cover additional services, according to individual preferences.

Entire health insurance system under review



Public consultations as approved policy tool

The “Chadelat Report” recommendations triggered such controversy that the MoH shelved them and in October 2003 appointed another commission, the Steering Committee on Health Insur-

ance (“Haut Conseil pour l’Avenir de l’Assurance Maladie”), whose major task is to hold public consultations.

Discussions have centered on better balance between individual and public responsibility, equitable access and the possible role of market mechanisms to achieve both.

Most proposals have come from insurance companies. Not-for-profit insurers favor various forms of a public-private mix and co-management of the system. By contrast, for-profit insurers prefer public minimum insurance (covering only catastrophic expenditure) or managed-care models such as health maintenance organizations or preferred provider organizations.

The Steering Committee report will compile and present proposals that may serve as a basis for the debate on the social security budget bill.

Critics initially blamed physicians for the inefficiencies of the system. The new government evidently holds patients responsible for the public health insurance system’s highest-ever deficit.

For-profit and not-for-profit insurers take different views

New government—new punching bag

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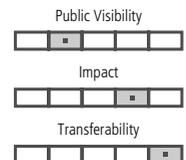
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Republic of Korea: Merger of health insurance societies in 2000

In 1998, a change in government opened a window of opportunity for long-overdue health care financing reform. In 1999, the South Korean parliament passed a law urging the country’s existing 350 insurance societies to merge. A single nationwide insurance company came into being in July 2000.

Many of South Korea’s insurance societies, especially those in rural areas or those covering the self-employed, were nearly bank-

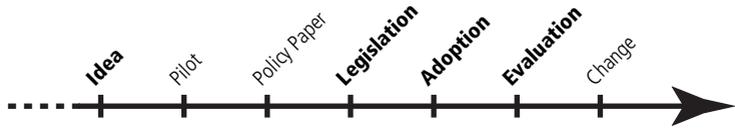


Monopsony in social health insurance

rupt. As a result, their members had to pay very high contribution rates. This raised concerns of inequity, because the contributions represented a higher proportion of the members' income. Under the new single-payer system, a sole agency will collect insurance contributions and provide coverage to all the insured.

Improved equity in health care financing

The major aim of the reform of the year 2000 was to achieve equity in health care financing and to solve the fiscal insolvency of some insurance societies. In addition, savings in personnel and administrative costs were expected to enhance efficiency.



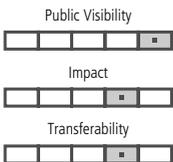
It remains for future evaluations to show whether difficulties concerning income assessment of self-employed workers and those employed in smaller companies give rise to new inequities.

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Kwon, Soonman: "Health care financing reform and the new single payer system in the Republic of Korea: Social solidarity or efficiency?" *International Social Security Review* 56 (1) 2003, 75–94.

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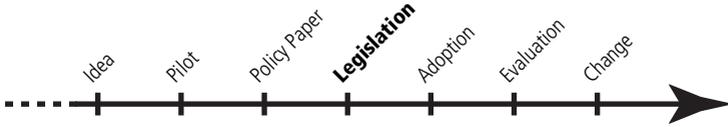
California: Democrats pass employer mandate for health insurance



Shortly before leaving office in autumn 2003, California Governor Gray Davis signed a law that expands the availability of health insurance for California's workforce (cf. HPD 1/2003). The new

law will allow some 14 percent of California’s uninsured to purchase health insurance. California has a very high proportion of uninsured citizens (19 percent, when the nationwide average is 15 percent).

New health insurance legislation



The new law affects companies differently depending on the number of employees. The Health Insurance Act of 2003, or Senate Bill 2 (SB 2), is a “pay or play” law that requires California employers to pay a fee to the state to provide health insurance unless the employer provides coverage directly, in which case the fee is waived.

Compulsory insurance for larger firms, small employers exempt

Beginning in January 2006, large companies (more than 200 California employees) must provide coverage for workers and their dependents. As of January 2007, mid-size companies (50 to 200 employees) must provide health insurance for their workers only, not for dependents. Smaller firms (20 to 49 employees) are exempt unless the state of California provides a tax credit equal to 20 percent of the employer’s net cost of the fee. Firms with fewer than 20 employees are exempt. However, with smaller firms employing the bulk of the workforce in California, under the new law many Californians will remain without health care coverage—just as before.

Limited reach, added financial burden, questionable outcome

Even though the law is expected to reduce the enormous public cost of emergency services for the uninsured and improve the overall health status of California’s population, it has drawn criticism from several sides.

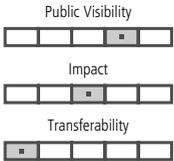
Businesses oppose the reform because of the additional financial burden. They must contribute 80 percent of the premiums—a daunting prospect especially for smaller companies.

Health care advocates object that the reform does not extend to the high proportion of workers employed by small companies. They view the recent legislation as more symbolic than effective and argue that it might hinder more fundamental reform.

Sources and further reading:

“Health Insurance Act of 2003” (www.leginfo.ca.gov/cgi-bin/postquery?bill_number=sb_2&sess=CUR&house=S&author=burton) www.chcf.org/sb2/index.cfm

USA: Presidential candidates’ proposals for health insurance

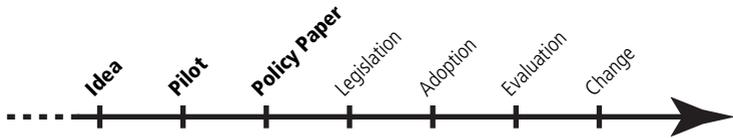


Coverage for 10 to 100 percent of the uninsured

In the United States, seven of the original nine Democratic presidential candidates and the incumbent president outlined proposals to extend health insurance coverage to millions of uninsured Americans.

The proposals offer coverage that ranges from 10 to 100 percent for 41 million uninsured Americans (last available data are from 2001).

Most of the proposals build on the existing health insurance system rather than outlining a fundamental reform of the health care system.



President Bush’s plan relies completely on the private insurance market. At the other end of the spectrum, Dennis Kucinich was the only candidate to call for a single-payer system covering all uninsured persons under Medicare. Dick Gephardt put the focus on employer-sponsored coverage. Joseph Lieberman emphasized new group insurance options and expansion of Medicaid/CHIP (Children’s Health Insurance Program). Howard Dean and John Kerry also mainly draw upon expansion of the CHIP program.

Estimated costs ranged from €70 billion to €4,800 billion

Depending on the number of uninsured to be covered, estimated costs vary widely, from €70 billion (Bush) to €4,800 billion (Kucinich).

Most of the Democratic candidates (Wesley Clark, Howard Dean, John Edwards, Dick Gephardt, John Kerry and Joseph

Lieberman) proposed to finance the cost of their health plans by repealing some or all of Bush's 2001 tax cut legislation and offering new tax credits. Other proposals included trimming the federal workforce (except defense and homeland security employees) by 10 percent and eliminating selected corporate subsidies or tax loopholes.

To support his proposed single-payer plan, Kucinich suggested a new payroll tax for employers and elimination of the tax deduction for employee health insurance.

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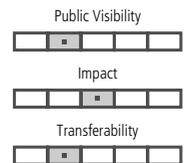
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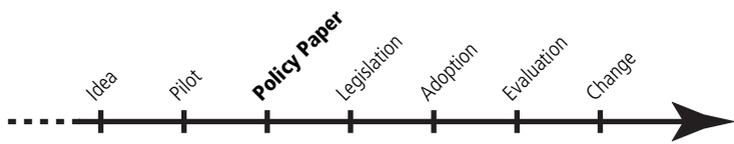
U.S. Department of Labor: www.dol.gov/dol/topic/health-plans/cobra.htm.

The White House: "A Blueprint for New Beginnings: A Responsible Budget for America's Priorities." www.whitehouse.gov/news/usbudget/blueprint/budo2.html.

Singapore: Increase in Medisave withdrawal limits

As reported previously (cf. HPD 1/2003), the Singaporean government had planned to change the formula for Medisave withdrawals from a procedure and length-of-stay basis to one based on severity of medical condition or complexity of care. Casemix (DRG) has been used for reimbursement in public hospitals since 1999.



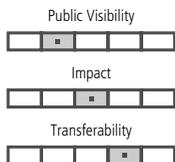


**Medisave
withdrawals
adapted to real
prices**

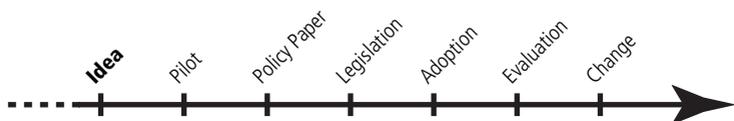
The adaptation of Medisave withdrawal limits to real prices is expected to yield greater flexibility and fairness, because it takes into account serious medical conditions and higher utilization of resources. Consequently, the government estimates that a much higher share of seriously ill patients will benefit from the new Medisave withdrawal limits.

Sources and further reading:
<http://app.moh.gov.sg/you/you020102.asp>

Singapore: Portability of employment medical benefits



In April 2003, the government of Singapore proposed two optional complementary insurance schemes that allow employees to accumulate unused employment medical benefits for future use. By enabling workers to continue coverage when they change jobs, are between jobs or retire, the policy addresses two recent developments: the aging of society and an increasingly mobile workforce.



The Portable Medical Benefits Scheme (PMBS) allows employers to make additional contributions to their employees' Medisave accounts. Employees who choose the Transferable Medical Insurance Scheme (TMIS) alternative can extend insurance coverage up to 12 months after they retire.

The policy emphasizes personal responsibility for health care coverage while expanding the role of medical insurance in financing health care costs. As an incentive, the government offers employers additional tax reductions of about 1 percent starting in April 2004.

Enhancing individual responsibility

Sources and further reading:

www.mom.gov.sg/MOM/CDA/o,1858,4469-----1760----1,00.html

www.mti.gov.sg/public/PDF/CMT/ERC_Wages_ExecutiveSummary.pdf?sid=148&cid=1440

USA: Health Insurance Portability and Accountability Act of 1996

In 2003, Congress passed important amendments to the 1996 Health Insurance Portability and Accountability Act (HIPAA). HIPAA protects citizens' health coverage during events such as changing or losing jobs, pregnancy, relocation or divorce. The portability aspects also provide rights and protection to employers when they implement and renew health coverage for their employees. The accountability measures protect the integrity, confidentiality and availability of electronic health information.

Improvements in insurance coverage

The HIPAA Administrative Simplification—the first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers—took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these new standards give patients access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. The new regulations do not affect state laws providing additional protections to consumers.

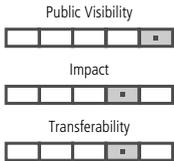
Privacy of health data

Other recent amendments to the HIPAA (particularly in 2001 and 2002) brought reforms in terms of portability, access and renewability requirements. The law prohibits discrimination against participants based on health status.

Sources and further reading:
www.hhs.gov/ocr/hipaa/
www.cms.hhs.gov/hipaa/online/default.asp
www.cms.hhs.gov/hipaa/hipaa1/content/HIPAASTA.pdf

Quality management

Netherlands: Quality management more compulsory

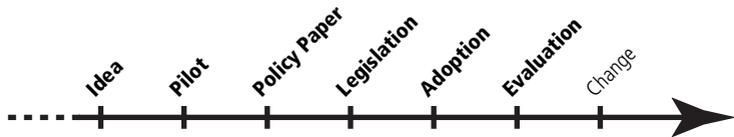


**The sooner
the better**

Following the recommendations of the Health Care Quality Law evaluation in late 2002, the Minister of Health announced specific measures to make quality management compulsory.

In November 2003, the Minister of Health published a catalogue of kick-off measures (*Sneller Beter*) to be introduced in 2004:

- Benchmarking in primary care for all GPs and ten pilot hospitals
- Introduction of indicators for safer and better care
- Program on quality, innovation and efficiency with priority on patient safety and patient-centered delivery of care.



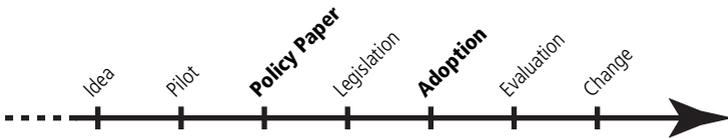
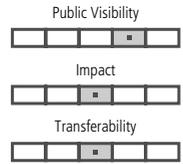
The Dutch Inspectorate of Health Care will supervise performance with the help of two research institutes. Potential penalties have yet to be defined.

Sources and further reading:
www.snellerbeter.nl

Canada: Independent council for quality improvement in health care

At a health ministers’ meeting in September 2003, the federal and provincial governments agreed to establish a national-level Quality Council modeled after that in Saskatchewan Province. Nomination of council members began in October 2003.

The council consists of health policy experts, government officials and representatives of the public. Its principal goal is to improve the health status of the Canadian population. To this end, the council offers advisory services concerning health reform issues, financing, health care supply and other topics vital to the health care system. In one key task, the council reports to the public on the performance of the health care system. The council provides those who shape health policy decisions the resources to do so in more transparent and evidence-based ways. Its efficacy will depend primarily on whether it gives priority to the interests and health status of the Canadian population.



Sources and further reading:

“The Final Report of the Commission on the Future of Health Care in Canada” (www.hc-sc.gc.ca/english/care/romanow/index1.html)

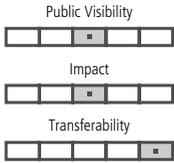
“The First Ministers’ Accord on Health Renewal” (www.hc-sc.gc.ca/english/hca2003/index.html)

Minister of Health. “The Minister of Health calls for federal candidates to the Health Council”. Press release. September 25, 2003

(www.hc-sc.gc.ca/english/media/releases/2003/2003_76.htm). www.hqc.sk.ca

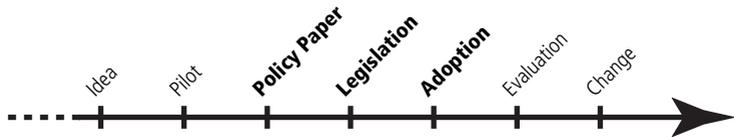
www.health.gov.sk.ca/info_center_pub_commission_on_medicare-bw.pdf

Australia: Optimizing cancer management: the New South Wales Cancer Institute



In September 2003, the government of New South Wales announced the establishment of the Cancer Institute (NSW) Act.

The NSW Cancer Institute will guide and coordinate cancer care under a patient-centered, high-quality and multidisciplinary approach. It will provide expertise on cancer control for researchers, providers, patients and the public.



The major aim is to improve survival rates and quality of life as well as reduce incidence rates for cancer. Given the complexity of cancer, it seems nearly impossible to evaluate how well the institute fulfills this ambitious mandate.

Both political and personal factors propelled the drive to establish the NSW Cancer Institute: The Australian Labour Party made the proposal a key plank in its March 2003 election platform, and the partner of the Minister Assisting the Minister of Health had recently died of cancer.

Sources and further reading:

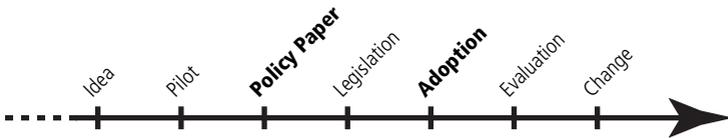
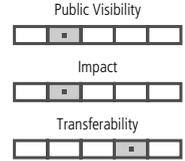
“Cancer Institute (NSW) Act 2003” (www.legislation.nsw.gov.au/maintop/scanact/inforce/NONE/09)

“Cancer Institute [NSW] Bill. Second Reading”

(www.parliament.nsw.gov.au/Prod/Parlament/HarnArt.nsf)
www.health.nsw.gov.au/

New Zealand: Improving quality—a strategic approach

In September 2003, the New Zealand Ministry of Health issued a policy paper outlining a uniform strategic direction for all quality improvement measures. The goal is to provide safe, effective and efficient health care services, especially for underprivileged population groups such as the disabled and the Maori people. The development of a special quality culture comprising communication, teamwork and appropriate working conditions is a driving force behind this new strategic orientation. A core objective is to build a learning organization capable of handling unanticipated events through reasonable management.

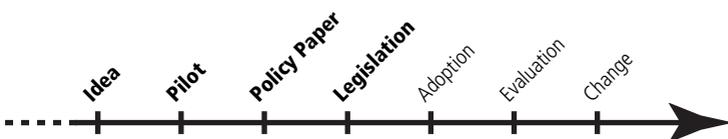
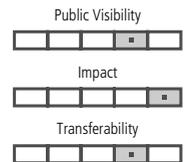


Sources and further reading:

www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d47d0/3792aa50e9ef5ff2cc256d9f0016b2ab?OpenDocument

USA: Medical malpractice reform

President George W. Bush has called for malpractice reform, arguing that malpractice awards drive up the costs of government health care programs by forcing physicians to practice defensive medicine. His proposed reforms cap awards for noneconomic damages (such as pain and suffering) in malpractice suits and limit the number of malpractice suits.



**Escalating costs:
premiums and
malpractice
awards**

Medical malpractice awards—a perennial issue in the health care debate—draw particular attention when malpractice insurance premiums rise.

Some cases of women desperately seeking obstetricians to deliver their babies recently brought the topic to the forefront again. The Republicans are pushing for legislation to cap malpractice awards, despite weak evidence that such caps lead to lower premium rates. Opponents of caps on noneconomic damages point to the risk that patients will not receive fair compensation.

Sources and further reading:

www.aafp.org/x20919.xml

US Office of Congressional Relations: Congressional testimony, September 23, 2003.

US Office of Congressional Relations: Fact Sheet, April 13, 2003.

International Monitor on Health Policy Developments¹

Questionnaire (September 2003)

The approach

Overall goals

Does health policy reform work? How and why? This is what this questionnaire intends to explore. The focus of this survey is therefore on

- the analysis of the common features of health policy and health care reform across industrialized countries; and on
- the sequential analysis of health policy ideas, change processes and change management in health policy. Particular attention will be paid to key players, their interactions and on stewardship in health policy as a factor of change.

Network objectives

- To obtain and analyze information on changes and developments in health sector reform on a regular basis and over time
- To scout, monitor and follow a (new) health policy idea or approach from its inception stage through the policy and law-making process to implementation
- To describe and analyze the formal and informal interactions of all players and stakeholders at each stage in the decision making process
- To capture best practice models already established

1 The term “Health Policy Development” has been chosen to capture both active reform processes (e.g., laws and acts) as well as technological and/or organizational changes with their implications for health policy. Similarly, the term “development” encompasses the various stages of a “health policy idea” from its inception or appearance via acceptance, adoption and implementation to decay, abandonment or change.

What we want to do with it

- To establish an effective tool for monitoring innovative ideas as they evolve and travel within and across health care systems
- To systematically analyze decision-making processes leading to health sector reforms or facilitating change in health policy
- To review and disseminate that information in an efficient, straightforward and rapid manner among all network partners (half-yearly reports, Internet platform)
- To organize the transfer of findings and results into the German health policy making process (consultations, advisory activities)

A word of caution

We do not seek to provide health system descriptions for the countries participating in this network. For most network countries, comprehensive health system descriptions do already exist. We particularly recognize the country studies developed and published by the European Observatory on Health Care Systems, the “Health Care Systems in Transition” (HiT) profiles. HiTs exist for 12 out of currently 16 network countries (for Canada, the report is from 1996 though). For Japan and the OECD, OECD Labour Market and Social Policy Occasional Papers are similarly comprehensive. For Singapore and South Korea, other suitable documents have been identified.

Structure of this survey

In each survey phase covering six months, we will ask you to provide information on the progress of a health policy idea, approach or instrument from the early stage of inception towards implementation over time.

For every six-month period, you will be asked to describe five or more such key health policy developments, selected according to the four criteria mentioned below. We are interested in comparing the background/context of a key health policy issue, its players/process interactions, and, with a view to implementation, its potential impact.

The criteria for selection of a health policy development are:

- Relevance and scope
- Impact on status quo

- Degree of innovation (compared with national and international standards)
- Media coverage/Public attention

We are particularly interested in those reforms with significant impact on the overall structure and organization of your country's health system.

The questionnaire (one each for each of the selected health policy developments) starts with a two-dimensional matrix, picturing key issues (14 categories) and their development over time (seven process stages). For each of the selected key health policy issues, we will ask you to provide a more detailed analysis of stakeholders and their interests and interactions along the stages of the process. The matrix will allow you to categorize both the issue addressed and the current stage of the process.

It is possible that some ideas evolve very fast from one stage to the next. You may also observe that others do not necessarily follow the process, “surfacing” in at stage 2 and/or “jumping” across various stages during the period observed.

Matrix—First dimension: Issue clusters²

1. Sustainable financing of health care systems:

This cluster has been divided into “funding and pooling of funds” and “remuneration and paying providers,” i.e., the relationship between population/patients and payers on the one side and between payers/purchasers and providers on the other. The first sub-section includes generation and collection of funds for health care (i.e., taxes, social insurance contributions or copayments) as well as their pooling and (re-)distribution to the payers (sickness funds or health authorities, including risk structure compensation). Important considerations relate to efficiency and equity. The second sub-section includes budgeting, diagnostic-related group (DRG) systems, drug pricing policy, etc.

2. Human resources:

Education and training, numbers and planning, projected shortages of qualified medical and non-medical personnel, etc.

² The issue clusters in this matrix are a result of the kick-off meeting of the network participants in Germany in September 2002. In a brain-storming exercise, participants were asked to identify the current five major health policy challenges in their countries. The brain-storming was followed by a factor analysis grouping all issues raised in clusters/categories. The categories were completed during discussions and reorganized for survey purposes.

3. *Quality issues:*

This should include tools such as guidelines, evidence-based medicine, peer reviews, re-certification of physicians, outcome measurements as well as measures to make them work (e.g., purchaser-provider contracts, financial/non-financial incentives), patient safety and medical errors/malpractice, public disclosure of provider performance data, benchmarks, best-practice.

4. *Benefit basket and priority setting:*

This cluster includes both the decision-making process on (new) technologies and services, e.g., the question of whether health technology assessment becomes mandatory, as well as actual changes in the benefits covered, e.g., the exclusion of dental care.

5. *Access:*

In contrast to the previous cluster which deals with technologies and services, this cluster is about de facto access by individuals to health care, including problems such as rationing, waiting lists (equity concerns!), strategies for solving these restrictions and for reducing disparities in care.

6. *Responsiveness and empowerment:*

Responsiveness of the health care system and of health policy to patients, payers³ expectations, patient rights and patient charters.

7. *Political context and public administration:*

Refers to levels of competency (including EU), centralized vs. decentralized responsibilities, policy making styles, stewardship role, etc.⁴

8. *Organization/integration of care across sectors:*

This cluster incorporates developments which aim at the reconfiguration of health care providers, especially to overcome institutional and sectoral boundaries in order to provide disease management and other forms of integrated care.

3 The term “payer” is used of health care in both (social) health insurance systems (the insured) and state/public health care systems (tax payers). In a larger sense, payers can also be purchasers of health services (public or private insurers, social services institutions covering determined population groups), employers contributing to health insurance funds and patients paying out of pocket.

4 Political context: Here we would like to know more about changes affecting health policy competencies (mix/split) at the government level (ministry of health, ministry of labor/social security, ministry of consumer protection, ministry of the environment), shifting competencies and/or responsibilities in the organization of the health care system (funding, remuneration and service delivery). Key words maybe: decentralization (devolution, delegation) or centralization trends; role of corporatism and interest group lobbying in health policy making; fragmented levels of responsibility for service delivery (in-patient vs. out-patient services); (changing) role of local government vs. central government in health planning, facility management, etc.; mechanisms of civil society participation in health care issues.

9. *Long-term care:*

Long-term care and care for the elderly (aiming particularly at this group even if it also fits into one of the dimensions above).

10. *Role of private sector:*

This cluster deals with developments which specifically aim at changing (regulating, deregulating) the role of the private sector in funding and/or delivery of health care. Depending on your country, it may be useful to make a distinction between private for-profit and private non-profit health facilities. You may also want to report a development that occurred within the private sector (mergers, concentrations of payers and/or providers, i.e., HMOs/PPOs, health insurances, hospital chains, group practices). However, the invention of a break-through technology should be categorized in the next cluster and not here.

11. *New technology:*

While we are not interested in all new technologies, this cluster has been included to report and assess technological innovations expected to have a major impact on the effectiveness, quality, costs or the organization of the system (genetic testing, chip card, electronic patient records; teleconsultations, etc.).

12. *Others:*

If you feel that the health policy development you wish to describe does not fit in any of the clusters, you may create an additional one.

Matrix—Second dimension: Time line/How ideas travel/Process stages

1. Ideas for reform voiced, discussed in different forums (e.g., think tanks, professional/providers' groups, advisory councils, consumer organizations, supra-national agencies)—even at an early stage, possibly far from a larger expert audience and/or the political arena
2. Innovations or putting into practice of ideas voiced previously (e.g. at the local level, within institutions, as pilot projects)
3. Acceptance of ideas within relevant professional community and/or (governmental) policy paper at central or regional level
4. Legislative process: This is perhaps the most complex and interesting stage of all, critical for the success or failure of a reform proposal. Please tick here for any legislative proceedings—from the moment a bill is proposed through hearings and lobbying until the effective enactment or rejection of the proposal.

5. Adoption: Measures to facilitate the implementation of a policy at the regulatory and professional level.⁵
6. Evaluation of change—acceptance or failure?
7. Abandonment or further change

The subsequent questions center on the causes and determinants of a particular health policy issue and around the steering and regulatory aspects of this issue.

While we ask you to take into consideration the criteria for the selection of a health policy development (i.e., relevance and scope, impact on status quo, degree of innovation and media coverage/public attention), the choice of what health policy development is worth reporting and commenting on in any given round will obviously depend on your expert judgement.

Please note that the answers to the questions can be brief: Ten to 40 lines per item, or a maximum of three to four pages per policy should do.

We would like to encourage you to structure your responses according to the guiding questions at the beginning of each sub-set, for two reasons: One, the sub-questions under (5) follow the rationale of the time line in the matrix. Two, evaluation and overall reporting will be easier for us when we receive step-by-step answers.

Finally, it would be helpful if you could give references for your information or indicate Web sites for more detailed information on a given policy.

5 Adoption should include: formulation of accreditation requirements, standards of professional organizations, influence of private sector/market/industry in the adoption process. Note that this step may follow process stage 2 or 3 directly if no legislation was enacted.

Please photocopy and fill out the following questionnaire for each of the selected health policy issues!

Health Policy Network Questionnaire—Survey # 2

Period covered: [month] 2003—[month] 2003

Country: _____

Survey No. _____

Please fill in here the name or names of the authors, co-authors or reviewers who have contributed to this report. If your report is representative of your institution's position, you may want to add the institution's name—e.g., "CRES (review)":

Author/s and/or contributors to this survey: _____

Policy development # _____

i. Title of health policy development reported

Short title

Has this policy been reported in previous surveys?

Yes, in survey # _____, date: _____

No

2. Anchoring the selected health policy issue in the matrix

Please go through the categories of health policy issues listed in the matrix below and tick where appropriate:

- This may be a mark in one box only or a horizontal line if a health policy development has progressed through several columns (stages) during the six months.
- If a policy clearly relates to more than one category (e.g., the introduction of a new remuneration system to facilitate integrated care), then all the appropriate boxes/lines should be marked accordingly.

		Process stages						
	Issue categories	"Idea" ⁶	Local or institutional innovation	Acceptance/ Policy paper ⁷	Legislative process ⁸	Adoption and Implementation ⁹	Evaluation	Abandonment/ Change
1.1	Sustainable financing I: Funding and pooling of funds							
1.2	Sustainable financing II: Remuneration/Paying providers							
2	Human resources— training and capacity issues							
3	Quality improvement and assurance							
4	Benefit basket, priority setting							
5	Access to health care (rationing, waiting lists, etc.)							

6	Responsiveness to and empowerment of patients							
7	Political context, e.g. centralized vs. decentralized policy making							
8	Organization/integration of care across sectors							
9	Long-term care, care for the elderly							
10	Role of private sector							
11	Pharmaceutical policy							
12	New technology							
13	Prevention							
14	Public health							
	Other							

- 6 This first section refers to any idea floating but not anywhere near a more formal inception stage. Under this heading, you should list ideas that have surfaced only recently and ideas which have been in the pipeline for some time (retrospective view). This means that the reporting period for this column is not restricted to the past six months. That way, we will establish a “stock of health policy ideas-in-development.” Over time, we should be able to observe ideas (re)appearing a few years down the road (e.g., medical savings accounts in the Australian health policy debate, Primary Care Trusts in the UK).
- 7 This refers to any formal written document short of a bill: Tick here for any health policy paper or program, health plan or similar paper issued for the policy described here over the past six months.
- 8 We renamed this column (previous title: Enactment) to explicitly cover all aspects of the legislative process: from the formal introduction of a bill legislation to parliamentary hearings, lobbying by interest groups and industry and the success (legislation passed) or failure of a proposal.
- 9 Please use this column for any steps taken towards adoption and implementation at both legal and professional levels: e.g., secondary legislation/regulations, accreditation requirements, organizational standards, etc. That way, the distinction between legislative process and adoption phase should become clear.

3. Content of idea or health policy

Please describe the main objectives, characteristics and expected outcomes of the policy (idea), approach or instrument. What type of incentives (financial, non-financial) are built into or related to this policy? Whom do they affect and how?

Search Results Abstract

This brief abstract will only show on the Web site’s search results page when users click on “Show results with summaries.” Please describe the purpose and outcome (or expected outcome) of the policy or development you describe in a comprehensive manner (500 characters max.).

Structured summary Q3 (optional)

Main objectives/characteristics of instrument:

Type of incentives (financial, non-financial):

Group(s) affected

- 1) _____
 - 2) _____
 - 3) _____
- etc.

Sources of information

Please indicate links, papers or publications as suggestions for further reading, as well as the sources of information or data used for this survey.

4. Overall political and economic background of policy development

Was there a change in Government or political direction? Was there a need or pressure to comply with EU legislation (if applicable) or with WTO/GATS regulations?

Has this health policy been derived from or does it aim at attaining a goal formulated in an overall national (or regional) health policy statement such as health policy program, health plan, health goals? If so, which one?

Structured summary Q 4 (optional)

- Change of government—comment: _____
- Need to comply with EU regulation—comment: _____
- Need to comply with WTO/GATS—comment: _____
- Need to comply with something else—comment: _____
- Change based on an overall national health policy statement (title):

5. Process

5.1 Origins of health policy idea

Where, when, and by whom was the idea generated? What is the main purpose of the health policy idea? What ideas will be used to achieve the idea's or policy's main principle purpose? Who were or are the driving forces behind this idea and why?¹⁰ Is it an entirely new approach, does it follow earlier discussions, has it been borrowed from elsewhere? Is it aimed at amending/updating a prior enactment ("reforming the reform"), and why would it have been passed? Who were the main actors? Are there small-scale examples for this innovation (e.g., at local level, within a single institution, as pilot projects)?

Structured summary Q.5.1 (optional)

Please check, using the text field to specify.

Initiators of idea/main actors

- Government/Ministry/Department/Region/Municipality _____
- Parliament _____
- Providers _____
- Payers: insurance company/sickness fund _____
- Patients, consumers, etc. _____
- Civil society (unions, churches, charities, NGOs, minorities, professional groups, foundations) _____
- Scientific community (academic institution, think tank) _____
- Private sector or industry _____

¹⁰ Driving forces/causes could be: Failure or poor performance of a previous approach (which one?), pressure by interest groups (which one[s]?), socio-economic conditions, budget constraints or the media. Also, new ideas may have been initially developed from within single institutions (bottom-up initiatives rather than top-down policy initiatives or legislative motions).

- International organizations _____
- Media _____
- Individual opinion leaders _____
- Other driving forces pushing the idea or innovation (please describe):

Approach of idea

The approach of the idea is best described as:

- New
- Renewed (First voiced, approx. year of entering debate, country of origin?)

- An amendment (Of which reform/bill/legislation?)

5.1.3 Innovation or model project

Are there any (small-scale) examples of innovation (experiences)?

- No
- Yes,
 - at the local or regional level: _____
 - within institutions: _____
 - as a pilot project: _____
 - other: _____

5.2 Policy papers and stakeholder positions

How were or are other stakeholders/affected groups positioned towards this idea or policy and its main purpose? Who opposes/opposed this idea or policy and why? Has the idea or policy been accepted by relevant actors; or was it abandoned? Was a policy paper formulated? By whom? Who held the leadership role in bringing forward this idea or policy? Were there alliances between stakeholders in support of the idea or new policy? Who mediated conflicts of interest between stakeholders?

Structured summary Q 5.2 (optional)

Actors: Position toward policy

In the following table, please indicate the position of the major players toward the policy described. For groups or actors not positioned yet or not holding any stakes in the process, do not mark any box. The middle box should be used for neutral actors or those having voiced mixed reactions. In case of the latter, please give details in the space provided above.

A word of caution: A table can only illustrate positions, influences or priorities to some extent. It is not a tool for the analysis of alliances or more complex interaction. For more detailed descriptions, in-depth analysis and/or expert estimates (e.g. concerning the likeliness of success of a health policy or idea, chances of implementation, interest group alliances etc.) please use the space provided above.

Stakeholder position toward development of idea or policy:

Actor/Position	very strong	strong	neutral	weak	none
Government	<input type="checkbox"/>				
Parliament	<input type="checkbox"/>				
Providers	<input type="checkbox"/>				
Payers	<input type="checkbox"/>				

Patients	<input type="checkbox"/>				
Civil society	<input type="checkbox"/>				
Private sector/ industry (specify)	<input type="checkbox"/>				
Scientific community	<input type="checkbox"/>				
International organizations	<input type="checkbox"/>				
Media	<input type="checkbox"/>				
Individual opinion leaders (specify)	<input type="checkbox"/>				
Others (specify)	<input type="checkbox"/>				

5.3 Legislative process: Influences in policy making and legislation

Did or will the development of this idea or health policy lead to a formal piece of legislation? In how far has the original proposal been changed or modified in the process? Can you describe the powers and the influences of the various actors and stakeholders involved in the legislative process?

Structured summary Q 5.3 (optional)

Legislative process: Outcome

- Success
- Failure
- Major changes
- N/A

Actors: Influence and powers

Actor/Position	very strong	strong	neutral	weak	none
Government	<input type="checkbox"/>				
Parliament	<input type="checkbox"/>				
Providers	<input type="checkbox"/>				
Payers	<input type="checkbox"/>				
Patients	<input type="checkbox"/>				
Civil society	<input type="checkbox"/>				
Private sector/industry (specify)	<input type="checkbox"/>				
Scientific community	<input type="checkbox"/>				
International organizations	<input type="checkbox"/>				
Media	<input type="checkbox"/>				
Individual opinion leaders (specify)	<input type="checkbox"/>				
Others (specify)	<input type="checkbox"/>				

5.4 Adoption and implementation

Which actors and stakeholders were, are or will be involved in the adoption process towards implementation? Which means are necessary, i.e. tools for successful implementation/achievement of policy purpose? Who moderates the process? Were or are these actors and stakeholders actively participating in the process? If not, why? Who else is or will be directly or indirectly affected by implementation? Why and how? How successful was implementation or what are the chances of implementation? (For expert opinion, please use questions 6 and 7.) Where were or are the obstacles? What incentives would facilitate the implementation of this policy, in addition to, or instead of the incentives provided? What was done to convince, or promised to appease, the opponents to this policy?

Structured summary Q 5.4 (optional)

Actors: Priority of policy on their agenda

Actor/Position	very high on agenda	high	neutral	low on agenda	not on agenda
Government	<input type="checkbox"/>				
Parliament	<input type="checkbox"/>				
Providers	<input type="checkbox"/>				
Payers	<input type="checkbox"/>				
Patients	<input type="checkbox"/>				
Civil society	<input type="checkbox"/>				
Private sector/industry (specify)	<input type="checkbox"/>				
Scientific community	<input type="checkbox"/>				
International organizations	<input type="checkbox"/>				
Media	<input type="checkbox"/>				
Individual opinion leaders (specify)	<input type="checkbox"/>				
Others (specify)	<input type="checkbox"/>				

5.5 Monitoring and evaluation

Does this policy foresee a mechanism for regularly reviewing the implementation process, the impact, the overall appropriateness of its objectives and its consistency with your national health policy (where applicable)? If yes, please elaborate. Have precautions been taken to minimize the undesirable effects of the reform? If evaluation has already taken place, please provide results. Did evaluation lead to change or abandonment?

Structured summary Q 5.5 (optional):

Review mechanism

- Mid-term review or evaluation

- Final evaluation:
 - Internal (e.g., quality management system, quality manager)
 - External (e.g., consulting company, academic institution, independent expert)

Dimension of evaluation

- Structure
- Process
- Outcome

Results? Please describe:

6. Expected outcome/overall assessment of policy (expert opinion)

Looking at the intended objectives and effects of the health policy assessed: Will the policy achieve its objectives? What might be its unexpected or undesirable effects? What are or will be the effects on costs, quality, access/equity etc.?

7. Rating this policy (expert opinion)

7.1 Characteristics of this policy

1. How innovative is the policy in your country's present situation?	<input type="checkbox"/>	traditional approach	innovative approach				
2. Was/is the policy process comparatively ...	<input type="checkbox"/>	consensual	highly controversial				
3. Actual or expected impact on status-quo	<input type="checkbox"/>	marginal	fundamental				
4. Visibility in public discussion (media coverage)	<input type="checkbox"/>	very low	very high				
5. Transferability	<input type="checkbox"/>	strongly system/ context-dependent	transferable system-neutral				

Please give your overall assessment of this policy.

7.2 Rating the impact of this policy (expert opinion):

6. Impact on quality of health care services	<input type="checkbox"/>	marginal	fundamental				
7. Impact on level of equity (access)	<input type="checkbox"/>	system less equitable	system equitable				
8. Impact on cost-efficiency	<input type="checkbox"/>	very low	very high				

Please comment upon your assessment of the *impact* of this policy:

Thank you for your cooperation!

Call for Support

International Network for Health Policy & Reform

Dear friends and colleagues,

With this letter, we cordially invite you to actively support our network. Your contribution of connections, expertise or funding can help us consolidate and broaden our initiative and sustain the continuity of this project through the years to come.

Why do we invite you to join us? What's in it for you?

The Bertelsmann Foundation initiated this network of health policy experts to bridge the gap between research and policy. Our reports highlight information—mostly from the world of health economics or medicine—that deserves a broader audience, a wider context. We focus on the politics of policy: the dynamics, interactions and driving forces that bring about health policy reform. If we know the solutions (e.g., evidence-based practice), where do obstacles arise? What makes it so difficult to put sound proposals into effect? The answer to these questions underpins our work: Health policy reform is about interests, values, opportunistic considerations—not just about efficiency, equity, factual evidence or rational decision-making.

So how does health policy work, and why? What can we learn from other countries? Are health reform policies transferable? If so, under what conditions? What constitutes “good” health policy reform? How do various countries cope with demographic transition and technology on the one hand and issues of equity, access and distribution on the other?

Do these questions appeal to you? Join us! You can help us find answers that promote sustainable health policy reform.

Are you interested in going beyond what you read in the newspapers or see on television? Join us! You can help us deepen and broaden our network, making it more representative of the health policy reform processes taking place in industrialized countries around the world.

What you can do

You can provide the Health Policy Network with virtual, practical and financial support through one or more of the following activities:

- Become an ambassador
- Become a country patron
- Become a host
- Become a health policy facilitator

- Become a co-publisher
- Become a virtual friend
- Become a peer

Become an ambassador

Inform people, networks and institutions about the International Network for Health Policy & Reform. You can also provide us with names and addresses of representatives (presidents, general secretaries, editors in chief, etc.) in electronic format.

Provide us with member lists (mailing lists, lists of press contacts for scientific journals) so we can inform them about the International Network for Health Policy & Reform, its publications and key findings on an up-to-date basis.

Become a country patron

This form of support allows you to express your particular interest in one or more of the countries in our network. You can also choose to help us add an additional country to the network; we are eager to include any countries with significant, valuable reform experiences to share.

Please contact us to discuss the options and the criteria for inclusion of a country and an appropriate partner institution.

Become a host

As a host, you express your commitment to the network at its liveliest: Your generous grant funds the network's annual meeting, which takes place in a different location each year, in early July or early September.

Your sponsorship of a network meeting covers accommodations and catering for the network experts, special guests and key speakers, for two days (three nights).

In July 2004, we will hold our third meeting in Berlin, Germany. The venue will be the Bertelsmann Company's new conference center right in the heart of the city.

Our fourth meeting, near Barcelona, Spain, is conveniently scheduled to allow our experts to attend the iHEA Biannual Conference in July 2005.

Become a health policy facilitator

Health policy facilitators enable bi-, tri- or multilateral exchange on specific areas of health policy reform. In a closed working setting, our practice-oriented technical briefings bring together the thinkers and the doers from science and practice, philosophy and politics, to look into experiences, investigate transferability, and jointly develop applicable solutions to shared problems.

Topics could be

- Integrated care and disease management programs for chronic disease: getting incentives right (a detailed workshop outline for an expert meeting in October 2004 is available upon request)
- Coping with the workforce gap in nursing
- Wellness in old age: strategies toward healthy aging
- The role of commissions, lobbyists, and scientists in health policy reform: How much advice (science) does the government really need?
- Communication in health policy reform: Can economists talk to lawmakers?
- Ethics and health finance: Is transparency the solution when tradeoffs are tough?

We welcome your suggestions about issues for which an in-depth exchange of this kind promises to benefit all parties.

Become a co-publisher

We produce two reports per year (in English). If you sign on as a co-publisher, we will honor your sponsorship by placing your institution's name and logo on the cover.

Become a virtual friend

Our Web site at www.healthpolicymonitor.org is a lively work in progress. We continually strive to improve its design, content, database and user friendliness. We welcome your comments—and your donations. You might even want to help us broaden our international base by sponsoring translation into other languages.

Become a peer

You may place an Internet link to our Web site, www.healthpolicymonitor.org, on your own or your organization's Web site. In return, we will link your site to ours.

You may publish a brief description of our network in your newsletter or magazine.

Again, we will return the favor.

Whether you join us as a peer, an ambassador, a country patron, a host, a health policy facilitator, a co-publisher or a virtual friend, we welcome your collaboration.

In recognition of your efforts, we will publish friends' and supporters' names on our Web site and in all network publications. Through our network, we can also grant privileged access to country background information, distinguished research institutions and policymakers.

Please contact us with any further questions about the project, its objectives, and your possible support to the International Network for Health Policy & Reform.

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