

Health Policy Developments

Issue 4

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Health Policy Developments

Issue 4
Focus on Access,
Primary Care,
Health Care Organization

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Introduction

The Bertelsmann Stiftung has a tradition of comparative policy research and international benchmarking. It has established a reputation for providing sound advice and innovative problem-solving in the field of economic and social politics.

An example of the Foundation's expertise in comparative health policy research is "Reformen im Gesundheitswesen" (Esche, Böcken and Butzlaff (eds.) 2000), a study that compared health policy reforms in eight countries.

The success of this project 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 for Health Policy and Reform.

The International Network for Health Policy and Reform

Since 2002, the International Network has brought together health policy experts from 17 countries from around the world to report on current health reform issues and health policy developments in their respective countries. Geared toward implementation, the Network aims to narrow the gap between research and policy, providing timely information on what works and what does not in health policy reform.

Participating countries were chosen from a German perspective. We specifically looked for countries with reform experience relevant for Germany.

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	IRDES, Institut de Recherche et de Documentation en Economie de la Santé, Paris
Germany	Bertelsmann Stiftung, Gütersloh Department of Health Care Management, Berlin University of Technology (TUB)
Israel	The Myers-JDC-Brookdale Institute, Smokler Center for Health Policy Research, Jerusalem
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	School of Public Health, Seoul National University
Singapore	Department of Community, Occupational and Family Medicine, National University of Singapore (NUS)
Spain	Research Centre for Economy and Health (Centre de Recerca en Economia i Salut, CRES), University Pompeu Fabra, Barcelona
Switzerland	Institute of Microeconomics and Public Finance (MecoP), 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
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Survey preparation and proceedings

Issues were jointly selected for reporting 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
- Pharmaceutical policy
- Prevention
- Public health

If an issue did not fit into one of the clusters, participants could create an additional category to report the topic.

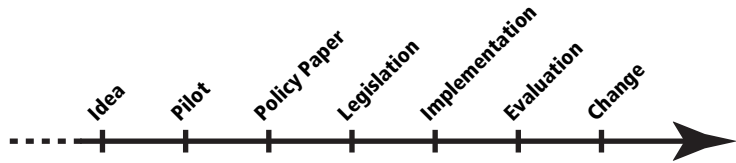
Reporting criteria

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 (measured 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. At the end of the questionnaire, our correspondents give their opinion regarding the expected outcome of the reported policy. Finally, they 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 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 forums. Idea could also mean “early stage”: any idea present but not anywhere near formal inception. In this way, a “stock of health policy ideas in development” is established, permitting the observation of ideas appearing and disappearing through time and “space.”

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

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

Legislation covers all steps of the legislative process, from the formal introduction of a bill to parliamentary hearings, the activities of driving forces, the influence of professional lobbyists and the effective enactment or rejection of the proposal.

Implementation: This stage is about all measures taken towards legal and professional implementation and adoption of a policy. Implementation does not necessarily result from legislation; it may also follow the evidence of best practices tried out in 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

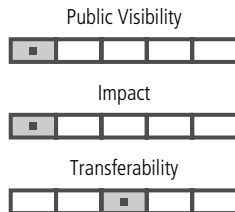
A second figure is used to give the reader an indication of the character of the policy. For this purpose, three criteria are shown: public visibility, impact and transferability.

Public Visibility refers to the public awareness and discussion of the reform, as 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” (on the left) to “fundamental” (on the right), 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 strongly context-dependent (on the left) to neutral with regard to a specific system, i.e., transferable (on the right).

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



Project management

The Bertelsmann Stiftung's Health Program organizes and implements the half-yearly surveys. The Department of Health Care Management, Berlin University of Technology (TU Berlin), assisted with the development of the semi-standardized questionnaire. We owe special thanks to Celia Bohannon for proofreading and to Heike Clostermeyer in the Bertelsmann Stiftung for managerial and editorial support.

The results from the fourth biannual survey, covering the period from May 2004 to October 2004, are presented in this book. Out of 59 reported reforms, 30 were selected.

While we describe current developments from the reporting period in detail on our Web site, we chose a somewhat different approach for presenting the findings in this report. 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 three surveys independently of their present stage of development or implementation.

Reports from the previous three and the fourth survey round can be looked up and researched on the network's Web site, www.healthpolicymonitor.org. Both these reports and this publication draw upon the partner institutions' reports and do not necessarily reflect the Bertelsmann Stiftung's point of view.

Thanks of course go to all authors from our partner institutions and to those who helped as reviewers and proof readers.

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

Reinhard Busse

Sophia Schlette

Susanne Weinbrenner

Overview

Issue 4 of Health Policy Developments focuses on issues that are relatively new or that have so far received relatively little attention. Access to health care, while less prominent in terms of public interest and visibility, nevertheless runs like a red thread through many health policy efforts. Depending on the context in a given country, access can surface as an official health policy target, as a tool for achieving better and more equitable health care, or as a criterion of good governance. Efforts to improve health care organizations through managerial and financial innovation remain an issue high on the health policy agenda.

Health Policy Developments 4 further spotlights issues of continuing concern to policymakers worldwide: primary care and quality management, the latter with a particular view to developments in the hospital sector.

As in previous issues, in our Newsflash chapter we keep an eye on reform processes reported earlier by our network partners. In addition, this book provides a reform tracker to facilitate the retrieval of earlier health policy development reports.

Emerging issues

In this section we highlight new issues emerging on various health policy agendas. Some issues are only now emerging because health care is often viewed with a focus on physical health problems—a one-sided view that excludes other areas of illness such as mental disorders, as well as the broader environment and the political and administrative framework in which health care takes place.

Another emerging topic—and an innovative policy tool—is Health Impact Assessment, a policy evaluation tool based on the theory of health determinants that aims to measure any public policy against its impact on population health. A report from Switzerland illustrates how Health Impact Assessment can be put into practice.

Access

This issue's chapter on access depicts a wide array of approaches taken as countries deal with the challenge of access. The range of issues covered also attests to the overall commitment of health policymakers to health care—and to access—as a public good.

The concept of access can vary widely in different health care systems or at different stages of health policy reform. Definitions include the general availability of health care and the affordability of services, but access also surfaces as a deliberate policy instrument for curbing health care consumption and as a criterion for health system performance.

In many countries, access to services is at the center of the debate about health care. Those assessing the appropriateness of access within a particular health care system typically raise the following questions: Are there waiting lists or waiting times for certain interventions? Are services available for after-hours consultations? Do all population groups have access to (the same type of) health care services? Are services tailored to ethnic or linguistic minorities? How much does access to appropriate medical care depend on income or wealth? To what extent do policymakers make use of financial barriers (prices, co-payments or fines) to curb overconsumption of health care services?

Access is thus one of the key objectives of health care systems as well as a tool for securing appropriate care and a criterion for assessing health care systems.

An underlying assumption is that accessible health care is a public good. Consequently, good health and good access have much to do with “good governance,” political commitment, and appropriate stewardship in health care politics geared toward

equity and responsiveness. With equitable access, any citizen can enter the health care system regardless of social status, ethnic origin, place of residence, literacy, affluence or physical condition. Thus, health care systems should be organized to fit the needs of the population, not vice versa.

Primary care

International evidence suggests that the quality of primary health care has an important effect on the equity, efficiency, and responsiveness of health care systems. Increased availability of primary health care is generally associated with higher patient satisfaction and reduced spending; by contrast, orientation towards a specialist-based system leads to inequity in access and higher health care costs. However, expansion of primary health care services may not always reduce costs, for its ramifications can include identification of unmet needs, calls for improving access, and higher service utilization.

Many developed countries emphasize the development of primary care as a means to improve the efficiency of their health care systems. The United Kingdom, for example, tries to improve performance of primary health care providers by linking health outcomes to reimbursement. New Zealand puts emphasis on the coordination of care through patient empowerment. France and Germany, by contrast, are introducing gatekeeper systems that are aimed only partly at improving coordination but above all at containing costs. Australia is implementing a strategy to improve access to primary care especially for remote areas and disadvantaged groups. Israel introduced a set of performance indicators to allow benchmarking between its four sickness funds with regard to the quality and effectiveness of their primary care provision.

Quality assurance—Are hospitals taking the lead?

The way societies organize, finance, manage and deliver health services has a strong impact on the performance of health systems. Therefore, governments, funders and patients increasingly

expect health care purchasers as well as providers to introduce quality control systems and outcome improvement strategies.

Current health policy reforms in developed countries underscore the particular importance of efficient hospital organization for quality of care. Measurement of hospital performance becomes more and more routine, supporting hospitals in assessing their performance and building the findings into measures for quality improvement. The chapter on quality assurance in this issue addresses reforms from various countries striving for superior hospital performance, reporting on experiences with systematic hospital quality reviews and managerial incentives as well as presenting findings from structure and outcome evaluations.

Germany recently published a comprehensive quality report. All hospitals now report on outcomes of 33 types of services in medicine and nursing. The English National Health Service introduced NHS Foundation Trusts in 2004. These entities allow hospitals that meet high performance standards to act as independent public interest companies. The cities of Barcelona in Spain and Montreal in Canada teamed up to assess the performance of hospitals within a comprehensive performance evaluation of their health care services. South Korea is also evaluating its hospitals, though limiting its quality review to structural indicators.

Advancing health care organization

Across many countries, health care systems possess structural characteristics that do not adequately address the most urgent problems the systems face. For example, despite the growing needs of patients with chronic conditions, health care systems are still predominantly tailored to acute illness. Additionally, the interface between purchasers and providers is still suboptimal, be it because responsibilities for the major sectors of health care are split or because health care provision is uncoordinated among providers and sectors. Thus the same results could be achieved more efficiently in another form. Some approaches featured in this section rely on market mechanisms; others involve new forms of organizing care delivery. In some cases, the described

reforms call for profound structural change to the way the system is steered and financed.

Newsflash

Last but not least, the Newsflash section tracks policies and developments reported in earlier issues of Health Policy Developments. This time, we follow up on pharmaceutical policies, specifically on recent developments in prescription drug re-importation in California and generic substitution in Finland. We catch up with the ongoing discussion of public sector reform in Denmark and take another look at the Netherlands, where reform is about to reshape the social security programs for health and long-term care in a fundamental way.

Emerging Issues

In this section we highlight new issues emerging on various health policy agendas. Some issues are only now emerging because health care has often been viewed with a focus on physical health problems—a one-sided view that excludes other areas of illness such as mental disorders, as well as the broader environment and the political and administrative framework in which health care takes place.

Depression, for instance, is a mental health problem that is attracting more and more interest as its burden grows in both scope and cost. According to the World Health Organization (WHO), depression is the most common cause of nonfatal disability worldwide, putting an increasing strain on economies and health care systems. This chapter reports on recent initiatives from Australia and New Zealand that address the economic, social and clinical challenges of depression.

Health Impact Assessment (HIA) is an evaluation tool based on the theory of health determinants (Fig. 1) that aims to measure any policy against its impact on population health.

Environment and health

Fig. 1: Health determinants

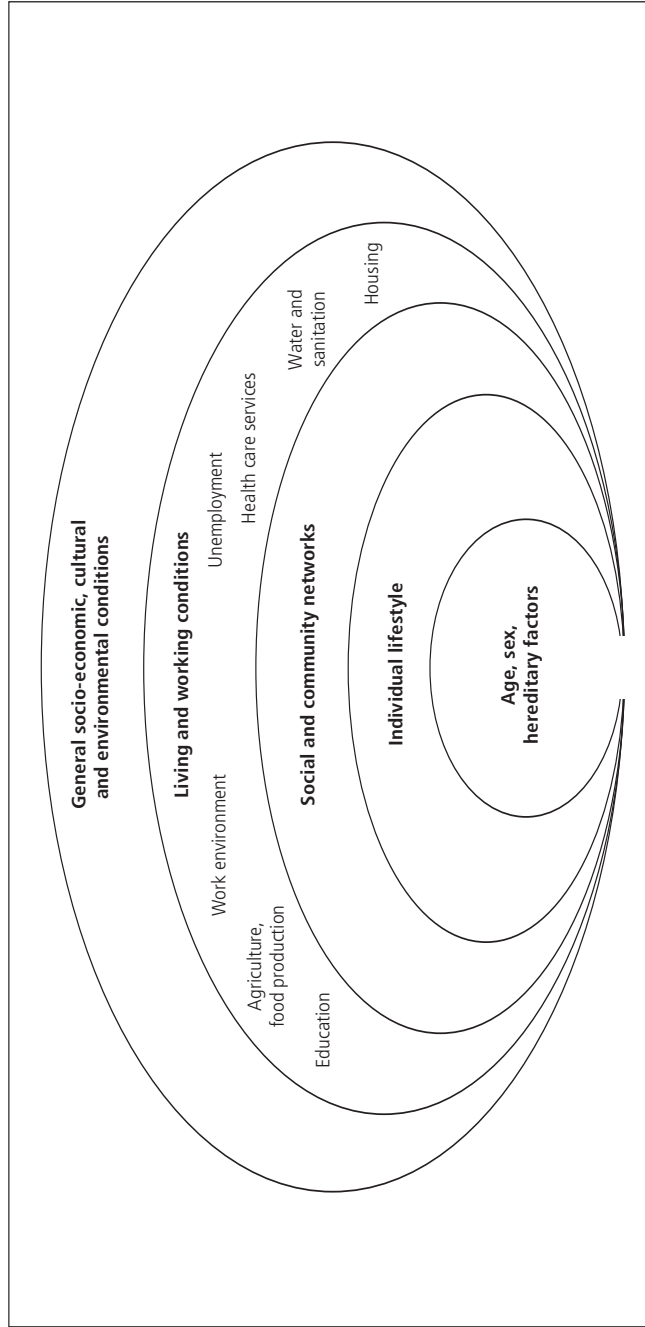


Illustration adapted from Dahlgren and Whitehead 1991

Our report on Switzerland in this chapter illustrates how HIA can be put into practice: Inspired by WHO and the experience from a few European countries such as the Netherlands, Sweden and the United Kingdom, the Swiss canton of Ticino has begun to introduce HIA.

Sources and further reading:

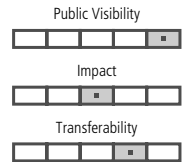
Dahlgren, Goran, and Margaret Whitehead. *Policies and strategies to promote social equity in health*. Stockholm: Institute for Futures Studies 1991.

Australia: Beyond Blue—A national depression initiative

Beyond Blue is a national, independent and not-for-profit organization created to address issues associated with depression, anxiety and related substance-abuse disorders in Australia. In October 2004, four years into its existence, the Beyond Blue initiative published its first report. “The Way Forward 2005—2010” highlights substantial success in some key areas and outlines the future direction of the organization’s work. A bipartisan initiative of the Australian national, state, and territory governments, Beyond Blue sets out to raise community awareness about depression, anxiety and related conditions. It also aims to reduce the stigmatization associated with mental distress and illness.

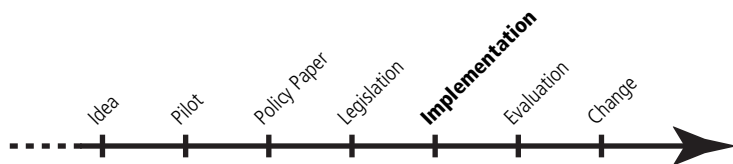
The initiative was stimulated both by the WHO, which lamented the disregard of depression as a health care issue, and by Australian data on the economic consequences of depression-related absences. Depression costs the Australian economy around €2 billion in lost productivity each year. Six million working days are lost, plus another 12 million days of reduced productivity.

Only 10 people work at Beyond Blue. The staff members act as change agents, launching projects and building networks with relevant actors and stakeholders in settings such as health services, schools, workplaces, universities, media and community organizations. People living with depression are also actively involved in these networks, bringing together expertise on depression and related conditions.



Depression is expensive

Tackling depression in multiple settings



Activities give priority to increasing community awareness of depression, anxiety and related substance-abuse disorders and to addressing the associated stigma. People living with depression and their caregivers receive information on the illness and effective treatment options. Prevention and early intervention programs are under development. There are plans to improve training and support for general practitioners and other health care professionals on depression as well as to initiate and support depression-related research. Thus, the program focuses on system improvement and patient advocacy.

Findings from the report on the first four years of Beyond Blue are encouraging:

- Community awareness and media coverage improved.
- 4,000 general practitioners were reached by training activities.
- Public insurance now covers services related to mental disorders.

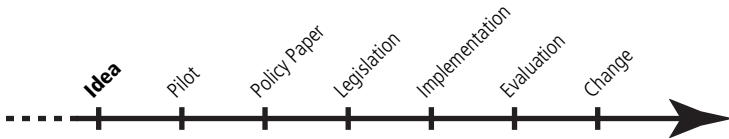
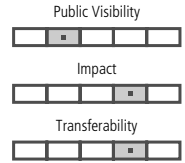
However, without data from formal and independent evaluations, the real impact of Beyond Blue on health outcomes remains difficult to estimate.

Sources and further reading:

Beyond Blue: www.beyondblue.org.au

New Zealand: A national mental health plan

In August 2004, the Ministry of Health in New Zealand published “Improving Mental Health—A draft second national mental health and addiction plan 2005–2015.” The first plan of this kind was published in 1997.



The new plan serves as a discussion paper for public consultations on improving mental health care in New Zealand. Interested parties were invited to provide feedback until the end of October 2004. Taking a very broad perspective on mental health care, the draft plan sets forth a vision for the next ten years and outlines goals and a series of actions to be implemented during the next five to seven years.

Seven main strategic aspects are outlined in the draft:

- More and better specialist services
- More and better services for the Maori people
- Responsiveness of services
- Systems development
- Mental health in primary care
- Promotion of mental-health and prevention
- Social inclusion of the mentally ill

**Advancing broad
community-based
strategies**

After some reviews of mental health care in New Zealand in the early 1990s found funding and organization inadequate, New Zealand has steadily pursued efforts to improve this area of health care. There is no relevant opposition, and the process of public consultations makes it very unlikely that any conflict may arise.

Sources and further reading:

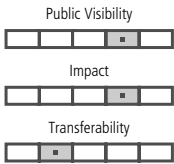
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New Zealand Ministry of Health. Moving Forward: The National Mental Health Plan for More and Better Services. September 1997. www.moh.govt.nz/moh.nsf/7004be0c19a98f8a4c25692e007bf833/11c63c69edc27d114c25667a0074d3de?OpenDocument.

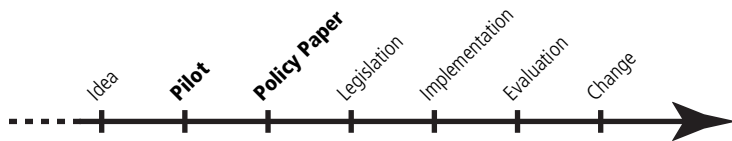
Switzerland: Health impact assessment of Ticino's public policy



The WHO stresses the impact of social, economic and environmental policies, programs and projects on the health of a given population. Following models from the Netherlands and the UK, the Department of Health and Social Welfare of the Swiss canton Ticino decided to take a new approach to evaluating cantonal policies with respect to their potential health impact in 2004. The systematic use of health impact assessment is intended to enable policymakers to make more health-conscious policy decisions.

Promoting healthy and sustainable policies

The innovative feature of Ticino's health impact assessment is the merger of instruments for sustainable development (environmental impact assessment) with those for health impact assessment. Health impact assessment is not a set method, yet it is based on the theory of health determinants. It draws upon a scientific knowledge base and various research methods to review the effects of any policy on the health status of the population.



By this means, Ticino aims to enhance healthy policy effects and to abandon or amend policies with negative health effects. Besides the relevance of identifying potential risks and indicating necessary corrections, a focus on health determinants may provoke a shift from the traditional, predominantly pathogenetic to the salutogenetic approach in health care. In the long term, Ticino expects to control health care costs by advancing multisectoral policies and improving the quality of any of these policies.

Sources and further reading:

International Health Impact Assessment Consortium:

www.ihia.org.uk

Health Impact Assessment Gateway:

www.hiagateway.org.uk

World Health Organization Regional Office for Europe:

www.euro.who.int/healthimpact

Banken, Reiner. *Strategies for Institutionalising HIA*. Brussels: WHO European Centre for Health Policy 2001.

European Centre for Health. Health impact assessment: main concepts and suggested approach. Gothenburg consensus paper. Brussels 1999.

Taylor, Lorraine, Natasha Gowman and Robert Quigley. *Influencing the decision-making process through health impact assessment. Learning from Practice Bulletin*. London: Health Development Agency 2003.

Access

Access can mean many things in different health care systems and at different phases of health reform. Definitions range from the general availability of health care services in the broad sense of social inclusion (overall physical access to care, to information on providers and services and to quality in both) to access as a policy instrument to control consumption.

In many cases, access stands for (the debate about) the ready availability of specific services: Must patients wait in line for certain interventions? Are outpatient services open for after-hour consultations? Access can also relate to geography: Are health care services available in certain areas? Moreover, access can mean financial access or affordability: How much does access to appropriate medical care depend on income or wealth? Or, from the policymaker's perspective, to what extent can deliberately created financial barriers (prices, co-payments or fines) be used to curb overconsumption of health care services? Cultural factors may also play a role in determining access: Is health care accessible to migrants and immigrants? Do ethnic or religious minorities find the available services acceptable?

Access:
Objective, tool
and a measure of
health care

Access is thus one of the key objectives of health care systems. At the same time, access is a tool for securing appropriate care as well as a criterion for assessing health care systems. The WHO defines accessibility as “a measure of the proportion of a population that reaches appropriate health services” (www.euro.who.int/observatory/Glossary/TopPage?phrase=A). An underlying assumption is that accessible health care is a public good. Consequently, good health and good access have much to do with “good governance,” political commitment, and appropriate stewardship in health care politics geared toward equity and responsiveness.

With equitable access, any citizen can enter the health care system regardless of social status, ethnic origin, place of residence, literacy, affluence or physical condition. Thus, health care systems should be organized to fit the needs of the population, not vice versa.

Many developed countries have managed to provide nearly universal coverage of their population. Most of these countries ensure access to services at little or no cost at the time of service, often as a result of some kind of public insurance arrangement.

Comprehensive coverage usually entails a broad package of health services. However, since all systems face rising health care costs and shrinking revenues, various barriers to health care are gaining importance. Potential obstacles to appropriate access include shortcomings in the type and scope of health insurance coverage, in the contents of the benefit basket, in infrastructure and supply in remote areas, in the extent of cost-sharing measures, in the availability of human resources, in the quality and efficiency of services, and in sensitivity and responsiveness toward cultural differences. Access is thus often measured by describing deficits and obstacles.

This chapter depicts a wide array of approaches taken as countries strive for equitable access. It also attests to the overall commitment of health policymakers to health care—and to access—as a public good.

To overcome poor access for some population groups, some countries, e.g., France, offer extended subsidies of coinsurance payments to put health insurance coverage within reach of low-income patients. Subsidy levels for primary health services are also being increased in New Zealand. While this is gradually reducing patient co-payments, the extra funds are not always passed on to patients in full (see chapter on Primary Care in this issue and HPD 1).

On the other hand, sickness funds in Germany charge co-payments for doctor visits, with or without bonus provisions or refund mechanisms for no-claim patients. Whether this leads to perverse effects such as underuse or critical delays in the use of health care services has been a recurrent question, as evaluation data from Israel, France, and Switzerland have been interpreted to feed the debate on either side.

**Old and new
barriers to access**

Financial incentives and access

**Expected and
unexpected side
effects of barriers**

Countries such as Spain and the United States, Finland, Canada and Great Britain are striving to remove various barriers to equitable access. Some measures target specific population groups, as in Catalonia and California. Finland and Canada continue the struggle to reduce waiting times. Denmark has focused on patient compliance, authorizing fines on those who fail to show up for hospital appointments. As part of the NHS modernization commitment, Great Britain continues to remove obstacles to certain services for which the public sector feels responsible, such as dentistry.

Moreover, access can take different meanings in different countries. In Austria and France, the term occurs in discussions of efforts to improve access to medical data using sophisticated IT carriers or platforms. We have decided to limit this chapter to access for the patient, that is, access to services and drugs, not to medical records.

From another perspective, restricted access is sometimes used as a policy tool to induce more rational use of services on the part of consumers or to improve quality and coordination of care, as can be observed in various models that countries are testing to improve health care organization. Gatekeeping schemes (Netherlands) and integrated care networks (Switzerland) postulate improved quality and better access as their primary targets. We cover these financial aspects of access from a more structural reform perspective in a later chapter (Advancing Health Care Organization).

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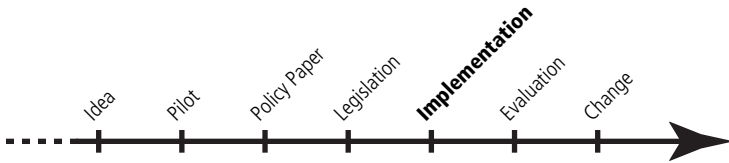
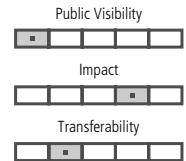
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France: Health insurance vouchers plan

Patients in France bear various co-payments: 30 percent of general practitioner bills, 20 percent of hospital bills and 25 to 100 percent of pharmaceutical costs, depending on the drug's quality rating. All these co-payments have increased notably in recent years, mounting a barrier to the health care system. In 2005, health reforms will introduce a new uninsurable co-payment for almost all users of the French health care system, potentially reinforcing this trend.



Worried about the consequences of this co-payment, public authorities now emphasize the health insurance vouchers plan (or tax credit plan). In 2000, complementary universal health insurance coverage (“Couverture maladie universelle complémentaire”, CMUC) was introduced. This means-tested free supplementary health insurance is aimed at the very poor only. During the implementation phase, the negative impact of the threshold became evident, for it effectively excluded a part of the population, some three million people.

Mending the social safety net

**Public subsidies
for supplementary
insurance**

However, individuals not eligible for the CMUC may still qualify for the health insurance vouchers plan. In that case, the individual must choose a supplementary contract using a certificate of eligibility from the public local health insurance fund that states the level of subsidy. The insuree pays only the residual costs. Grants range from €75 to €250 annually per person, depending on household income and the age and number of persons in the household.

**Annuling the
effects of steering
tools?**

The reform acknowledges that compulsory health insurance does not guarantee fair access when out-of-pocket payments are very high. With the subsidies, voluntary insurance is gaining acceptance and legitimacy. However, the debate on the role and acceptance of co-payments and supplementary insurance continues, and the controversy over demand-induced versus supply-induced utilization remains unresolved.

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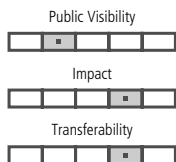
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Israel: Co-payments, access, equity



The Israeli health care system is a mix of a tax-funded and a social health insurance system. About a quarter of total expenditures is funded through an earmarked health tax collected by the National Insurance Institute. In response to constant budget strains on health care funding, the Israeli parliament passed the 1998 Budget Arrangement Law authorizing the sickness funds to charge patients additional co-payments for visits to specialists. Co-payments already existed, e.g., for emergency care and para-

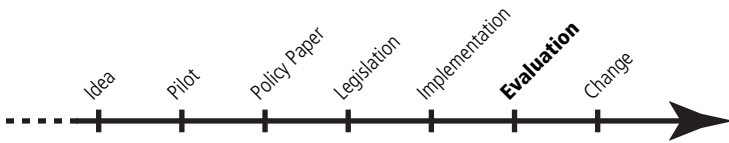
medic services. On top of that, the 1998 law raised co-payments for medications while stipulating that certain population groups be eligible for exemptions and discounts. Over the following years, rates of co-payments increased, with fewer people eligible for exemptions.

The government introduced co-payments to shift health care costs from the public to the private purse and to minimize over-demand of services. Sickness funds are expected to compete on the level of co-payments, but they could also fix prices and thus increase revenues without becoming cost-effective. This entails the risk that they set high co-payments to deter sick and low-income people from joining. Patients are expected to reduce unnecessary use of the system, but sick people may postpone necessary care.

**Risk of cream
skimming**

The policy was driven mainly by the Ministry of Finance, a powerful force in the Israeli system, as part of its campaign to reduce government spending. The Ministry of Health was divided on the issue. Some professionals vehemently opposed the idea, while others supported the additional source of revenues.

**Israel's public
values equity**



Because equity is a very important value in the Israeli public discourse, the introduction of co-payments for physician visits is one of the most controversial developments in the Israeli National Health Service. The calls for their repeal persist.

In 2004, the Myers-JDC-Brookdale Institute was commissioned to evaluate the former policy, examining the impact of co-payments on equity and access. Additionally, the evaluation studied the effectiveness of policy tools designed to safeguard access for vulnerable population groups, namely the exemption of low-income people from co-payments and the quarterly payment ceilings for people with specific diseases.

**Co-payments do
not meet
expectations**

The results were not as evidence from other countries, such as the U.S. RAND study, would suggest. In total, co-payments contribute about 1.5 percent of sickness fund revenues. Over the

examined period, 1995–2003, co-payment rates increased, but the absence of significant differences in co-payment rates between the funds suggests that they did not compete in setting these rates. Preliminary results find no evidence that co-payments have an effect on aggregated visit rates. But some three percent of the population and about six percent of the poor report forgoing visits due to costs over the past year. In the long run, this may have deleterious effects on their health status, potentially making more expensive treatments necessary later.

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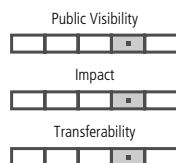
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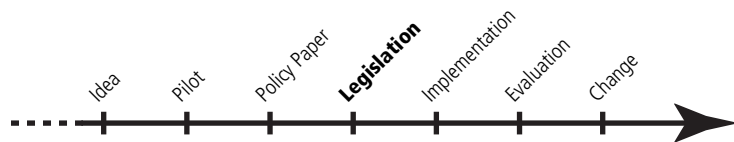
Spain: Facilitating specialized services and medication for illegal immigrants

In Spain, access to health care services and pharmaceuticals is linked to possession of the Tarjeta Sanitaria Individual (TSI), an individual electronic health card. Since 2001, the TSI is available to citizens and foreign residents. All citizens and immigrants must register at their place of residence. Once registered at the municipal office, individuals can apply for the TSI there or at a local primary care center. The TSI permits access to health care services according to the official benefit basket. There is no discrimination between Spanish citizens and immigrants, no matter what their legal status. Since 2001, the number of immigrants holding a TSI has increased considerably.

Nevertheless, a new initiative in Catalonia aims to broaden the number of immigrants with a TSI. The program aims to improve awareness of services included in the TSI and develop strategies to facilitate access for marginalized populations.



Electronic health card often excludes immigrants



As the initiative is at an early stage, measures, incentives and resources have not yet been specified. The NGOs, professionals

and interest groups supporting the initiative include the Health Department of the Catalan Government, the Barcelona City Council, the Municipal Council of Social Welfare of Barcelona, other councils in Catalonia, universities and migrant associations. However, regulations for illegal immigrants are regarded as a major obstacle, because irregular immigrants are considered unlikely to register. It remains to be seen whether immigration regulations will undergo changes that support this policy.

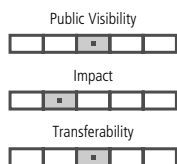
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California: Emergency Medical Care Initiative rejected



In early 2004 the Emergency Medical Care Initiative, also known as Proposition 67, was introduced.

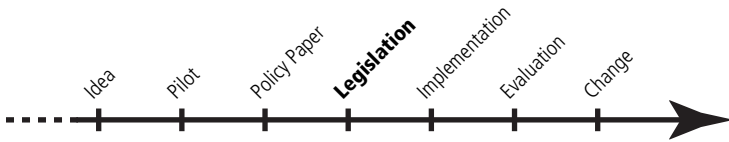
A group of doctors, nurses, health care providers, firefighters and paramedics had rallied behind the initiative and prepared the corresponding bill. It appeared on the November 2004 ballot but was rejected by 72 percent of the voters. The proposition would have instituted a broad-based phone tax to help the Californian emergency system solve its financial crisis. The tax would have

affected every household with a telephone line (except low-income groups qualifying for a Lifeline telephone), cell phone users and businesses, even those whose lines were already being taxed.

**Coalition to
Preserve
Emergency Care**

During the past decade, extensive financial losses experienced by many hospitals have led to the closure of over 70 emergency rooms throughout California. The crisis is due to several problems, but it chiefly reflects serious shortcomings in the emergency system as a whole. Emergency rooms are legally bound to provide care to everyone presenting, regardless of their insurance status or ability to pay. Indeed, emergency rooms are the only place where the six million uninsured Californians, about 19 percent of the population, receive care.

**Californian
emergency care in
a desperate
situation**



Additionally, physicians and hospitals are only partly reimbursed for treating people insured under medical assistance programs such as Medi-Cal or Medicaid. Even for patients with insurance coverage, providers are often not completely reimbursed, as insurers frequently decide afterwards that the health problem did not qualify for emergency treatment. Currently, an estimated 51 percent of Californian hospitals are operating at a loss, and bankruptcy has forced many facilities to shut down.

**Costly legal
requirements
for structures
and staff**

Recent legislation imposes additional severe funding problems: One mandate requires hospitals to undergo renovation and reconstruction by January 1, 2008, to meet earthquake safety requirements. The total costs of these measures are estimated at €31.1 billion—more than total hospital revenues in 2002. Accessory regulations of the Department of Health Services require increased nurse-patient ratios (see HPD 2/2003). It is estimated that supplementary hiring will cost the hospitals another €713 million annually from 2008 on.

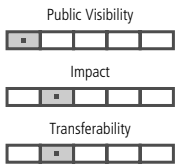
The reaction to the Emergency Care Initiative's proposition was mixed. Taxpayers, voters and especially small businesses were opposed, as they would have been heavily affected by the

phone tax. Governor Schwarzenegger had promised to avoid new taxes but would have been supportive in this particular case, as the bill offered an easy way to alleviate the crisis.

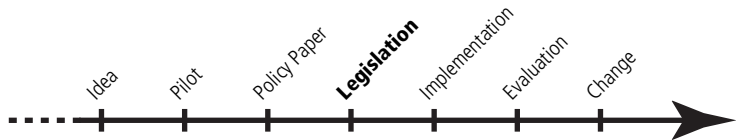
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Finland: Supplementary outpatient fees



In March 2003, legislation to reduce waiting times came into force in Finland. Based on a 2002 government paper aimed at “Securing the Future of Health Care,” the law establishes baselines for maximum acceptable waiting times with respect to a particular service. Municipalities that cannot maintain these standards must provide for utilization of services in another jurisdiction without charging the patient.



Abolishment of privileges

The law also introduces a new payment scheme for hospitals, doing away with the Special Payment Category set up in the 1950s, which provided private patients with the opportunity to choose a doctor by paying a special fee. Over the years, the Special Payment Category became a shortcut for patients who did not want to wait their turn for surgery. Although charges were not very high, this was perceived as a threat to equal access.

Will outpatient fees increase retention of health personnel?

The law introduces a new payment scheme. Public hospitals can create special outpatient departments for private patients. After-hours services provided by these departments are charged fully to the patients, allowing physicians and other health care professionals to earn extra money. In addition, the new fee

schedule may enable hospitals to retain their staff by offering them additional income opportunities.

However, it is unclear how effective the new policy will be and what its outcome will be in terms of equity, as the new scheme is optional for hospitals.

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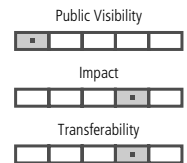
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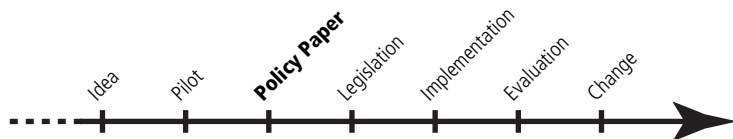
Canada: Is the Health Care Guarantee losing ground?

For several years, waiting times have ranked high on the health policy agenda in Canada, and the issue's urgency has shown no sign of abating. Waiting times were a major issue in the Canadian federal elections in June 2004, in a report issued by Statistics Canada in July 2004, and again at the First Ministers' Meeting in September 2004. The Health Care Guarantee, regarded as a proven remedy, enjoyed a top spot on the agenda. Despite all of this, the Health Care Guarantee is no longer a priority. What happened?

Western Canada and provinces such as Alberta, Ontario, and New Brunswick have been running initiatives to tackle waiting times for quite some time now. Alberta, for example, initially aimed at implementing a general 90-day Health Care Guarantee after investigating waiting times in specific priority areas. But since January 2004, the guarantee has evolved remarkably, into the softer, less binding Access Standards. Other initiatives assess patients' needs to arrange waiting lists for procedures or services, or apply a similar assessment procedure to patients waiting for cardiologic services. A growing number of provinces maintain Web sites where patients can view waiting times for particular services.



“The taming of the queue”



**Still lacking:
Evidence-based
solution for
waiting times**

The First Ministers' accord outlines the government's concession that waiting times are a top priority and states its willingness to allocate further resources to develop evidence-based benchmarks for medically accepted waiting times. These standards are to be developed by the end of 2005, as performance reporting is regarded as one of the most relevant mechanisms for advancing timely access.

The current indecision concerning a Health Care Guarantee probably reflects the many problems that remain unsolved. For instance, data allowing an evidence-based approach to waiting times are still fragmentary. Nor are appropriate information technologies and a model to calculate waiting times for individual needs yet available.

**Are fines
for bypassing
waiting lists
unconstitutional?**

At the same time, a potentially very influential lawsuit is pending before the Canadian Supreme Court. The claimants argue that penalties imposed on patients who purchase services privately to bypass waiting lists violate the Canadian Charter of Rights and Freedoms. The case is still being heard, but a victory by the plaintiffs would open the door to a second, private tier in the Canadian health care system—a development most Canadians still oppose.

Thus, the ultimate goal of a Health Care Guarantee may be reached via a detour rather than by the main road.

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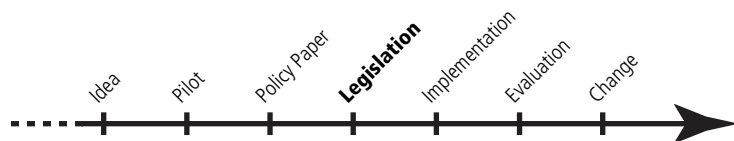
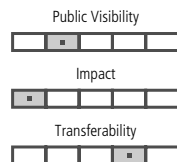
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Denmark: No-show fees for non-attending patients

Denmark has considerable problems with waiting times for specific medical procedures, such as eye surgery, joint replacement and cardiac surgery. To address this issue, in March 2004 the central government presented a bill proposing fines for patients who miss ambulatory or surgery appointments in hospitals.



The draft law foresees incentives for patients aimed to enhance conscious and efficient utilization of health care services. The proposal is part of a broader package of measures to reduce the misuse of public services. Kindergartens had already piloted similar fines for parents who do not pick up their children on time.

The bill passed in June 2004. Hospitals are now allowed to impose penalties for missed appointments. The counties oppose the

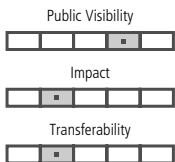
**Counties fear
bureaucracy, doubt
effects of fines**

law because they expect considerable bureaucratic problems. Without an appropriate structure to collect fines, they fear an increase in administrative expenses. Beyond that, the penalties affect patients' rights while the legal consequences remain unclear. The Association of Counties is not convinced that there will be more than a marginal effect on missed appointments. Implementation of the "no-show" law depends on the counties, which own and manage the hospitals. It remains to be seen whether the law will actually be enforced.

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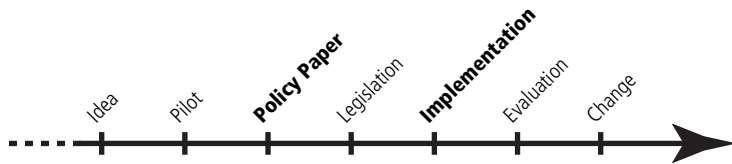
United Kingdom: Knights, knaves and gnashers



**Dentistry:
Intransparent
market, adverse
effects on equity**

Dentistry is an example of creeping privatization within the National Health Service (NHS) of the UK. During the 1990s, co-payments for dental services increased to such an extent that 80 percent of financing is now borne privately. Variable access to dental services, with discrimination against vulnerable populations, has been a focus of media attention during the past decade. In addition, a rising number of dentists have cut back the hours they work for the NHS to focus on private patients. Private dentistry now accounts for 48 percent of the total dentistry market. According to the Office of Fair Trading, this market is not functioning very well. Information is available unevenly, so that patients lack adequate information about different therapy options and other matters.

Though many European countries do not regard dentistry as a core element of public health care and leave it to private provision, the British government does consider dentistry an essential part of the NHS. In the late 1990s, the government started to reform the dental service sector.



In July 2004, the government announced its intention to invest another €541 million to recruit 1,000 dentists from the UK and abroad, offering financial incentives and attractive working conditions. Starting in 2005, it will also fund 170 additional slots for undergraduate dental training. The government earmarked another €116 million for capital investment and €13 million to assist dentists who agree to prepare their practices for the additional recruits.

Dental care remains core element of the NHS

Earlier reforms focused on organizational changes rather than on increased funding. As of 2002, Primary Care Trusts (PCTs) can commission and purchase dentist services according to the needs of the population they serve. Starting in 2005, the entire budget for NHS dental services, amounting to €2.3 billion, will devolve to PCTs. The trusts are already the main purchasers of health care in the NHS, administering 75 percent of the NHS budget. Thus, further developments in dental care will depend not just on the government and the dental professionals, but mainly on these trusts. There are some concerns about this, as PCTs may not really be prepared for this role.

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Primary Care

In 1998, the World Health Organization (WHO) defined primary health care as “the first-level contact with people taking action to improve health in a community” (www.euro.who.int/observatory/Glossary/TopPage?phrase=P). The WHO glossary includes this note: “In a system with a gatekeeper, all initial (non-emergency) consultations with doctors, nurses or other health staff are termed primary health care, as opposed to secondary health care or referral services. In systems with direct access to specialists, the distinction is usually based on facilities, with polyclinics, for example, providing primary care and hospitals secondary care.” (ibid.)

International evidence suggests that the quality of primary health care has an important effect on the equity, efficiency, effectiveness and responsiveness of health care systems. Increased availability of primary health care is generally associated with higher patient satisfaction and reduced health care spending; by contrast, orientation towards a specialist-based system leads to inequity in access and higher health care costs.

Consequently, expansion of primary health care services is encouraged in many countries. Expansion of primary health care services may not always reduce costs, for its ramifications can include identifying unmet needs, improving access, and higher service utilization. Nevertheless, many developed countries emphasize the development of primary care as a means to improving efficiency of their health care systems.

The United Kingdom, for example, tries to improve performance of primary health care providers by linking health outcomes to reimbursement. New Zealand emphasizes the coordination of care, basically through patient empowerment. France and Germany, by contrast, are introducing gatekeeper systems that are

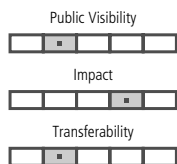
aimed only partly at improving coordination but above all at containing costs. Australia is implementing a strategy to improve access to primary care especially for remote areas and disadvantaged groups. Israel introduced a set of performance indicators to allow benchmarking between sickness funds with regard to the quality and effectiveness of their primary care provision.

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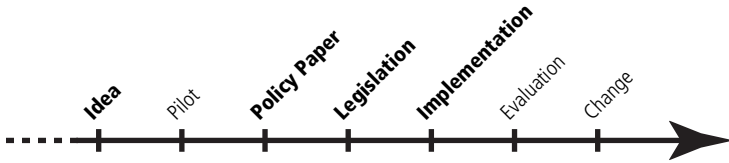
United Kingdom: The new general practitioner contract



Payment by results

In April 2004, the vast majority of general practitioners in the United Kingdom started to be paid under a new national contract. The contract is practice-based and introduces a range of important changes including a quality and outcomes framework.

General practitioners are independent contractors of the National Health Service (NHS). Efforts to make them more accountable for the services they provide began in the early 1990s. As providers of primary care but at the same time commissioners of secondary care, general practitioners have a crucial role at the interfaces of the health care system. The new contract broadens the approach of payment for results that started ten years ago with payments for achieving population-based health targets such as immunization rates. The contract allows practices greater flexibility to determine the range of services they wish to provide, rewards practices for delivering clinical and organizational quality, and requires improving the patients' satisfaction.



Payments are now related to performance in specific clinical areas, such as coronary heart disease, stroke, hypertension, diabetes and cancer. Beyond that, practices may earn additional income when offering extra services, such as cervical screening, contraceptive services, vaccinations and immunizations, child health surveillance or maternity services. Finally, under the new contract general practitioners may elect not to provide out-of-hours services, passing that responsibility to Primary Care Organizations. The contract required GP cooperatives to organize the emergency services by 31 December 2004.

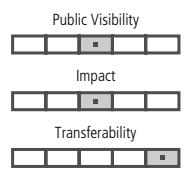
Outcome rewards for disease management improvements

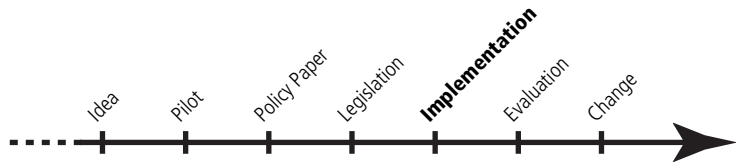
After hard and protracted bargaining, 80 percent of the general practitioners voted in favor of the contract. One of the main reasons for acceptance was the ability to opt out of emergency services. Critics argue that this may endanger one of the major strengths of the NHS, namely comprehensive primary care.

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New Zealand: Care Plus for high-needs patients

In October 2004, a new initiative was introduced as part of the New Zealand Primary Health Care Strategy. Care Plus provides extra funding to provide superior care to people with high needs and high levels of utilization. As of February 2005, 61 of 77 primary health organizations are offering Care Plus.





Individual care plans improving outcomes

Care Plus seeks to provide low- or reduced-cost access to nurses' and/or doctors' expertise and time. Using a care plan developed with the patient and regularly reviewed, the program aims to improve health outcomes through better self-management and continuous support in achieving realistic health goals. The Ministry of Health provides extra funding earmarked to implement the strategy. Preconditions and implementation will be optimized according to evaluation results from three pilot sites.

Interestingly, the pilots indicated a high level of job satisfaction among providers. Nurses in particular were happy to be working more closely with patients and their families, providing more continuing care with a focus on health rather than on disease.

Previous experience lacked high-need orientation

Since July 2002, primary care in New Zealand has been re-organized around the primary health organizations (see also HPD 1/2003). They are not-for-profit organizations funded on a capitation base to provide primary care to their enrolled population. Some groups expressed concerns that the needs of high users of health care are not met by the frequently episodic and sometimes uncoordinated approach of traditional care. Despite the new organizational approach of 2002, people with acute, severe medical or mental diseases or people with chronic or terminal illnesses still do not receive optimal care. In addition, access to care is jeopardized because of the daunting cumulative expense of co-payments for consultations and drugs.

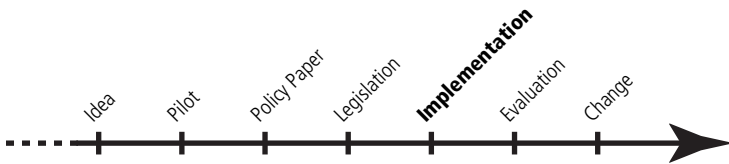
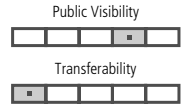
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France: Improved coordination in health care

In August 2004, the French parliament passed a general health reform bill. To improve cooperation and coordination of health care, the reform introduces a comprehensive package of delivery reorganization consisting of gatekeeping, electronic medical records, and various financial incentives for providers and patients. Certain incentives encourage patients to accept restricted freedom of choice and increased control of access to specialist care.



The level of reimbursement for specialist consultations depends on whether the patient was referred by a “family doctor” (“médecin traitant”), who may be a general practitioner or a specialist. Citizens who choose a family doctor are reimbursed for specialist care at higher levels. Except for pediatricians, gynecologists and ophthalmologists, a surcharge is added for any consultation without a referral. In addition, an electronic personal medical record will be introduced by 2007. All medical professionals involved in the treatment of a patient will be able to access the data. All relevant information on consultations, procedures, treatments, drugs and medical advices of the respective patient will be stored in this record. Patients without an electronic record are charged extra user fees.

Financial incentives increase efficient health care utilization

Finally, exemptions of co-payments for seriously ill people will be linked to acceptance of a care protocol agreed on by the family doctor and the sickness fund doctor. A precursor of this system was the “referring doctor” system. However, that system was unpopular; it led to direct conflicts between referring doctors and specialists, and only 12 percent of general practitioners and one percent of the population participated. Under the new legislation, referral is compulsory and fines are imposed on patients who do not comply. All relevant stakeholders participated in drafting the bill, so there is no relevant opposition. The Ministry of Health expects improvements in quality, and cost containment is estima-

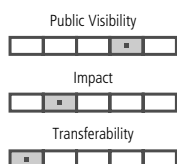
Noncompliance is expensive

ted to amount to €10 billion annually. Savings generated by the electronic medical record may, at least in the beginning, be offset by the costs of development and implementation.

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Australia: General practitioners' remuneration



In July 2004, a major change to Medicare, the Australian tax-based health insurance system, came into law. Medicare covers services according to the Medicare Benefits Schedule (MBS) for the entire Australian population. Care is provided to anybody in need, irrespective of income. Medicare offers 85 percent reimbursement of the schedule fee for outpatient services and 75 percent of the schedule fee for services provided in hospitals. Rising co-payments during recent years have increasingly jeopardized access to health care for low-income people. In an effort to ensure access to primary care, remuneration of general practitioners became a major issue in the Australian health policy debate (see also HPD 1&2/2003 and 3/2004).

Preserving the spirit of Medicare

In April 2003, a preliminary reform proposal called A Fairer Medicare was introduced. Heeding concerns that fundamental changes would reconfigure Medicare to provide a safety net solely to low-income people, thus introducing a two-tier system, the Senate (the upper house of parliament) did not pass the bill.

In November 2003, a slightly modified proposal called Medicare Plus was introduced, incorporating some of the suggestions resulting from a Senate inquiry. The November proposal recommended the following measures to address the access and remuneration issues under review:

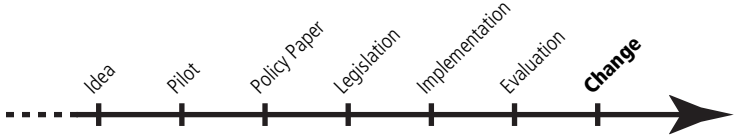
- Reduction of the annual threshold at which concession card holders (poor, sick or elderly people) become eligible for safety net benefits. This means an annual deductible of €172 for concession card holders, compared with €401 for others.
- Payment of €4.30 by the Ministry of Health to general practi-

tioners for consultations for bulk-billing concession card holders and children under 16, especially in remote or rural areas such as Tasmania. Under bulk billing, general practitioners bill Medicare directly and accept 85 percent of the normal Medicare fee as full reimbursement for the consultation (nearly 80 percent of services are bulk-billed).

- Introduction of a new Medicare Benefit Scheme for services of allied health professionals (e.g., psychologists, physiologists, dieticians) covering five consultations from professions working “for and on behalf of” general practitioners under a multidisciplinary care plan. The purpose is to improve multidisciplinary and coordinated management of patients with chronic and complex conditions. It was introduced in 1999 under the Enhanced Primary Care Programme.
- Funding of additional medical school places as well as the rollout of an integrated medical record system.

Benefits for multidisciplinary management of chronic conditions

The bill passed in July 2004 with the backing of four independent senators who gained specific concessions for their states in return, such as medical school places for Queensland.



Since the conservative government returned to power with an increased majority in October 2004, the new law will be implemented. New Medicare Plus spending is €245 million, bringing the total cost of Medicare Plus to €1.63 billion. Resistance comes from the parliamentary opposition, consumer groups and experts, as the introduction of a two-tier system is suspected. Furthermore, incentives for bulk billing are quite weak and may even cause adverse effects.

Equity concerns persist

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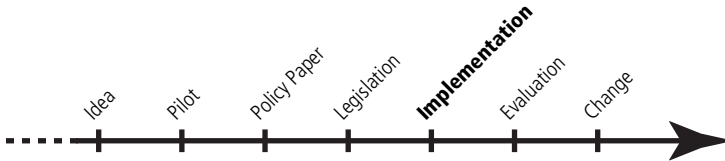
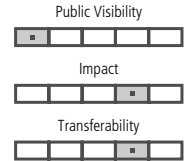
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Israel: Improvement of primary care quality

In 2004, the Israeli Ministry of Health began to apply a national measurement system to assess the quality of care provided by the sickness funds. The system uses assessment measures developed by researchers from Ben Gurion University, who adapted indicators from the U.S. HEDIS-2000 project to Israeli conditions.



To date, the system includes measures for prevention of asthma, care of diabetes, screening for breast cancer and influenza vaccinations for the elderly. The Primary Care Quality Measures Project is guided by a steering committee consisting of all relevant stakeholders. The methodology is based on census data and is uniform for all sickness funds. An auditing process assures validation of data with respect to comprehensiveness and credibility. Each sickness fund receives its own performance data and the overall national score as reference. At the moment, only the national score is published, giving sickness funds the chance to improve their performance during the implantation period.

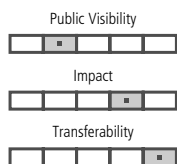
Despite obligations under the National Health Insurance Law, it had not been possible to monitor performance and compare quality indicators because each sickness fund collected its own data set. A research project funded by the National Institute for Health Policy Research proved the feasibility of a uniform measurement system and a national score of quality indicators. With supervision of the project assigned to qualified and independent researchers, the sickness funds found the project acceptable. Thus, the Ministry of Health at last took responsibility for quality measurement. Researchers, convinced of the need to monitor sickness funds that had weak incentives to provide high-quality care, pushed for the project. They also insisted that visibility of the measures was crucial. Performance improved through the first three years of the project; nevertheless, quality in unmeasured areas remains at risk.

Feasibility and visibility

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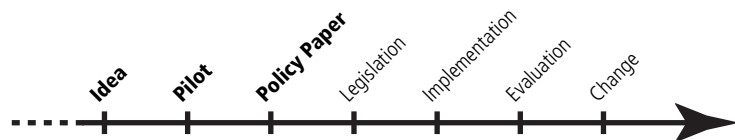
Germany: Family doctors as gatekeepers



The health care reform act of 2004—the Statutory Health Insurance Modernization Act—introduced a new option for primary care delivery in the German health care system, centered on the family physician.

As in the Netherlands and elsewhere, the family physicians serve as gatekeepers and “navigators” through the health care system. A specialist can be seen only upon referral from the family physician. Exceptions are gynecologists, pediatricians and ophthalmologists.

With this new model of care, the German Ministry of Health and Social Security aims to improve quality and to achieve more efficient use of available funding in the German health care system. Improved coordination of care and the reduction of overuse, underuse and misuse have been long-standing issues in the German reform debate. More specifically, the new model aims to reduce hospital admissions, encourage more efficient use of pharmaceuticals and avoid redundant examinations.



The recent reform act requires all providers of statutory health insurance (SHI) to offer their members the option of care centered on the family physician. To receive such contracts, family physicians must meet criteria established by agreement between

the sickness funds and the Federal SHI Physicians' Association: They must participate in quality circles, treat their patients according to evidence-based guidelines, run a quality management program within their practice, and meet minimal administrative standards (technical equipment, IT for patient records and billing information, etc.).

The insured person can choose whether to register for this model or to remain in the regular system. An individual who enrolls in the new model is eligible for a bonus from the sickness fund: The quarterly €10 user fee is waived. Once registered, the individual must stay with that family physician for one year unless the relationship between patient and physician is seriously damaged.

Enrollment bonus

Several contracts were signed during the new program's first year. One of the first to take effect was between the QualiNet, a regional physicians' network in Mannheim, and the AOK sickness fund in Baden-Württemberg. The Barmer Ersatzkasse, the largest single SHI in Germany, recently signed a contract with the German Family Physicians' Association that is valid nationwide.

Another prominent example is an agreement among the AOK, the regional physicians' association and the regional association of family physicians in Saxony-Anhalt. After just two months, about 1,000 of 1,600 family physicians had signed the agreement and some 200,000 out of 900,000 AOK members had registered.

Gatekeeping in ambulatory care is not uncontested. Opposition comes from specialists who claim that the freedom to choose a physician is an important asset of the German system that ought to be safeguarded. Criticism also comes from the Federal SHI Physicians' Association and the German Family Physicians' Association, who object to the special criteria for family physicians who participate. They argue that two-thirds of family physicians already qualify as general practitioners and that even in the case of those who do not, there is a high level of education.

Physicians' plea for free choice

Another criticism is that if even certain highly-qualified family physicians are not eligible for contracts, then the sickness funds might take advantage of the situation by excluding those physicians with a high percentage of elderly and high-risk patients with certain chronic conditions.

Are sickness funds picking good risks?

**Getting incentives
right—for all
parties**

The Gesundheitsmonitor, an annual Bertelsmann Stiftung survey of 1,500 insured persons and 500 physicians, found in 2004 that 81 percent of the insured prefer a care model centered on the family physician if participation has economic advantages; by contrast, half of the physicians were unsure whether they were capable of guiding their patients through the system.

The ongoing debate and these findings show that the implementation of a gatekeeping model in the German health care system remains controversial, even though insured individuals prefer to have a family physician (and most actually have one). The diversity and strong sectoral boundaries of the German system, combined with vested political and economic interests, will make it difficult to implement a working gatekeeping system in Germany.

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Quality Management in Hospitals

The way societies organize, finance, manage and deliver health services has a strong impact on the performance of health systems. Therefore, governments, funders and patients increasingly expect health care purchasers as well as providers to introduce quality control systems and outcome improvement strategies.

Current health care reform processes in developed countries underscore the particular importance of efficient hospital organization for quality of care. Measurement of hospital performance becomes more and more routine, supporting hospitals in assessing their performance and building the findings into measures for quality improvement. For instance, WHO Europe is currently piloting an assessment tool for hospitals called PATH (Performance Assessment Tool for Hospitals). Developed by WHO Europe, a pilot began in spring 2004 in six European countries (Belgium, Denmark, France, Lithuania, Poland/Silesia Region, and Slovakia) and two countries outside Europe (South Africa/Kwazulu Natal and Canada/Ontario). In this pilot, performance assessment is designed for internal use on a voluntary basis. It does not aim at external monitoring and evaluation or at use by any local or national agency for restructuring purposes.

In this section we report on reforms from various countries striving for superior hospital performance. Germany recently published a comprehensive quality report, in which all hospitals reported on outcomes of 33 types of services in medicine and nursing. The English National Health Service introduced NHS Foundation Trusts in 2004. These entities allow hospitals that meet high performance standards to act as independent public interest companies. The cities of Barcelona in Spain and Montreal in Canada have teamed up to assess the performance of hospi-

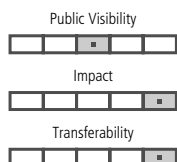
tals within a comprehensive performance evaluation of their health care services. South Korea is also evaluating its hospitals, though limiting its quality review to structural indicators.

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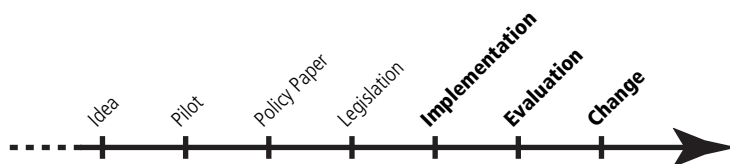
Germany: Compulsory external quality assurance for hospitals



Over 300 indicators for hospital care quality

In November 2004, the Federal Office for Quality Assurance (BQS) issued its “Qualitätsreport 2003” (Quality Report 2003), a report on external quality assurance that published full and specific outcome data for all German hospitals authorized to take part in public health care. This report, the first of its kind in any country, presents the assessment of 33 surgical and diagnostic measures against quality indicators for medical and nursing procedures. Statistics of the complete report are based on 330 quality indicators and 439 quality classification numbers.

Examples of indicators are the incidence of wound infections after knee joint replacement, of surgery for complications after removal of the gallbladder, and of decubital ulcers. In its methodology, the BQS procedure closely follows the international standard of external comparative quality assurance (Joint Commission on Accreditation of Healthcare Organizations 1990), comparing the real situation to expected standards according to guidelines.



External comparative quality assurance was previously used only in those areas reimbursed on a per case basis, which in practice are mostly operative and interventional services. From 2005 on, non-invasive procedures will also be included. The Quality Report 2003 covered 20 percent of all treated hospital cases. However, the federal associations of Statutory Health Insurances, the Association of Private Health Insurers, the German Hospital Organization, the Federal Physicians' Chamber and the German Nursing Council have agreed to further develop quality assurance by expanding the database for assessment.

Quality assessment had already become a requirement under the 1989 Health Care Reform Act. But expert reports, such as the 2000 Report of the Advisory Council for Concerted Action in Health Care, still described severe shortcomings in quality assurance. The Reform Act of 2000, the Case Fees Amendment Act of 2002 and the Statutory Health Insurance Modernization Act of 2004 introduced further measures. In 2004, overall responsibility for quality assurance was moved from the providers to the Federal Joint Committee, the highest decision-making board in the German self-governing health care system. This move underscores the growing importance of quality assurance in hospitals in recent years.

Quality assurance for hospitals in Germany now rests on several pillars:

- The obligation to provide internal quality assurance and quality management.
- Definition of a minimal volume for specific procedures such as liver transplantation; minimal volume must be met as a precondition for reimbursement.
- Requirement to provide data for the report on external quality assurance published annually by the Federal Office for Quality Assurance. Hospitals showing poor performance will face intensive dialogue including advice and support or even visitation by experts.
- Quality reports to be compiled by every individual hospital and published on the Internet by the sickness funds every two years. These reports comprise two parts: data on structural characteristics and services provided; and a description of the quality policy, of the external quality assurance and of the qual-

Quality assurance gains importance

Increasing support for quality assurance

ity management of the respective hospital. Hospitals failing to prepare the first report (due August 31, 2005) will be visited by the Statutory Health Insurance Medical Review Board every year.

- Finally, the appraisal of hospital procedures on the basis of scientific evidence is the prerequisite for reimbursement by the sickness funds.

Hospitals can use the required reports for quality improvement processes, for internal reporting and for management purposes. From 2005 on, hospitals may also use the data generated through the BQS to externally demonstrate their capacity in their structured quality reports.

A critical aspect is the need to ensure the quality of the data. As information about quality becomes ever more important in an increasingly competitive health care system, the risk of intentional false reporting rises. Hence, BQS planners are developing a method of validating the primary data.

**DRGs likely
to compromise
quality
measurements**

Another problem arises from the implementation of the DRG (Diagnosis-Related Groups) reimbursement system, which can lead to shorter hospital stays. Shorter Hospital stays, in turn, narrow the time frame for measuring the quality of treatment in a hospital because many important treatment results occur only after the patient is released. Currently, the only opportunity to assess a whole treatment process is under the regime of an integrated care contract.

BQS-generated data are not yet available to patients but plans are underway to offer this decision-making aid in the near future.

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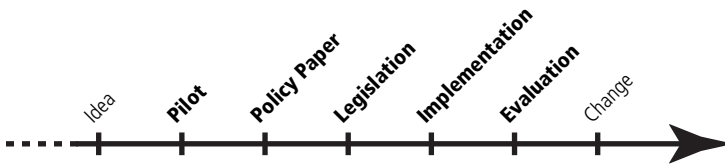
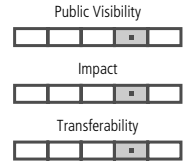
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England: NHS Foundation Trusts

NHS trusts were established in the early 1990s as part of the purchaser-provider split in an effort to enhance efficiency within the NHS. These trusts have considerable managerial competencies. In practice, though, competencies are limited by restrictions imposed on the trusts in an effort to ensure accountability to the Secretary of State for Health. Since December 2002, the Department of Health has supported and promoted the idea of NHS Foundation Trusts.



Foundation Trusts are expected to realize their managerial competencies, as they are responsible solely to patients and local authorities. In April 2004, the first trusts in England to be awarded foundation status were selected, amid continuing concerns that the policy might worsen inequalities in health care. Inequalities are an issue because improved financial strength and independence may enable foundation trusts to offer better services than the normal trusts.

NHS Foundation Trusts are independent public interest companies with specific managerial freedom, e.g., they may determine their own investment plans or retain revenues from land sales. Their accountability is to local authorities rather than to the Secretary of State for Health. Enabling the Management Board to come to decisions tailored to their particular population, the new trusts embody ideas of decentralization and democratization based on models of cooperative or mutual societies as seen in Nordic countries.

The status of an NHS Foundation Trust is a status of earned autonomy. Trusts are rated according to a set of performance indicators, and only those earning top grades are eligible for this option. Trusts with the highest levels of performance earn a performance rating of three stars; trusts that perform well overall but have not quite reached the same consistently high standards are

Will trusts deepen the quality gap?

Is Scandinavian decentralization exportable to the UK?

Earned autonomy

awarded two stars; trusts where there is some cause for concern regarding particular areas of performance receive one star; and, finally, trusts that have shown the poorest levels of performance against the indicators or little progress in implementing clinical governance have a performance rating with no stars.

The issue of “losing autonomy”—that is, whether and how hospitals can revert to the status of ordinary trusts—is not yet well-regulated. However, the topic appeared on the agenda in July 2004 when four three-star hospitals faced downgrading by the UK Health Commission.

**Public wants
public control**

In the beginning, there was no serious opposition either from within or from outside the government. Following the publication of a report by the House of Commons Health Committee, however, criticism grew vociferous. Local autonomy is expected to enhance efficiency and decision making, but because the foundations are tax-funded, they are expected to be answerable to Parliament through the Secretary of State. Additionally, board elections of the first NHS Foundation Trusts have indicated an alarming indifference on the part of staff and public. Lack of interest and participation calls one of the basic principles—democratic legitimacy—into question.

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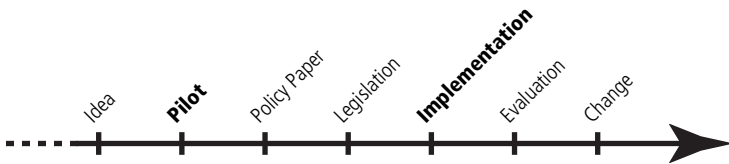
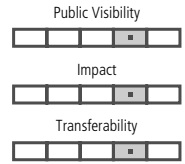
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Spain and Canada: Barcelona and Montreal compare their health care services

Between 2001 and 2003, the city of Barcelona, in collaboration with the city of Montreal, developed a set of indicators to assess the performance of their respective health care services. Starting with 51 performance indicators outlined by the English National Health Service in 2002, agencies from both cities undertook a concerted process of identifying, selecting, adapting, completing and prioritizing indicators. The working group ended up with a set of 83 indicators.



In 2004, both cities started to collect data. Data sources are primarily epidemiological databases and registers of resource consumption. Information on these indicators will be collected annually for both cities. Through assessing the performance of their services, Barcelona and Montreal expect to monitor and improve the quality and efficiency of health services to enhance the health status and satisfaction of their respective populations.

Comparing both cities and, possibly in the future, Barcelona and Catalonia or Barcelona and other regions of Spain may allow for benchmarking and thus further improving the output of health care services. The main initiators and actors are the public health authorities and municipalities of both cities. At the moment, there are no other stakeholders involved, but they are expected to enter the stage as soon as first results are published.

Spanish and Canadian urban areas

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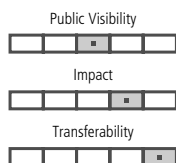
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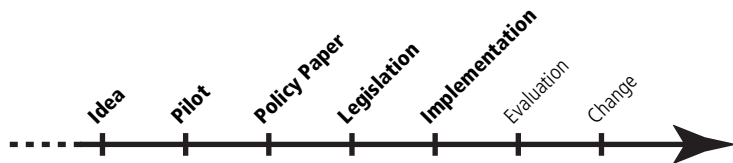
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South Korea: Evaluation of hospitals



In 2004, the Korean government established mandatory evaluation of hospitals. A National Review Committee comprising representatives of the hospital association, patients, civic groups, insurers and academics began conducting evaluations in August 2004. Thus, evaluation of hospitals takes place as a joint collaborative exercise of government, providers and consumers.

The 18 members of the National Review Committee agree on major decisions related to the evaluation, such as methods, schedules and coverage. The government appoints the members of the Review Committee. For providers, the government appoints candidates nominated by provider associations. Now that this task has been assigned to a third-party agency representing all stakeholders, mandatory evaluation is expected to gain acceptance.



Learning from the best

The Ministry of Health and Welfare plans to publish results from high-performing hospitals only, rather than “threatening” all hospitals with the disclosure of their data. However, because only

structural and tangible factors are assessed, hospitals may tend to focus on better facilities rather than superior health outcomes.

After some years of piloting hospital evaluation, fierce resistance from the Korean hospital association brought assessments to a halt in 2000. Those evaluations had been carried out by the Korean Health Industry Development Institute, a not-for-profit research organization funded primarily by the government, which also exerted significant influence on both the governance of the institute and the appointment of its president.

The Korean hospital association had sought to assume leadership in the evaluation process, arguing that its hospital accreditation program for teaching hospitals had a similar component of quality assessment. But there was severe public distrust of the hospital accreditation program. By 2001, the government had assessed only 33 of 95 public hospitals. However, as 90 percent of hospitals (954) are private, discussions and negotiations between the hospital association and the Ministry of Health and Welfare continued, especially as quality and the dissemination of quality reviews remained of great concern to the public.

Earlier evaluation attempts had failed

Sources and further reading:

Ministry of Health and Welfare: www.english.mohw.go.kr/index.jsp

Advancing Health Care Organization

Health care systems do not always possess structural characteristics that are adequate to address the most urgent problems they face. Despite the growing needs of patients with chronic conditions, health care systems are still predominantly tailored to episodes of acute illness. Additionally, the interface between purchasers and providers is still organized unsatisfactorily, whether because responsibilities for the major sectors of health care are split or because health care provision is uncoordinated among providers and sectors.

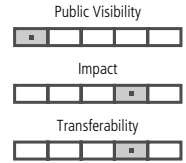
This section deals with initiatives to tackle these problems. Some approaches rely on market mechanisms; others involve new ways of organizing care delivery. In Israel, for instance, the Minister of Finance, in collaboration with the Minister of Health, plans to introduce a for-profit sickness fund to enhance competition and thereby improve efficiency. The Dutch Ministry of Health is pursuing a similar approach to reform the health care system as a whole. In Austria, the Minister of Health is preparing to create entirely new regional health institutions responsible for purchasing and organizing health care services.

In Japan, the Ministry of Health plans to merge insurance companies in order to improve efficiency and financial sustainability. The Swiss government, having already facilitated the implementation of managed care plans in the mid-1990s, now aims to spread this type of insurance via legislation establishing provider networks with budgetary responsibility. Singapore, on the other hand, is piloting a small-scale community-based health care project to improve care coordination among the myriad health care providers.

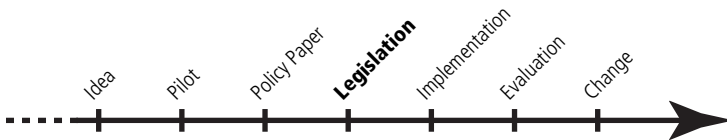
Israel: For-profit sickness fund

The Israeli health care system is a mix between a tax-funded and a social health insurance system. All residents are insured and entitled to the benefits defined in the National Health Insurance Law. Currently, four not-for-profit sickness funds administer the National Health Insurance program; that is, they insure their members and purchase or provide, in part directly, the services and goods defined in the benefit package. 100 percent of the population are enrolled with these sickness funds. The funds receive their funding through the National Insurance Institute, which allocates them capitation payments calculated according to number of enrollees and their age.

Following discussions with the director of a leading insurance company, the Minister of Finance proposed the introduction of a for-profit sickness fund in September 2004. The new sickness fund was to operate only under the terms of the National Health Insurance Law. A suitable company would be selected through a tendering process. One of the most relevant selection criteria within this process would be the proposed funding rate, as this new sickness fund would receive reduced capitation fees from the National Insurance Institute.



Managed competition—a euphemism for two-tier medicine



The new fund would have to purchase health services from private or public providers already operating in the system and would not be allowed to develop its own structure of service delivery. This requirement is expected to produce incentives to operate the fund efficiently. However, it remains unclear exactly how efficiency is to be achieved. Critics fear that it might be reached mainly through cream-skimming—that is, concentrating on healthy individuals—and through providing poor quality of (low-cost) services.

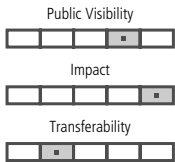
Sources and further reading:

Filk, Dan. Health becomes a merchandise. Position paper. Adva Research Institute, September 2004.

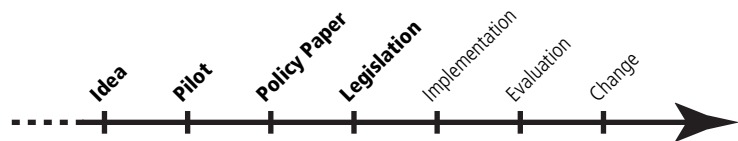
Israel Medical Association. Letter to the Minister of Finance. September 2004.

Rosen, Bruce. Health care systems in transition: Israel. Copenhagen: European Observatory on Health Care Systems 2003.

Netherlands: New health insurance system



The Dutch health care system has undergone many reforms over the years. After his reelection in May 2003, Prime Minister Jan Balkenende proposed reform plans reviving and adapting ideas already presented by the Dekker Committee in the late 1980s. A bill relating to basic health insurance for the entire population was submitted to parliament in September 2004. The bill has already passed the lower house of parliament without significant changes and is due for a final decision in the upper house in May 2005. Under the new health insurance plan, every citizen would have to buy health insurance. Private health insurance in the current sense or staying uninsured would no longer be possible.



Mixture of income-related and nominal premiums

Contribution of employers to health insurance would be organized as a compulsory income-related contribution, collected by the Tax Department and paid into the new Health Insurance Fund. This contribution would not exceed 50 percent of the total burden of national insurance contributions. Insurees would pay their nominal—that is, not income-related—premium directly to the chosen insurer. To avoid excessive premium burden, an income-related health care allowance could be approved. That allowance would be geared to the average nominal premium.

Under the Balkenende proposal, the government would pay premiums for children under 18. The respective premium would be linked to a specific type of insurance policy—in other words, the same price for the same service package. Accordingly, basic health care insurance would cover a benefit package similar to the current benefit package. The planned package foresees the provision of essential care tested against criteria of efficacy, cost effectiveness and the need for collective financing.

Services may be provided as services in kind offered by providers preselected and contracted by the insurer. Alternatively, insurers would be reimbursed for services provided by independent providers and utilized by the insured, up to a limit determined to be reasonable in the Dutch health care market. The Balkenende plan does not allow insurers to set reimbursement limits on their own. Rather, insurers may offer some kind of managed care plan, free choice of providers or a mixture of these models.

Insurance companies are obliged to contract with every citizen applying for insurance. To avoid cream skinning, the proposal puts in place an adjustment for risk imbalances between insurers (risk compensation scheme). For a transition period, insurers will also be obliged to contract with every hospital requesting a contract.

Insurers can compete on nominal premiums, on performance and on elements of choice, such as personal excess or no-claim bonuses. They are allowed to make profits and to distribute dividends.

Critics have expressed reservations about the lack of transparency of the insurance market. Therefore, a new organizational structure with cooperation and streamlining of various public supervision institutions is also foreseen. A major bone of contention, though, is the fact that private for-profit insurance companies would play a dominant role in the health care system. On these grounds, the Dutch Socialists (SP) strongly oppose the reform. Questions about compliance with European legislation have prompted opponents to bring a lawsuit before the European Court of Justice. It remains to be seen whether this new type of managed competition is the much-hoped-for solution of striking simplicity.

**Managed care
versus free choice**

**No scope for
selection of good
risks**

Skepticism

Sources and further reading:

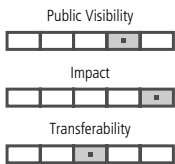
Council of State (Raad van State): www.raadvanstate.nl

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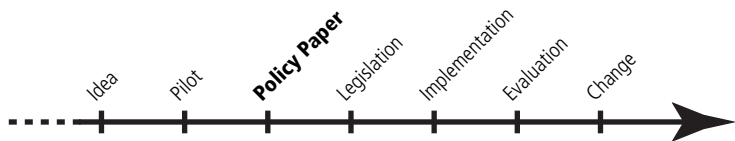
Ministry of Health, Welfare and Sports:
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The Dutch Insurers Union (ZN): www.zn.nl

Austria: Health Reform 2005



The Austrian Health Reform 2005 has recently been negotiated between the central government and the state governments in the course of consultations about financial equalization. The reform act proposes three changes. Two of these focus on financing issues, with measures to increase revenues (e. g., raising contribution rates, co-payments and tobacco tax) and to contain costs (e.g. reducing the number of hospital beds and length of hospital stays); the third creates health purchasing agencies (HPAs). The reform's objective was to contain cost growth and, even more importantly, to integrate service delivery.



The proposal to create both federal and regional HPAs would mean the biggest system change since the Social Security Act of 1955.

HPAs—A health system overhaul?

Health purchasing agencies had been designed as independent agencies acting as purchasers and organizers of health care, consisting of representatives from the federal and the regional government as well as from social health insurance. The Minister of Health and the regional governors expected health purchasing agencies to optimize resource allocation, enhance service integration and pool financial resources by purchasing health service according to predefined quality criteria and price. As the estab-

lished Austrian health care system is a statutory health insurance system, the envisioned health purchasing agencies are entirely new to the system.

The concept of health purchasing agencies was launched for the first time in the Austrian state of Vorarlberg, triggering discussion about the creation of health regions throughout the country.

Given the tight schedule for the Ministry of Health to find a solution by the end of 2004 and the persistent opposition of sickness funds and physician associations in particular, the idea of health purchasing agencies was substantially altered during negotiations on the health care reform. Under the newly created “health platforms” (replacing and somewhat diluting the original concept of health purchasing agencies), almost every stakeholder managed to achieve relevant changes and retain powers:

- States resisted complying with regional health service planning.
- Sickness funds retained their autonomy in contractual powers.
- Doctors, not at all represented in the health purchasing agencies, now participate in the health platforms.

There are nine regional Health Platforms and one federal Health Agency. The regional health platforms consist of representatives of the state and of social health insurance, with different majorities and composition depending on the health service under discussion. The federal health agency stipulates needs-based health planning, establishes quality measures and develops guidelines for the use of the newly created reform pool. It consists of all relevant stakeholders.

Negotiations on integrated regional health planning are to be concluded during 2005. Thus, the current agreement sets no obligations; it merely includes the option of a needs-based health planning approach. As the regulatory framework is rather weak, it remains to be seen whether the goals will be achieved.

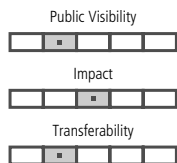
**Time pressure
impeded major
change**

**From HPAs to
“health plat-
forms”**

Sources and further reading:

Federal Ministry of Health and Women: <http://bmgf.gv.at>

Switzerland: Relaunching integrated networks of care



The Swiss health care system is often seen as a huge supermarket for health. Capacity on the supply side is enormous, surpassing that in most other European countries. At the same time, patients enjoy nearly unlimited freedom of choice. This combination of supply and choice makes the Swiss health care system the most expensive in Europe (both in expenditures per capita as well as a percentage of GDP). It also acts as a strong driver for substantial changes.

Health expenditure as percentage of gross domestic product (GDP)

	1970	1980	1990	2002
Austria	5.3	7.6	7.1	7.7
Finland	5.6	6.4	7.8	7.3
France	n.a.	n.a.	8.6	9.7
Germany	6.2	8.7	8.5	10.9
Israel	n.a.	n.a.	7.3	8.8
Netherlands	n.a.	7.5	8.0	9.1
Spain	3.6	5.4	6.7	7.6
<i>Switzerland</i>	5.6	7.6	8.3	11.2
United Kingdom	4.5	5.6	6.0	7.7
EU average prior to May 2004	5.2	7.0	7.3	9.0

Source: WHO Health for All Database 2003

Second chance for managed care

Taking small steps to reform the Health Insurance Act (see also HPD 3/2004), the Swiss government—the Federal Council—is also promoting new models of managed care. The Federal Council proposes to establish provider networks with budgetary responsibilities as a particular insurance type under federal law.

Not a success story

Managed care had been introduced into the Swiss health care system on an optional basis in 1994. In spite of an initial surge in popularity, the number of enrollees started to fall after peaking in 2000/2001. With large regional variations, only 7.6 percent of

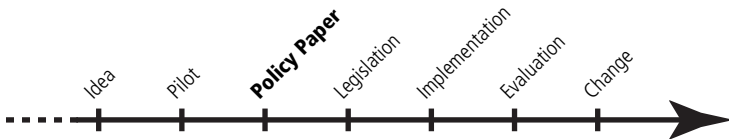
the Swiss adult population was enrolled in managed-care plans in 2002. Only 1.9 percent participated in capitation-based managed insurance, even though expenditures per capita are significantly lower in such plans.

Two types of managed-care plans were offered. Capitation-based health plans with restricted choice were unpopular from the start because the Swiss value freedom of choice. The weaker forms of managed care, especially the quite popular Independent Provider Association with family doctors as gatekeepers, were discontinued when they proved more expensive compared to a population with ordinary insurance plans.

**Less choices,
more costs**

Under the new Health Insurance Act, managed care would not be insurer-driven but would depend on provider groups. Such groups would form a network across sectors that would assume budgetary responsibility for all services as agreed under a contract with the sickness fund.

**Provider groups
to replace HMOs**



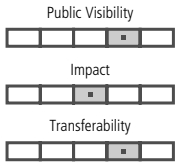
The bill foresees that providers are free to organize care according to what they deem to be each patient's needs. Patients must accept restricted choice combined with the implicit risk of rationing of services. The government hopes that this new form of managed care—which to a large extent resembles the German idea of “integrated care”—will prove more popular. However, it may turn out that the population views it as only a last resort for those who can no longer afford the ordinary premiums.

**Provider groups
for the less
well-off?**

Sources and further reading:

Swiss Ministry of Health: www.bag.admin.ch (in German and French)

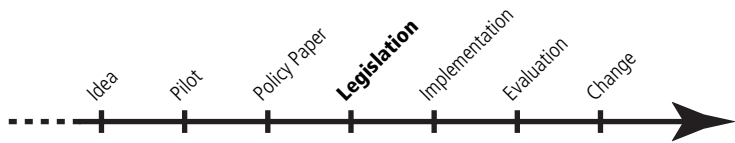
Singapore: HealthConnect— A community health care model



Promoting community-based care

In March 2004, the Singaporean Minister of Health announced a new community-based health care model for the district of Jurong Town. Starting as a pilot project, the model aims to provide patient-centered seamless access to a network of health care providers connecting public and private sectors as well as outpatient and inpatient facilities.

The minister decided to pursue the integration of community-based health care services rather than building a new hospital in an area already provided with an adequate number of facilities. To the minister, advancing primary care means allocating resources in a more efficient way. Improving the knowledge of community services is of particular concern to the elderly, as this population group is more vulnerable and often in need of a variety of health care providers and coordination among them.



Singapore also promotes the empowerment of patients and relatives to encourage self-help rather than dependence.

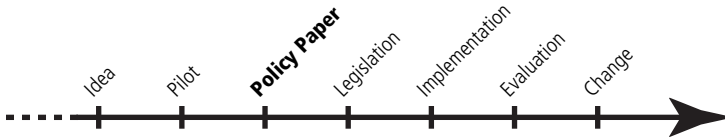
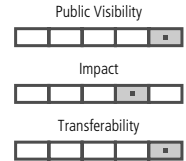
Therefore, the Jurong HealthConnect Web site was launched in August 2004. A 24-hour call center opened in October 2004. These tools are intended to enable patients and caregivers to make informed decisions. Additionally, in the near future, health data for patients will be collected from all providers and will be accessible via the Internet. It is expected that offering information on services and connecting these services via the Web site will foster community care. The Jurong Town model is projected to run for three years, after which successful components will eventually be spread across Singapore.

Sources and further reading:

Jurong HealthConnect: www.juronghealthconnect.com.sg/eng/index.aspx

Japan: Plan for merger of insurers

The Japanese health care system is based on social health insurance. It has provided both basic care and free choice of doctors to every citizen at affordable cost. However, evidence has mounted during recent years that the Japanese system has difficulty ensuring financial equity and sustainability and adapting to changing patterns of demand. The Japanese population is one of the world's healthiest, with an average life expectancy of 85.3 years for women and 78.4 for men. As a result, however, its percentage of elderly is also the world's highest. Japan's health care systems now struggle to meet the challenges posed by an increasingly aging population.



In spring 2004, the Ministry of Health launched an initiative to reform the Japanese health care system. The Framework for Health Care Reform addresses three main issues: creation of a new health care system for the elderly, revision of medical reimbursement schemes and reorganization of insurers. The latter has advanced farthest, as consultations between the Ministry of Health and the municipalities are already underway.

The plan calls for municipalities, which act as insurers for the self-employed and the elderly in the National Health Insurance (while employees are insured under Employees' Health Insurance), to merge into bigger entities at the prefectural level with a larger financial base, starting in FY 2004. Accumulation of resources is expected to reduce the risks associated with changing health care demands, to improve efficiency of administration and

Accessible local services, efficient regional pooling

to equalize levels of contribution. Concrete measures to organize merging are not stated yet, as consultations are still ongoing.

Initially, the plan sought to have a single insurance entity for each prefecture, but resistance from prefectural governors scuttled that proposal. It is difficult to assess the impact of this policy as it is still under negotiation. Critics point to the possible decrease in competition, which might diminish the incentive for quality improvement.

Sources and further reading:

Ministry of Health, Labour and Welfare: www.mhlw.go.jp/english/index.html

World Health Organization in the Western Pacific Region. Country Health Information Profile 2004. Japan. www.wpro.who.int/chips/chip04/jpn.htm.

Newsflash

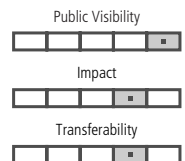
In this section, we track policies and developments reported in earlier issues of Health Policy Developments.

We start with two follow-ups on pharmaceutical policies, or rather on the unfortunate outcome of attempts to disentangle the pharmaceutical industry from politics. What happened, for example, to the prescription drug reimportation bill in California? Did central regulators enter the stage? And how well did Finland's very promising generic-substitution legislation perform in the real world? What's new in the discussion of public sector reform in Denmark? How are local and centralist preferences balanced? While some countries adapt their health care systems to fit the local interface, others are working on more structural issues. The Netherlands, for instance, is about to fundamentally reshape its social insurance system (see also Organizations section). How will long-term care be reorganized in this context?

California: Prescription Drug Reimportation Bill

California has seen a shrinking health care budget, with a rapidly growing share spent on pharmaceuticals. Between 1996 and 2003, expenditures on prescription drugs by the Department of General Services, the public drug purchaser for prisons, state hospitals and state agencies, skyrocketed from €30 million to €132 million.

Counting on several million dollars in savings, the California legislature passed four separate bills on drug reimportation in 2004 (see also HPD 3/2004). Two of the bills would have permitted state agencies to purchase lower-priced prescription drugs from Canada. The other two would have required the state to set



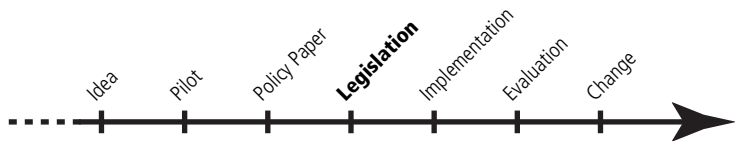
Million-dollar savings lost

up Web sites assisting consumers in purchasing drugs from licensed Canadian pharmacies. Both the Senate and the Assembly approved the bills, but they were ultimately vetoed by Governor Schwarzenegger.

Besides the fact that federal law prohibits drug reimportation, the pharmaceutical industry is heavily lobbying the federal and state governments to support its position. As their profits are jeopardized, drug companies threaten to suspend their research and development activities. Beyond that, some commentators conjecture that Governor Schwarzenegger felt pressure to reject the reimportation legislation because some pharmaceutical companies subsidized his trip to the Republican National Convention.

Catch-22

Other states are in the same financial situation; seven have already enacted plans to purchase drugs from Canada. Minnesota and New Hampshire already practice reimportation, and at least 25 other states are considering such measures.



Reimportation of pharmaceuticals means purchasing from foreign countries prescription drugs originally manufactured by U.S. companies. U.S. pharmaceuticals are often sold at much lower prices to other nations; even when reimported, they are notably cheaper than in the United States. For instance, Canadian price controls and a favorable exchange rate lower the price of reimported US-manufactured drugs by about 30 to 60 percent. If the Californian Department of General Services were to purchase five widely used pharmaceuticals from Canadian pharmacies, it could save about €17.3 million annually just on those five products.

However, reimportation of drugs is illegal under US federal law. State governments are seeking to save money through legislation allowing reimportation of prescription drugs even while they expect sanctions from federal regulators. None of the states allowing reimportation has yet been officially penalized.

Sources and further reading:

California HealthCare Foundation: www.chcf.org

California Healthcare Institute: www.chi.org

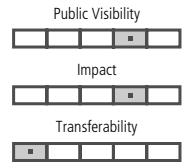
California State Senate: www.sen.ca.gov

Sacramento Bee: www.sacbee.com

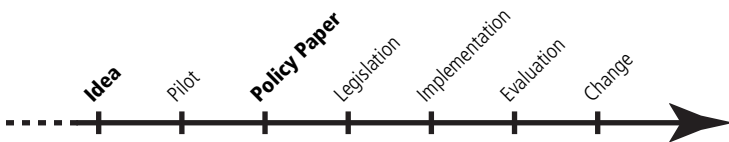
Finland: Restricting generic substitution

Finland initiated obligatory generic substitution of prescription drugs in April 2003 (see HPD 2/2003). Because of price competition between pharmaceutical companies and substitution of generics for brand products, this policy was more successful than expected. Pharmaceutical companies lowered prices of both brand-name and generic products by up to 50 percent. For more than 70 percent of substitutable medicines, doctors prescribed pharmaceuticals at prices low enough to avoid substitution. Savings were expected to come to about 2.5 percent of prescription drug costs, but in the first year of generic substitution patients and the Social Insurance Institution (which runs the public health insurance system) saved €88.3 million, which amounts to approximately six percent of total yearly outpatient drug expenses. The obvious success of the policy, however, has rankled the pharmaceutical industry.

As efforts to lobby doctors and patients proved ineffective, top executives of international pharmaceutical companies visited the Finnish Ministry of Health and Social Welfare in summer 2004 to express concerns about the drug substitution policy. Arguing that if the situation continued they would be unable to introduce new drugs to the Finnish market, they also stated that they might restrict their research and development activities in Finland.



Pharmaceutical industry takes off the gloves



The prospect of delayed introduction of new drugs in particular galvanized the Ministry to draft legislation excluding from substitution any pharmaceuticals with process patents. The National Agency of Medicines, the organization responsible for issuing the list of substitutable medicines, expressed strong reservations about this political setback, arguing that removing a significant proportion of drugs from the list of substitutable medicines list would seriously affect generic substitution.

Another objection was that it would be very difficult to define which process patents were in fact relevant for exclusion from the substitution list, as manufacturers often apply for process patents for different processes at different times. In some countries even the coloring of a pill could be patented.

**Process vs.
product patents**

Finnish pharmaceutical patent protection has been based mainly on process patents, and the Finnish drug industry has focused almost exclusively on the production of generic drugs. Product patents were introduced in 1995 as a part of the process of harmonizing Finnish and EU legislation, but so far, no medicine with a Finnish product patent has been sold in Finland. Since the majority of European countries introduced product patents long before Finland, generic drugs are often marketed in Finland before they can be sold in other European countries.

**Generic
drug policy
under scrutiny**

Realizing that they had not evaluated the policy properly, the Ministry of Health and Social Welfare stopped the legislative proposal and started a more thorough analysis in autumn 2004. It is too soon to estimate whether and to what extent the proposal may be altered and what the consequences might be. In any case, the experience has bruised the relationship between the pharmaceutical industry and governmental representatives. At the same time, however, it has had a negative impact on the public image of the pharmaceutical companies.

Sources and further reading:

Ministry of Social Affairs and Health:

www.stm.fi/Resource.phx/eng/news.htx

The Social Insurance Institution of Finland (KELA):

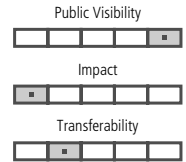
<http://193.209.217.5/in/internet/english.nsf>

The Social Insurance Institution of Finland (KELA). Generic Substitution. <http://193.209.217.5/in/internet/english.nsf/NET/220703130721MP?openDocument>.

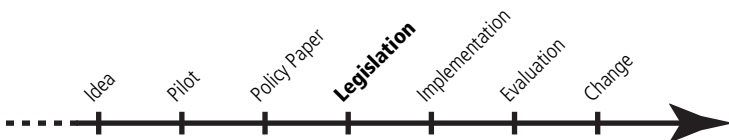
Denmark: Public sector reform and hospital management— A political agreement

Denmark has a decentralized public sector, consisting of 14 counties and 273 municipalities. Counties and municipalities are assigned specific tasks in the health care system. In 2002, the government installed the Commission on Administrative Structure in order to develop sustainable solutions for the reform of the public sector (see also HPD 3/2004). A previous advisory committee on the organization of health care had focused on hospital performance as needing improvement. Thus, weak performance of hospitals was one of the main drivers for administrative reform. The Commission on Administrative Structure incorporated that advisory committee’s results in their inquiry.

In April 2004, the account of the Commission was published. The bottom line of both reports was a recommendation to reduce the number of counties, as fragmentation was regarded as a major obstacle to efficient and sustainable management of resources. The counties strongly opposed the reform, and a consultation process was initiated. After extensive hearings and debate, the “Agreement on Structural Reform” was reached between the Danish government (the Liberal Party and the Conservative Party) and the Danish People’s Party in September 2004. It calls for the central government to establish a general framework for a new administrative structure. Counties will be dissolved, and five regions with elected assemblies and governments will be formed. Larger and more sustainable municipalities will be given the responsibility of handling most citizen-related services.



**Centralization
to safeguard
sustainability**



**Five regions
instead of
14 counties**

The five Danish regions will be responsible for hospitals, general practitioners and psychiatric services; municipalities will be responsible for prevention as well as for care and rehabilitation services not offered in hospitals.

**Centralizing
quality
management**

Central health care authorities will be held responsible for ensuring systematic follow-up on quality, efficiency and IT application in the health care services, based on common standards. Health care services will be financed primarily through block grants based on objective criteria for expenditures: need, a smaller state activity pool and local co-financing.

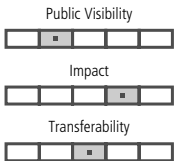
The new regions are expected to be operational on January 1, 2007. Most researchers are chiefly concerned about the fact that regions will have only very weak incentives to contain costs, as they are not responsible for financing their activities through taxes. Accordingly, as the incentive structure for hospital performance is by no means changed, some experts fundamentally question this policy.

Sources and further reading:

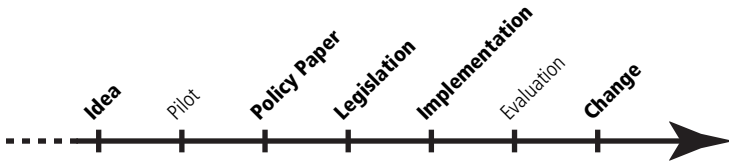
The Ministry of the Interior and Health. Agreement on a Structural Reform. www.im.dk/publikationer/agreement/index.html.

The Ministry of the Interior and Health. Recommendation of the Commission on Administrative Structure. Summary. Recommendation No. 1434. www.im.dk/publikationer/struktur_uk/index.html.

Netherlands: Social Support Act (WMO)



In the Netherlands, medical services and long-term care are provided under the Exceptional Medical Expenses Act (“Algemene Wet Bijzondere Ziektekosten”, AWBZ, see also HPD 2/2003). At the moment, the AWBZ is the compulsory national health insurance scheme. After reelection in May 2003, Prime Minister Balkenende introduced a reform package for social insurance.



According to this proposal, the Social Support Act (“Wet Maatschappelijke Ondersteuning”, WMO) offering care for the disabled was conceptualized. The draft will be presented to parliament in January 2005. Focusing on the integration of disabled people, the proposal is meant to reorganize on a local level services such as home care, supporting and activating care, transport regulation, client support and various subsidies. The WMO combines portions of the former AWZB, the Act on Services for the Disabled and of the Welfare Act.

Welfare activities, home adjustments, information and advice will enable handicapped persons to take responsibility for their own affairs and to stay at home longer. The AWBZ scheme will remain under the responsibility of the government and cover citizens with serious chronic illnesses who need permanent care that is not insurable. Concerns about this policy center around three issues:

- Decisions about the type and scope of services lie within the discretion of municipalities; this may endanger equal access across the Netherlands.
- The implementation period will be fairly short. Introduced in parliament in January 2005, the law is expected to become effective in January 2006.
- Finally, local authorities oppose the bill, as they fear the additional financial burden it entails.

Empowerment for disabled citizens

Concerns about equity, access and cost

At the moment, public consultations and negotiations between the Ministry of Health and local authorities are taking place. It remains to be seen what kind of changes will be necessary to arrive at a sound consensus.

Sources and further reading:

Ministry of Health: www.minvws.nl (in Dutch)

Reform Tracker

(Country, Chapter, Title, Issue, Page)

Australia

Funding and Reimbursement

Private health insurance incentive scheme; I, 22

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An open and transparent health care system; III, 22

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Accountability and Participation

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Towards long-term care reform; II, 35

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Integration of Care/Coordination of Care

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National Health System Act—The debate about decentralization, cohesion and quality of care; I, 43

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Advancing Health Care Organization

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- California: Democrats pass employer mandate for health insurance; II, 78 (Newsflash)
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- USA: Proposal for SCHIP Reform; I, 59
- USA: Presidential candidates' proposals for health insurance; II, 80 (Newsflash)
- USA: Health Insurance Portability and Accountability Act of 1996; II, 83 (Newsflash)

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- USA: Medical malpractice reform; II, 87 (Newsflash)

Pharmaceutical Policies

- California: Prescription drug reimportation legislation; III, 62 (Newsflash)
- California: Prescription Drug Reimportation Bill; IV, 75 (Newsflash)

Human Resources for Health

- California: First-in-nation rules on nurse-to-patient ratios; II, 67

Health and Aging

- USA: Expansion of prescription drug coverage for the elderly; II, 45

International Monitor on Health Policy Developments¹

Questionnaire

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 to 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 to 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, however, the report is from 1996). 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 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 subsection 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 subsection 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.

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.

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.

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 that 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.

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 that specifically aim at changing (regulating, deregulating) the role of the private sector in funding and/or delivery of health

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 may be: 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.

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 breakthrough 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, supranational 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

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.

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 subset, 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.

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

Health Policy Network Questionnaire—Survey # 4

Period covered: April–September 2004

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:*_____

1. 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 maximum).

Structured summary Q 3 (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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parliament	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Payers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Civil society	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private sector/ industry (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scientific community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
International organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual opinion leaders (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parliament	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Payers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Civil society	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private sector/industry (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scientific community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
International organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual opinion leaders (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parliament	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Payers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Civil society	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private sector/industry (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scientific community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
International organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual opinion leaders (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	traditional approach	innovative approach
2. Was/is the policy process comparatively ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	consensual	highly controversial
3. Actual or expected impact on status quo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	marginal	fundamental
4. Visibility in public discussion (media coverage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	very low	very high
5. Transferability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	marginal	fundamental
7. Impact on level of equity (access)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	system less equitable	system equitable
8. Impact on cost-efficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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 and 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).

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 trade-offs are tough?

① 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. 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.

- ① You may publish a brief description of our network in your newsletter or magazine. Again, we will return the favor.
- ① 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:

Health Policy Network Team Bertelsmann Foundation

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