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Sophia Schlette (eds.)*

## **Health Policy Developments 12**

Focus on Value for Money, Funding and  
Governance, Access and Equity

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# Preface

Dear readers,

Well into its sixth year of existence, the International Network Health Policy & Reform is alive and thriving. With no signs of age or wearing out, we continue to develop ourselves further and venture for new partnerships and cooperations.

For this most recent issue number 12 of our biannual series *Health Policy Developments*, we—the long-time editors—take great pride in introducing our new author, *Ray Moynihan*, from Byron Bay, New South Wales, Australia. Though thousands of miles apart, we discovered that we are following the same key themes of health policy, particularly around issues such as access, affordability, and equity, as well as determinants of health and governance issues. Following Ray's suggestion, we also produced a companion video and a short promo film to disseminate the book's key messages the virtual way (watch at [www.hpm.org](http://www.hpm.org) in the download section).

**New author Ray Moynihan**

We are equally delighted to announce our new partner institute and liaison person from Spain, *Joan Gené Badia*. Based at the University of Barcelona, Joan is an experienced expert on primary care advancements and international developments. With him on board we are somewhat shifting focus from a health economics perspective, so well presented by our former partners from Universidad Pompeu Fabra, to a health services research focus, so active a community these days in Spain.

**New partner in Spain**

So what is number 12 all about? Departing from the primary care and care coordination focus of the previous volume, this current issue focuses more on economic aspects. Quite interestingly, we see this as a re-emerging pattern across the 20 countries that

**What should we spend the money on ...**

we observe. While care coordination remains high on the agenda everywhere, countries again turn to funding and efficiency questions. In chapter 1, we examine how health systems are trying to maximize *value for money*, going beyond traditional avenues. In the United Kingdom, for instance, the National Institute for Health and Clinical Excellence no longer just assesses drugs and procedures but now asks how well public health interventions work—and which ones offer value for money.

... and who should  
pay for what?

However, preceding the value question there is a much simpler question: Where does the money come from in the first place? As rising cost is one of the most consistent pressures on health systems everywhere, cost containment has long been one of the more salient themes in health policy discussions. Chapter 2 therefore looks at debates around *who should pay for what?* How much of total expenditure on health care should originate from general taxation, (social) health insurance, or out-of-pocket? And what should be the share of voluntary or private health insurance? Even in Canada, where this has long been a taboo, some see growing privatization as a way of reducing the costs to the public purse. France, on the other hand, has decided to increase taxes for private health insurers to help fund rising national health expenditure.

Governance in  
Bismarckian  
systems

With blurring roles between the private and public sphere and more and more cross-system learnings between classic Bismarckian and Beveridge type healthcare systems taking place, the former continue to suffer from their somewhat inbuilt paradox: Bismarckian systems, while tightly controlled by the state, are based on privately owned and operated funds. The paradox remains, as we will see in chapter 3 on *governance*. For example, in Switzerland, the unresolved question is whether the introduction of more competition will result in a reduction in solidarity if the sick ultimately have to pay a lot more for their premiums than the healthy. And in France, the debate turns the other way: Will decentralized control of purchasing hospital care result in more privatization in provision?

Responding to  
patients' needs

In Asia, nations as diverse as Japan, South Korea and Singapore are *responding to the needs* of aging populations and the ethical challenges of demographic change. As will be illustrated in chapter 4, a common theme is enabling people to die with dignity

at home or in hospice care, rather than in big hospitals. Countries need to balance how much care is being provided in institutions and how much at home, or in intermediary settings. At the same time, countries have to be cautious: If structures in patients' living environments are not well prepared, sending people home to die might be a simple way to get rid of costly and needy patients (also see our video on [www.hpm.org](http://www.hpm.org) in the download section).

Last but not least, questions of how to ensure access and equity, and how to guarantee patient safety and quality of care, and how to organize healthcare services do remain high on the policy implementation agenda in the countries we observe. We present the latest measures addressing these questions in chapters 5, 6 and 7.

The sources of information for this book were the expert reports of the International Network for Health Policy & Reform and other materials cited at the end of each chapters. The current volume presents the results of the twelfth half-yearly survey which covers the period from May 2008 to September 2008. From the 82 reports received, we have selected 33 for inclusion in this report.

Our thanks go to all experts from the partner institutions and their external co-authors: Ain Ain Aaviksoo, Gerard Anderson, Toni Ashton, Chantal Cases, Elena Conis, Fiona Cram, Luca Crivelli, Asher Elhayany, Patricia Fernandez-Vandellos, Gisselle Gallego, Joan Gené Badia, Peter P. Groenewegen, Revital Gross, Maria M. Hofmarcher, Jessica Holzer, Soonman Kwon, Margaret MacAdam, Stephanie MacKenzie, Jan Mainz, Ryoza Matsuda, Lim Meng Kin, Julien Mousques, Michel Naidich, Adam Oliver, Zeynep Or, Gerli Paat, Hannele Palosuo Tanaz Petigara, Rade Pribackovic Brinovec, Marita Sihto, Taro Tomizuka, Lauri Vuorenkoski.

We hope you enjoy the read and as always look forward to receiving your feedback and suggestions.

*Kerstin Blum, Reinhard Busse, Sophia Schlette*

**Organizing  
healthcare services**

**Reporting period  
spring to autumn  
2008**



# Value for money?

Are we getting value for money in health care? As perplexing as it is important, this monster of a question casts its shadow over almost every debate in health policy, whether we have the temerity to ask it or not. But perhaps an even more frightening question is its lesser-known cousin: How do we know that we are getting value for money in health care? In this opening chapter we look at how some health systems are facing up to these questions and in some cases starting to look for answers.

One of the first countries to build this question of cost-effectiveness into the very infrastructure of its healthcare system was Australia. Following changes to the national laws in the early 1990s, all new prescription medicines would be assessed for their benefits, harms and “cost-effectiveness” before they were added to the national list of subsidized drugs, the Pharmaceutical Benefits Scheme (Harris 2008; see also *Health Policy Developments* 5, p. 71). The approach involves independent committees of experts—notably the Pharmaceutical Benefits Advisory Committee—assessing at what price (if any) a new drug might offer value for money, and making a recommendation to the federal health minister to add the drug to the schedule of the Pharmaceutical Benefits Scheme. Initially unhappy with many aspects of the new approach, the pharmaceutical industry has slowly accepted the reality of this method. Moreover, in recent years improvements in transparency have meant that extracts from the cost-effectiveness deliberations are routinely made public.

Now, 15 years later, the importance of analyzing whether a new pill, procedure, or process is cost-effective is widely acknowledged everywhere—at least in theory. In a report on technology assessment and value for money, published by the World Health

**Leading the way  
down under**

**Calls for value  
assessments**

Organization on behalf of the European Observatory on Health Systems in 2008, authors wrote that “products that provide the most value for investment must be identified and supported” (Sorenson et al. 2008). The report also recommended more attention giving to transparency in decision-making, and broadening the focus of analysis from technology and treatment to preventive strategies.

**Public health:  
a good punch  
for the pound?**

In the United Kingdom, policy makers have for some time been asking whether new clinical interventions give value for money, but now as we will read in this chapter, there is a fascinating push to examine whether public health strategies are also giving a good bang for the buck—or better: punch for the pound. For almost a decade, the influential National Institute for Health and Clinical Excellence (NICE) in the United Kingdom has been analyzing the cost-effectiveness of clinical interventions—largely but not exclusively looking at pharmaceuticals (see *Health Policy Developments 2*, p. 54). Following criticism that NICE was focused too heavily on clinical interventions, in 2005 its remit was broadened to start examining the effectiveness and cost-effectiveness of public health approaches like programs to increase physical activity in the workplace. Given the large numbers of stakeholders, including non-health players, involved in public health strategies, new systems have been created to analyze whether public health strategies are offering value for money (see report on the United Kingdom, p. 16). The new approach is raising intriguing questions about whether new methods of cost-effectiveness analysis will be needed to assess whether public health strategies offer value for money.

**Are personal  
financial incentives  
worthwhile?**

One such public health strategy in the United Kingdom may well be analyzed to see if it offers value for money: It is the new plan to offer direct personal financial incentives to people to change their behavior in order to prevent illness and improve health (see report on the United Kingdom, p. 20). Proposals at various stages of planning or piloting include incentives for people to exercise more; incentives for pregnant mothers to seek healthy eating advice; and incentives for adherence to certain anti-psychotic medications. The emerging debate around these plans is raising more questions about whether governments should use taxation to pay people to do things many consider they

ought to be doing anyway, and whether such payments will perversely reduce healthy activities already being performed voluntarily.

In Australia a different sort of incentive is being introduced: a financial disincentive to drinking alcohol, in the form of a massive increase in taxation on sweet “alcopops” favored by many young people (see report on Australia, p. 23). In early 2008, the then relatively new federal government announced a 70 percent increase in the tax on “ready-to-drink” products, which combine alcohol and non-alcoholic beverages such as soft drinks or milk. The tax increase is part of a new national strategy on binge drinking, and the hopes are that the expected increase in tax revenue will be re-invested into prevention activities. Elements within the spirits and hotels industry are opposed to the plan, and concerns have been raised that the move will not reduce binge drinking because alcopops may be simply be replaced by other drinks. Experience from Germany, which increased taxes for alcopops by around € 1 per bottle as far back as 2004, shows that such replacement partly happens to a small degree. Alcopop consumption declined sharply and certain producers even completely withdrew their products from the market.

**How about a disincentive?: binge drinking tax**

While these examples from Australia and the U.K. show how financial incentives are used to try and influence behavioral patterns in the population, two reports from Estonia and the United States describe current efforts to pay incentives for physicians to improve performance. While both schemes unsurprisingly have had strong support from health professionals, after preliminary evaluations questions remain as to whether such incentives are the best way to spend health resources.

**Paying physicians for performance**

The Estonian Health Insurance Fund is offering family physicians financial incentives to improve the way they prevent disease and monitor chronic illness in their patients, as well as lift their general competence (see report on Estonia, p. 26, and earlier reports on P4P in *Health Policy Developments* 6, 9, and 10). From the beginning the reform was supported by family physicians, as it was designed in part to enhance the credibility and income of this sector of health professionals. An analysis of data from the Estonian Health Insurance Fund suggests the participation by doctors in the scheme has greatly increased, and more than half

**P4P—“success” without much proof**

have received bonus payments. However, despite no published data on effects on health outcomes, and no formal published cost-effectiveness evaluation at this time, it appears the scheme is considered a success by the implementing organization, raising the possibility it will be expanded to hospitals. Similarly, financial incentive schemes for physicians in the United States are regarded as popular, despite there being little evidence of positive impact on health outcomes (Petigara 2008). And in the United Kingdom, where doctors are offered similar incentives, serious questions are being raised by some commentators about the value of this approach to trying to improve the quality of care (Heath et al. 2007).

**How to assess and control high cost biologics**

It's obviously very hard to work out whether we will get value for money from paying people to exercise more, or paying incentives to doctors to perform better. But perhaps more and more pressing is the question of whether we are getting value for money from the resources being invested in expensive new drugs, investments which characterize large and in some cases growing proportions of total health expenditures. So in the United States, for example, will the nation be getting the best use of the roughly one billion dollars a week that it will soon spend on "biologics"? (See report on the United States, p. 29.) Different from conventionally synthesized pharmaceuticals, biologics can cost anywhere from \$10,000, to \$200,000 per treatment regime, and there are a number of strategies being tested to try and reduce the cost. Given that biologics are part of a different paradigm of therapies, there is now a lively debate about how they should be evaluated and regulated. And the fact that many physicians have actually been making significant profits from dispensing these new therapies raises other questions about the extent to which prescribing behavior—and national expenditure on this class of treatments—is being driven by genuine patient need or naked professional self-interest.

**The fearful D-word**

The already mentioned recent report on technology assessment calls specifically for post-marketing re-evaluation of new products, to confirm both clinical effectiveness and cost-effectiveness, particularly in the case of novel therapies that have been fast-tracked to market in the first place (Sorenson et al. 2008). Furthermore, the report raises the fearful D-word, arguing that

much more attention should be paid to disinvestment, to remove ineffective or obsolete practices in order to make way for investment in newer approaches. However, making decisions about which old drugs or procedures to abandon because they are no longer cost-effective would require even more than the considerable skill and courage required to assess new ones for their value for money.

*Sources and further reading:*

Harris, Anthony, Suzanne R. Hill, Geoffrey Chin, Jing Li and Emily Walkom. The role of value for money in public insurance coverage decisions for drugs in Australia: A retrospective analysis 1994–2004. *Med Decis Making* (28) 2008: 713–722.

Heath, Iona, Julia Hippisley-Cox and Liam Smeeth. Measuring quality through performance: Measuring performance and missing the point? *British Medical Journal* (335) 2007: 1075–1076.

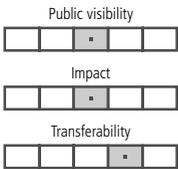
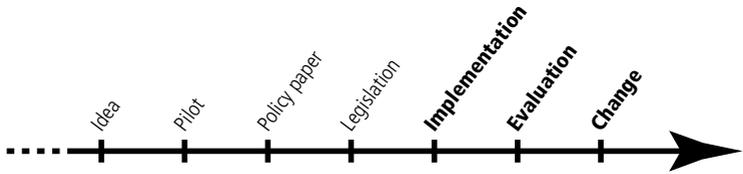
Oliver, Adam. Update on the performance of payment by results. *HealthPolicyMonitor*, April 2008. [www.hpm.org/survey/uk/a11/4](http://www.hpm.org/survey/uk/a11/4).

Petigara, Tanaz, and Gerard Anderson. Pay for performance in the U.S.—An update. *HealthPolicyMonitor*, April 2008. [www.hpm.org/survey/us/a11/2](http://www.hpm.org/survey/us/a11/2).

Pharmaceutical Benefits Scheme (PBS). Public Summary Documents by Meeting. [www.health.gov.au/internet/main/publishing.nsf/Content/public-summary-documents-by-meeting](http://www.health.gov.au/internet/main/publishing.nsf/Content/public-summary-documents-by-meeting).

Sorenson, Corinna, Michael Drummond and Panos Kanavos. *Ensuring Value for Money in Health Care: the Role of Health Technology Assessment in the European Union*. Copenhagen: WHO on behalf of the European Observatory on Health Systems and Policies 2008.

## United Kingdom: Value for money from public health care



While it is generally agreed that in principle public health care can have a big impact on the health of a population, there are questions about whether particular public health strategies may have little or no impact. Against this backdrop of uncertainty, the National Institute for Health and Clinical Excellence (NICE) has recently started to assess public health strategies for both effectiveness and value for money (see *Health Policy Developments* 7/8, p. 54). The task is a daunting one, and new committees and methods of assessments have been created, involving multiple stakeholders inside and outside the health arena. The ultimate aim is to improve the effectiveness and cost-effectiveness of public health interventions and programs.

### Embracing public health care, too

The decision to move in this direction was motivated by criticism from individuals and groups—including public health specialists—that NICE was too narrowly focused on assessing clinical interventions. Responding to this criticism, in 2005, NICE broadened its remit, and it has started to assess whether public health strategies offer value for money. These strategies are divided into public health interventions and the more broad and complex public health programs. New processes of evaluation are being designed for both types of strategy. The plan is to produce evidence-based “guidances” which are to be re-evaluated every three years or sooner if important evidence comes to light.

### Evaluating public health interventions ...

Public health interventions are clearly defined local actions that aim to reduce the chance of occurrence of particular illnesses, or which promote a healthier lifestyle. Examples include providing needle exchange schemes for drug addicts and encouraging breast feeding in new mothers. NICE has formed a committee—the Public Health Interventions Advisory Committee—to consider and interpret the effectiveness and cost-effectiveness evidence of those public health interventions that are selected for

assessment. This new committee has a multidisciplinary membership of 26 healthcare professionals, practitioners, technical experts, and representatives from the general public and community groups. It ultimately produces recommendations on whether an intervention represents good value for money and hence whether it ought to be provided in the National Health Service. It also identifies gaps in the evidence base and makes recommendations for research. The guidance is published on the NICE website, and the process from initial consideration to publication of the guidance is meant to take 12 months.

Public health programs are broader in scope and are defined as multi-agency packages of policies and services. For these, assessment can be a highly complex and difficult process, because many sectors of public service are potentially involved (education, environment, etc.) that do not see an improvement in health outcomes as their primary concern. Examples of public health programs include services to help support physical activity targets—ranging from traffic calming measures to fun runs—and smoking cessation advice from doctors, pharmacies, local authorities and employers. As for interventions, NICE has formed a new multidisciplinary group—which varies its membership depending on the program under consideration—to develop guidance based on its consideration of the effectiveness and cost-effectiveness of public health programs. This Program Development Group comprises up to 16 members, including professionals, community members and technical experts, and takes 18 months to develop its guidance on any particular program.

The public health strategies to be assessed can include anything from interventions targeting individuals to programs targeting the broader social determinants of health. The recommendations can thus affect a whole range of health determining factors, from traditional health promotion activities around individual behavior to environmental and structural determinants of health. This means that in practice the recommendations can target many different levels within the society, including the individual, the family, the community, and the organization—such as employers.

Clearly these new processes of assessing value for money in public health care, and making recommendations targeting such

... and public health programs

Recommendations for different audiences and settings

**Many stakeholders  
and much  
consultation**

a wide range of players, are demanding new levels of stakeholder engagement—in line with broader trends to engage more stakeholders—in the health technology assessment processes (Sorenson et al. 2008). According to NICE, stakeholders in public health are an extraordinarily wide array of players, including the national public; community and care organizations; health professionals and interested researchers; providers, purchasers, local government and the voluntary sector; and various departments including health, home office and education. The new plan allows for stakeholders to comment on the scope of proposed guidances, the review of the evidence about effectiveness and cost-effectiveness, and the draft recommendations before final recommendations are made.

**New methods of  
cost-effectiveness  
analysis?**

The method currently used for analyzing the cost-effectiveness of clinical interventions involves the standard Quality-Adjusted Life Year, or QALY method. While this is currently the dominant form of analysis, it is possible that it could change over time because the methods for assessing public health strategies are under review. Several factors make this assessment more complex than assessing clinical procedures and interventions, not least because public health approaches impact on and are impacted by many areas within the public and private sector—beyond the reach of the traditional health service. A recent article highlighted the challenges of this new kind of assessment and called for a reduction in the “disconnect” between health economists and public health practitioners (Neumann et al. 2008). There is even discussion about whether “health” and “maximization of health” are appropriate outcomes for public health policies. And with non-health players now involved, other questions are arising about just how much jurisdiction health agencies like NICE will have anyway.

**Toothless tiger?  
The challenge of  
implementation**

An extensive global survey of organizations involved in the bridge between research and action found that implementation was often the poor cousin in the translation of research into recommendations and action on the ground (Moynihan et al. 2008). Even the best evidence-based guidance that has been informed by systematic reviews, commented on by stakeholders and produced transparently can come to nothing if its recommendations are not implemented. This of course is the motivation for the global

move to build more effective bridges between evidence and policy and practice. It is too early to know whether the new value-for-money assessments will have an impact on practice, and ultimately on health, but there are questions about whether NICE will be able to wield any influence over the non-health sector. Already it has been reported that only half of local health purchasers adhere to existing NICE guidance about clinical interventions which are supposedly mandatory, raising questions about the extent of future voluntary adherence from the non-health sector.

*Sources and further reading:*

Oliver, Adam. On the value for money of public health care. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/uk/a12/5](http://www.hpm.org/survey/uk/a12/5).

Department of Health. *NICE 18th Work Programme: Clinical Guidelines and Public Health Guidance Referred in March 2008*. London: DoH 2008.

McDaid, David, Michael Drummond and Mark Suhrcke. *Investing in and Implementing Population Health Strategies*. WHO Policy Brief. Copenhagen 2008.

Moynihan, Ray, Andrew Oxman, John Lavis and E. Paulsen. Evidence Informed Health Policy: Using research to make health systems healthier. Report to WHO committee on Evidence Informed Health Policy, 2008. [www.kunnskapscenteret.no/Publikasjoner/469.cms](http://www.kunnskapscenteret.no/Publikasjoner/469.cms).

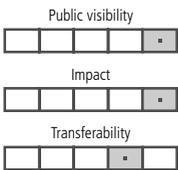
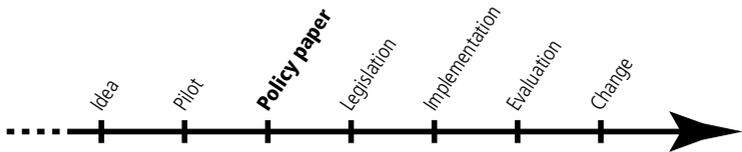
National Institute for Health and Clinical Excellence (NICE). *The Public Health Guidance Development Process. An Overview for Stakeholders including Public Health Practitioners, Policy Makers and the Public*. London: NICE, 2006.

Neumann, Peter J., Peter D. Jacobson and Jennifer A. Palmer. Measuring the value of public health systems: The disconnect between health economists and public health practitioners. *American Journal of Public Health* (98) 12 2008: 2173–2180.

Sorenson, Corinna, Michael Drummond and Panos Kanavos. *Ensuring Value for Money in Health Care: the Role of*

*Health Technology Assessment in the European Union. Copenhagen: WHO on behalf of the European Observatory on Health Systems and Policies 2008.*

**United Kingdom:  
Personal financial incentives for healthy behavior**



**Personal financial incentives: loved and loathed?**

**Autonomy or coercion?**

One of the public health interventions that may one day be assessed for value for money is the strategy of giving money directly to members of the public to behave in more healthy ways. “Personal financial incentives” are a topical issue in health policy and are being actively considered in the United Kingdom. While they can take different forms, these incentives are essentially offering people payment—or the equivalent such as vouchers for medications or groceries—to partake in healthy activities like exercise or refrain from unhealthy activities like smoking. Different incentives are currently being conceived, piloted, trialed and in some cases implemented in the United Kingdom—though mainly at the local level—against a backdrop of debate about their practical utility and political acceptability.

Proponents of personal financial incentives argue this approach protects autonomy and is less paternalistic than other regulatory policies, as those targeted are free to take up the relevant advice and accept the incentive or ignore the healthy advice and decline the incentive. Others see that the incentives could introduce the possibilities of some kind of coercion over the long term, and there are fascinating questions about the political acceptability of paying people to do things that many believe people ought to be doing anyway.

The rationale underlying personal financial incentives is regarded by proponents as simple economics—money is a source of utility, people are utility maximizers, and therefore if you pay someone to do something, they are more likely to do it. However, objections can be raised against this rationale. For example, paying people to undertake some actions may undermine their intrinsic motivation to do them, as demonstrated in Titmuss’ classic Gift Relationship (Titmuss 1970). In his work he showed that paying people to give blood rather than requiring them to donate voluntarily led to a poorer quality blood supply. Observations like these are known as “crowding out”—i.e., paying people to do things may crowd out or marginalize their willingness to do it. Thus, one may sometimes find that behaviors move in the opposite direction to the one that the policy maker intended to encourage. To find out more about whether personal financial incentives are feasibly and useful, several initiatives are currently being pursued in the areas of healthy diets, physical exercise, adherence to medication and substance abuse.

**A correct rationale for incentives?**

Financial incentives have been mooted in relation to national attempts to reduce the problem of obesity. There is currently a cross-government strategy to reduce obesity, and the government has considered using incentives to encourage people to lose weight by eating more healthily and taking more physical exercise. However, it seems the government has decided, at least temporarily, not to pursue such incentives because of nervousness of a potential backlash from within the electorate. The fear is that many people may not be excited by the idea that public taxation would be used to pay people to take on a healthy lifestyle—something that many people think should go without saying. It is possible, however, that the idea of financial incentives will re-emerge in relation to the fight against obesity.

**Incentives to fight obesity?**

One personal financial incentive that looks set to happen is the idea of a small grant to pregnant women who attend an advice session on how to eat a healthy diet, at week 25 of their pregnancy. This incentive will be introduced as part of the Health and Social Care Bill in 2009. Elsewhere in the health system, researchers are piloting a program to test the impact of giving people payments to increase adherence to anti-psychotic medications. Meanwhile the National Institute for Health and Clinical

**Incentives for pregnant women, psychotics and drug abusers**

Excellence—considered to be an organization interested in assessing financial incentives—has approved the use of vouchers that can be used for treatment-related goods (e.g., medications) by people addicted to illegal drugs. It is likely that this voucher scheme will be tested in a randomized controlled trial. And in Scotland, a health authority has already piloted a scheme where smokers are offered vouchers that can be exchanged for groceries, if the smoker demonstrates a “smoke free” carbon monoxide breath-test.

**Early days and  
mixed evidence for  
personal financial  
incentives**

It is very early days in the development and testing of these personal financial incentives. For Adam Oliver from the London School of Economics—whose report has informed this segment of the book and is cited below (Oliver 2008)—it is far too early to predict whether and how these reforms will be adopted. His assessment is that in the existing research about financial incentives there is mixed evidence of effectiveness. For example, they have been shown to increase compliance with medication, but in terms of encouraging people to adopt healthier lifestyles or reduce smoking, the evidence suggests the impact may be minimal. A Cochrane systematic review of studies looking at the use of competition or incentives to help people stop smoking found they may attract more people to attempt to quit smoking, but the cessation rates are similar for those offered rewards and those not offered rewards (Cahill and Perera 2008). In relation to the question of whether these incentives offered value for money, the Cochrane reviewers noted it was too early to even consider the question: “cost-effectiveness analysis is not appropriate to this review, since the efficacy of the intervention has not been demonstrated.” In general, the size of the incentive, where it comes from, and the type of behavior it targets are all important factors determining potential success.

**Ethical concerns**

Aside from equivocal preliminary evidence of effectiveness, there are broader ethical questions about whether offering people financial incentives is an appropriate public policy measure. It is not at all clear they will be effective, and not at all clear that they will not have unintended consequences—for example in terms of the “crowding out” effect where offering a monetary award to behave healthily may lead to a reduction in innate motivation towards healthy behavior. Another key ethical consideration is

whether financial incentives may in some way be coercive, particularly if they are targeted at people who are economically disadvantaged, who may be motivated to do things because they need the money, not because they really want to do them. It is clear that more thinking, debating and research is required before these kinds of incentives are rolled out on a national or global scale.

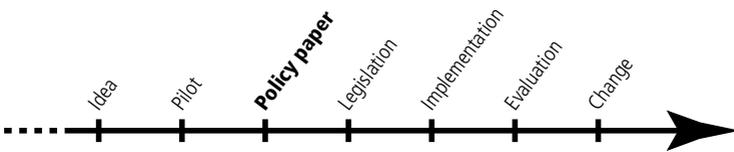
*Sources and further reading:*

Oliver, Adam. Personal financial incentives to improve health. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/uk/a12/2](http://www.hpm.org/survey/uk/a12/2).

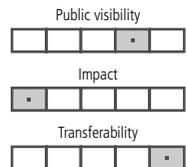
Cahill, K., and R. Perera. Competitions and incentives for smoking cessation. *Cochrane Database of Systematic Reviews* 2008, Issue 3. [www.cochrane.org/reviews/en/ab004307.html](http://www.cochrane.org/reviews/en/ab004307.html).

Titmuss, Richard. *The Gift Relationship: From Human Blood to Social Policy*. London: George Allen & Unwin 1970.

**Australia: Personal financial *disincentives* to drinking**



In early 2008, the newly elected federal government announced plans to significantly raise the tax on pre-mixed, “ready-to-drink” alcoholic beverages, otherwise known as “alcopops.” These drinks are part spirit or wine and part non-alcoholic drink, such as soft drink or milk. Low prices, colorful marketing and sweet flavors that mask the taste of alcohol have made these drinks very popular with young people. The federal government’s stated plan was



to raise taxes on these alcopops by 70 percent, in order to try and provide a financial disincentive to those purchasing them, and thus reduce their consumption. Framed as an attempt to reduce binge drinking by Australian youth, the report accompanied an announcement by the new prime minister of a wider National Binge Drinking Strategy. The plan proved extremely controversial, with critics from industry and the political world claiming it was primarily a taxation measure that would not benefit the health of young people. It also sparked some debate about the responsiveness of alcohol consumption to changes in price.

**Youth binge drinking—girls drink more than boys**

The health of many Australians has long been harmed by the overuse of alcohol. But the impetus for this particular reform came from emerging data suggesting a growing problem of binge drinking among young Australians. For example, the results from the 2005 Australian secondary students alcohol and drug survey suggested that in a given week, approximately one in ten 12 to 17 year olds reported binge drinking or drinking at risky levels. The 2007 national household drug survey suggested that girls aged 12 to 15 are more than three times as likely as teenage boys of the same age to consume alcohol at least once a week. That survey also found that more than one in ten girls was drinking at levels regarded as harmful.

**Alcopops had been favorably taxed in the past**

Another important part of the background to this reform was that in 2000 there was a significant lowering of the tax applicable to these pre-mixed drinks, introduced by the previous federal government. In early 2008, after the preliminary results of the national drug and alcohol survey were released, the new prime minister, Kevin Rudd, expressed public concern about an increase in binge drinking, particularly among young women. Part of the blame for this phenomenon was attributed to the lowered tax on pre-mixed drinks, with the new government citing figures showing a growth in sales of these drinks since the year 2000. In April 2008, the Prime Minister announced the sharp increase of the excise tax on these ready-to-drink beverages, which would cause increases of between AU\$0.30 and AU\$1.30 a bottle. The government announced that it hoped to raise more than AU\$3 billion (€1.5 billion) over several years from this change, and that a proportion of the expanded revenue would be redirected to preventive health measures.

From its announcement, this tax increase was highly contentious. The main opposition party expressed opposition, and various industry groups said it would lead to people simply switching drinks, rather than meeting the expressed aim of reducing drinking. Some spirits producers, the Australian Hotels Association, the Winemakers Federation of Australia and the Wine Grape Growers' Australia argued that between 1991 and 2007 alcohol consumption patterns of individuals 14 and over have remained largely unchanged, and that the assumed link between raising taxes on alcopops and reducing binge drinking was tenuous at best. The Australian Green party argued for a more aggressive anti-bingeing strategy including a ban on the alcohol industry's advertising, sponsorship and promotional activities. The government's move was however supported by key drug and alcohol organizations, public health groups, and a subsequent government-dominated Senate inquiry.

**Controversial from the start**

Since the introduction of the tax increase, there has been an ongoing battle between the alcohol industry and the government about both the measure and its expected effectiveness, including debate about the correct level of sales of alcopops. Agreement on what are the right numbers may even not be reached. In November 2008, new government figures revealed that the federal government may have overestimated the revenues that would flow from this tax increase. News reports cited fresh government calculations that the tax increase would bring in AU\$1 billion less over two years than had been previously estimated (Siobhain 2008). Those government financial calculations also revealed that the 70 percent increase in excise had caused a drop in production of ready-to-drink beverages, which was partly offset by a substitution of other spirits. At this point there are no figures on consumption to allow any conclusions about the reform's effectiveness, but it seems that creating effective financial incentives for healthy behavior, or financial *disincentives* for unhealthy behavior, may prove a lot harder than we might think.

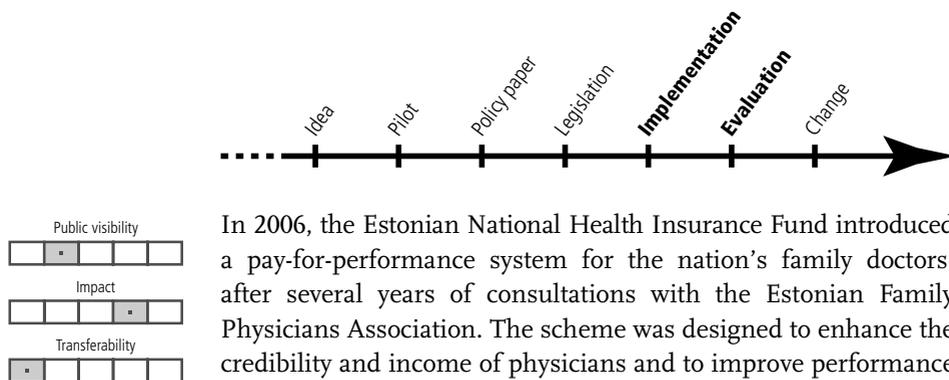
**Revenue increases lower than expected**

*Sources and further reading:*

Gallego, Gisselle. Doubling the Alcopop Tax. *HealthPolicy-Monitor*, September 2008. [www.hpm.org/survey/au/a12/4](http://www.hpm.org/survey/au/a12/4).

Siobhain, Ryan. Alcopops revenue overestimated by \$1bn. *The Australian*, November 06, 2008.

## Estonia: Paying for physician performance



In 2006, the Estonian National Health Insurance Fund introduced a pay-for-performance system for the nation's family doctors, after several years of consultations with the Estonian Family Physicians Association. The scheme was designed to enhance the credibility and income of physicians and to improve performance against a range of measures. Over the short life of this young reform, the rates of participation and the proportion of physicians receiving bonus payments have increased, although the thresholds for receiving bonuses have been reduced and financial incentives have been increased. While the scheme is considered a success, there has so far been no formal evaluation of its effects on health outcomes. As in the United States, where schemes have been in place for longer and have been more closely evaluated, there is little evidence that financial incentives for physician performance offer value for money or that they are having any positive impact on the health outcomes of the population (see *Health Policy Developments 11*, p. 97; Petigara and Anderson 2008; Conis 2008).

The pay-for-performance scheme rewards family doctors for undertaking certain activities within three different domains of

care: prevention of disease; monitoring of chronic illness; and wider professional competencies including certain examinations and small scale surgical procedures. When the scheme was started, priority areas included vaccination coverage, screening procedures, measurement of lipids and glucose levels, among other activities—though some screening activities have since been dropped from the program.

**What is the Estonian P4P scheme?**

The proportion of family physicians taking part in the scheme has grown from 49 percent in 2006 to 56 percent in 2007 and to 80 percent in 2008. The proportion of successful bonus recipients decreased from 100 percent of participants in 2006 to 39 percent in 2007. However, the picture is complicated by changes to the scheme which have raised the threshold to receive a bonus payment and by more participants receiving a higher bonus in 2007.

**Quality incentive or income-generating?**

The scheme has been led by family doctors from the beginning and has had a relatively high level of support from them. However, as the scheme has matured there are some signs of hesitation. There is particular concern about whether the incentive payments are worth the administrative energy and investment required to comply with the scheme. The concern echoes similar ongoing concerns in the United States, where health professionals feel the incentives are sometimes not high enough to warrant the burden of compliance or make a significant difference to their overall income (Petigara and Anderson 2008).

**What do the doctors think?**

While measures to improve the quality of care are clearly welcome, offering financial incentives to professionals to do a job that may be considered what they ought to be doing already raises concerns similar to those surrounding plans to pay people personal incentives for regular healthy behavior. But apart from questions about the nature of this approach, there are deeper concerns about the methods. Some observers have made sharp criticisms of the narrow nature of pay-for-performance schemes, most notably the British general practitioner Dr. Iona Heath and colleagues, writing in the *British Medical Journal* in 2007 (Heath et al. 2007).

**Criticism of P4P schemes**

In a strongly worded critique of pay-for-performance schemes designed to improve the quality of care in the United Kingdom, Heath wrote that the “whole initiative is based on reductive linear reasoning that views the body as a machine and assumes that a

**Rewarding the right things?**

standardized treatment will produce an equally standard unit of beneficial outcome” (Heath et al. 2007). The argument is essentially that these schemes by their nature tend to focus too much on what is easily measurable, potentially at the expense of the more complex nature of medical care. So doctors are rewarded for engaging in more *processes*—like measuring lipids, glucose, or blood pressure—rather than being rewarded for any real increase in the health *outcomes* of their patients. Moreover, according to Dr Iona Heath and her colleagues there is a real concern that such schemes could in some cases do more harm than good, by reinforcing inappropriate medicalization of the experiences of ordinary life, or encouraging overtreatment—for example by unnecessarily treating hypertension in some older people. Heath’s commentary offers a salutary note to enthusiasm about high participation rates in pay for performance schemes.

**Better outcomes—  
or only better  
measured  
processes?**

“Until the undoubted and now well documented increase in process is translated into tangible outcomes such as diabetes complication rates, renal failure in hypertension, or incidence of myocardial infarction or smoking related deaths, the benefits and *cost effectiveness* of the exercise cannot be estimated. *Outcomes* are much more difficult to measure than *processes*, especially at the level of individual practices, but the heightened emphasis on process brought about by the framework should not be allowed to distract from the fundamental aims of medical care.” (Heath et al. 2007; *italics added*)

**Little evidence of  
impact on health  
outcomes**

While the Estonian National Health Insurance Fund has expressed interest in evaluating the scheme, so far there has been no evaluation of the effects of these incentives on health outcomes yet published. In the United States, where similar incentives have been used for a longer period, and in some cases evaluated, there is still a lack of evidence of both effectiveness and cost-effectiveness. According to the respective *HealthPolicyMonitor* report, “there have been few formal evaluations of these programs and there is little evidence to suggest that these programs improve the quality of care” (Petigara and Anderson 2008). Despite enthusiasm for these schemes among both purchasers and providers, it may be worth applying more rigor to the evaluation of early schemes before they are extended and more widely adopted.

*Sources and further reading:*

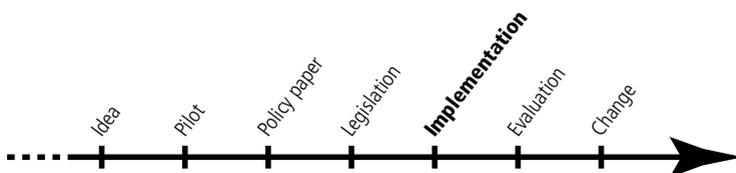
Aaviksoo, Ain and Gerli Paat. Scaling up P4P to family doctors. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/ee/a12/1](http://www.hpm.org/survey/ee/a12/1).

Conis, Elena. California's pay for performance program: Update. *HealthPolicyMonitor*, November 2008. [www.hpm.org/survey/us/c12/5](http://www.hpm.org/survey/us/c12/5).

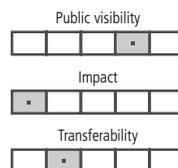
Heath, Iona, Julia Hippisley-Cox and Liam Smeeth. Measuring quality through performance: Measuring performance and missing the point? *British Medical Journal* (335) 2007: 1075–1076.

Petigara, Tanaz, and Gerard Anderson. Pay for performance in the U.S.—An update. *HealthPolicyMonitor*, April 2008. [www.hpm.org/survey/us/a11/2](http://www.hpm.org/survey/us/a11/2).

## United States: The high cost of “biologics”



It seems very relevant in any discussion of value for money in health care to look at one of the fastest growing areas of expenditures in health care today: the new form of pharmaceuticals called “biologics.” Derived from living tissue, rather than synthesized from chemical compounds, these new therapies can offer significant clinical benefits but can cost between US\$10,000 and US\$200,000 per treatment regime. The market for these high-cost biologics is reported to be growing at twice the rate of conventional pharmaceuticals, having reached over US\$40 billion (€31.2 billion) in 2006, and projected to grow to US\$60 billion (€46.8 billion) by 2010. While there is clearly an urgent need to assess whether this investment is good value for money, this novel form of therapy is creating major challenges to conven-



tional systems of evaluation, including cost-effectiveness analysis. In the concluding section of this chapter we offer some brief insights into those challenges and look at how the system is reacting to these exploding costs.

**Challenges to conventional evaluation**

The development and marketing of these novel therapies has far outstripped the development of new evaluation strategies to assess their potential benefits, harms and cost-effectiveness. While patents on the first generation of these biologics are soon to expire, the United States Food and Drug Administration (FDA) has still not developed a regulatory approval process for these drugs and is still awaiting guidance from Congress. (NB: The FDA does not conduct cost-effectiveness analyses.) In contrast, Europe has established some standards, though the European Agency for Evaluation of Medicinal Products has adopted a case-by-case review mechanism.

**Several strategies to reduce expenditure:**

Notwithstanding debates about how to evaluate the value of biologics, health insurers in the United States are exploring how to reduce the growth in total costs. Strategies include “step therapy”, physician administration fees, and “fourth tier” coinsurance programs.

**Step therapy, physician fees and patient co-pays**

- The step therapy approach requires that patients receive the new high-cost therapies only after other treatments have proven unsuccessful. In this approach, during prior authorization required by the insurer, physicians would have to supply documentation showing the patient’s diagnosis and prior treatments.
- Many biologics are administered to patients by physicians, through injection or infusion, rather than sold through pharmacies. This means physicians often buy them from the manufacturers and sell them to patients at significant profit, creating potentially perverse incentives to increase prescriptions and increasing the costs to patients. One strategy being pursued is to increase physician administration fees, to try and reduce the incentive to mark up prices.
- Some insurers are now requiring that patients pay a percentage of the total drug cost, rather than a fixed level co-payment.

One of the most pressing issues is how to evaluate new generic versions of these biological pharmaceuticals. With conventional

medicines, generic manufacturers in the United States have simply needed to prove “bioequivalence” with the branded drug, but due to the complexity of manufacturer processes with biologics, and heightened fears about potential adverse events, such a system may not be appropriate. Currently there is ongoing debate about how to evaluate and approve new generic versions, as well as about the appropriate length of patents for branded biologics.

**Do generics offer a way to reduce costs?**

*Sources and further reading:*

Petigara, Tanaz, and Gerard Anderson. Strategies to reduce the high cost of biologics. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/us/a12/3](http://www.hpm.org/survey/us/a12/3).



# Who should pay for what?

Before we ask whether we are getting value for money, there is a much simpler question that plagues those responsible for running health care systems: Where does that money actually come from in the first place? How much of total expenditure on health care should originate from general taxation or (social) health insurance? What should be the contribution of voluntary or private health insurance, what is the optimum size of out-of-pocket payments, and to what extent should industry shoulder the burden for the expensive assessments of its new products? A lot of these questions are answered in large part already through the distinctive historical developments and regulatory characteristics within separate healthcare systems, each one arriving today at their own unique mix of funding sources. But the specter of rising health costs and the axiomatic challenge of achieving financial sustainability for health systems are forcing policy makers in different nations to focus on the same question: Who should pay for what?

One of the most consistent features of health systems everywhere is rising costs, making methods of cost containment one of the more salient themes in health policy discussions. The challenge, of course, as we discussed in the opening chapter of this book, is to try and design systems that pay for safe effective treatments and programs that give value for money, while at the same time discouraging use of ineffective, harmful or unnecessary health services. While similarly focussing on money, this chapter has a different emphasis, looking more narrowly at debates around how to fund those rising costs, and who should fund them, rather than debates about whether the funded services provide good value. As we will discover, there is a rich diversity of

**Facing up to  
rising costs**

responses to the problem of forging financial sustainability for a health care system, and lively public debates about each of those different responses.

**The four main sources of funding**

The four main sources of funding health systems are taxation, social health insurance, private health insurance and out-of-pocket payments, as outlined so clearly in a policy brief on funding options prepared several years ago for the European Observatory on Health Systems and Policies (Mossialos et al. 2002). Taxation can take several different forms, direct or indirect, and general or hypothecated—meaning earmarked specifically for health care. Taxes can be levied by different levels of government, from national to local. Social health insurance can take different forms too, but contributions are usually legally binding on part or all of the population, and are levied by a third party independent from government. Private health insurance can substitute for compulsory insurance or it can supplement or complement it. Similarly, private health insurance can be mandatory and/or voluntary. And out-of-pocket payments can come in all shapes and sizes, including co-payments, co-insurance and deductibles (Mossialos et al. 2002). This of course is a rough categorization, and the reality doesn't always fit neatly into this theoretical classification.

**Growing use of cost-sharing**

One of the trends in recent decades in European systems funded predominantly through public taxation or social health insurance has been growing levels of private expenditure on health care, which is coming mainly from greater reliance on out-of-pocket payments, also called cost-sharing (Jemiai et al. 2004). Arguments in favor are that cost-sharing can help reduce excessive and unnecessary utilization of health services, while simultaneously raising revenue and sustaining and expanding the provision of needed care. Opponents argue that apart from reducing equity by shifting costs from the pool to the individual, individuals cannot always distinguish between effective and ineffective care. Most decisions of whether to undergo a treatment or take a drug, the critics argue, are made by providers and thus excess utilization may be a consequence of supply-induced demand, and increasing out-of-pocket payments may not be the best way of reducing inappropriate care (Jemiai et al. 2004).

Arguments about how to sustain the financial viability of a health system at the same time as maintaining or even enhanc-

ing equity will be familiar to many readers. Similarly, readers will be familiar with the tensions between policy approaches that favor more social solidarity or more individual responsibility, tensions covered recently by our network, particularly in reports relating to the question of cost-sharing or cost-splitting (see *Health Policy Developments* 9, pp. 87–104). In this chapter, these tensions over what is fair and reasonable while being practical and prudent policy will resonate implicitly through each of the national debates.

Shying away from the politically unpalatable option of raising out-of-pocket payments, the French government is planning to significantly increase the turnover tax for private health insurance companies, in order to help fund rising national health expenditure (see report on France, p. 38). In Finland, by contrast with France, having only a very small voluntary insurance sector, a newly elected federal government is opting to raise out-of-pocket payments (see report on Finland, p. 41). Across the Atlantic in Canada, where the taxation-funded system of universal care remains extremely popular, the search for long-term financial sustainability is raising contentious questions about the appropriate size of the private sector, and a vigorous national debate is ensuing (see report on Canada, p. 42). Meanwhile, in the southern United States, state employees in Alabama at high risk of certain diseases will be effectively penalized with the introduction of a new scheme that means higher health insurance premiums (see report on the United States, p. 46). And in Australia there is an innovative though controversial plan to charge drug companies a user fee for cost-effectiveness assessments (see report on Australia, p. 48).

While France may not have the same reputation for cost-effectiveness analysis as Australia does, the reputation of the French health system is enviable. Yet France like many other nations is facing the perennial challenge of trying to pay for, and control, rising costs. As the national compulsory insurance scheme has over recent years reduced the proportion of healthcare costs that it reimburses, out-of-pocket payments have increased, and the nation's voluntary health insurance funds have become more and more popular, growing today into something close to a complementary universal system of coverage. With this growth has come

**Sustaining financing and equity?**

**A fascinating array of reform options**

**France boost taxes on private insurance**

growing turnover and profits for the insurance funds, creating new pots of money that the state is now looking to dip into, to try to fund the national health insurance scheme.

**Finland hikes  
out-of-pocket  
payments**

Unlike the French system, voluntary health insurance is only a small part of the system in Finland, where local municipalities raise a large portion of healthcare funding through taxation. A feature of the Finnish system is user fees for services like seeing doctors or dentists, and in 2008, those fees have been significantly raised, by a new federal government elected the year before. The reform is not technically new, as it is simply adjusting user fees to keep up with changes in inflation. What is new are rules to make sure that user fees are automatically raised regularly in the future. Unsurprisingly, the move is politically controversial.

**Canada debates  
privatization**

Meanwhile, in Canada, rather than hiking user fees or taxes on voluntary insurers, some see growing privatization as a way of reducing the costs to provincial governments that are spending increasing proportions of total outlays on funding their province-based healthcare system. While there are prohibitions on private doctors or hospitals providing care privately that is also provided by the public system, these restrictions appear to be loosening or are being poorly enforced. However, set against a backdrop of overwhelming public support for the publicly funded scheme of universal health coverage, the growing privatization is highly controversial: promoted aggressively by some politicians and entrepreneurial providers, and opposed by other politicians and provider groups who do not want to see the emergence of a two-tier system.

**Alabama:  
premiums based on  
individual's risk**

If you were to try to chart reforms on the spectrum of championing individual responsibility at one end and advancing social solidarity at the other end, there is little doubting where an initiative in the southern state of Alabama might sit. Beginning in 2009, state employees in Alabama at high risk of certain diseases—including those with a high body mass index—will be offered discounted health insurance premiums if they undertake measures to manage their risks. If they don't, they will be charged higher premiums. Described as an unfair "fat tax" by some, the program has the backing of key state institutions and is being watched by other states eager to contain healthcare costs.

And finally we discover that in Australia an unusual proposal is being floated to charge drug companies user fees to pay for statutory assessments of the cost-effectiveness of their new medicines. Perhaps a little tangentially related to the suite of other initiatives covered in this chapter, the move has nevertheless raised an interesting debate about the appropriateness of this sort of cost recovery, already widely used in some places—such as the United States—to fund regulatory approval of pharmaceuticals and medical devices. Introduced by the incoming federal government, whose health spokesperson was previously critical to it, the proposal is expected to recoup only a small amount of money and is facing widespread opposition from different stakeholders, including industry.

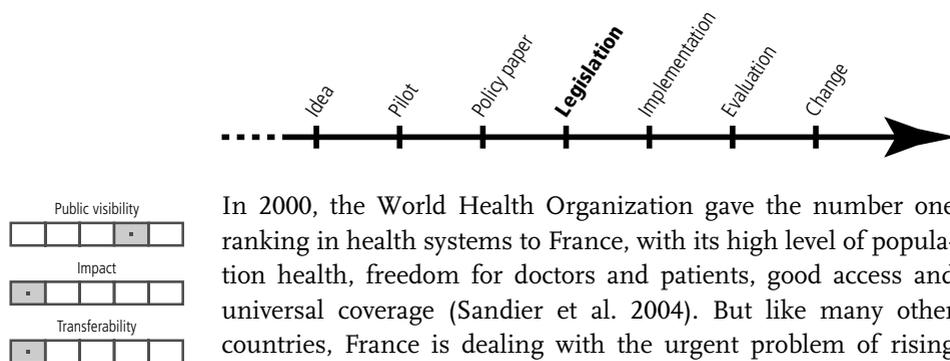
**Australia: raising user fees for drug companies?**

*Sources and further reading:*

Jemai, Nadia, Sarah Thomson and Elias Mossialos. An overview of cost sharing for health services in the European Union. 2004. [www.euro.who.int/Document/Obs/EuroObserver6\\_3.pdf](http://www.euro.who.int/Document/Obs/EuroObserver6_3.pdf).

Mossialos, Elias, Anna Dixon, Josep Figueras and Joe Kutzin. Policy Brief on “Funding health care: options for Europe.” Copenhagen: WHO on behalf of the European Observatory on Health Systems and Policies; 2002. [www.euro.who.int/document/obs/Fhcpolbrief4.pdf](http://www.euro.who.int/document/obs/Fhcpolbrief4.pdf)

## France: Raising taxes on private health insurers



In 2000, the World Health Organization gave the number one ranking in health systems to France, with its high level of population health, freedom for doctors and patients, good access and universal coverage (Sandier et al. 2004). But like many other countries, France is dealing with the urgent problem of rising costs, exacerbated ironically by the high level of freedom of both patients and providers, which has helped earn France its enviable status. As a consequence, cost containment is seen as one of the major aims of the reform process, and one of the key strategies has been to reduce reimbursement levels and thus increase cost-sharing. According to the European Observatory on Health Systems and Policies, while professional groups play an important role in implementing reforms in France, “increasing doctors’ responsibility for containing costs has been largely ineffective” (Sandier et al. 2004).

### Rising costs, swelling deficits

While the budget deficit of the national public health insurance scheme declined in 2005 and 2006, healthcare expenditure increased dramatically in 2007. The situation has now got to a stage where the budget deficit of the national public health insurance scheme is estimated to reach more than € 4 billion in 2008 and € 7.6 billion in 2009. Meanwhile, over the past four years, private insurance funds have increased premiums by 30 percent and profits by 25 percent. The government’s aim is to try to balance the books of the public scheme by 2012, so it has asked the private health insurance funds to pay just over € 1 billion in 2009, in the form of a turnover tax, in order to help fund the deficit. (About 85 percent of the French population own a private supplementary insurance mainly covering the copayments for different health services, which can be quite significant for specialist and certain types of hospital care. The poorest 7 percent of the population benefit from free complementary insurance.)

The complementary insurance funds have already been paying a tax to support the public health budget, because they part-finance the complementary universal health insurance fund, which was created in 2000 to cover services for the poorest part of the population. Technically the new tax consists of increasing the rate of this contribution from 2.5 percent to 5.9 percent of their healthcare turnover. Interestingly, as a result of negotiations between the state and the voluntary funds, the funds will be offered a seat at the table to take part in collective bargaining with the medical profession over fees.

**Increasing the turnover tax**

The government has already introduced new co-payments in 2008, in the form of deductibles, and more cost-sharing to fund the deficit was ultimately deemed politically unpalatable. The initial package of measures responding to the budget deficit had included reducing reimbursement levels for treatment costs, thus increasing out-of-pocket payments, but after attacks from many parties, the government produced a new plan for the increased tax on turnover to happen in 2009. Other options not pursued were increases in general income tax and increases in social insurance contributions through workplaces.

**Other options unpalatable**

While complementary insurance companies generally disapproved of the new contribution, the industry was split over whether or not to support it. The non-for-profit mutual insurance companies, which account for 60 percent of the insurance market turnover, have the most modest position, and agreed to the contribution in return for a role bargaining with providers. The sector also announced it would not increase premiums in 2009, if the tax is not renewed in 2010. In contrast, a third group of payer-stakeholders, the for-profit companies and not-for-profit provident institutions—which provide mandatory health and retirement schemes for employees—are strongly opposed, and have said premiums will rise, which may cause some people to drop insurance.

**Insurance funds split over new taxes**

Medical professionals have mixed feelings about the new arrangements whereby the complementary insurance sector will now be part of negotiation over doctors' fees. Some professionals fear having to negotiate with two health insurance sectors, while others see the complementary sector as having softer budgetary constraints. Patient groups have mixed feelings because they fear

**Providers and patients have mixed feelings**

premiums may rise but are glad that co-payments have not again been increased. They have also argued that this measure—which is designed to fill a temporary deficit—does not tackle systemic structural problems, and they have asked for measures to better control medical fees.

Is this regressive or progressive?

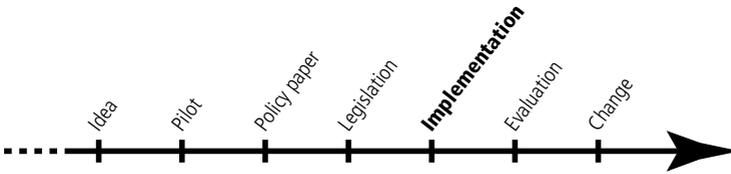
One element of the reform is that the extra revenue raised through this tax will flow into the public health budget, some or all of which will be spent on the complementary universal health fund, which helps cover the healthcare costs of the poorest section of the population. In this sense the reform can be seen as progressive. Looked at another way, the reform could lead to rising premiums for complementary insurance, which will disproportionately hurt those on low incomes, causing some of them to drop out of private health insurance. No doubt there will soon be some data to help answer this question as the reform is monitored and evaluated.

*Sources and further reading:*

Cases, Chantal, and Zeynep Or. New turnover tax for private insurers. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/fr/a12/3](http://www.hpm.org/survey/fr/a12/3).

Sandier, Simone, Valérie Paris and Dominique Polton. *Healthcare Systems in Transition: France*. Copenhagen: WHO on behalf of the European Observatory on Health Systems and Policies; 2004.

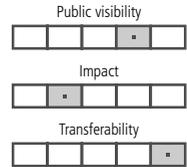
## Finland: Raising out-of-pocket payments for individuals



While France has opted not to lift co-payments again in 2009, Finland, like France, did just that in 2008. Unlike France, in Finland a large share of the taxation that funds health care is raised by the local municipalities who have the organizational responsibility for public health services. A feature of the system is a modest user fee, which on average has covered 8 percent of the expense on primary health, 4 percent of the costs of specialized services and 20 percent of the costs of oral health services. In 2008 the government raised the maximum levels of those user fees quite dramatically, hiking them by an average of 17 percent, and almost 30 percent for dental care.

While there has been opposition to the increase, the last time the user fees were raised was 2002, and this current increase was to adjust for inflation. So the increase is not technically a new reform. What is new is that the government has decided to regularly raise the user fees at two-year intervals. The municipalities do not get any financial benefit from the increase, because the national government will adjust the amount of money it gives to the municipalities by the same amount that it expects will be raised by the user fee increase. The majority of municipalities raised the user fees to the new maximum within a month of the government decision coming into effect.

The political background to the increase in the use fee was the election of a new government in Finland in early 2007, considered more conservative than previous governments. Left-wing political parties in the current opposition strongly opposed the increase in user fees, arguing it could create an even higher barrier to access to health services for low-income people. In addition, several patient groups have opposed the raise. Meanwhile, the government has defended the raise as being modest and simply returning the fees to the level they were in 2002, in real terms.



**User fees will now rise regularly**

**Left-wing and patient groups against higher fees**

Is the increase in out-of-pocket payments equitable?

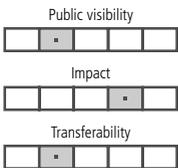
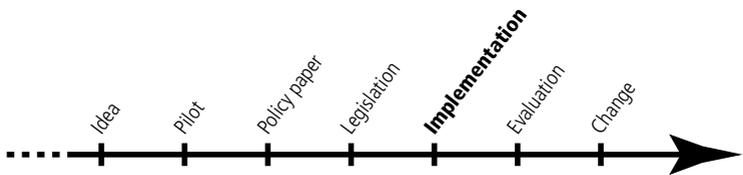
Some see the reform increasing social-economic differences in access to services, which are already evident as a problem in Finland, as elsewhere. Part of the argument is that raising user fees in a municipal healthcare system will have a particular influence on low-income people because more affluent people use occupational health services—which are free of charge—or private health services. It is unclear how this move will increase the quality of care, or access, which was one of the objectives of the reform.

Of special concern is the almost 30-percent increase in user fees for dental services, which again will likely have a detrimental impact on access for people on low incomes in Finland—and on their oral health status.

*Sources and further reading:*

Vuorenkoski, Lauri. Raising user fees in public sector health services. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/fi/a12/4](http://www.hpm.org/survey/fi/a12/4).

**Canada:  
Privatization as a way of forging financial sustainability?**



The two theoretical policy poles of pure state administration and pristine private market mechanisms have largely melted in recent decades, as countries everywhere have warmed to more hybridized health systems that combine some degree of public and private approaches to both health financing and service provision (see *Health Policy Developments 10*, pp. 119–127). If the extraordinary events of the late 1980s sounded a death knell for comprehensive bureaucratic control of health systems, then perhaps the

recent cataclysmic developments in financial systems sobered up those still intoxicated by the promise of a system driven primarily by the dynamics of the private marketplace.

So thus, in the heart of a nation passionately committed to a system of publicly funded universal health insurance, a private market in health services separate from the public system is slowly but steadily growing. Today this privatization still remains at the margins, but if current trends continue, Canada will witness a slow but deep shift in the fundamentals of her system. Some see the expansion of private clinics offering specialized services to those who can afford them as inevitable, and more importantly as a welcome solution to the challenge of financial sustainability. Others see the inevitable outcome as dual increases in inequity and expenditure. For all of us interested in the interplay of private and public forces in health care, observing contemporary developments in Canada is certainly captivating.

**Canada witnesses growing privatization**

The funding of Canada’s public health system is split between the federal government and the provinces, which are also responsible for the delivery of health services. The Canadian Health Act of 1984 made provision that public funding of “necessary” health services would flow to the provinces as long as the provinces ensured the services would be covered by five principles: universality; accessibility; portability; comprehensiveness and public administration. Under the accessibility provision all Canadians are entitled to receive medically necessary health services without any additional private payment—though “medically necessary” covers physician and hospital services, not pharmaceuticals or other types of health expenses. Moreover the private provision of medically necessary services already provided by the state is discouraged by other rules and regulations in Canada, though that discouragement is being challenged by those actively creating or supporting a new private market.

**The Canadian system’s five principles**

Just as in France and so many other systems, expenditures on health care have been rising rapidly in Canada in recent years. Typically the federal government supports something like 20 to 25 percent of the total health budget in each province. However, the provinces are spending a greater proportion of their total budgets on health all the time. Some political leaders at the provincial level, called premiers in Canada, report that health expen-

**Expenditure escalating**

diture is fast approaching an average of 50 percent of the total budget of some of the provincial governments. Meanwhile, health expenditures in real terms continue to rise, raising very difficult questions about sustainability. In such a climate, the idea of a private market taking pressure off the growth of public expenditure, and offering more choice to those who can afford it, has become appealing to some within Canada.

**Privatization has been historically discouraged**

One of the five principles of the national law is public administration of health services, and in addition several provinces also have rules discouraging or prohibiting the offering of private insurance for medically necessary hospital or physician services provided by the state (Marchildon 2005). However, it is legal to offer private care for medically necessary services, if the providers of that care have completely opted out of the public system. Such opting out though is not common. Notwithstanding these rules, there is a private health insurance market in Canada, covering health services such as pharmaceuticals, which are not technically categorized as being “medically necessary” under the national law.

**The prohibition is loosening**

Against this traditional backdrop of discouragement of privatization, there are several important signs of change, indicating that constraints are loosening. One recent report from a group opposed to privatization found there are now more than 130 for-profit surgical/medical/diagnostic clinics across Canada, and that foreign-owned for-profit chains are now a feature of the domestic healthcare landscape (Mehra 2008). That report estimated there may have been almost 90 violations of the Canadian Health Act, usually by clinics billing patients for services covered by public authorities under the act. In many cases, private clinics bill the public system and charge the patients extra. Meanwhile in 2006 the Supreme Court in the French-speaking province of Quebec struck down a Quebec law that prohibited people from buying private insurance for services already offered by the public system. Needless to say, the court decision has encouraged those promoting more privatization.

**Can privatization relieve the public purse?**

Some premiers believe that allowing people to access care with private payment for medically necessary services will help make their provincial systems more sustainable, by bringing in additional revenue. Other premiers argue that privatization will bring

a two-tier health care system that is antithetical to the principles of the nation's popular public system, which is both equitable and cost-effective. Around 80 percent of Canadians are satisfied with their access to their healthcare system, and the population consistently supports it, notwithstanding concerns about problems like wait times and access to family physicians.

Some doctors are very enthusiastically promoting the expansion of privately delivered provision of medically necessary services. One promoter, for example, is a past president of the influential Canadian Medical Association, who also owns a large private clinic in one of the provinces. Similarly the current president of the same doctor's lobby, a co-owner of private radiology clinics in another province, is also clear in wanting reform of the system that would allow greater options for private payment for care. By way of contrast, a group called the Canadian Doctors for Medicare are advocating against private payment for medically necessary services. This group is opposed to outsourcing care to private clinics and shifting costs to patients, and sees growing privatization as creating a two-tiered system characterized by less fairness and growing expenditure.

**Doctors are split too**

And speaking of a two-tiered system, it may be that it has already arrived, at least in some parts of Canada. A company called Copeman Healthcare, which runs private health clinics, is already offering Canadians an "Elite Program" of care described as an "all inclusive health service." Meanwhile the Ontario Health Coalition sought a legal opinion specifically on whether the setting up of new Copeman clinics in the province of Ontario violated any laws. In the view of that legal opinion, publicly available on the advocacy group's website, the setting up of such clinics would constitute violations of the Canada Health Act and provincial laws. No doubt the debates about the merits of privatization and its appropriateness as a strategy for sustainability will continue to rage in Canada in both legal and lay circles for a long time to come.

**Already a two-tiered system?**

*Sources and further reading:*

MacAdam, Margaret. Sustainability of Canada's Health Care System. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/ca/a12/1](http://www.hpm.org/survey/ca/a12/1).

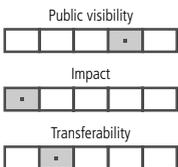
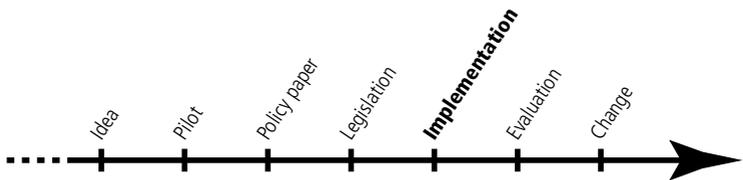
Copeman healthcare site, Elite Program. [www.copeman-healthcare.com/services\\_elite](http://www.copeman-healthcare.com/services_elite).

Marchildon, Gregory. *Health Systems in Transition. HiT summary Canada*. Copenhagen: WHO on behalf of the European Observatory on Health Systems and Policy; 2005. [www.euro.who.int/Document/E87954sum.pdf](http://www.euro.who.int/Document/E87954sum.pdf).

Mehra, N. Eroding Public Medicare, Ontario Health Coalition, report 2008. [www.web.net/ohc/Eroding%20Public%20Medicare.pdf](http://www.web.net/ohc/Eroding%20Public%20Medicare.pdf),

Ontario Health Coalition legal opinion on Copeman healthcare clinics. [www.web.net/ohc/copemanlegal.pdf](http://www.web.net/ohc/copemanlegal.pdf).

## Alabama: Raising insurance premiums for high-risk people



While France taxes insurance companies, Finland raises user fees and Canada flirts with private financing, a state insurance plan in Alabama in the United States is raising premiums for those at higher risk of disease: another measure designed to establish sustainability by controlling costs, enhancing revenues, or both. As with all the other reforms covered in this chapter, the move is contentious, as it goes to the heart of the delicate question of how to fund the healthcare system while maintaining elements of fairness and equity—a subject we will explore in more detail in the chapter “Spotlight on access and equity around the world,” p. 11.

Under the rather convoluted rules of the new plan, state employees in Alabama will be offered access to a free health screening service in 2009. Any employees identified as having a high body mass index, high blood pressure, high cholesterol or high blood sugar will be given a voucher for a free consultation with a doctor. Those employees who don't take advantage of the screenings will face higher monthly insurance payments than those who do. Those at high risk will face no penalty, as long as they provide evidence that they have taken steps to manage any risk factors. Higher rates apply to smokers, as compared to non-smokers. The scheme is called the Wellness Premium Discount Program.

**Alabama plan for differential health premiums**

Several other states in the United States already offer state employees free health screenings and wellness or risk-management programs. Two states—a leading alcohol-producing state Missouri in the midwest and the politically conservative Arkansas in the south—already offer lower premiums to workers who participate in screening or wellness programs, and several states already offer discounted premiums to non-smokers. However, the details of the current plan make Alabama the first state to offer discounts on the basis of such a specific set of risk factors, including measurements of body mass index.

**Similar to other state-based plans**

Alabama is a state with very high rates of obesity, stroke, diabetes and hypertension, and the state insurance plan, the insurance board, and the employees association all support the new plan. The aims of the plan are to reduce the rate of chronic illness and thereby ultimately cut the costs relating to treatment. The insurance board has argued, for example, that the healthcare costs of people with high body mass index are more than US\$ 1,700 greater per year—€ 1,328—than costs for people with a lower body mass index. And there is also research suggesting money invested in employee wellness programs is money well spent and can result in healthcare savings.

**Responsible cost-cutting ...**

On the other hand, some patient advocacy groups, particularly those representing the obese, have labelled the plan as unfair and discriminatory against people predisposed to being overweight or obese. The insurance plan has defended the new scheme against claims it is a new "fat tax." The criticisms are reminiscent of concerns covered elsewhere in this book about the potentially coercive nature of individual financial incentives being considered in

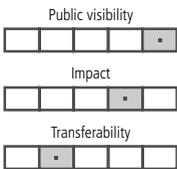
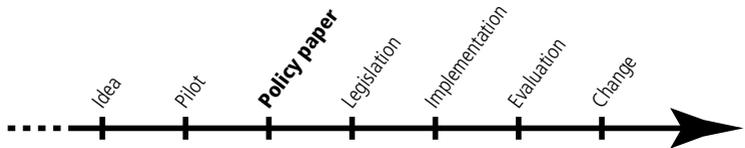
**... or an unfair "fat tax"?**

the United Kingdom (see report on p. 20). In the sometimes topsy-turvy world of health policy where the goal of financial sustainability looms large as the new holy grail, it may be quite reasonable to be asking whether a wellness discount program is an unfair tax in disguise, and whether the generous offer of a financial incentive might inadvertently become a tool of coercion, wielded against those least able to meet the requirements for receiving it.

*Sources and further reading:*

Conis, Elena. Alabama's Wellness Premium Discount Program. *HealthPolicyMonitor*, November 2008. [www.hpm.org/survey/us/c12/3](http://www.hpm.org/survey/us/c12/3).

**Australia:  
Raising user fees for industry, to assess value for money**



Australia's system of assessing whether new medicines offer value for money is relatively well known, and has been referred to in an earlier chapter in this book (see chapter on Value for Money, p. 11 of this book). Similarly, we have recently reported on a reform in Australia involving mandatory reductions in the prices of some medicines, aimed at trying to reduce the considerable costs of the national Pharmaceutical Benefits Scheme (*Health Policy Developments 10*, p. 110). This time, however, Australia is asking whether the pharmaceutical industry should contribute to the cost of the cost-effectiveness analysis at the heart of Australia's system of subsidized medicines.

**Australia's two levels of regulation**

Under the rules governing the Australian health system, drugs are approved to be marketed initially by the Therapeutic Goods

Administration. After that, manufacturers have to apply to have their medicines listed and reimbursed on the national statutory formulary, the Pharmaceutical Benefits Scheme, which is considered one of the pillars of Australia’s system of taxation-funded universal health insurance. Once listed on the scheme, a medicine is available to all Australians at an affordable price.

The body which considers the application for listing on the Pharmaceutical Benefits Scheme—and whether the drug offers value for money—is the Pharmaceutical Benefits Advisory Committee and its related subcommittees. Already the Therapeutic Goods Administration is 100 percent funded through “cost-recovery”, that is through the fees charge to manufacturers to have their applications assessed. The proposed reform would see similar cost-recovery measures apply to the workings of the Pharmaceutical Benefits Advisory Committee.

The proposal was first announced in 2005, under a previous federal government, which planned to introduce it in 2007–2008. At the time it generated public concerns, primarily related to whether industry funding might undermine the independence of the advisory process, which is considered critical to the functioning of the national system of affordable medicines. Elections held in late 2007 saw the election of a new federal government, which went ahead and announced that it planned to introduce the same measure in 2008, it being a natural extension from already existing cost-recovery measures.

Interestingly, before the election of the new federal government, the then shadow health minister—from the party now in government—noted there was no justification for the move to implement cost recovery, as it could undermine the independence of the advisory committee. Since its re-introduction, the proposal has attracted much criticism from many quarters. Industry itself has expressed its surprise and disappointment, while pharmacy and medical groups have also expressed reservations. And media reports have again raised fears of the move undermining independence. The initial start date of July 1, 2008, has been postponed and the enabling legislation has been referred to a parliamentary committee.

Asking industry to pay for the costs of assessing and regulating its products may well be considered a means of reducing grow-

**Manufacturers billed for assessment of products**

**Proposal predates the current government**

**Criticism ... from many quarters**

**Is regulatory  
independence  
under threat?**

ing public expenditure, but those benefits may come with another cost. For example, in the United States, debates have raged for many years about whether the giant Food and Drug Administration can be considered truly independent when more than half its bills were being paid by the industries it is supposed to be regulating (Moynihan 2002). In Australia there is a history of public concern about the independence of the Pharmaceutical Benefits Advisory Committee, whose decisions can make or break a new drug financially. A previous health minister famously sacked an entire committee, and controversially appointed an industry representative to the newly constituted one. Watching the course of this current reform, and tracking its potential impacts on the process, will be fascinating.

*Sources and further reading:*

Gallego, Gisselle. Cost Recovery Arrangements for PBS. *HealthPolicyMonitor*, September 2008. [www.hpm.org/survey/au/a12/5](http://www.hpm.org/survey/au/a12/5).

Moynihan, Ray. Alosectron: a case study in regulatory capture, or a victory for patients' rights? *British Medical Journal* (325) 2002: 592–595.

# Governance in Bismarckian Systems

As some readers will already be aware, “Bismarckian” is the term used to describe the social health insurance systems of many European nations (as well as other countries such as Japan), in contrast to the taxation-funded health systems sometimes referred to as Beveridge systems. The sickness funds or insurers at the heart of social health insurance systems, dating back to late medieval times, developed into mandatory statutory structures starting during the time of chancellor Otto von Bismarck and Germany’s Health Insurance Act of 1883. Under that act, workers were mandated to have health insurance and shared their insurance contributions with their employers. Sixty years later, in wartime United Kingdom, William Beveridge authored the Beveridge report—widely regarded as underpinning the creation of the post-war welfare state, with its centerpiece, the taxpayer-funded National Health System.

A group of health policy experts recently observed that there was broad agreement across Europe on the core objectives that health systems should pursue, in order to achieve a fair, efficient and effective system (Saltman et al. 2004). The short list included universal access for all citizens; effective care for better health outcomes; efficient use of resources; high quality services; and responsiveness to patient concerns. The way those same core objectives are turned into policy and ultimately into governance strategies will differ in different nations, as we will see in this brief chapter.

One of the key elements of social health insurance systems is that they rely on networks of stakeholders within their respective nations to negotiate the determination of health policy under the auspices of the government—thereby combining self-governance

**Five core objectives of European health systems**

**Drama of governance involves many actors**

of stakeholders with government regulation. Rather than dominating or dictating, the government sets the (fair) rules of the game via which the stakeholders are supposed to (fairly) play (Saltman et al. 2004). Moreover, this process of governance is ideally imbued with a strong sense of trust, helping to build a nation's social capital, and reflects the sense of social solidarity that is the soul of these sorts of health systems (Saltman et al. 2004). The list of stakeholders—often referred to as corporatist players or interest groups—involved in the networks can be long: employers and their associations; employees and their unions; insurers, both for-profit and not-for-profit, and their associations; citizens; providers; and governments, including national, provincial and local authorities (Saltman et al. 2004).

**Bismarckian  
systems: privately  
owned yet publicly  
controlled funds**

As Marc Danzon has observed, while social health insurance systems are seen by many citizens as a core building block of a good society, they also present us with key paradoxes (Saltman et al. 2004). The primary paradox is that the systems are based on privately owned and operated funds, which are very tightly controlled by the state. While the increasing blurring of roles between the private and public sphere may lessen the intensity of this paradox somewhat, it is still a source of tension, as we will see reflected in the reports in this chapter. For example, will the introduction of more competition in Switzerland result in a reduction in social solidarity if the sick ultimately have to pay a lot more for their premiums than the healthy? And in France, will decentralizing control of purchasing hospital care to the regions result in more privatization in provision?

**Switzerland in  
midst of deciding  
on radical reforms**

At least two key factors have aligned to force Switzerland to contemplate some radical reform of the way its health system is governed. Firstly, bilateral agreements with the European Union mean that medical practitioners from across Europe can practice in Switzerland, an attractive location in part because of the higher remuneration available there. And secondly, health insurance plans in Switzerland have traditionally been obliged by law to reimburse all medical services provided by authorized doctors under the framework of compulsory health insurance. The combination of these two factors can obviously produce an explosive mix in terms of costs, and so in 2002 a moratorium on the opening of new medical surgeries was introduced. That moratorium,

twice extended, is scheduled to finally end in 2009, and the nation is facing some very tough decisions about how to rationally control the supply of doctors after that (see report on Switzerland, p. 54).

Like Switzerland, France is in the middle of some controversial and far-reaching reforms of the governance of its healthcare system, in particular its hospital sector. The aim is to improve the supply and coordination of health care at the regional level, and the reform has been given high visibility, having been announced by President Nicolas Sarkozy. A key part of the plan is decentralizing the financing and governance of hospital care to newly created Regional Health Agencies, which will be responsible for everything from fair access to improving coordination between different sectors of the system and attaining certain standards in terms of quality (see report on France, p. 57).

Less radical than the reforms underway in Switzerland and France, the developments in Estonia could herald a new emphasis on prevention as opposed to clinical care (see report on Estonia, p. 59). In 2008 the Estonian Health Insurance Fund adopted a new four-year strategic plan which includes disease prevention and health promotion as one of its five strategic priorities. Unlike in many other countries, some health promotion activities are funded directly by the country's single insurance fund, though they remain a tiny part of the fund's total bucket of expenditure. The report from Estonia reinforces how the distinction in the roles of payers and players is these days often blurred (also see chapter on sickness funds in *Health Policy Developments 10*, p. 71).

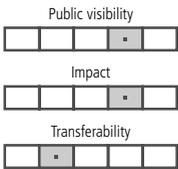
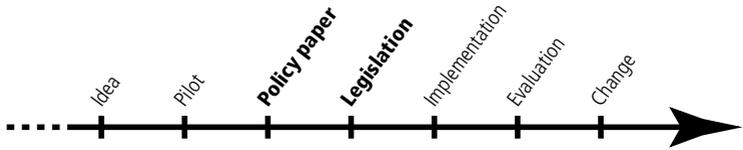
**France chooses major devolution of power to the regions**

**Estonian health fund expands from payer to player**

*Sources and further reading:*

Saltman, Richard, Reinhard Busse and Josep Figueras. *Social Health Insurance Systems in Western Europe*. Buckingham: Open University Press; 2004. [www.euro.who.int/document/E84968.pdf](http://www.euro.who.int/document/E84968.pdf).

## Switzerland: Who should control outpatient supply after 2009?



Like many nations, whether their health systems are Bismarckian, Beveridge-style, or just a wild mix as is the case in the United States, Switzerland is struggling to find the right balance between competition and regulation, and between the market and the state, in terms of how its system is governed and its care delivered. But right now that struggle for the Swiss is particularly acute, as they confront a structural reform of their healthcare system that could fundamentally shift the balance of power between different players. In 2009, the nation will make key decisions that could radically change the relationship between insurers and doctors, with major implications for patient choice, provider satisfaction, quality of care and financial sustainability. While the ultimate shape of that governance reform is still not known, its genesis makes for a fascinating and instructive story of the sometimes explosive interplay of different factors within health systems.

**Fee-for-service + compulsory contracting = high-flying costs**

Under the current health system in Switzerland, independent health professionals practice under predominantly fee-for-service arrangements. In addition, under Swiss law, health insurance plans are required to reimburse for all medical services carried out under the framework of compulsory health insurance by authorized medical practitioners. This situation, whereby all medical practitioners have a right to enter into a contract with all insurers, is referred to as “compulsory contracting.” And it is precisely this situation which is now the target of fundamental reform.

**Swiss health care: showcase of supply-induced demand**

The combination of compulsory contracting and fee-for-service arrangements has helped deliver doctors higher average incomes in Switzerland than in neighboring countries and given the nation one of the most costly systems in the world. It also pro-

duces a favorable context for the problem of supply-induced demand, and there is certainly evidence of widespread variation in the density of medical practices. Data from 2001 suggested some areas had more than three times as many doctors per capita as other areas. Moreover there are correlations suggesting that where there are more doctors in Switzerland, there are higher socialized health expenditures.

Against the backdrop of concern about a lack of control over doctors' incomes and activities, and worries about unnecessary medical services, new agreements with the European Union enabled free circulation of medical practitioners across the continent. The fear in the early 2000s was that the new European agreements would see a rapid influx of doctors from outside the country, particularly given the lack of language barriers, exacerbating already existing problems of poor distribution and supply-induced demand. This complex combination of historical domestic arrangements and new international agreements was seen as a serious threat to the financial sustainability of the Swiss health system.

In order to keep this threat at bay, in 2002, Swiss authorities decreed a moratorium on the opening of new medical practices for a period of three years. This of course benefited existing practitioners, created barriers to admission to the market, and reduced competition. There was a hope at the time that reforms would be introduced within that three-year period, to fix the problem of sustainability. However, the moratorium has been renewed twice, once in 2005 for another three years and then again in 2008. The current moratorium expires at the end of 2009, and there is a view that a lasting solution must be found by that point.

One option that has been proposed by the health insurance plans, considered and proven unpopular is the abolition of mandatory contracting. Another key option being considered is a new planning model for outpatient supply. Under this option, regional governments—i.e., the cantons—would consult with professional associations and then make decisions about which areas required the authorization of new medical surgeries. As part of this package, cantons would be able to offer financial incentives to encourage doctors to open surgeries in peripheral regions where medical supply is insufficient.

**European doctors  
to swamp  
Switzerland?**

**Moratorium on  
new medical  
surgeries running  
out**

**Cantons to plan  
for healthcare  
resources?**

**A new dual system  
of insurance?**

A third option being considered is something of a dual health insurance system, which offers the insured the freedom to choose to stay in the existing system—called the “basic model”—or to opt out into a new arrangement called the “cooperation model.” While these models are still being debated, this new cooperation model would look more like a managed-care arrangement characterized by capitation-style payments and selective contracting between insurers and doctors, rather than fee-for-service arrangements within a framework of compulsory contracts between all doctors and all insurers. Already around 17 percent of the Swiss population has accepted what is called an “alternative model” for their insurance—more like managed care—which restricts freedom of choice of provider in return for premium discounts. It is as yet unclear how closely any new “cooperation model” would match the “alternative model.”

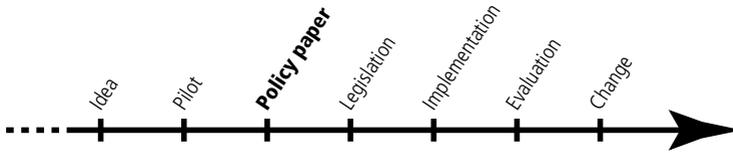
**Risks and benefits  
of more  
competition**

One of the key benefits of a new system will be bringing some control over expenditures on medical incomes and giving insurers and the state the ability to exert more influence over where doctors practice in order to address geographic variations. Similarly, there is a theoretical hope that if insurers have more ability to select the providers they purchase services from, the insurers can select those who offer better quality at better prices, and exclude those interested in unnecessary interventions. However, on the downside, there is a fear that in a new less-regulated managed-care-like situation, an unequal division would emerge over time with very differently priced premiums. In other words, the “good risks” within the population would enter the cooperation model, and the “bad risks” would stay in the basic model, producing a fundamental threat to the solidarity considered to be the value at the heart of social health insurance systems. It is no wonder the Swiss are finding these current reform decisions about governance to be very tough ones.

*Sources and further reading:*

Crivelli, Luca. Who should control outpatient supply after 2009? *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/ch/a12/2](http://www.hpm.org/survey/ch/a12/2).

## France: New regional health governance

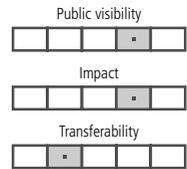


While Switzerland is focused on how to control outpatient supply, France is in the midst of a wide-ranging reform of how inpatient care is financed, organized and provided. While the focus in France is inpatient care, the reform will also have an impact on care outside the hospital system. Decentralization is at the center of this reform of the French system, and it has been promoted from the very top of the political tree: announced by the president as a way of boosting regional governance and modernizing the hospital system. The parliamentary debate on legislation underpinning the new reforms is set for early 2009 and the reform itself is scheduled to be in operation by 2010.

Several official reports prepared for the government in 2008 have identified what they describe as key problems in the health system generally, related to both quality of care and cost control. Those problems, as they describe them, include

- compartmentalization of healthcare providers and financers
- lack of articulation between central and regional levels
- separation between the management of healthcare provision and the management of healthcare expenditure
- separation between ambulatory, hospital and social care.

The reform package, while detailed and complex, has four main areas. First it is about promoting more regional governance, by introducing new Regional Health Agencies which will act as “one-stop shops” bringing together different public agencies, including insurers, under the one roof. These new agencies will have the daunting task of setting up regional objectives to assure fair access, improve coordination between hospitals and ambulatory care, at the same time as enhancing quality and improving prevention. The idea is to make these agencies responsible buyers, not just simple payers.



**A familiar set of problems**

**Multi-layered reform, regional one-stop shops**

**More autonomy for  
healthcare  
institutions**

Another key element of the reform package is the modernization of the organization of healthcare institutions. Hospitals will be regrouped into complementary groups or communities, to encourage rational transfer of patients between them. For example complex interventions will be concentrated in high volume hospitals, and less complex patients can be transferred from those large hospitals to smaller hospitals. Under the changes, hospital directors will have more autonomy and more flexibility in remunerating professionals, but will have to sign annual contracts with the new regional agencies setting out specific activity and quality objectives. Meanwhile, there are measures to improve geographic equality in access, measures to discourage physicians from setting up in areas already too crowded with doctors, and efforts to improve preventive policy.

**The end of small  
hospitals? And  
other strong  
reactions**

Not surprisingly, such a major reform proposal has met with firm reactions, with many players greeting the initial proposal with skepticism and strong criticism. Fears that the reform would mean the end of small hospitals sparked demonstrations. Most public hospital staff unions are against the reform because of concerns about pay flexibility and changes to management rules. Some people see public hospitals suffering under the reform because private hospitals may be able to attract more public funds. Doctors, unions are fiercely opposed to any inhibition on their freedom to install where they choose to practice, as we learn elsewhere in this book in discussions about new rules controlling nurses (see report p. 89). And for their part, insurers are worried that the new Regional Health Agencies will eventually mean more state control, given that directors will be nominated by the French cabinet.

**Too ambitious?**

The draft law for the reforms has already been modified several times, and the government has offered various assurances and guarantees in response to the criticisms and opposition, including promises of no hospital closures. There is also the possibility that the reform package, or some aspects of it, will be watered down in forthcoming political negotiations in parliament. Unclear too is how well the new reforms will be implemented, and whether they will help improve access, equity, quality and coordination, as they ambitiously aim to.

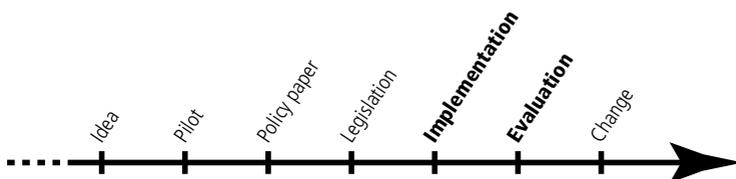
*Sources and further reading:*

Or, Zeynep. New regional health governance. *Health Policy-Monitor*, October 2008. [www.hpm.org/survey/fr/a12/2](http://www.hpm.org/survey/fr/a12/2).

Rapport Vallancien. L'évaluation de la sécurité, de la qualité et de la continuité des soins chirurgicaux dans les petits hôpitaux publics en France, Rapport à l'attention de Monsieur Xavier Bertrand, Ministre de la Santé et des Solidarités. 2006. [www.ladocumentationfrancaise.fr/rapports-publics/064000350/index.shtml](http://www.ladocumentationfrancaise.fr/rapports-publics/064000350/index.shtml).

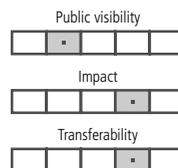
Rapport Larcher. Etat des lieux réalisé par la commission de la concertation relative aux missions de l'hôpital, 14 December 2007. [www.mutuelles-de-france.fr/autonomiz/uploads/\\_FMF/template2\\_69/mission\\_hopital\\_larcher.pdf](http://www.mutuelles-de-france.fr/autonomiz/uploads/_FMF/template2_69/mission_hopital_larcher.pdf).

## Estonia: Payer acts as player in disease prevention and health promotion



Less illustrious than the sweeping governance reforms in Switzerland and France, the move to give disease prevention and health promotion more strategic importance within Estonia sends an important signal about changing priorities, and it highlights the influential role insurers can play within health systems. As in the French reform plan, and in many other places, the roles of payer and player are blurring in Estonia, as the Estonian Health Insurance Fund sets out to make promotion and prevention activities part of its core business.

Initially, the Estonian Health Insurance fund was established as a “sickness fund” to cover the costs of illness. Still, it has been



**Balanced score  
cards to measure  
success**

financing health promotion projects since 1995 and disease prevention projects since 2000, though these activities had not been formally acknowledged in any of the fund's strategic documents. Since 2005, these health promotion projects funded by EHIF were part of the government's national health strategies, including defined objectives and indicators for a monitoring system to measure a project's outcome (Koppel et al. 2008). Now, perceiving its activities in health promotion and prevention as successful, EHIF has decided to include these areas in its own strategic planning.

Thus in 2008, the board of the fund adopted a four-year strategic plan, where these activities are defined as one of five strategic target areas. The plan also defines specific measures to meet its strategic objectives, including increasing coverage of public health activities; introducing patient guidelines; and developing injury prevention at the local level. The health fund's strategic plan is tied to its assessment of performance. Every year, achievement of the goals laid down in the strategy will be measured using balanced score cards—underscoring the importance of including promotion and prevention in the plan.

**The government  
is strongly  
supportive ...**

The government in Estonia offers strong political support for health promotion and prevention strategies, with these activities explicitly stressed in the Governing Coalition Agreement. This agreement mentions several goals for promoting healthy lifestyles and preventing disease, foreseeing the following actions:

- increasing the volume of health promotion programs
- promoting healthy nutrition in schools and other child care institutions
- stricter supervision of health requirements pertaining to study and work environments
- improving state supervision over adherence to occupational safety rules.

**Prevention and  
promotion still  
only a tiny part of  
the budget ...**

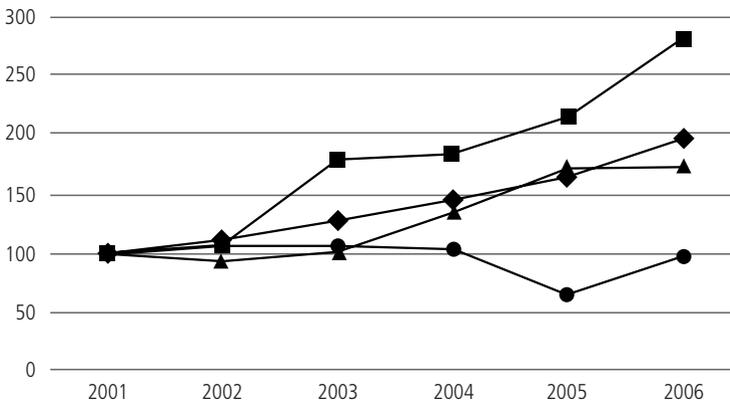
In 2007, the budget for disease prevention programs was 0.9 percent of the total Estonian Health Insurance Fund budget, and the percentage going to health promotion was only 0.12 percent. As we can see, just over 1 percent is going to prevention and promotion activities, while the vast majority is still going to purchase medical services. However, as the graph below makes clear, total

spending on prevention and promotion programs is growing in Estonia, relative to total spending (see figure 1).

Most activities in health promotion and prevention are still financed from the government budget, making up for 2.5 percent of total health expenditure (comparable with other EU countries, see table 1—even though these data should be interpreted with caution due to differences in definition and measurement). By adding these activities to the strategic plan, the big payer is becoming an increasingly influential player, signaling the possibility that the small amounts EHIF spends on health promotion and prevention could also grow in the future.

... in line with other European countries

Figure 1: Health expenditures in Estonia 2001–2006



- Prevention and public health programs (Estonia total)
- ◆ Total health expenditure (Estonia total)
- ▲ EHIF disease prevention
- EHIF health promotion

All data in percent

2001 = 100 percent

Source: Paat and Aivisksoo 2008.

*Table 1: Spending on health promotion and prevention in selected EU countries, percent of total health expenditure, 2006*

	<b>Overall expenditure</b>	<b>Public expenditure</b>	<b>Private expenditure</b>
Austria	1.8	1.6	0.2
Belgium	3.4	3.4	0.0
Czech Republic	2.1	1.8	0.3
Denmark	2.3	2.2	0.1
Finland	5.1	3.1	2.0
France	2.2	1.5	0.6
Germany	3.3	2.8	0.5
Greece			
Hungary	6.8	2.7	4.2
Ireland			
Italy	0.6	0.6	
Luxembourg	1.1	1.1	0.0
Netherlands	4.9	2.4	2.5
Poland	2.3	1.7	0.6
Portugal	1.8	1.1	0.7
Slovakia	2.3	1.3	1.0
Spain	1.2	1.1	0.1
Sweden	3.5	2.6	0.9
United Kingdom			

Data of 2006, for Luxembourg and Slovakia data of 2005. No indication means no data available.

Source: OECD Health Data 2008.

*Sources and further reading:*

Paat, Gerli, and Ain Aaviksoo. Prevention as Insurance Fund's strategic target. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/ee/a12/4](http://www.hpm.org/survey/ee/a12/4).

Koppel, Agris, Kristiina Kahur, Triin Habicht, Pille Saar, Jarno Habicht and Ewout van Ginneken. Estonia: Health system review. *Health Systems in Transition* (10) 1 2008: 1–230.



# Responsiveness

In the year 2000, the World Health Report of the World Health Organization broke new ground by identifying a novel goal for healthcare systems everywhere (WHO 2000). Along with aiming to maximize good health and achieve fairness in financial contributions, the WHO report urged health systems to become responsive to the expectations of the populations they serve. More importantly, the report argued that the performance of healthcare systems should be measured against this goal, and in the time since the publication of that report tools have been developed to do just that (WHO 2005).

Technically, the WHO defines responsiveness as the nonclinical aspects of the way people are treated and the environments in which they are treated. In this sense responsiveness is about the way the system interacts with people and with their expectations. The WHO has outlined eight domains of responsiveness, including such areas as dignity, confidentiality and clear communication. So, for example, in regard to the domain of “dignity”, the question is whether people are treated with respect by their physicians; with “confidentiality” the question is whether personal information is protected; and with “clear communication”, whether people are listened to and provided with information they can understand. Importantly, according to the WHO there is evidence of an association between responsiveness and health outcomes (WHO 2005).

In this chapter, we are looking more broadly at the interactions between people and health systems and asking how health systems are responding to the needs and voices of certain parts of the population. Specifically, we feature some examples of how health systems are responding to the needs of the dying, the dis-

**How people  
are treated**

**Responding to  
patients with  
severe conditions**

abled and the mentally ill. In Japan there are initiatives to try to offer people more choice in where to die. Similarly in Singapore, the government has embarked on a range of strategies to improve palliative care for those near death. And in South Korea there are attempts to reduce unnecessary treatment and enhance the quality of care for terminally ill cancer patients. Also in South Korea we look at plans to finance long-term care for the disabled, and in Slovenia, new legislation to protect the rights of the mentally ill.

**Responding to  
people with long-  
term needs**

Against a backdrop of aging populations, the provision of long-term care is an issue in health systems everywhere (see *Health Policy Developments 10*, pp. 11–33). Long-term care is defined as medical and nonmedical care for people who need help with basic daily living activities like dressing, bathing, and using the bathroom, which can include the chronically ill, the disabled or the aged. It is provided at home, or in institutions like nursing homes. How to pay for, deliver, and improve the quality of long-term care is proving challenging in many places—whether it is provided inside or outside of the home. For example, in 2007 both Germany and Austria introduced major reforms aimed at improving the quality of long-term care offered at home (see *Health Policy Developments 10*, pp. 23–31).

**Three Asian  
responses to the  
needs of the dying**

In previous updates we have described the wider push to improve care for the frail and elderly in Japan (see *Health Policy Developments 10*, pp. 19–22). Now the Japanese government is attempting to offer people more choice for end-of-life care, though this is occurring at the same time as major political controversy over plans for new health insurance for the elderly (Tomizuka and Matsuda 2008). Meanwhile in Singapore, in the context of one of the most heavily regulated market-based systems in the world, the government has signaled it will play a greater role in care for the dying, announcing several initiatives to encourage palliative care and help people die with dignity. And in a third Asian healthcare system, in South Korea, the needs of the dying are being addressed via plans to improve the care of terminally ill cancer patients and reduce unnecessary expenditure at the same time (see report on Asian reforms, p. 68).

**South Korea pilots  
LTC for people with  
disabilities**

Also in South Korea, a health system characterized by very large out-of-pocket expenses, a new pilot program is planned for 2009, to provide insurance coverage for long-term care for people

with disabilities. In 2008, a new long-term care insurance scheme was launched, but it provided coverage only for long-term care of the elderly. In response to concerns that those with disabilities were not covered by the new scheme, the government has decided to implement a pilot program for long-term care for the disabled. The aim is to try to enhance solidarity by meeting the long-term care needs of those with disabilities and their families (see report on South Korea, p. 12).

While it is roughly three decades since the closure of isolated, asylum-style institutions, the world is still struggling with how to offer the best care for those with mental illnesses. As each system searches for the right balance between community-based, specialized and institutional care for those with illnesses, in no country do modern preventive methods play a significant role in mental health budgets (see *Health Policy Developments* 9, pp. 37–52). In the light of growing attention to the needs and rights of the mentally ill in so many countries, and the development of the European Pact for Mental Health and a similar action plan developed by the World Health Organization, the parliament in Slovenia has recently adopted a new act on mental health (European Commission 2005, 2008; WHO 2008). The act provides a legislative framework for a national strategy on mental health, and it defines the responsibilities of the government and of healthcare providers. Its main focus is on legal protections and community approaches to helping those with mental illness (see report on Slovenia, p. 13).

**Slovenia responds  
to needs of those  
with mental illness**

*Sources and further reading:*

European Commission. *Promoting the Mental Health of the Population. Towards a Strategy on Mental Health for the European Union. Green Paper on Mental Health.* 2005. [http://ec.europa.eu/health/ph\\_determinants/life\\_style/mental/green\\_paper/consultation\\_en.htm](http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/consultation_en.htm).

European Commission. *Working Towards the European Pact for Mental Health.* 2008. [www.ec-mental-health-process.net/](http://www.ec-mental-health-process.net/).

Tomizuka, Taro, and Ryoza Matsuda: New Health Insurance for the Elderly. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/jp/a12/4](http://www.hpm.org/survey/jp/a12/4).

World Health Organization. *Health Systems: Improving Performance, The World Health Report*. Geneva: WHO; 2000. [www.who.int/whr/2000/en/](http://www.who.int/whr/2000/en/).

World Health Organization. *The Health Systems Responsiveness Analytical Guidelines for Surveys in the Multi-country Survey Study*. Geneva: WHO; 2005.

World Health Organization. *Mental Health Gap Action Program*. Geneva: WHO; 2008. [www.who.int/mental\\_health/mhgap/press\\_release\\_mh\\_mhgap\\_10\\_2008.pdf](http://www.who.int/mental_health/mhgap/press_release_mh_mhgap_10_2008.pdf).

### **South Korea, Singapore, Japan: Responding to the needs of the dying**

As if synchronized, the three Asian nations participating in the HPM surveys, South Korea, Singapore and Japan, are all responding to the needs of those at the end of their lives, with a range of reforms. While there are similarities in all three countries, actions, in terms of expanding and/or enhancing care for the dying, there are important differences in the nature and emphasis of the reforms. In part this is because of the specific history of the current initiatives, and in part because of the intrinsic differences in the natures of the health systems themselves.

#### **South Korea to pilot hospice care program in 2009**

Cancer is a leading cause of death in South Korea, and it is estimated that almost a third of the total expenditure on cancer is spent in the month before cancer patients die. At the same time, only a very small number of cancer sufferers use hospice services in South Korea. There is concern that important resources may be wasted on unnecessary care received by some cancer patients in the last stage of their lives. In order to try to improve both the quality of care for the dying and the efficiency of how that money is spent, plans are to expand the use of hospice care; and the Ministry of Health and Welfare intends to launch a pilot program of hospice care in 2009.

Just as South Korea moves to curb unnecessary care of dying cancer patients, new research from the United Kingdom suggests the problem may be widespread. A 2008 report from the National Confidential Enquiry into Patient Outcome and Death intensively examined the records of more than 500 cancer patients who had died within a month of receiving chemotherapy (Mort et al. 2008). It found that in more than 25 percent of cases, chemotherapy had “caused or hastened death.” Moreover, in almost 20 percent of cases, the decision to treat with the most recent round of chemotherapy had been deemed “inappropriate,” in the retrospective view of the advisers to the national enquiry. While making decisions about treating terminally ill cancer sufferers is extremely complex, these findings raise disturbing questions about potential harm and wasted resources.

**Disturbing evidence of unnecessary treatment**

One question already being asked in South Korea is whether the proposed hospice program will be too focused on big institutions. The proposed new per-diem payments for hospice care are based on the type of provider, and small hospitals are concerned that the new payment scheme may be more favorable to large healthcare institutions, resulting in their dominance of hospice care. Similarly, social workers have raised concerns that the payments do not cover social workers. And more broadly there are worries that increased fees for hospice care, designed to expand care, may act as a barrier to care, particularly in the context of a health system characterized by very large out-of-pocket contributions.

**Will South Korea's hospice care be too institutionalized?**

As in South Korea, the Ministry of Health in Singapore is enacting measures designed to improve the quality of life for those nearing its end. While there are similar plans to expand hospice care, there are also a range of initiatives designed to enhance palliative care in Singapore. In Singapore, where the government's contribution to total healthcare expenditure was less than 25 percent in 2005, palliative care has been a relatively underdeveloped area, left largely to charitable and voluntary welfare agencies. According to the Singapore Hospice Council, about 70 percent of people with terminal illnesses are dying without hospice palliative care in Singapore. Moreover, many patients are sent from nursing homes if their condition deteriorates, to die in hospitals. As in South Korea, the hope is that expanding hospice care could improve quality and save money.

**Singapore expands palliative care**

**A range of new initiatives in Singapore**

A raft of initiatives is being designed to encourage the growth of palliative care in Singapore. Firstly, the Ministry of Health plans to modestly expand the number of hospice places available over the next five to seven years. In addition, a pilot program will start soon involving six nursing homes, to try to bring more “end-of-life” planning into the routine care offered in nursing homes. As well, palliative care will be made into a sub-specialty in its own right, and more doctors and nurses will be trained in the area. And finally, there will be measures designed to give more information to patients about end-of-life care. The measures include plans to simplify the process of making living wills that specify directives about future medical care, and to encourage more public debate of this little-discussed topic.

**Most Japanese people want to die at home**

While most Japanese people express a desire to die at home, evidence suggests only about one in ten actually do. More than 80 percent of deaths occur in hospital. To meet the twin aims of responding better to the population’s needs and reducing unnecessary hospitalization, the Japanese government has embarked on a series of reforms to increase opportunities to die at home, or in a nursing home, rather than a hospital. While the moves are seen as an attempt to improve the health system and make it more responsive, some aspects of the reform have faced strong opposition, and there are serious questions about the extent to which it will really help people at the end of life and their families.

**The range of reforms in Japan**

As in Singapore, the push in Japan to offer more people the chance to die at home includes a range of initiatives:

- to establish new registration procedures for clinics that support 24-hour home care
- to increase reimbursement for provision of home care provided by these clinics
- to extend insurance coverage of the care at nursing homes
- to pay providers to set up agreements of care with terminally ill elderly
- to issue new guidelines for supporting decisions on end-of-life care
- to extend long-term insurance coverage for nursing care for cancer patients at home.

**End-of-life home care clinics**

One of the most contentious parts of these reforms has been the plan to pay clinics to provide information to people about end-of-

life care and make agreements with those at the end of life and their families. A key concern was that the making of the agreement may reduce the emphasis on curative treatments, and this element of the reform package has been so strongly opposed that the government had to suspend it. Related concerns include fears that the drive to reduce hospitalization may force some people close to death out of hospitals, even though there are not appropriate hospice arrangements in place near the patients' homes. And importantly, while the reforms bring bigger financial incentives for providers, they do not offer financial or nonfinancial help for families caring for dying members at home. Inflaming the questions and controversy further, one media report suggested many new registered home care clinics may not be providing home care at all.

*Sources and further reading:*

Kwon, Soonman. Pilot program on hospice care. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/jp/a12/3](http://www.hpm.org/survey/jp/a12/3).

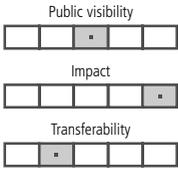
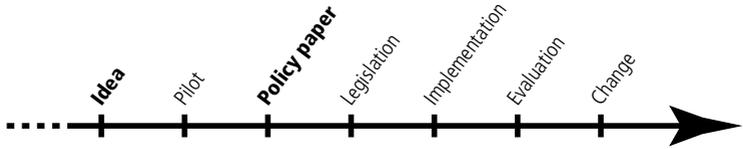
Meng Kin, Lim. Expanded state role in the care of the dying. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/sg/a12/3](http://www.hpm.org/survey/sg/a12/3).

Tomizuka, Taro, and Ryoza Matsuda. Promoting end-of-life care outside hospitals. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/jp/a12/3](http://www.hpm.org/survey/jp/a12/3).

Mort, Diana, Mark Landsdown, Neil Smith, Karen Protopapa and Marisa Mason. *Systemic Anti-Cancer Therapy: For better, for worse?* National Confidential Enquiry into Patient Outcome and Death. November 2008. [www.ncepod.org.uk/2008sact.htm](http://www.ncepod.org.uk/2008sact.htm).

Ministry of Health, Singapore. Web site. [www.moh.gov.sg/mohcorp/hcfinancing.aspx?id=104](http://www.moh.gov.sg/mohcorp/hcfinancing.aspx?id=104).

## South Korea: Responding to the needs of those with disabilities



Reforms in recent years in South Korea have sought to extend the “depth” of what sort of care is covered in its system of universal insurance coverage. Specifically, in 2008, long-term care insurance for the elderly was launched. However, this insurance does not cover the care of those with disabilities. In order to enhance solidarity, there are plans to build long-term care insurance for the disabled, and a pilot program is planned for 2009.

### Background to the current plan

When the law on long-term care for the elderly was passed in 2007, the need for long-term care financing for the disabled was raised. A task force was set up in early 2008, and by August 2008, the government and the Committee on Policy Coordination for the Disabled approved a five year plan for a new policy. As part of that, they will implement a one-year pilot of long-term care for the disabled.

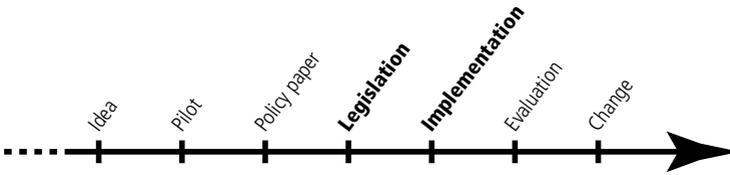
### Stand-alone system, or merge with LTC of elderly?

After the one-year pilot, the government will finalize long-term care financing for disability, including addressing the extent of benefit coverage and the question of whether it should be merged with the existing long-term care insurance for the elderly. People with disabilities are strong supporters of the introduction of this reform, but there seem to be differences over whether to have a stand-alone or a merged scheme. People with serious disabilities appear to be stronger supporters of a separate system of financing, whereas people with more minor disabilities seem to favor the extension of current welfare services for the disabled.

#### Sources and further reading:

Kwon, Soonman. Plan to finance long-term care for the disabled. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/rok/a12/1](http://www.hpm.org/survey/rok/a12/1).

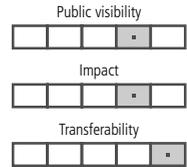
## Slovenia: Responding to the needs of those with mental illnesses



Slovenia has chosen to take a new approach to mental health, designed to respond more to the needs of those affected, offer them legal protection and enhance community-based solutions. The new approach is potentially very positive in that it may empower the most vulnerable members of society, namely those who might be involuntarily admitted to psychiatric care. It is accompanied, however, by ongoing controversies within the psychiatric community and between psychiatric and public health experts. While new in Slovenia, the approach itself is not new globally, but rather based on World Health Organization (2008) and European Union (European Commission 2005, 2008) recommendations, as well as solutions being trialed in other European countries.

A new mental health act was adopted in July 2008, but the history of the current reform traces back through much of the past decade. In 2001, the Ministry of Health actively entered the debate, attempting to put proposals together with members of parliament, only to have those proposals abandoned several years later. In 2003, the Constitutional Court in Slovenia decided that current practices of involuntary hospitalization in psychiatry were illegitimate and gave the parliament one year to adopt legislative change. Five years later, legislative change finally arrived.

A primary objective is the legal protection of the human rights of patients with mental illness, including patients facing involuntary admissions and/or special methods of treatment. However, the new approach also aims to boost patient advocacy, establish an institutional and legislative framework for a more integrated approach to care, and develop community-based mental health services. In addition, there is a plan to build a new national strategy on mental health, which aims to improve care and include



**Slow birth of new mental health act**

**Multiple objectives of the new approach**

public health strategies. In practical terms, new professions will be created, including positions of “coordinator of controlled care,” funded through insurance, and “coordinator of community care,” funded through the Ministry of Social Affairs.

**Controversies and  
different  
perspectives**

While the Ministry of Health has played a leading role in developing this reform, patient groups and nongovernmental organizations have been very supportive of the process, reflecting a growing influence of nongovernmental actors in Slovenia’s health system. On the other hand, psychiatric societies have been opposing some solutions regarding involuntary admissions, particularly those concerning the responsibilities of managers in psychiatric hospitals. Psychiatrists felt some aspects of the reform reflected a distrust of their professional decisions, though they have supported other aspects, including the community care approach.

**What happens  
now?**

The government has to prepare a national strategy on mental health within one year of the adoption of the new act. Similarly, new ombudspersons and coordinators of controlled and community care should be nominated within one year. Meanwhile, by-laws in related ministries and the harmonization of the activities of all healthcare providers affected by the act are supposed to be finalized within six months. In part because of the disagreements over aspects of the reforms mentioned above, it is not easy to foresee future developments or predict how quickly the legal rights of the mentally ill will be respected and their care enhanced.

*Sources and further reading:*

Pribakovic Brinovec, Rade. Mental Health Care in Slovenia. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/si/a12/2](http://www.hpm.org/survey/si/a12/2).

European Commission. *Promoting the Mental Health of the Population. Towards a Strategy on Mental Health for the European Union. Green Paper on Mental Health*. 2005. [http://ec.europa.eu/health/ph\\_determinants/life\\_style/mental/green\\_paper/consultation\\_en.htm](http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/consultation_en.htm).

European Commission. *Working Towards the European Pact for Mental Health*. 2008. [www.ec-mental-health-process.net/](http://www.ec-mental-health-process.net/).

World Health Organization. *Mental Health Gap Action Program*. Geneva: WHO; 2008. [www.who.int/mental\\_health/mhgap/press\\_release\\_mh\\_mhgap\\_10\\_2008.pdf](http://www.who.int/mental_health/mhgap/press_release_mh_mhgap_10_2008.pdf).



# Spotlight on access and equity around the world

Notwithstanding the challenges associated with achieving these aims, striving for greater access and equity in health systems has emerged as major issues in the contemporary health policy landscape. In recent years, several important reports have emerged from international organizations including the World Health Organization and the European Commission. These reports demonstrate—as do the country reports from our network featured in this chapter—that governments everywhere are facing up to these challenges and many are starting to tackle them, but it is still early days in terms of demonstrating success.

As this network has outlined in recent reports, while access to health care is enshrined as a basic right in most developed countries, barriers to that access still come in many different forms. As previously described, we can conceive of six different dimensions of access, or six different forms of barriers, though these are not mutually exclusive categories (see *Health Policy Developments* 7/8, p. 71). The six dimensions are

- the proportion of the population with insurance coverage
- contents of the basket of benefits offered
- cost-sharing arrangements
- geographical barriers
- organizational barriers, such as wait times
- acceptability and actual use of accessible benefits.

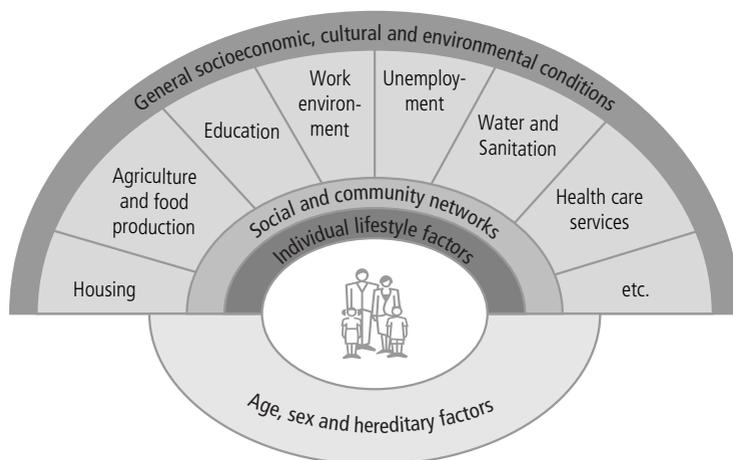
A report for the World Health Organization in 2005 on health inequality reviewed policies in 13 developed countries (Crombie 2005). It found that inequalities in health were recognized in all countries as a major problem, and that many countries reported inequality had worsened in the 1980s and 1990s. While inequalities

**Barriers to access come in different forms**

**Health inequalities also have different dimensions and social determinants**

were commonly related to differences in health status between different socioeconomic groups, they are also related to differences in geographic location, employment status, gender or ethnicity. The 2005 WHO report also noted the growing global recognition that a population’s health—and the inequalities therein—is related to large social and economic factors, the physical and social environment, the living and working conditions of individuals, factors collectively known as the “social determinants of health” (see figure 2). Thus macroeconomic strategies to tackle poverty and social exclusion are deemed to be intimately related to efforts to reduce inequalities in health.

Figure 2: Social Determinants of Health



Source: Dahlgren and Whitehead 1991.

**Health inequities:  
bad for the  
economy**

An important if often neglected justification for tackling health inequalities comes from the economic perspective. A 2005 report for the European Commission titled *The Contribution of Health to the Economy in the European Union* observed that health is not simply a by-product of economic development, but one of its key determinants (Suhrcke et al. 2005). The authors of the report “found considerable and convincing evidence that significant economic benefits can be achieved by improving health not only in developing, but also in developed countries.”

According to the report by Marc Suhrcke, Martin McKee and colleagues, health may contribute to economic outcomes in important ways, including higher productivity, higher labor supply and increased savings available for investment in physical and intellectual capital. Specifically, studies show health matters to wages, earnings, labor force participation, early retirement, and importantly it can affect the labor supply of those giving care to ill household members. And at a macroeconomic level, health measures such as increases in life expectancy are robust predictors of GDP growth. Hence the growing acceptance that investment in human capital is a necessary but not sufficient condition for “making the European economy more competitive in the wider world” (Suhrcke et al. 2005).

**Better health, more economic growth**

The interrelationship between strategies to reduce poverty, social exclusion and health inequality is the theme of a 2006 report prepared for the UK presidency of the European Union, called *Health Inequalities: a Challenge for Europe* (Judge et al. 2006). In line with current thinking, the report begins with a review of the importance of the wider social determinants of health, before describing how different nations have different approaches to promoting more social justice and reducing health inequalities.

**Reducing poverty, social exclusion and health inequality**

The report by Judge and colleagues also charts the different national approaches within Europe. Some countries are using the law and have introduced new legislation. Other countries have not opted for legal arrangements but have generated policy documents, and some have set quantitative targets for reducing inequality. Importantly, in line with the broader focus on “upstream” or social determinants, the report identifies coordination within different government departments as a key element that could bring success. “The more focused and integrated is the cross-government strategy for action, the greater is the probability that health outcomes will change in the desired direction” (Judge et al. 2006). Some countries have introduced formal mechanisms for coordination, some have started to coordinate, and some have instituted both comprehensive and coordinated national action plans, as Finland has recently done (see report on Finland, p. 82).

**Legal measures, target setting, coordination**

Alongside differences in implementation, there are also differences in the extent to which countries are measuring the impacts of their efforts. Several European countries have developed meth-

**Measuring success requires realistic targets**

ods to measure their progress, and some are more developed than others. The Judge report argues that evaluating and monitoring, using robust and sound methods, is important, as is taking advantage of natural experiments. And the report also asks whether European nations should be trying to harmonize their approach to measurement, and whether formulating quantitative targets for success can help or hinder implementation of effective action. For example, the United States set a target some time ago of eradicating all health inequalities by 2010, so there is good reason to question the wisdom of setting such obviously unrealistic targets (Crombie 2005).

**Progress made,  
good practice  
highlighted**

A report to the European Commission in 2008 focusing both on the quality of care and on equality of access to care analyzes the effectiveness of various initiatives around the world and highlights good practice (Huber et al. 2008). Like other materials on the subject, it stresses the two-way relationship between poverty and poor access to health care: poor access can compound poverty and poverty can compound poor access. And like previous reports by this network, it categorizes the various barriers to access, including problems such as

- holes in the safety net of universal coverage
- holes in the basket of coverage
- cost-sharing arrangements
- geographical variations
- organizational barriers, such as wait times
- low health literacy
- poor protection for migrants, older people, and people with mental disorders.

**Six fronts in the  
fight for access  
and equity**

Under the glare of this international spotlight, we feature exciting news from Finland, where new laws on maximum wait times seem to be reducing them in many parts of the country (see first report on Finland, p. 82). And as mentioned above, Finland also has an action plan to reduce inequalities in health (see second report on Finland, p. 86). France meanwhile is taking bold steps to regulate the supply of nurses, hoping to break down geographic barriers in under-served areas (see report on France, p. 89). In Israel, a philanthropist is helping remove the access barrier of co-payments for a group with chronic conditions (see report on Israel,

p. 91). New Zealand has a new tool to assess impacts of policies on inequalities (see report on New Zealand, p. 96), and the state of Massachusetts looks set to be the first in the United States to pull down the big access barrier and mandate (almost) universal health insurance coverage (see report on the United States, p. 96).

As more attention is focussed on the upstream causes of health inequalities, whether they be planning regulations or global trade arrangements, the differences between debates about access and equity may well become sharper. The growth of convincing evidence for the importance of the social determinants of health will surely raise questions about whether we currently have the best mix of allocating resources to acute care or broader population-based programs and interventions, and strategies to reduce social exclusion. And against this backdrop of a newly rising awareness of the social determinants, a more awkward but related question needs to be asked with much more vigor: how much of the perceived need for healthcare services is driven—at least in part—by the professional and commercial interests who directly benefit from more people gaining access to them. Undoubtedly the role of clinical and acute care is critical to any healthy health system, but if we start to reconceive the causes of ill health, and start to look elsewhere outside the healthcare system for solutions, the centrality of that care may well be fundamentally challenged.

**Tensions within  
the health policy  
family**

*Sources and further reading:*

Cromble, Iain K., Linda Irvine, Lawrence Elliott and Hilary Wallace. *Closing the Health Inequalities Gap: An International Perspective*. Copenhagen: World Health Organization; 2006. [www.euro.who.int/Document/E87934.pdf](http://www.euro.who.int/Document/E87934.pdf).

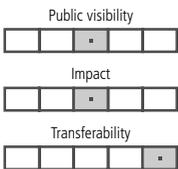
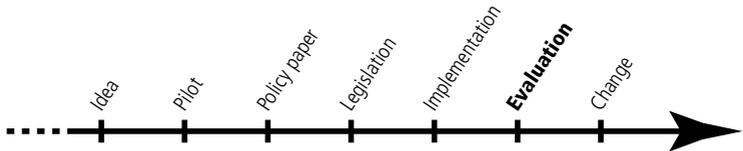
CSDH (2008). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008. [www.who.int/mediacentre/news/releases/2008/pr29/en/index.html](http://www.who.int/mediacentre/news/releases/2008/pr29/en/index.html).

Huber, Manfred, Anderson Stanciole, Jeni Bremner and Kristian Wahlbeck. *Quality in and Equality of Access to Healthcare Services*. Brussels: European Commission; 2008. [www.euro.centre.org/data/1217328350\\_39041.pdf](http://www.euro.centre.org/data/1217328350_39041.pdf).

Judge, Ken, Stephen Platt, Caroline Costongs and Kasia Jurczak. *Health Inequalities: a Challenge for Europe*. Report commissioned by the UK Presidency of the EU 2006. [ec.europa.eu/health/ph\\_determinants/socio\\_economics/documents/ev\\_060302\\_rd05\\_en.pdf](http://ec.europa.eu/health/ph_determinants/socio_economics/documents/ev_060302_rd05_en.pdf)

Suhrcke, Marc, Martin McKee, Regina Sauto Arce, Svetla Tsolova and Jørgen Mortensen. *The Contribution of Health to the Economy in the European Union*. Luxembourg: Office for Official Publications of the European Communities; 2005. [http://ec.europa.eu/health/ph\\_overview/Documents/health\\_economy\\_en.pdf](http://ec.europa.eu/health/ph_overview/Documents/health_economy_en.pdf).

**Finland:**  
**Laws succeed in reducing wait times and improving access**



One of the most tangible barriers to access is the waiting time for urgent or important care. Sometimes portrayed as long lines or unwelcome queues, the specter of people having to wait significant periods for much-needed care is highly emotive in many nations and is sure to generate media interest and high levels of public and political interest everywhere. Leaving aside for the moment debates about the extent to which waiting times can be manipulated by providers or politicians for professional or political purposes, there is much serious discussion—and in places like Finland, concerted action—aimed at trying to reduce the time

people have to wait for healthcare services. And in Finland that action includes tough enforcement. As we will learn, many municipalities are complying with tough new laws on maximum wait times, and hospital districts that do not are being fined.

Following years of debate in Finland about problems of access, the government announced in 2002 that the principle of access to treatment within a reasonable period would be enshrined in legislation by the year 2005 (Vuorenkoski and Keskimäki 2004). Wait times were seen as a key reason that people opted for private services, rather than public services, and there was political will from senior elements within the government to try to address the problem. In March 2005, legislation came into effect in Finland defining maximum waiting times for public sector health care. Furthermore, in the years following the introduction of the law, the government has begun to enforce it, in some cases even imposing fines on local hospital districts.

**Long-term campaign to improve access**

The details of the March 2005 law are as follows:

- Immediate contact with a health center by phone or visit is guaranteed.
- Non-urgent appointment for assessment must happen within three days.
- If referred to hospital, assessment must happen within three weeks.
- Non-urgent hospital treatment must take place within six months.

**The details of the new wait time laws**

In 2006, the supervision of health services was strengthened by expanding the functions of the National Authority for Medicolegal Affairs. This reform gave the government agency more power to directly supervise provider organizations, including health centers and hospitals.

Data on wait times in 2008 suggests the reform has had a significant positive impact in reducing waiting times, despite the fact that a proportion of municipalities and hospital districts still fail to comply. Some of the latest statistics are these: In April 2008

**Dramatic reductions in wait times**

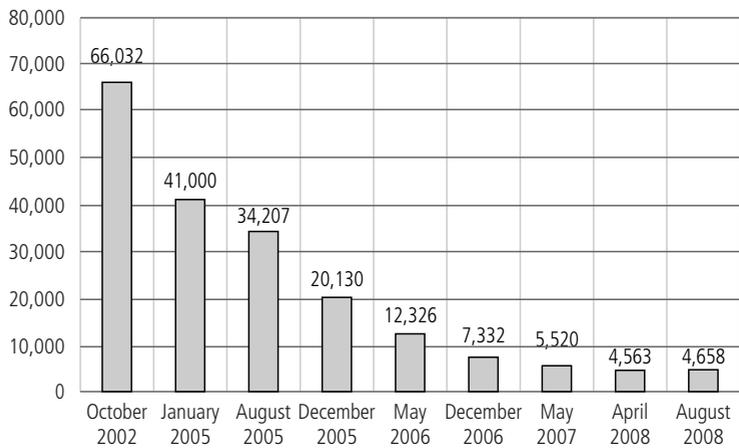
- 62 percent of people live in municipalities where they can get immediate access to primary health care, which is up from 37 percent in 2005.

- 95 percent of people live in municipalities where assessment in primary care setting takes place within three days, which is up from 49 percent in 2005.
- The number of patients who waited more than six months for a specialized operation was 4,600, compared to 41,000 in 2005 (see figure 3).

**Tough laws backed  
by tough  
enforcement**

Following the introduction of the expanded functions for Finland’s National Authority for Medicolegal Affairs in 2006, there was closer supervision of whether providers were complying with the new law. In 2007, the regulatory agency approached municipalities and health centers which did not comply, asking them to explain what was happening and encouraging them to comply with the maximum wait times. Similarly in January 2008, the agency approached hospital districts with the same demands, asking them to comply by mid-2008. In March 2008, in an unprecedented move, the agency imposed conditional fines on three hospital districts. So far, one of the three districts has rectified the problem and removed itself from the conditional fine.

*Figure 3: Number of patients who waited more than six months for a specialized operation in Finland*



Source: Vuorenskoski 2008.

Initially municipalities and hospital districts were somewhat opposed to the laws, as they felt they would not have enough resources to implement the reform. However, against expectations, there has not been a greatly increased need to purchase services from the private sector in order to comply with the new maximum wait times. Now, with the advent of the conditional fines being imposed on several hospital districts, there has been some criticism from this sector that the system is too strict.

**Acceptance,  
unexpected  
outcomes and  
mild criticisms**

While there have been significant reductions in wait times, significant numbers of municipalities are still not complying. One of the main obstacles to implementing the reform has been a lack of money and difficulties in recruiting health professionals. Ironically, another barrier to the successful implementation is the public itself. People have not been as active as they could have been in claiming their right to treatment within the specified time frames. One reason could be a lack of awareness about the new laws, though the public visibility of the reform was initially rather high. Another possible explanation is that municipalities are not as enthusiastic as they could be about informing people of the treatment guarantees. Despite the problems, it seems the reform in Finland is going more smoothly than in nearby Denmark, where similar rules guaranteeing care have been temporarily suspended following a major strike by health professionals (see University of Southern Denmark 2008).

**Lower barriers  
than ever**

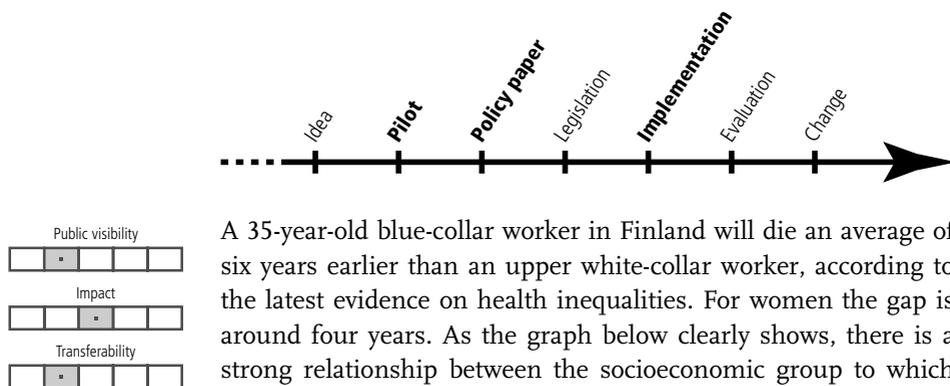
*Sources and further reading:*

Vuorenkoski, Lauri. Ensuring access to public health care—follow-up. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/fi/a12/5](http://www.hpm.org/survey/fi/a12/5).

University of Southern Denmark. Waiting time guarantee— an update. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/dk/a12/5](http://www.hpm.org/survey/dk/a12/5).

Vuorenkoski, Lauri, and Ilmo Keskimäki. Ensuring access to health care. *HealthPolicyMonitor*, April 2004. [www.hpm.org/survey/fi/a3/3](http://www.hpm.org/survey/fi/a3/3).

## Finland: An action plan to reduce health inequalities



A 35-year-old blue-collar worker in Finland will die an average of six years earlier than an upper white-collar worker, according to the latest evidence on health inequalities. For women the gap is around four years. As the graph below clearly shows, there is a strong relationship between the socioeconomic group to which one belongs and how long one can expect to live (see figure 4). There is a clear advantage for both men and women, as they move up the position on the socioeconomic ladder from blue-collar to farmer to lower white-collar and up to the top, to upper white-collar. And the differences are holding firm over time. As a recent presentation on this data summarized the situation: people with higher education, occupational status and income are healthier, behave in healthier ways, and live longer (Sihto 2008b). This is just one tiny drop of evidence in a rising tide of knowledge, demonstrating that health and health inequalities are socially determined.

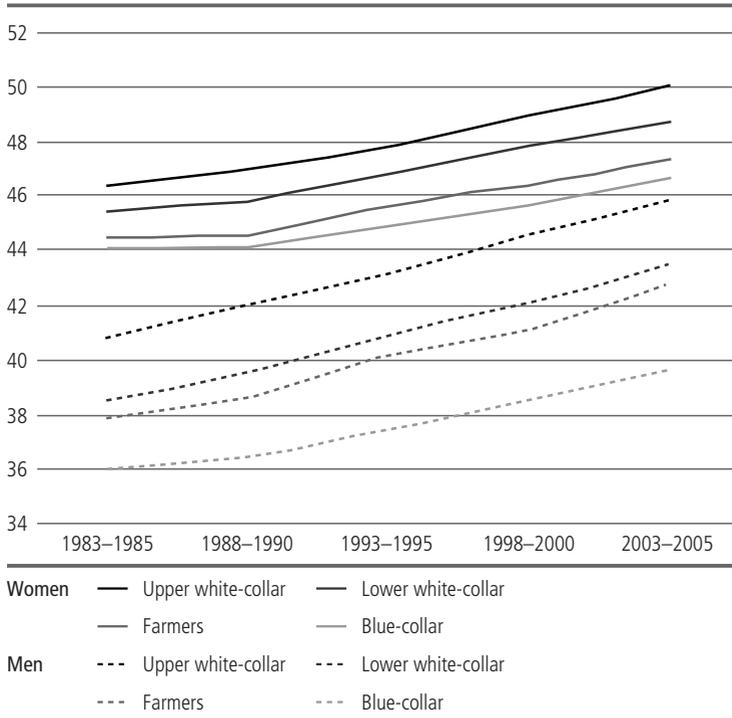
### National Action Plan to Reduce Health Inequalities

In the summer of 2008, the government launched a national action plan to fight health inequalities in Finland. Some of the main principles of the plan include focusing on “upstream” as well as “downstream” measures, reducing inequalities by leveling up, and responding to the needs of the most vulnerable. The plan has 15 action proposals that focus on initiatives relating to welfare, education, health and parts of the social service sector. Specifically, the proposals include targeting health promotion and education in areas where risks are most common, targeting the promotion of exercise and nutrition, raising taxes on alcohol and tobacco, and improving health services for immigrants and the long-term unemployed.

### Two decades of efforts

The reduction of health inequalities has been one of the main goals of the Finnish health system and an objective of all health policy programs for two decades or more. In 2001, one such pro-

Figure 4: Life expectancy of 35-year-old women and men in Finland, different social groups 1983–2005



All data = Life expectancy in years

Source: Sihto 2008b.

gram quantified the aspirations for a fairer society, calling for a reduction in the mortality differences noted above, by one-fifth by 2015. Given the worrying trends in the graph on inequalities, the focus is now firmly about using knowledge to inform effective action.

A group called TEROKA is at the centre of the knowledge-to-action process currently underway in Finland. TEROKA stands for “Reducing Socioeconomic Health Inequalities in Finland” and is a long-term collaboration between researchers and decision-makers. Over more than ten years, the project has harnessed knowledge about inequalities and informed policy-making. Its

**Collaboration  
between  
researchers and  
decision-makers**

most important effort has been involvement in preparing the National Action Plan to Reduce Health Inequalities, a plan led by a multi-sectoral public health committee within the Ministry of Social Affairs and Health and launched in 2008.

**Agreement—but  
also conflicting  
priorities**

The development of the action plan has involved many players, including researchers, officials from many departments, and representatives from the different levels of national, provincial and local government. Almost universally, there is strong support for the idea of ending health inequalities, including from patient groups and other elements of civil society. The dark cloud that accompanies this silver lining is the ongoing uncertainty about what will be the most effective strategies. And more importantly, there is concern that the current political environment—with its emphasis on competition and individualism—does not support more solidarity and equity. Moreover, other policy developments may retard moves to more equality, including increases in co-payments (see report on p. 41) increases in poverty and inequality more broadly, and the liberalization of alcohol policies.

**Will the plan be  
implemented and  
evaluated?**

The details of how to implement the plan are currently being hammered out, and the various partners involved with the TEROKA project are developing a set of follow-up indicators to measure progress. The TEROKA partners are also partly responsible for implementation of some parts of the plan, particularly at the municipal level. There is also a plan to prepare a situation analysis of the implementation of the action plan in 2010 before the end of the term of the present government. But while there is great hope, it is as yet unclear how vigorously the plan will be implemented.

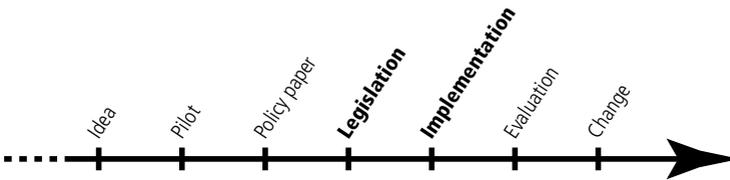
*Sources and further reading:*

Sihto, Marita, and Hannele Palosuo. Reducing socio-economic inequalities in health II. *HealthPolicyMonitor*, October 2008a. [www.hpm.org/survey/fi/a12/1](http://www.hpm.org/survey/fi/a12/1).

Ministry of Social Affairs and Health. *National Action Plan to Reduce Health Inequalities 2008–2011*. Helsinki 2008. [www.teroka.fi](http://www.teroka.fi).

Sihto, Marita. Presentation entitled: Reducing Health Inequalities in Finland—Experiences from TEROKA Project. Berlin, July 10, 2008b. [www.hpm.org/Downloads/Events/HPN\\_Events/Sihto\\_TEROKA\\_080710.pdf](http://www.hpm.org/Downloads/Events/HPN_Events/Sihto_TEROKA_080710.pdf).

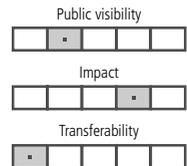
## France: Regulating nurse settlement for better access



As Finland watches its wait times fall and prepares to act decisively on inequalities, France has developed a tough new approach to try to bring down geographical barriers to access, by regulating where private nurses can work. As part of a package of reforms aimed at enhancing the role and status of nurses, the government plans to encourage nurses to work in under-served areas, while simultaneously restricting the numbers working in over-served areas. The move is controversial not only because it cuts into the cherished freedom so characteristic of the French system, but also because it prefigures similar moves to regulate physicians in order to reduce geographic barriers to access.

The context for the reform is an agreement finalized in late 2008 between the French unions of private nurses and the nation’s sickness funds. The agreement was initially made for a period of two years and is considered to be an experiment. The three main points are these:

- Nurses won a general pay raise of 10 percent of their hourly wage, over two years, as a way to insulate against nursing shortages.
- A number of highly significant financial and other benefits are offered to nurses who want to install their practices in areas defined as “under-served,” including financial advantages that could mean increases of up to 20 percent of their gross income.



**Details of the new approach to regulating nurse settlement**

- There are strict controls over nurse settlement in areas where nurse density is already high; and under details of the reform, unless there is an exit, no authorization will be given for installing a practice in these areas.

**Also disparate distribution of doctors**

The background here is evidence of geographic differences in access to healthcare professionals, including general practitioners and specialists. As part of the agreements, signed initially in 2007, nurses were given greater responsibilities and enhanced roles, including some of those previously performed by physicians, such as certain prescribing tasks (e.g., vaccination) and complex wound dressing. The policy aim was also to give nurses more responsibility for the management and coordination of the care for the elderly and dependent patients, with a view to improving people's access to care at home. More generally it was designed to lift the status of nurses in France.

**Where and what is the need for better access?**

As part of the new arrangement between the nurses, unions and the funds, there has to be agreement on what constitutes an "under-served" or "over-served" area. So before the agreement becomes operational, the Regional Health Missions have to define these areas, according to national criteria which are as yet unknown. In the longer term, future Regional Health Agencies will take responsibility for regional nurses supply, and the laws about new forms of regional governance are due to be voted on in early 2009.

**Effects of location incentives unclear**

At this stage it is unclear what the outcomes of this new agreement will be. It is possible that once the over-served areas are defined, if nurses find they are not allowed to work in these areas some may choose not to continue practicing as nurses. And while the financial incentives being offered to nurses to move to under-served areas are significant, there are obviously other factors which influence people's choices of where to work. However, given that insurers, the Ministry of Health and nursing unions are all supportive, there must be a good chance that the reform will work to some extent.

**Doctors bitterly opposed to this kind of regulation**

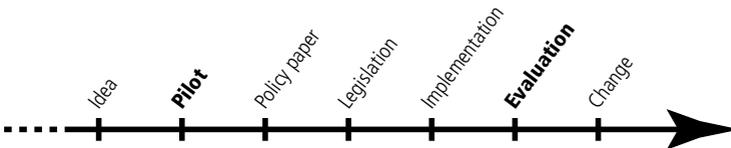
The one group fiercely opposed to this reform is the physicians, who fear they may be next. In fact, observers read this regulation of nurses as the government sending a strong message to other health professionals as well. So far, the government has

tried to reduce geographical barriers to access by offering incentives to doctors. However, physicians now fear that this new agreement with the nurses may signal the government’s intention to challenge the traditional freedom of installation, and the doctors’ unions are strongly against it.

*Sources and further reading:*

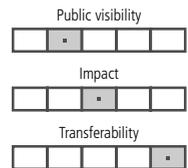
Mousques, Julien and Michel Naidich. Regulating nurses—follow up. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/fr/a12/1](http://www.hpm.org/survey/fr/a12/1).

**Israel: Charities funding co-payments for the chronically ill**



As we discussed above, another of the big barriers to access is the out-of-pocket costs that are becoming an increasingly common characteristic of health systems everywhere. In fact, the increase is double barreled: co-payments are increasingly being used to help fund the rising costs of health systems, and the actual level of these payments is also increasing in many places, as we saw in the chapter “Who Should Pay for What?” elsewhere in this book (see p. 33). In Israel, there is an unusual attempt to lower this rising barrier to access, involving funding from a private philanthropist.

As has been previously described by this network, rising co-payments in Israel as elsewhere are seen as an incentive to stop the use of unnecessary services, but there is concern they may overburden those on low incomes, the sick and the elderly (see *Health Policy Developments 4*, p. 26). Evidence from a 2005 population survey on the effect of co-payments in Israel suggests that 17 percent of the general population, 21 percent of the chronically



**Co-payments hurt the poor, sick and elderly**

ill and 29 percent of the poor reported forgoing medical care or medication due to cost.

**Philanthropy to  
the rescue?**

Following increasing evidence of the adverse effects of co-payments on chronically ill patients with low socioeconomic status, the nation's largest sickness fund initiated a demonstration program using philanthropic private donations to fund co-payments for medications and eradicate out-of-pocket expenses acting as a barrier to care for some patients. The people being targeted were patients with diabetes, hypertension and hyperlipidemia who had failed to purchase prescription medicines due to cost. The goal was to improve their compliance with medications, and the ultimate aim was controlling their chronic conditions. The program was initiated in two cities. Evaluation has shown high levels of compliance with medication and improvements in the patients' surrogate markers of the target conditions, over periods of both six and twelve months.

**Some criticism  
ensues**

While the program received support from all involved, at least two forms of criticism have arisen. First, there was concern that not all patients with the specified chronic conditions could be included in this local project, compromising the legal requirement of equal treatment to all sick fund members. For this reason, the sickness fund then involved an external company to help select patients eligible for the scheme. A second wider criticism came from some patient organizations and academics, concerned that projects like this may reduce pressure on government to address the issue of access within a national universal frame, which is the only way to ensure that such programs will be sustainable and be delivered to all those in need. In this case, the charity promised to continue funding the co-payments for these patients.

*Sources and further reading:*

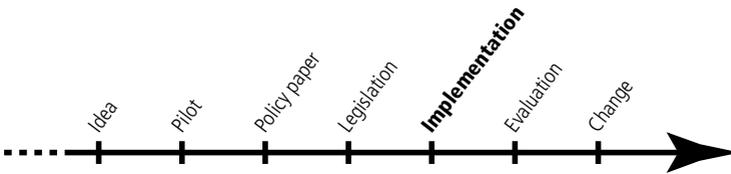
Elhayany, Asher, and Revital Gross. Eliminating co-payments for chronic patients. *HealthPolicyMonitor*, November 2008.

Gross, Revital, Shuli Brammli-Greenberg and Ronit Matzliach. *Ten Years of National Health Insurance: Public*

*Opinion of the Level of Service and Performance of the Health System.* Research report RR-487-07 Myers-JDC-Brookdale Institute, Jerusalem 2007 (Hebrew with English summary).

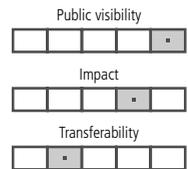
Gross, Revital, Shuli Brammli-Greenberg and Bruce Rosen. Copayments: The implications for access to services and equity. *Law and Business* (6) 2007: 197–224 (in Hebrew).

### United States: Overcoming the first barrier to access—insurance coverage



The golden dome of the Boston statehouse that dominates the downtown of this quaint old American city has an extra sparkle to it these days. A law passed there in 2006 looks set to deliver Massachusetts the prize of becoming the first state in the union to achieve something close to resembling universal health insurance coverage (see *Health Policy Developments* 7/8, p. 100). And it only took the good New Englanders 159 years to achieve it: One of the nation’s first health insurance schemes was set up in Massachusetts in 1847. Clearly one of the biggest barriers to access to health care a person can have is not being insured, and despite the state-based reforms in Massachusetts and elsewhere, the United States still has an estimated 45 million people, or around 15 percent of its population, in exactly that predicament. If the new president and his administration are serious about achieving universal health insurance, they may well be looking to this old northeastern state for some clues on how to get there.

Since the signing of the legislation into law in early 2006, there has been enormous energy put into implementing this re-



<b>Rapid implementation of universal insurance reforms</b>	<p>form, with the creation of new plans and programs designed to extend insurance coverage to all residents—the aim of the new laws. Within months, the state began offering fully subsidized coverage, called Commonwealth Care, to individuals on very low incomes, and by 2007 the state had created a second program, Commonwealth Choice, facilitating affordable private insurance options to those who were not eligible for the fully subsidized plans. At the same time, the state-based federally supported Medicaid program, MassHealth, expanded its eligibility criteria and funds were allocated so the program could reach out to eligible individuals not yet enrolled.</p>
<b>Penalties for taxpayers not insured</b>	<p>Another part of the strategy to achieve universal insurance was to penalize state taxpayers who did not have health insurance. This meant that in 2007, any taxpayer without insurance would be penalized by having to pay US\$219 (€171). The disincentive seemed to work, as by the end of the 2007 tax season, only 5 percent of the state’s three million taxpayers were without health insurance. Two percent reported they could not afford the insurance or were exempt on religious grounds, and the other 3 percent chose to pay the US\$219 penalty. In order to motivate this remaining 3 percent to take insurance, the penalty will be increased, possibly to a maximum of almost US\$1000 (€782) per person.</p>
<b>Numbers of uninsured fall rapidly</b>	<p>There are reliable estimates that the new laws are working well. Before the reforms, close to 650,000 people in the state were without health insurance. Within just two years, insurance coverage has been provided to almost 440,000 people, close to 70 percent of those who were uninsured. Most of the newly insured are enrolled in either the new fully subsidized plans or the new affordable private plans. In terms of demographics, the greatest increase in coverage rates has so far been among young adults, minorities and low-income adults.</p>
<b>Problems emerging already</b>	<p>Due to a higher-than-expected number of people enrolling so soon in the new health insurance plans, there have been challenges both in funding the subsidized insurance and in terms of provider shortages, particularly in primary care. There is also some evidence that people enrolled in the subsidized plans are using emergency rooms much more often than other insured people. One of the explanations is very long wait times to see pri-</p>

mary care providers, with reports that wait times for some can be as long as three months: As one barrier to access falls, another emerges. And this is of course a particularly stark failure in a nation where a wealthy person with the right insurance can summon a coterie of the most exclusive medical specialists within minutes. One response by the state of Massachusetts has been introducing initiatives to encourage new doctors in training to work in community health centers and underserved areas.

Several states, including Massachusetts, have been trying for years to achieve universal coverage, but so far without luck. Hawaii passed a universal access law in 1974 requiring employers to offer healthcare coverage for employees working 20 hours or more a week, but nearly 10 percent of the population there remains uncovered (Schulz and Medlin 2006). Similarly, plans to cover all citizens in Massachusetts in 1988, and Minnesota and Vermont in 1992, fell over in the mid-1990s when important elements of their respective state bills were repealed. And of course, many people will remember the Clintons' moves towards a national health insurance system famously collapsing around that time too. In the 2000s, Maine and California also enacted reforms, but Massachusetts in 2006 was the first state to require all citizens to have health insurance.

It is probably clear to readers already that there is widespread public support for this reform. Survey evidence suggests more than 70 percent of the state's population view the reforms favorably. Moreover, it seems the reforms also have the support of the private sector and local employers. Local businesses, which are now required to offer insurance options to their employees, decreasingly cite the new law as a financial burden, and there has been no drop-off in the number of employers offering coverage. So popular is the plan, it is being touted as a possible model for national reform under the newly elected president, Barack Obama.

**Other states also moving towards universal insurance coverage**

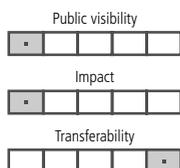
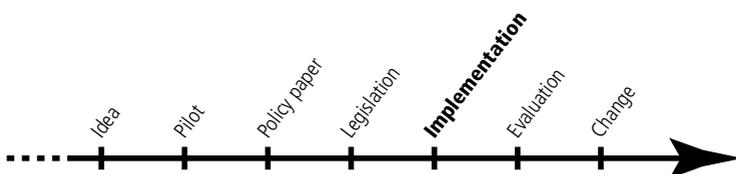
**Widespread support and enthusiasm for Massachusetts reform**

*Sources and further reading:*

Conis, Elena. Update on Massachusetts Health Care Reform. *HealthPolicyMonitor*, November 2008. [www.hpm.org/survey/us/c12/4](http://www.hpm.org/survey/us/c12/4).

Schulz, Anke Therese, and Carolin Medlin. Massachusetts Health Insurance Coverage Mandate. *HealthPolicyMonitor*, April 2006. [www.hpm.org/survey/us/d7/3](http://www.hpm.org/survey/us/d7/3).  
 The Uninsured in America, March 30, 2007, PBS. [www.pbs.org/newshour/indepth\\_coverage/health/uninsured/timeline/index.html](http://www.pbs.org/newshour/indepth_coverage/health/uninsured/timeline/index.html).

## New Zealand: A tool to measure impact on health inequalities



Just like Finland, on the other side of the planet New Zealand has been taking the issue of health inequalities very seriously. And like Finland, New Zealand has recently voted in a new government, moving in the opposite direction politically than the United States. The previous government regarded health inequalities as avoidable, unnecessary and unjust, and reducing them has been one of the main objectives of the New Zealand Health Strategy. As everywhere, the challenge is to design interventions that can help reduce inequalities—whether geographical or socio-economic or race-based—and a new tool has been developed in New Zealand to help planners, funders and providers assess the potential of policies, programs and services to reduce inequalities.

### Health Equity Assessment Tool

The tool was developed in New Zealand based on a similar tool from Wales. It is essentially a list of ten questions, accompanied by a user guide. The questions include the following:

- What inequalities exist in relation to the health issue in question?
- Who is most disadvantaged and how?
- How will the intervention improve Maori health outcomes and reduce health inequalities experienced by Maori?

- What might the unintended consequences be?
- What will you do to make sure the intervention does reduce inequalities?
- How will you know if inequalities have been reduced?

For the full ten questions, see the report cited below.

The Ministry of Health in New Zealand has funded training courses in the use of the tool for health sector personnel, and publication of the new user guide in 2008 has stimulated wider interest and requests for further training. Adoption of the tool may have been constrained because of confusion with other tools such as Health Impact Assessments, or tools developed specifically to assess the impact of health policies on the Maori population. While it was initially used in assessing public health programs, wider use is now being encouraged, though a buildup of some case history will help users understand its application.

**Tool needs more case history to be widely adopted**

*Sources and further reading:*

Cram, Fiona, and Toni Ashton. The Health Equity Assessment Tool. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/nz/a12/4](http://www.hpm.org/survey/nz/a12/4).



## Patient safety and quality

Any contemporary discussions about how to build a safer, more high-quality health system take place in the shadows of the data on practice variation driven by Dartmouth University, the esteemed academic institution nestled amidst the picturesque forests of the northeastern United States. For more than 20 years, a cohort of researchers has been charting what are described as “glaring variations in how medical resources are distributed and used” across different parts of the nation, and producing what has come to be known as the Dartmouth Atlas of Health Care—which has now inspired a similar project in Spain, one of the reforms we examine in this chapter which focuses more on good practice and less on reporting the latest news (see report on Spain, p. 105).

Of the more than 100 scientific articles that have emerged from the influential Dartmouth Atlas project, a two-part series published in 2003 by Elliott Fisher, Jack Wennberg and colleagues is particularly pertinent to any discussion of improving the safety and quality of care (Fisher et al. 2003a, 2003b). The authors analyzed data on almost one million patients, and confirmed again the astounding variations across different regions of the country. They found that a patient in a high-spending region received roughly 60 percent more care than exactly the same sort of patient in a low-spending region. But this time they had the statistical power and the medical records to closely examine the link between practice variation and health outcomes. They made the extraordinary discovery that the health outcomes—and satisfaction levels—of the people receiving 60 percent more care were no better. In fact, these people were at slightly increased risk of premature death compared to similar people in other regions.

**More care does not  
mean better care**

The powerful and provocative take-home message: more care does not necessarily mean safer, better quality care. While this data is highly influential, it is important to note that it is also controversial, and questions about the work of the Dartmouth group are in fact part of a vigorous debate in a recent issue of the journal *Health Affairs* (Health Affairs 2009).

**Data on harmful effects of health care mounts**

Accompanying the emerging data on variation has been mounting evidence about medical errors and adverse events. While many nations have been collecting such data, the figures have been particularly alarming in the giant medical marketplace of the United States. According to the landmark 2000 report from the Institute of Medicine, *To Err Is Human*, up to 100,000 Americans may be dying every year as a result of medical errors, more people than die from vehicle accidents or breast cancer combined (IOM 2000). A subsequent report the following year—*Crossing the Quality Chasm*—categorized key problems in quality as relating to overuse, underuse and misuse (IOM 2001).

**Global alarm about safety**

These problems are not unique to the U.S.—they are ubiquitous in our healthcare systems. When the *Quality Chasm* report came out, the Advisory Council for the Concerted Action in Health Care, an expert committee appointed by the German Federal Ministry of Health, in its 2000/01 report also laid a focus on *Overuse, Underuse and Misuse* of health care (SVR 2001). As anyone interested in safety will know already, many of these errors and adverse events are associated with pharmaceuticals, with hard evidence that these harms occurred in more than one million hospital stays in the United States in 2004 (Healthcare Cost and Utilization Project 2007).

**Movement to improve quality more than a hundred years old**

As we have observed in recent discussions of quality assurance reforms, efforts to make care safer and improve its quality date back at least as far as the time of Hungarian gynecologist Ignaz Semmelweis (1818–1865), who suggested patients might benefit if doctors would wash their hands (see *Health Policy Developments 10*, p. 85). In recent years, quality assurance has been built into national infrastructures, as in Germany since 1993, but there is still a great need for improvement. According to a recent analysis of what European nations are doing, while there is much activity, the central issue of patient safety “is only slowly being prioritized; only a few countries, such as Denmark and the

United Kingdom, have formal structures in place” (Legido-Quigley et al. 2008).

In this chapter, we briefly feature examples from four countries in our network, including Denmark and its decade-long national indicator project (see report on Denmark, p. 102). As we flagged above, there is also news from Spain, which has created its own Atlas on Variability in Medical Practice inspired by the Dartmouth model (see report on Spain, p. 105). In Austria we learn about a project to reduce the harms associated with the use of prescription medicines (see report on Austria, p. 107). Similarly, New Zealand has initiated a program to improve prescribing practice, and another to make it easier for people to navigate complex healthcare settings—both part of the nation’s quality improvement strategy (see report on New Zealand, p. 109).

**A brief round-up of safety and quality reforms**

*Sources and further reading:*

Advisory Council for the Concerted Action in Health Care 2001: Appropriateness and Efficiency. Volume III: Overuse, underuse and misuse. [www.svr-gesundheit.de/Gutachten/Gutacht01/Kurz-f-engl01.pdf](http://www.svr-gesundheit.de/Gutachten/Gutacht01/Kurz-f-engl01.pdf).

Dartmouth Atlas of Health Care; [www.dartmouthatlas.org/index.shtml](http://www.dartmouthatlas.org/index.shtml).

European Observatory on Health Systems and Policies. Role of information in assuring quality of services—case studies on England, Denmark, Norway and Sweden. Euro Observer Autumn 2007. [www.euro.who.int/document/OBS/EuroObserver\\_Autumn2007.pdf](http://www.euro.who.int/document/OBS/EuroObserver_Autumn2007.pdf).

Fisher, Elliott S., David E. Wennberg, Thérèse A. Stukel, Daniel J. Gottlieb, F. L. Lucas and Étoile L. Pinder. The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. *Ann Intern Med.* (138) 4 2003: 273–287. [www.annals.org/cgi/content/abstract/138/4/273](http://www.annals.org/cgi/content/abstract/138/4/273).

Fisher, Elliott S., David E. Wennberg, Thérèse A. Stukel, Daniel J. Gottlieb, F. L. Lucas and Étoile L. Pinder. The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care.

*Ann Intern Med.* (138) 4 2003: 288–298. [www.annals.org/cgi/content/abstract/138/4/288](http://www.annals.org/cgi/content/abstract/138/4/288).

*Health Affairs* 28, no. 1 (2009):w103-w115 (published online 4 December 2008; 10.1377/hlthaff.28.1.w103).

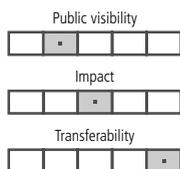
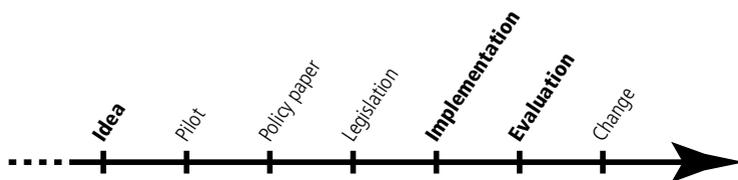
Healthcare Cost and Utilization Project. 2007 Statistical brief. Adverse drug events in US hospitals 2004. [www.hcup-us.ahrq.gov/reports/statbriefs/sb29.pdf](http://www.hcup-us.ahrq.gov/reports/statbriefs/sb29.pdf).

Institute of Medicine. *To Err is Human: Building a Safer health System*. Washington DC: National Academy Press; 2000. [www.nap.edu/openbook.php?record\\_id=9728&page=1](http://www.nap.edu/openbook.php?record_id=9728&page=1).

Institute of Medicine. *Crossing the Quality Chasm—A New Health System for the 21st Century*. Washington DC: National Academy Press; 2001. [www.nap.edu/openbook.php?isbn=0309072808](http://www.nap.edu/openbook.php?isbn=0309072808).

Legido-Quigley, Helena, Martin McKee, Ellen Nolte and Irene A. Glios. *Assuring Quality of Health Care in the European Union*. Copenhagen: WHO on behalf of the European Observatory on Health Systems and Policies; 2008. [www.euro.who.int/observatory/Publications/20080616\\_3](http://www.euro.who.int/observatory/Publications/20080616_3).

## Denmark: The National Indicator Project



The Danish National Indicator Project is part of a movement to improve quality within the Danish health care system that dates back to the late 1990s. This project specifically aims to document and improve quality and is based on eight key disease categories: stroke, diabetes, hip fracture, schizophrenia, acute intestinal surgery, heart failure, chronic obstructive lung disease and lung can-

cer. Active for most of the past decade, the project has involved a range of activities, including developing disease-specific clinical indicators and standards; collecting, analyzing and interpreting data; feeding back findings to providers, managers and the public; and implementing quality improvement.

The aim of the project is not to find goats—or clinicians—and then load all of the sins of the system onto them before sending them out into the wilderness. Rather, the goal is to produce and use reliable data and find ways of maximizing improvements in quality. The formal aims include improving the quality of prevention, diagnosis, treatment and rehabilitation; providing documentation for setting priorities; and getting information about quality to patients and the general public. Participation is mandatory for all hospital wards that manage the treatments within the eight specified disease conditions.

This Danish project grew out of concerns that few countries were able to document the quality of care offered by their health system. Moreover, few countries have a mandatory system to track the quality of care delivered to citizens; data on quality is limited, and often of poor quality. Thus there was a view that there was an urgent need for systematic approaches to the measurement of the health system's performance and the impacts of care on health outcomes.

The National Indicator Project makes its findings available to different players, who use the data for different reasons. Providers want to know how well they are performing, and they want to have effective ways of assessing and improving the care they give. This means having meaningful, interpretable data of demonstrable value in assessing the quality of care. On the other hand, regulators and purchasers are interested in transparency and accountability, and the cost-effectiveness of the health care offered in terms of what gives the best bang for the buck in improving health outcomes. For patients and the public, information about quality can help inform choices, though there is uncertainty and debate about the extent to which people want to be able to access quality information and will make choices based on that (European Observatory on Systems and Policies 2007).

One of the conclusions of a recent analysis of quality activities across Europe was that “quality assurance activities seem to be

**Not about making  
scapegoats**

**We don't know  
enough about  
the effects of  
what we do**

**All use quality  
data for different  
reasons**

**Better quality in multi-disciplinary teams**

more common where health professionals work in multidisciplinary teams, presumably because it is easier to organize peer review with colleagues than with competitors when practicing single-handedly” (Legido-Quigley et al. 2008). At a meta-level, the National Indicator Project is itself an example of a multi-disciplinary team at work, involving government departments and institutes, professional associations, and health management agencies. Moreover, each disease has an indicator group, which involves different health professionals, including physicians, nurses, physiotherapists, occupational therapists and others. Importantly, the group must represent a disease area both clinically and scientifically, and clinical epidemiologists are integral to the process.

**Continuous feedback to doctors and public audits**

Each clinical unit or department involved in the project receives their own results every month, so they can track their performance, in terms of the care they have provided to patients in their hospital. Once a year, a structured audit process takes place, where audit groups at local, regional and national level review the data, explain the risk-adjusted results, and prepare implementations of improvements for care within each disease category. Material is then also prepared for public release, which contains data on each participating department and a short summary of the audit comments.

**Positive outcomes and planned expansion**

The evaluations show in a general sense that within these eight disease categories, people in Denmark are receiving more of the care which is classified as recommended care, as a result of the project. Evidence suggests that the amount of recommended care has increased since 2003, when the first results of the National Indicator Project were generated. As a result, Danish regions have decided to implement the project as a permanent part of the Danish healthcare system. Furthermore, the project will be expanded to three more areas in 2009: birth, depression and inflammatory bowel diseases.

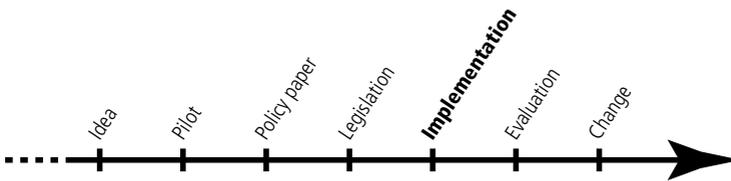
*Sources and further reading:*

Mainz, Jan. The National Indicator Project. *HealthPolicy-Monitor*, October 2008. [www.hpm.org/survey/dk/a12/3](http://www.hpm.org/survey/dk/a12/3).

European Observatory on Health Systems and Policies. Euro Observer Autumn 2007. Role of information in assuring quality of services—case studies on England, Denmark, Norway and Sweden. [www.euro.who.int/document/OBS/EuroObserver\\_Autumn2007.pdf](http://www.euro.who.int/document/OBS/EuroObserver_Autumn2007.pdf).

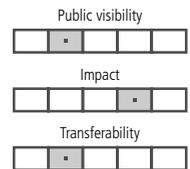
Legido-Quigley, Helena, Martin McKee, Ellen Nolte and Irene A. Glios. *Assuring Quality of Health Care in the European Union*. Copenhagen: WHO on behalf of the European Observatory on Health Systems and Policies; 2008. [www.euro.who.int/observatory/Publications/20080616\\_3](http://www.euro.who.int/observatory/Publications/20080616_3).

## Spain: The Atlas of Variability in Medical Practice



Since 2003, fifty researchers across Spain have been involved in a project to chart variations in practice. They adapted the idea of the Dartmouth Atlas of Health Care and created the Atlas of Variation in Medical Practice in the Spanish Healthcare System. The project has the dual goals of documenting the geographic differences in care across the 17 autonomous regions of Spain and improving healthcare quality and safety. The aim is to translate the evidence gathered in the Atlas into regional decision-making processes and ultimately reduce health inequalities across the nation.

The network of researchers is based in Zaragoza and is funded jointly by the public Institute of Health Carlos III and Ibercaja, a nonprofit bank saving institution linked to regional governments. The group identifies geographic variations in medical care by using hospital discharges in 156 healthcare areas serving 35 million inhabitants. This data reveals information on rates



**What data does the Spanish Atlas use?**

of various procedures, access to effective care, and factors associated with variation. The network also has a second provider-based approach, which uses hospital discharge data from 200 hospitals that have around 3.5 million admissions every year. This particular data-set enables analysis of the rates of adverse events attributable to individual providers, and identifies factors associated with good and bad outcomes. A national survey on hospital information is also used.

**It's all about  
the regions**

Over the last quarter of a century, the Spanish healthcare system has undergone a radical decentralization, with much responsibility being transferred to the 17 autonomous regions and the national Ministry of Health maintaining a reduced regulatory role. The Atlas project is formally involved with 16 of the 17 regions, which provide local expertise and translate the resulting evidence into action. All of the participating regional authorities strongly support the Atlas as a way of improving the safety and quality of the public health system, and thus they help provide data and information to the researchers involved.

**Another example  
of research-  
into-action**

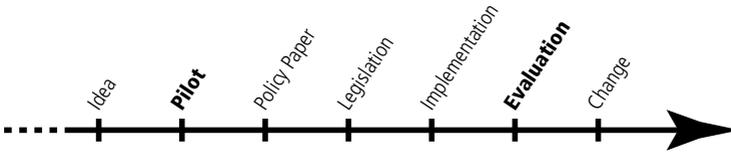
The knowledge generated by the Atlas network of researchers is used to create a Web-based tool for decision makers, with the hope of transforming the research into action by regional authorities responsible for health care. At this stage there is no mechanism in place to monitor or evaluate the effects of the Atlas project, though its results are distributed to more than 3,500 professionals around the country and have contributed to more than 40 research articles. There are also plans to extend the analysis of geographic variation to new areas such as drug utilization in primary care and to engage with pan-European work on health differences.

*Sources and further reading:*

Fernandez-Vandellos, Patricia. A Spanish Atlas on Variability in Medical Practice. *HealthPolicyMonitor*, November 2008. [www.hpm.org/survey/es/a12/2](http://www.hpm.org/survey/es/a12/2).

Atlas of Variations in Medical Practice in the Spanish National Health System. [www.atlasvpm.org](http://www.atlasvpm.org) (English documents available).

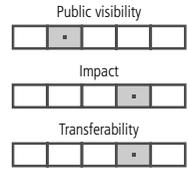
## Austria: The pharmaceutical safety belt



The adverse events associated with the use of medicines are a big component of the broader concerns about quality and safety within health care, and it is well known that the underreporting of these problems is common and widespread. In Austria, a small pilot project launched in 2007 used information technology to help identify problems in terms of duplications of prescriptions and potential adverse interactions between different drugs. Despite ongoing concerns particularly among doctors, early results of an evaluation of the scheme suggest it may improve safety and save money.

The multilayered pilot project, called the Pharmaceutical Safety Belt, commenced in early 2007 and involved 71 out of 76 public pharmacies in the city of Salzburg. Specifically, it involved the creation of special software, which cost more than one million Euros and was funded by the national clearing house of the pharmacies and their chamber. Previous to the project, in 2005, full electronic billing of prescription drugs had been introduced, in an arrangement between the pharmacies and the federation of social health insurance. Then in 2006 the new e-card was introduced, enabling the identification of drug interactions for individual patients. The third important part of the context for the pilot project is the electronic medical record. According to recent government propositions, the nationwide roll-out of the Pharmaceutical Safety Belt is considered the first application of this e-record.

Over 9,000 patients participated in the project, in which a total of 175,000 packs of pharmaceuticals were distributed. As a result of the pilot project, more than 26,000 security alerts were generated regarding both prescription and over-the-counter pharmaceuticals. Of the 26,000 alerts, more than half were for possible adverse drug effects, almost a third were associated with compliance, and just under one fifth were duplications of prescriptions.



### A Salzburg case study in e-health

**Outcomes show significant effects on safety ...**

The project also identified major adverse drug events associated with aspirin/marcoumar, with multivitamin/osteoporosis drugs and with cholesterol/antibiotics therapy.

... and possible  
cost savings

On top of the putative positive outcomes in terms of safety, the new scheme also looks like it could save money. The chamber of pharmacists estimated that about € 150 million a year could be saved if the Pharmaceutical Safety Belt were buckled up at all public pharmacies, including hospital pharmacies. If costs caused by duplications were accounted for as well, an additional savings of € 78 million per year could be achieved. While the Ministry of Health has welcomed the initiative and supports a nationwide roll-out of the project, there is still a major question over whether doctors will support it.

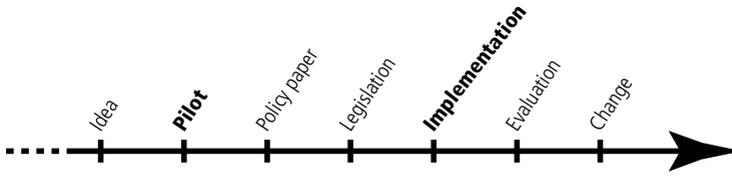
Doctors not  
enthusiastic

Doctors say they have been left out of the implementation of the project, which has been driven in large part by pharmacists. They also seem skeptical about the results of the evaluation, and it is unclear whether they will support a national roll-out. Noting the medical concern, the health minister has claimed it necessary to better involve doctors in this initiative. More broadly, doctors have concerns about the emergence of the electronic health record. The public seems supportive of the safety belt initiative, but this may change if doctors' resistance grows. Importantly, participation is voluntary; patient consent is needed before they participate in this e-health project, and they can ask to have their files deleted.

*Sources and further reading:*

Hofmarcher, Maria M. Pharmaceutical Safety Belt: e-health kicks in. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/at/a12/2](http://www.hpm.org/survey/at/a12/2).

## New Zealand: Quality improvement on two fronts

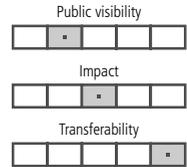


As in many other nations, New Zealand has become increasingly aware in recent years of the incidence and costs of adverse events, and adverse drug events in particular. A study undertaken in the small nation in the late 1990s indicated that almost 13 percent of admissions to public hospitals were associated with an adverse event, with around 80 percent of these events actually occurring in the hospital. One third of those events were in medicine, most of which were drug-related. Like managers and policy-makers everywhere, in New Zealand those running the system are keen to implement quality improvement programs to try to turn horrendous statistics like these around.

In 2008 the government funded a program called Safe Medication Management, which is designed to reduce adverse drug events within the health sector. The initial focus of the program will be on prescribing, dispensing, administering and reviewing medication in public hospitals and in interface between hospitals and primary care. However, the ultimate aim is to improve systems for safe medication use across the entire health sector. Specifically, the project will look at medicine reconciliation; packaging drugs in unit doses with barcodes; bedside verification; standardized and coordinated hospital information systems; standardized medication charts; and the introduction of an e-medication record or e-prescribing.

The Safe Medication Management program is one of five projects which are part of the national quality improvement program, primarily aimed at public hospitals. The program was developed by a statutory committee created by an act of parliament in 2000. The five projects were developed in 2007, and funding for their implementation was made available in 2008.

Another of the five projects is called “Optimizing the Patient’s Journey,” which will involve District Health Boards in New Zea-



**Improving safety  
in the use of  
medicines**

**Part of broader  
quality initiative**

land nominating participating teams within primary and secondary care.

**Optimizing the Patient's Journey**

Optimizing the Patient's Journey is a national collaborative project for improving the quality of care, focusing on helping people navigate inpatient care, starting from before their entry to hospital, through their in-hospital care, and then right through to their discharge. Like other initiatives described in this book's chapter on responsiveness (see chapter on p. 65), the government has the twin aspirations of improving care and reducing cost—a wish list that is often hard to achieve. The ambitious aims of this project include

- reducing wait times for emergency and elective admissions
- reducing cancelled operations
- reducing cost per patient episode
- reducing the length of inpatient stays.

A second element of the project is focused on improving the care of those with chronic conditions, and similar strategies will be employed.

**High hopes**

Each of the two collaborative elements of this project will run for a defined period of time, after which materials flowing from the project will be published and pilots possibly upgraded. As in Spain, there are plans to develop a Web-based tool to allow District Health Boards to directly input agreed measures for the project and provide evidence of anticipated progress, both locally and nationally. While it is early days, there are preliminary indications that the project could result in improving efficiency and cost-savings, particularly through a reduction in cancelled operations, hospital admissions generally, and emergency department attendances specifically for those with chronic conditions.

*Sources and further reading:*

Ashton, Toni. Optimizing the patient's journey. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/nz/a12/5](http://www.hpm.org/survey/nz/a12/5).

CHSRP. Safe medication management. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/nz/a12/3](http://www.hpm.org/survey/nz/a12/3).

## Care Coordination News

Many people with recent first-hand experience of being a patient in an acute care setting will know well that frightening feeling of being lost in the medical labyrinth. Anyone with a friend or loved one with a serious or chronic illness will understand what it means to be buffeted from one “specialist” episode to the next in a convoluted health system itself suffering chronic amnesia, constantly forgetting it is supposed to be caring for human beings who are often at their most vulnerable.

This is the paradox of contemporary complex care, and, ironically, it also is the result of continuing medical innovation—a process that brings about professional specialization and the fragmentation of care, of the care system and of its many funding streams. The vision of seamlessly coordinated patient-centered health care is inspiring many changes everywhere, but the fight against fragmentation is going to be a long one, whether in systems as a whole or in localized networks and institutions. Thus, the global move towards more coordination, pushed by individual experiences and health services researchers with a vision, is a move which has been covered regularly in previous updates (see *Health Policy Developments* 6, p. 33; *Health Policy Developments* 10, p. 35) and one that deserves ongoing coverage.

And certainly those promoting coordination will take heart from the World Health Organization’s 2008 Annual Report, *Primary Care Now More Than Ever*, which argues that the renewal of primary care is the way towards a less fragmented, more patient-centered care (WHO 2008).

A recent report for the Organization for Economic Co-operation and Development (OECD) identifies widespread global concern over problems of fragmented or disintegrated care and notes

**The paradox of  
complex care**

**OECD finds  
widespread  
concern over care  
coordination issues**

the growing interest in coordination and integration (Hofmarcher 2007). Problems identified by the report are characterized most commonly by the experiences of chronically ill patients who have multiple contacts with the healthcare system or see multiple specialists in multiple settings, without any overall coordination of that care. Compounding this problem is the familiar fact that healthcare delivery has historically evolved on the basis of separate settings, or “silos,” which can be institutionally independent, can operate under different budgetary regimes and can be administered by different levels of government. And of course making matters even worse is the inexorable growth of medical specialization with the rise and rise of new-subspecialties, making the likelihood of coherent care for many people even more elusive.

**The roar and  
the whisper**

The policy efforts aimed at making care more coordinated and more patient-centered are related in some ways to the reforms outlined earlier in this book, aimed at making systems more responsive (see chapter on responsiveness, p. 65). According to the OECD report, the aim of more coordination is to make systems “more attentive to the needs of individual patients” (Hofmarcher et al. 2007). While the aim is indisputably laudable, the contemporary reality of medical care in many countries is the power of physicians, often represented politically by influential associations and professional groupings whose primary focus remains largely on expanding monetary rewards and enhancing conditions for those they represent. The voices of patients—which must be heard in any system of patient-centered care—are growing louder, but they are still a whisper compared to the roar of professional interests.

**Global survey of  
moves towards  
coordination**

Based on a global survey of nations about their approaches to care coordination, the OECD report found that currently the most common strategies involved disease-management and case-management type approaches (Hofmarcher et al. 2007). The report highlights four areas where reforms could help coordinate care, including

- developing better information systems to allow access to and transfer of patient records
- shifting resources from inpatient to ambulatory care
- integrating care across sectors, for example social welfare and health sectors

- enhancing the role of nonmedical people and multidisciplinary teams in coordination of care.

A particularly interesting and likely controversial suggestion flowing from the OECD report concerns expanding the role of non-medical staff in the growing area of the coordination of care, particularly for the chronically ill. The authors write: “While there is some presumption that professionals at the primary care level are best placed to take on this role, multidisciplinary teams involving medical and non-medical professionals may be better placed to provide more coherent care, particularly for patients with multiple pathologies. Systems dominated by providers operating in solo practice and paid for on a fee-for-service basis may be less well suited to meeting the care needs of the chronically ill” (Hofmarcher et al. 2007).

**Multidisciplinary teams may give more coherent care**

In this chapter, we look briefly at three different reform projects in Canada, Spain and the United States, which incorporate coordination or integration as their focus in some way. Currently, all three examples are locally or provincially based, though due to preliminary findings of success, two of these reforms may soon be rolled out in more places in their respective countries. Not surprisingly, two of the reforms, in Canada and the United States, have an emphasis on the elderly, where the downsides of a fragmented and disintegrated system of care are arguably more dangerous and the need for coordination more urgent. And in line with suggestions from the OECD report, all three reforms are aimed at shifting the focus of care, where appropriate, away from the resource-intensive acute care setting and back into the community.

**Three attempts to coordinate or integrate, with mixed results**

We open with very encouraging news from the Canadian province of Quebec, where a long-term trial of coordinating the care of the elderly is bearing positive albeit modest results (see report on Canada, p. 115). The reform has involved changing the way organizations work to try to make the care of frail seniors living in the community more coordinated, efficient and effective. From the start, this project called PRISMA involved researchers, managers, and health professionals, and it can be seen as another example of the benefits of building a bridge between evidence, policy and practice.

**Successful care coordination in Canada**

**Putting evidence-  
into-action**

Just as it has helped lead the evidence-based approach towards clinical medicine over the past two decades, Canada is now a key player in promoting a much stronger relationship between those who produce evidence and those who use it. One positive outcome of this bridge-building may well be improving the coordination and quality of care.

**Canada is also  
moving towards  
more teamwork**

A related reform in Canada is the suite of initiatives to promote more teamwork in health care, referred to as “Interprofessional Care” (MacAdam and Mackenzie 2008). With strong backing from federal and provincial governments, this multi-pronged campaign has started largely within the educational arena, promoting collaborative relationships between the next generations of budding young health professionals from the first years of training as students. Despite widespread support, it is still early days, though, in terms of pulling down the walls that separate professional domains and restrict teamwork and collaboration in professional practice.

**Integration plan  
in Catalonia  
hits a wall**

In the Spanish autonomous region of Catalonia, the news is less encouraging (see report on Spain, p. 119). A radical and ambitious plan to change the healthcare system seems to have run into trouble, in part because of strong opposition from powerful players within the system who had not been actively involved in the making of the plan. A key aim of the Catalan Health Department’s “Innovation Plan” was to achieve person-centered integrated primary health care within the region’s public health services. But the overly ambitious nature of the reform, the complex interplay of professional and industrial interests, and concerns from within the influential hospital sector in particular, have meant that the reform’s future is in doubt.

**Hospital at Home  
in the  
United States**

Hospital at Home is a model of care where patients get access to hospital-level services provided to them in their own homes, in order to avoid the problems of navigating the often dangerous pathways of the acute-care setting. Early results of evaluation are promising, suggesting decreases in the rates of complications and costs (see report on the United States, p. 120). Moreover, it seems that these benefits can be accrued without shifting the burden of care and its attendant stress onto the shoulders of the family supporting the patient at home (Leff et al. 2008). The innovative approach has been tested in a small number of cities but is now being promoted nationwide.

*Sources and further reading:*

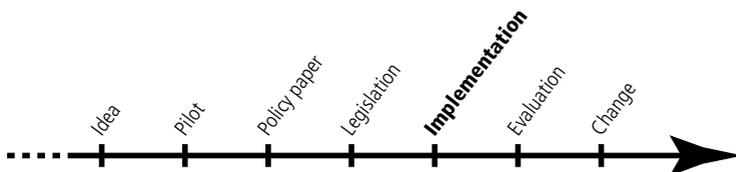
Hofmarcher, Maria M., Howard Oxley and Elena Rusticelli. OECD Health Working Paper No. 30—Improved health system performance through better care coordination. 12 December 2007.

Leff, Bruce, Lynda Burton, Scott L. Mader et al. Comparison of stress experienced by family members of patients treated in hospital at home with that of those receiving traditional acute hospital care. *Journal of the American Geriatrics Society* (56) 1 2008: 117–123.

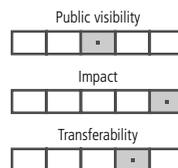
MacAdam, Margaret, and Stephanie Mackenzie. Interprofessional Education: A progress report. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/ca/a12/3](http://www.hpm.org/survey/ca/a12/3).

World Health Organization. *The World Health Report 2008: Primary Care, Now More than Ever*. Geneva: WHO 2008. [www.who.int/whr/2008/whr08\\_en.pdf](http://www.who.int/whr/2008/whr08_en.pdf).

## Canada: PRISMA—Integrating care for the elderly



Navigating the complex and confusing world of health policy reform can sometimes feel a little like being lost in the corridors of a giant hospital, which is why one can be so impressed with projects that can demonstrate clarity as well as success. The Program of Research to Integrate the Services for the Maintenance of Autonomy, or PRISMA, is one such project. Created in French-speaking Quebec, the project's goal is to develop new systems and mechanisms to help provide coordinated, effective and efficient services to frail seniors living in the community. Ultimately, the project aims to improve the health, empowerment and satisfaction of older people while modifying service utilization without increas-



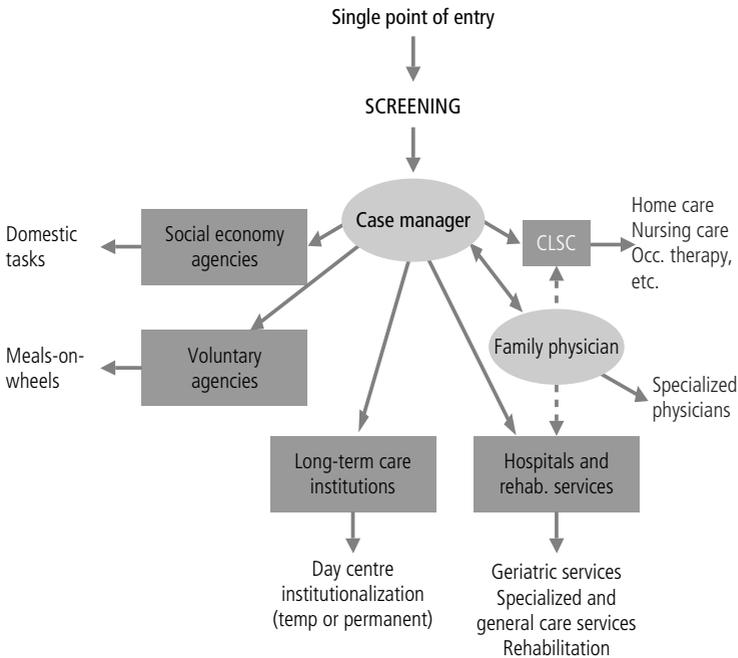
**The problem of fragmentation** ing caregiver burden, and there is preliminary evidence it may have started to achieve exactly those aims. The group of researchers, clinicians and managers who developed this project are very clear about how they see the problems for frail elderly trying to negotiate the healthcare system. According to the strongly-worded no-nonsense Web site of the PRISMA project, the problems include many possible entry points to the system; the multiplicity of redundant client evaluations without standardized tools; the unjustified utilization of costly resources such as hospital and emergency care; delays in service delivery; the inadequate transfer of information; and the fragmented response to needs (see [www.prismaquebec.ca](http://www.prismaquebec.ca)).

**A decade developing the new reform** Pushing for systems of care to become more integrated, PRISMA is a collaboration between university-based researchers, healthcare professionals and healthcare managers in Quebec, Canada. It started more than a decade ago with one small pilot study in over-75-year-olds, which found that better coordination and integration led people to have more autonomy and a decline in their opting to be institutionalized. At the same time, the burden of effort of the person's informal caregivers was reduced. The features of this pilot were then implemented in three different areas of the region, including rural and urban areas.

**The six elements of PRISMA** According to the organizers, the PRISMA project has six elements "essential to the integration of services" (see figure 5):

- A *single entry point* is established, where people are received and initially evaluated to see if they meet the requirements for integrated care.
- If requirements are met, a person is referred to a *case manager* who conducts a more detailed evaluation and helps coordinate a multidisciplinary team of caregivers.
- An *individualized service plan* is developed for each person as a care planning tool.
- A *needs classification system* is used that standardizes measurement of the autonomy of the elderly, based on a paradigm proposed by the WHO.
- A *computerized clinical file* is used to keep up-to-date electronic records.
- *Coordination between institutions* occurs both at management level, through the creation of new panels and committees, and at the level of service delivery.

Figure 5: The PRISMA model



Source: Hébert et al. 2003.

Four years of study data on the new integrated systems has now been accumulated, including data on 728 experimental and 773 control group participants. The main conclusions are that over the four years there has been no effect on death, institutionalization or disability, though there was a non-statistically significant trend towards lower hospitalizations in the experimental group. The incidence and severity of functional decline is modestly lower in the experimental group, and there are positive effects in terms of reported levels of satisfaction and empowerment. The evaluation of the project also found that informal caregivers felt an increased burden in line with the increased number of hours of assistance they were offering to their relative, though this

**Results of  
the four-year  
evaluation**

occurred without any effect on the caregivers, desire to institutionalize those they were caring for. The project also found a 20 percent reduction in emergency room visits, and no increase in costs, even after implementation costs were included.

**A great example of  
bridge-building**

One of the key innovative design features of this reform is that the researchers and the health administrators involved had shared powers of decision-making, making this a strong example of building the bridge between evidence and action. This bridge-building is slowly changing the landscape of the Canadian health-care infrastructure, transforming the reality of the care provided to those who fund it. Specific funds for this project came from a key proponent of this bridge-building, the Canadian Health Services Research Foundation in partnership with the “Fonds de la Recherche en Santé du Québec” (Quebec health research fund), the Quebec Ministry of Health and Social Services, the Sherbrooke Geriatric University Institute and five Regional Health and Social Service Boards.

**PRISMA influence  
spreading**

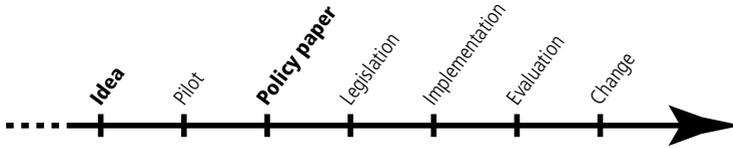
Significantly, the reform is strongly supported by different layers of government, healthcare providers (including home care programs and hospitals), and the scientific community of health policy researchers and local medical schools. As an example of the level of political support, the Minister of Health and Social Services has written the preface to two books that the project has produced on its implementation. Moreover, early results were instrumental in shaping new laws in Quebec aimed at getting more integrated services, and a pilot project based on the Canadian PRISMA is being tested in France.

*Sources and further reading:*

MacAdam, Margaret, and Stephanie MacKenzie. System Integration in Quebec: The Prisma Project. *HealthPolicy-Monitor*, October 2008. [www.hpm.org/survey/ca/a12/2](http://www.hpm.org/survey/ca/a12/2).

Hébert, Réjean, Pierre J. Durand, Nicole Dubuc, André Tourigny and The PRISMA Group. PRISMA: A new model of integrated service delivery for the frail older people in Canada. *International Journal of Integrated Care* (3) 18 March 2003: e08. [www.prismaquebec.ca](http://www.prismaquebec.ca).

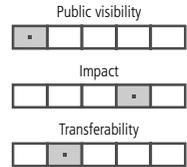
## Spain: Innovative reform in Catalonia hits a wall



In the Canadian reform outlined above, participating organizations retain their structures but have adapted their systems and processes. In the Catalonian “Innovation Plan,” a radical change of the whole system was proposed, involving reform of the payment system, the organization and the provision of primary care services. Like the Canadian reforms, this one aimed to get more patient-centered integrated care. But unlike the Canadian reform, the reforms in Catalonia have not gained universal support. On the contrary, they have generated strong opposition from influential players.

The proposed Innovation Plan arose in recent years when the Catalan Department of Health initiated a consensus process with professional leaders and primary care providers to renew primary care in Catalonia, the autonomous Spanish region which boasts Barcelona as its capital. The plan that process came up with is nothing if not ambitious. The vision was for a radical change in the system, and it was entirely in line with contemporary thinking in health policy circles: to shift the provision of conventional healthcare services from multiple disintegrated organizations towards providing more patient-centered care delivered by integrated structures incorporating public health, primary care and social services.

The new policy was inspired in part by the experiences of Kaiser Permanente in California and Primary Care Trusts in the U.K., but was mainly influenced in its political genesis by a very important strike by unhappy primary care doctors. Apart from aiming for more integration, it also wanted to see universal application of the Catalan Health Information System Network and the publication of national evidence-based guidelines. The plan envisaged that purchasers and providers align their objectives and performance to local policies fixed by new geographically



**Not a modest proposal**

**Inspired by U.S. and U.K. experiences**

based governance councils that would include representatives from local government, citizens and health professionals.

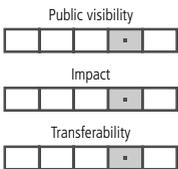
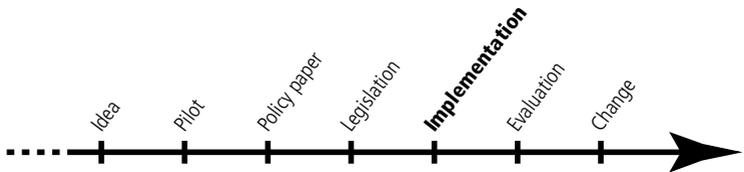
**Opposition**

Despite apparently very worthwhile intentions, the ambitious reforms have stirred a storm of opposition. Some of the strongest opposition has come from within the community hospital sector which is linked to some primary care doctors. This hospital sector may be threatened in any move from vertical to horizontal integration, and it was not included in the initial group who developed the plan. And, interestingly, there has also been opposition from the trade unions representing health professionals who are civil servants, due to concerns that new reformed structures could reduce the proportion of health professionals who would have civil servant status. Ironically, the opposition to the plan unites two groups that traditionally would rather fight one another rather than third players: hospitals and union representatives.

*Sources and further reading:*

Gené Badia, Joan. Primary Care Innovation Plan of Catalonia. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/es/a12/3](http://www.hpm.org/survey/es/a12/3).

**United States: Hospital at Home**



Imagine a specially trained nurse meeting an ambulance as it arrives at an elderly person’s home, and that nurse then providing one-on-one care to that patient for many hours. Then picture that nurse making regular visits to that patient’s home, at least daily while the patient is acutely ill. And suspend disbelief just a little longer to visualize a physician also making home visits—daily—and being on call at any time if an emergency situation

arises at home. Just to fill out the fantasy, envisage a host of home care agencies and contractors supplying other medical necessities for the home-based care, including oxygen therapy and electrocardiograms. Imagine no longer. At least in a few locations, in a handful of cities across the United States, “Hospital at Home” really does mean hospital at home.

This reform grew in part out of the experiences of home-bound older patients and the geriatricians who provided ongoing care to them through house calls. The physicians observed that many patients experienced adverse events in hospital, while others refused hospitalization because their experiences in hospital were so complex and difficult—reflecting the concerns that were identified in the OECD report mentioned earlier (see p. 111) and are driving care coordination reforms in Canada and elsewhere. One particular version of this innovation in the United States was driven by a local group of physicians, nurses, economists and researchers associated with Johns Hopkins University, who helped design demonstration projects in three hospitals in three cities. At the end of that study, two hospitals maintained the innovation, and the program is currently being promoted nationwide.

Early evaluation of the program implemented at three hospitals showed a decrease in complications and costs, as well as increases in patient and family satisfaction. If further evaluation has similar findings, it is possible other hospitals and insurers will push for the adoption of the reform. In anticipation of its adoption elsewhere, proponents have developed a toolkit for implementation at new sites. Barriers to expansion may include a lack of institutional, provider or financial support and a lack of patient interest.

A recent study of the Hospital at Home program looked at how it affected the stress levels of the relatives providing the informal care of elderly patients at home (Leff et al. 2008). Over two hundred elderly patients with a range of illnesses including pneumonia and exacerbated chronic heart failure took part in the study. One group were offered the sort of hospital-at-home care outlined in the opening paragraph above, and the other received their treatment in the hospital itself. The family members of the patients receiving the care at home had significantly lower levels of stress. Maybe this is not a bad thing.

**Origins of hospital at home**

**Fewer complications, more satisfaction**

**A relief for family carers**

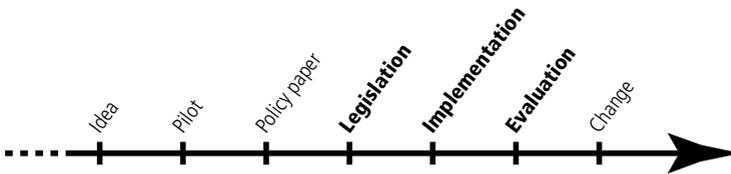
*Sources and further reading:*

Holzer, Jessica, and Gerard Anderson. Hospital at Home. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/us/a12/1](http://www.hpm.org/survey/us/a12/1).

Leff, Bruce, Lynda Burton, Scott L. Mader et al. Comparison of Stress Experienced by Family Members of Patients Treated in Hospital at Home with That of Those Receiving Traditional Acute Hospital Care. *Journal of the American Geriatrics Society* (56) 1 2008. 117–23.

# Update

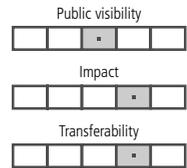
## The Netherlands: Nurse practitioners now institutionalized



What started a decade ago as a small experiment is now becoming a permanent feature of the Dutch healthcare system: nurse practitioners are part of the institution of health care. While there is now widespread support for these newcomers, there is still ongoing antagonism coming from some elements within the medical profession, who see nurse practitioners as threatening doctors' traditional monopolies over critical health services like the prescription of drugs. Despite the concerns, evaluation suggests nurses provide longer consultations, with equal or improved quality, and better continuity of care, with decreased costs.

The goal of this delegation of tasks from physicians to nurses is to reduce the workload of physicians, while providing at least the same quality of care. So far, literature reviews show little effect on the workload of physicians, but added quality and patient satisfaction due to better management of chronic diseases and more attention to patients' psychosocial needs plus more support (Gezondheidsraad 2008).

In the Netherlands nurse practitioners are to be recognized as nurse specialists, and the Board of Specialisms in Nursing has devised various specialties, including nurses specialists in prevention; acute care; intensive care; and care for the chronically ill. With



**Added quality and patient satisfaction**

**Nurse practitioners taking over from docs?**

their expanded roles and under a special legal framework—still to be decided upon by the Minister of Health—nurse practitioners in the Netherlands will soon be allowed to do what are defined as reserved procedures. These were previously supposed to be performed only by the medical profession or under direct supervision of a physician—in actual practice, however, some delegation was already taking place. Reserved procedures include such activities as assessing the need for and/or prescribing drugs; administering injections; and surgical interventions.

**Nurse practitioners study at special “Hoge Schools”**

Education of nurse practitioners in the Netherlands began in 1997, and today nine professional schools offer a two-year masters program of Advanced Nurse Practitioner. In 2000 came the establishment of a professional organization. Then in 2004/2005, funding of the education of nurse practitioners came jointly from the Ministries of Health and Education. Following this was the establishment of the Board of Specialisms in Nursing, and the official registration of specialized nurses, including nurse practitioners, expected in 2009. It is estimated that there are more than 600 nurse practitioners now practicing in the Netherlands.

**Global trend towards expanding nurses’ roles**

Reforms in the Netherlands in relation to this expanded role for nurses were initially borrowed from international experiences, especially in the United Kingdom. There are similar developments in the sparsely populated northeastern part of Germany, where they are referred to as community nurses (see *Health Policy Developments 7/8*, p. 151). Despite concerns in Germany from segments within the medical profession and elsewhere, the government is positive about the idea, seeing the introduction of nurse practitioners as a way of improving access to care without hurting quality, and possibly saving money at the same time.

**Dutch Medical Association supports NPs—GPs don’t**

As is the case in Germany, there is support from the government in the Netherlands for reallocating tasks from physicians to nurses. Not surprisingly, nurses’ associations are very supportive, but it is interesting to note that one of the main bodies representing medical practitioners is also supportive, the Royal Dutch Medical Association. The professional association of general practitioners, however, is not supportive.

**Nurse practitioners or practice nurses?**

Instead of supporting nurse practitioners, general practitioners are interested in promoting the role of practice nurses, who work within a doctor’s practice and perform tasks formerly performed

by doctors, under a doctor's supervision. Practice nurses are nurses, not administrative employees. They were introduced in 1999 because general practitioners were increasingly delegating tasks to practice assistants whose mid-level vocational training set limits to what could be delegated. In the Netherlands, practice nurses have been successful because there was funding for their services, initially as a special arrangement with the health insurance organizations. In the current system their services are remunerated separately.

One of the key differences between the two nurse roles is that nurse practitioners have much more autonomy than practice nurses, who have been introduced into primary care in the Netherlands very quickly and successfully. Notwithstanding the reservations of general practitioners, evidence suggesting nurse practitioners can perform the tasks previously restricted to physicians, at equal or better quality and potentially lower cost, seems certain to assure that their role continues to expand both here and elsewhere.

**More autonomy  
for NPs**

*Sources and further reading:*

Groenewegen, Peter P. Update on Nurse Practitioners. *HealthPolicyMonitor*, October 2008. [www.hpm.org/survey/nl/a12/2](http://www.hpm.org/survey/nl/a12/2).

Gezondheidsraad. Taakherschikking in de gezondheidszorg. Inzet van praktijkassistenten en -ondersteuners, nurse practitioners en physician assistants. Den Haag: Gezondheidsraad, 2008; publicatienr. 2008/25 (English summary).



# The International Network Health Policy and Reform

Since 2002, the International Network Health Policy and Reform has brought together health policy experts from 20 countries 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 (IHS), Vienna
Canada	Canadian Policy Research Networks (CPRN), Ottawa
Denmark	Institute of Public Health, Health Economics, University of Southern Denmark, Odense
Estonia	PRAXIS, Center for Policy Studies, Tallinn
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	Kinugasa Research Organization, Ritsumeikan University, Kyoto
Netherlands	Department of Health Organization, Policy and Economics (BEOZ), Faculty of Health Sciences, University of Maastricht
New Zealand	Centre for Health Services Research and Policy (CHSRP), University of Auckland
Poland	Institute of Public Health, Jagiellonian University, Krakow
Singapore	Department of Community, Occupational and Family Medicine, National University of Singapore (NUS)
Slovenia	Institute of Public Health of the Republic of Slovenia, Ljubljana
South Korea	School of Public Health, Seoul National University
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
United Kingdom	LSE Health & Social Care, London School of Economics and Political Science (LSE)
United States	Institute for Global Health (IGH), University of California Berkeley/San Francisco; Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore; Center for Health, Culture and Society, Rollins School of Public Health, Emory University, Atlanta

## 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

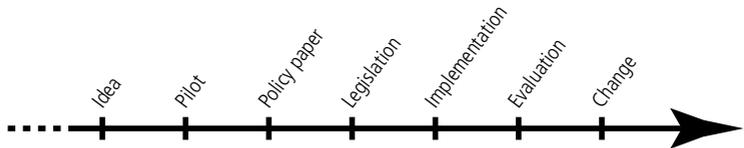
## Reporting criteria

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 toward 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.

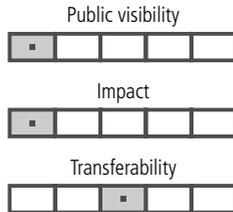
## Policy ratings

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, that is, transferable (on the right).



## Project management

The Bertelsmann Stiftung’s project team of the International Network Health Policy & Reform 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.

Reports from the previous eleven and the twelfth survey round can be looked up and researched on the network’s Web site, [www.healthpolicymonitor.org](http://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.



# Reform tracker countries

(Country, Topic, Title, HPD Issue, Page)

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### *Funding and reimbursement*

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### *Health and aging*

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### *Human resources for health*

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### *Information and communication technologies*

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### *Integration of care/coordination of care*

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Chronic care collaboratives; VI, 39

### *Mental health*

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## **Austria**

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### *Health and aging*

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### *Information and communication technologies*

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### *Patient orientation and participation*

Law to protect the will of the individual; VII/VIII, 126

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