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Reinhard Busse (eds.)*

Health Policy Developments 11

Focus on Primary Care, Appropriateness and
Transparency, National Strategies

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Preface

Dear readers,

In this series, we have been reporting on the latest health policy developments in the 20 partner countries of the International Network for Health Policy and Reform ever since 2003. In order to allow you to express your opinion of our twice-yearly publications, we included a reader questionnaire with issue 10. We would like to thank all those who have already provided us with feedback and would like to invite all others to follow their example.

The feedback we have received has been most encouraging. It is especially pleasing to note that *Health Policy Developments* is considered of interest to and helpful for a very varied readership which includes policy-makers and members of staff from the political arena as well as representatives from the worlds of self-management, journalism and academic disciplines. It is our goal to present health policy developments and approaches in an objective, impartial and comprehensible manner and thereby to build bridges between the worlds of academic study and politics. According to our readers, this series of book publications makes a significant contribution toward this goal. Some of our readers would find compact booklets on individual topic areas useful. We intend to incorporate this idea, together with your suggestions for topics, in our project work in the near future.

The main focus of *Health Policy Developments 11* is on primary care. In this, we are in good company. In its 2008 World Health Report, published 30 years after the declaration of Alma-Ata, the World Health Organization (WHO) has re-examined the concept of primary health care as defined at that time and emphasized

**A bridge between
academic study
and policymaking**

**Now more
than ever**

that the 1978 declaration has lost none of its relevance in the intervening years. On the contrary, primary care is now more vital than ever before.

A subject area which for so long has been neglected and even disparaged by physicians and politicians alike is therefore becoming more and more important in the current climate of demographic change and the changing needs of older and chronically ill patients. Primary care is much more than general medical care. Ideally, it overcomes the divide between the outpatient and inpatient sectors and crosses the borderline to other medical disciplines by coordinating services and service providers from different sectors. Its integration into the care and service systems operating outside the health service and a clear focus on prevention and support for self-management are already key components of primary care in a number of developed countries.

**Primary care
reform as a work
in progress**

The trend today is clearly in favor of strengthening primary care. In many countries, more resources are being allocated to research in this area, new university chairs are being set up and model projects are being promoted. Primary care is currently a highly dynamic area of ongoing reform and is subject to constant development, integration and expansion. In this publication, we present the latest developments from nine countries.

**Appropriateness,
fairness and
transparency**

Under the heading “Appropriateness, Fairness and Transparency” we turn our attention to a further topic which is of great concern to health policymakers and experts all over the world. How can the benefits of medicine be evaluated with a view to ensuring that available resources are allocated based on need, effectiveness, cost-effectiveness and appropriate use? How can suitable evaluative procedures be developed that are both transparent and comprehensible to all concerned? How can the quality of health care provision be measured in a way that is both reliable and conducive to transparency? Our examples from nine partner countries show how different healthcare systems are addressing these issues. Part and parcel of this subject is the concept of Health Technology Assessment, which is being applied in an increasing number of countries. This is a process of systematic assessment of medical technologies, procedures and resources, but one which also extends to the organizational structures in which medical services are provided. This involves analyzing a

number of criteria ranging from effectiveness, safety and cost factors to social, legal and ethical aspects.

As always, the sources of information for this book were the expert reports of the International Network for Health Policy and Reform. The current volume presents the results of the eleventh half-yearly survey which covers the period from October 2007 to April 2008. From the 81 reports of reforms received, we have selected 26 for inclusion in this volume.

Our special thanks are due to Susanne Werner, freelance journalist and consultant (of the agency 'Kommunikation • Gesundheit • Netzwerk'), for her help in compiling the first draft of the German issue of this book, to LinguaServe Language Services for the English translation and to Ines Galla (Bertelsmann Foundation) for her organizational assistance in preparing this publication.

Above all, our thanks also go to all experts from the partner institutions and their external co-authors: Ain Aaviksoo, Tit Albrecht, Gerard Anderson, Benjamin Bittschi, Yann Bourgueil, Chantal Cases, Terkel Christiansen, Elena Conis, Luca Crivelli, Stefan Eichwalder, Anne Frølich, Gisselle Gallego, Kees van Gool, Peter Groenewegen, Maria M. Hofmarcher, Minna Kaila, Troels Kristensen, Markus Kraus, Christian Kronborg, Soonman Kwon, Siret Läänelaid, Lim Meng Kin, Philippe Le Fur, Hans Maarse, Ryoza Matsuda, Carol Medlin, Adam Oliver, Gerli Paat, Tanaz Petigara, Michaela L. Schiotz, Martin Strandberg-Larsen, Eva Turk, Lauri Vuorenkoski and Cezary Wlodarczyk.

We are grateful for any comments and suggestions you may have regarding issue 11 of *Health Policy Developments* and these may be addressed to the editors. We look forward to receiving your suggestions for improvement.

Sophia Schlette, Kerstin Blum, Reinhard Busse

Reporting period
autumn 2007
to spring 2008

Strengthening Primary Care

Primary care is a key instrument of control for an effective and efficient health service. Countries with a well-structured system of basic health care usually perform better in terms of selected health indicators. Evidence-based studies from England show, for example, that each additional GP per 10,000 inhabitants reduces the mortality rate by six percent (Starfield et al. 2005: 462). The World Health Organization (WHO) has emphasized the importance of primary care in a number of policy statements. The 1978 Declaration of Alma-Ata, which today still holds valid as a guiding principle and which has been confirmed by the WHO as its goal in the organization's 2008 World Health Report, defines primary care as

“... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. [...] It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (Declaration of Alma-Ata, Section VI).

In the WHO's 1998 program entitled *Health21: Health for the 21st Century*, the Target 15 is the vision of an integrated health sector in which primary care takes on a more important role. In this concept, it is envisaged that patients should be able to turn as their first point of contact within the health service to a well-trained “family health nurse” and a “family health physician.”

Primary care in the Declaration of Alma-Ata

The WHO's vision of an integrated health sector

Working together with local community structures, this team would then coordinate the subsequent stages of care (Health21 1998: 25).

Primary care is always part of a chain of health care

To date, there is no universally agreed definition of the concept of primary care. For this reason, most attempts to approach this topic commence with a discussion of terminology and definitions. At a meeting of the WHO Regional Office for Europe on “Primary Care and General Practice/Family Medicine: Definition and Link to other Levels of Care” in Barcelona in 2002, the experts taking part agreed to regard primary care as being always a part of the overall provision of health care services. It can not therefore be seen in isolation from other services. Unlike the firmly established concept of general practice provided by a family doctor, primary care is a much wider concept which also includes supplementary services provided outside the health service for the care of an (ailing) population as a whole and which extends the narrow concept of treating individual patients to a much broader notion of providing care for an entire population. In the absence of a binding, unequivocally and universally accepted definition, primary care can therefore be defined by any country, health system or profession according to levels of care, roles and activities or even by reference to organizational structures.

Primary care is always the first point of contact

In view of the vagueness of the term, it seems wise to take a pragmatic approach on the basis of actual developments that have long since taken place in all industrialized countries. In most health services, primary care is the initial point of contact for the patient. It embraces diagnosis, therapy, rehabilitation and palliative medicine but also covers preventive measures. It sees the patient in the entirety of his or her personal and social context and guarantees continuity of treatment (Saltman/Rico/Boerma 2006: 14, cf. also Starfield/Shi/Macinko 2005: 465). Primary care is therefore able to unite a number of different professions such as private practice physicians, general practitioners, family doctors and pediatricians but also internists and gynecologists. In a wider sense it also includes nonmedical health professions such as nurses and coordinates its own services with those of local social services.

Coordination and communication

In theory, therefore, it is more than just a matter of providing general health care; in theory, primary care overcomes the highly

fragmented nature of the relationship between the inpatient and outpatient sectors found in many places and bridges the gap to other medical disciplines by coordinating services and service providers from different sectors. Its integration into care systems outside the health service and a sophisticated system of coordination and communication with these sectors are already key components of primary care in a number of developed countries.

In view of the initiatives being promoted by policymakers in many countries to strengthen primary care, it is apparent that in spite of all the evidence which documents it, this concept is still in need of further practical experience, positive results and a more solid theoretical basis. Many healthcare systems need to be restructured before primary care can have a beneficial effect on the system as a whole. Here, it is not only a matter of innovative forms of care, organization and control, but also of professional self-image and new cooperations within and outside the health service.

In this chapter on primary care, we are therefore dealing with a field of activity which is currently in a state of flux. Primary care—an area which has long been much neglected and even disparaged by physicians and politicians alike—is gaining in importance in the present climate of demographic change and the changing needs of older and chronically ill patients. In many countries, therefore, more resources are being allocated to research into concepts of care, new university chairs are being set up and model projects are being sponsored. In some places (in Germany, for instance), health policy initiatives are running ahead of medical practice; in others, such as in the United States, it is the service providers themselves who for pragmatic reasons are taking the initiative in order to tackle the shortcomings in care and coordination confronting their patients, the practical effects of which they encounter in daily practice. At the present time, primary care is therefore a highly dynamic area of reform which is subject to ongoing development, integration and expansion.

This chapter considers three aspects:

- Local primary care in the context of regional and local structures: Denmark, Finland, United Kingdom, Estonia and Austria

Professional roles are in need of revision

Variety of initiatives to strengthen primary care

- Health professions, new professional skill mixes, division of labor and distribution of roles: New Zealand, France and Japan
- Primary care and the chronically ill: Denmark and Singapore

A diversity of approaches with similar goals

Irrespective of whether the reforms are concerned with organizational structures, the professional mix or care for the chronically ill, the expectations are always the same. It is hoped that the activities, tasks and services of primary care will make the health service more efficient and secure the long-term future of health care. The initiatives presented in this chapter not only illustrate the diversity of the various strategies being adopted in developed countries to strengthen primary care, but in part at least also highlight the parallels between these initiatives.

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Organization, competence and levels of care

The following sections deal first of all with the way that care is organized in the context of regional and local structures. The strengthening of primary care is not infrequently bound up with the expectation of relieving the inpatient sector and thereby making the whole system more cost-effective.

In Denmark, specialized care in hospitals became more centralized in 2007. This means that GPs are expected to take on additional responsibilities, to become case managers for their patients and thereby also to achieve a high quality of care at as low a cost as possible. This is to be achieved by creating larger group practices with a mix of professionals (see the report on Denmark, p. 16).

Denmark: More responsibility for GPs

In Finland, primary care has so far fallen within the remit of local health centers, owned and run by the municipalities. Since these have a median population of only 5,000 inhabitants each, most of them are too small to guarantee high-quality, efficient care. A law enacted in 2007 decreed that primary care centers should be responsible for at least 20,000 inhabitants. This was initially greeted with protests from local authorities but in the meantime, the law has given rise to new cooperative initiatives (see the report on Finland, p. 20).

Finland: Larger units of primary care

In addition to greater efficiency, the goal of structural changes can also be improved coordination of health care and social services in the sense of a more comprehensive concept of primary care. In July 2008, the United Kingdom enacted a new law on health and social care (Health and Social Care Act 2008). The most important innovation here is the setting up of an intersectoral quality commission charged with promoting closer integration between the health service and the social services (see the report on the United Kingdom, p. 21).

UK: Closer integration of health and social services

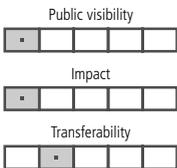
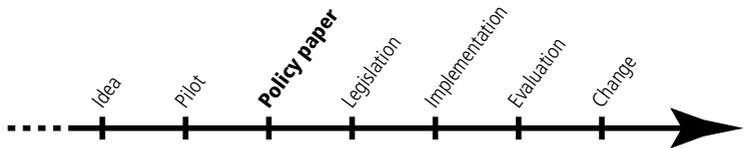
Estonia: care centers and regional control

In many countries, a clear trend can be observed in which primary care is increasingly no longer provided within single-handed medical practices, but by care centers (see also the example from Israel in *Health Policy Developments 10*, p. 39). The aim here is to improve efficiency and establish a more coordinated system of care. Authorities in Estonia intend to expand the system of primary care by 2015 through the establishment of primary care centers. These centers are to be set up as close as possible to the practices of existing GPs and are to offer social services in addition to medical care. In addition, regional coordination units are to be set up for the central planning and control of primary care for regions with 40,000 inhabitants (see the report on Estonia, p. 23).

Austria: Ambulatory care centers on hold

The Austrian government similarly had the intention of supplementing outpatient care by setting up ambulatory care centers, partly in order to reduce the number of hospital admissions. However, the bill has initially failed to attract approval; above all, it came in for harsh criticism from physicians. This project is currently on hold and the matter has been referred to a working group (see the report on Austria, p. 25).

Denmark: Redefining the role of general practice



General practitioners in Denmark find themselves on the verge of far-reaching changes. Firstly, they will in future be expected to take on new responsibilities, predominantly in the areas of patient management and coordination, and secondly, their work will be embedded in new organizational structures. This modernization of general practice is a response to structural changes in the hospital sector.

A few years ago, the government designated a number of acute hospitals in all five administrative regions, each charged with

offering a 24-hour service and maintaining a number of key specialist departments. This reorganization, which will reduce the number of acute hospitals from 40 to around 20–25, is currently being implemented (see also Christiansen 2007). The next step is to reorganize the general practice sector, a process in which GPs are expected to play a key role.

Health experts from the Danish regions have released a report setting out the future division of labor and new forms of organization. In this model, general practitioners will increasingly act as case managers, treating each illness in a proactive and forward-looking manner, providing or organizing pre-hospital and postoperative care and rehabilitation. They will become coordinators responsible for liaising with hospitals and municipalities in order to ensure a smooth course of treatment for their patients. In the Danish health system, the GP is the patient's first point of contact; he or she acts as a kind of gatekeeper, and is therefore both a door opener and a custodian. On the one hand, GPs provide access to specialist health care and social services but on the other hand they are in a position to deny a referral to these services. This presents a dual challenge to practitioners, since they must strive to maintain a close relationship with their patients while at the same time keeping the costs of effective treatment to a minimum.

The coordination between hospitals, municipalities (responsible for rehabilitation, district nursing, home care, nursing homes, prevention and health promotion activities) and general practitioners has so far been less than ideal, mainly because the public and private sectors are marked by different working cultures and remuneration systems. The key question is what organizational changes are needed to firmly integrate the future role of general practitioners within the existing care structures.

Writing from the point of view of the regions, the report's authors also recommend improving the coordination between general practice, the regions and the municipalities at an administrative level. Until now, representatives from the Danish regions and from general practice have negotiated financial agreements every two years. Agreements on care structures are negotiated by regional health coordination committees. Although general practitioners are already represented on these committees, the report

GPs take on the role of case managers

Stronger influence at administrative level

recommends extending their influence and participation in the negotiations.

**Coordinating care
across sectors**

Furthermore, the regions support the recommendations of the National Board of Health, which proposes that representatives of the three sectors should collaborate in formulating joint patient management programs and treatment strategies for the chronically ill and that primary care should play a central role in caring for these patients (see also the report on caring for the chronically ill in Denmark, p. 40). These measures are to be supported on the one hand by more extensive use of electronic communication and data transfer between hospitals, municipalities and general practice, which in the long term could include home care services, and on the other hand, making greater use of the competence of so-called practice consultants. As a rule, these are general practitioners who are attached to one or more hospital departments and who liaise with service providers of postoperative ambulatory care.

**Larger practices
recommended**

In addition to these structural changes, the reforms also envisage new forms of organization in primary care. General practice services in Denmark are currently provided solely by the private sector. Reimbursement consists of a combination of capitation and fees for individual services. Some 43 percent of all GP practices are single-handed, i.e., operated by only one physician. A quarter of all practices are jointly run—physicians share offices, waiting rooms, equipment and staff—but GPs only treat their own patients. Only one third of practices are genuine group practices in which from two to eight physicians not only share costs but also maintain joint patient lists.

In future, larger practices are to be set up, in which more physicians collaborate and jointly employ other staff to provide preventative services and care for the chronically ill. In this model, the GPs would themselves treat minor acute conditions that were previously treated only in hospital accident and emergency departments. There is currently an ongoing debate as to whether group practices are preferable to single-practice clinics. A study by the Danish Institute for Health Services Research (Dansk Sundhedsinstitut DSI) has recently investigated the strengths and weaknesses of different types of clinic. One of the findings was that GPs vary in their preferences for different forms of orga-

nization and that various types of practice should therefore be taken into account.

In their report, the regions also identified structural barriers to the creation of larger clinics and proposed methods of overcoming these obstacles. For example, there is quite simply a shortage of suitably large premises and furthermore, the tax laws have so far offered little incentive for physicians to take on the role of entrepreneurs. And finally, larger clinics incur greater administrative burdens than sole practices. General practitioners are therefore being required to introduce professional standards of management and administration into their clinics. In this context, the regions are expected to assist them by assuming an active role in collecting and disseminating relevant information.

The authors of the study also propose that the regions themselves should employ GPs, in particular to make home visits to patients with chronic conditions and offer specific preventative services. It is hoped that this would help to attract GPs back to regions with low population density. The regions had previously hoped that this aspect would be self-regulating and that enough physicians would set up practices in these areas. The prospect of permanent employment could be an incentive to physicians to settle in practices that have become vacant.

**Lack of premises
for larger clinics**

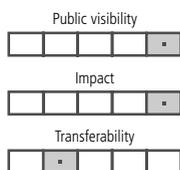
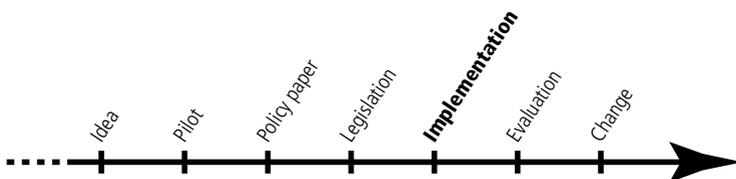
**GPs may be
employed by
the regions**

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Finland: Restructuring municipal health care



In Finland, the restructuring of primary health care is turning out to be more difficult than expected. Here, the 415 municipalities with a median population of only 5,000 inhabitants are responsible for the provision of health care. In the secondary sector, municipal federations have already been formed, but for primary care the municipalities still maintain their own individual health centers. However, most of the municipalities are too small to provide efficient primary care. In January 2007, the Finnish government therefore presented a bill aimed at transferring primary care to these federations (see also *Health Policy Developments 9*, p. 71).

Primary care centers for 20,000 inhabitants

The plan was to make primary care and social services closely related to health services the responsibility of organizations covering at least 20,000 inhabitants. Currently, only 23 percent of municipal health centers cater to a population of this size. Whereas these larger centers can therefore remain unaffected, municipalities with smaller health centers were called upon to make their own suggestions for possible mergers or cooperation models.

In Finland, there is a long-standing tradition of autonomy in small communities. Many municipalities therefore initially resisted these reforms. Municipal stakeholders were reluctant to surrender responsibility to larger organizations and had to be more or less forced to enter into closer cooperation with neighboring municipalities.

Most municipal models failed to satisfy government

When the municipalities presented their plans for cooperation in the fall of 2007, the state administration accepted only a minority of them without demur. For example, some of the plans entailed placing the responsibility for social services and medical care in the hands of separate organizations. In such cases, the government feared that rather than promote greater integration, the new structures would result in increased fragmentation in

the provision of care. In some cases, the plans had to be renegotiated, while other municipalities were called upon to redraft their proposals. All in all, however, the process is under way, even if it started more slowly than anticipated.

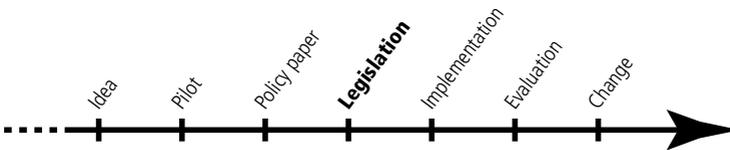
So far, 60 “joint municipal federations” have come into existence. Whereas a federation is responsible for the provision of primary care, the necessary funding remains in the hands of the individual member municipalities. A further 20 federations work on the principle that participating municipalities transfer the administrative responsibility for organizing primary care to a single community with which they then enter into a contract. A third effect is the reduction of the number of municipalities through mergers. In a first step, the number of municipalities has decreased by 67 from January 2009.

Municipal federations have been formed

Sources and further reading

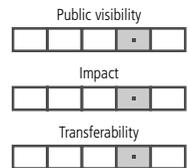
Vuorenkoski, Lauri. Restructuring municipal services—follow up. *Health Policy Monitor*. April 2008. www.hpm.org/survey/fi/a11/5.

United Kingdom: Health and Social Care Act



On July 21, 2008, the British government enacted a law, the Health and Social Care Act, containing a number of policy measures designed to promote closer integration between the provision of health care and the social services.

In recent years, health experts and policymakers in the United Kingdom have devoted a great deal of attention to investigating ways of improving primary care and integrating health care with the social services. Mid-2005 saw the development of the vision of

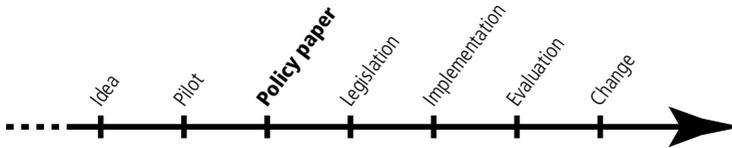


The vision of a comprehensive system of care	<p>a comprehensive system of care; concepts were discussed and developed, according to which the health and social services would work hand in hand to provide care for specific sectors of the population, such as the elderly or cancer sufferers (see <i>Health Policy Developments</i> 6, p. 41). In January 2006, the Department of Health published a white paper outlining further steps aimed at improving primary care. The white paper is based mainly on a survey of the general public, patients and medical personnel, in which they were asked about their healthcare needs (see <i>Health Policy Developments</i> 7/8, p. 120).</p>
Intersectoral quality commission	<p>The most important innovation contained in the law passed in July 2008 is the creation of a Care Quality Commission (CQC) formed by merging the existing Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission. The main function of the new quality commission is to guarantee the safety and quality of medical and social services, to assess the quality and performance of service providers and to safeguard the rights of mental health patients. Since the CQC will in future combine the regulation and inspection of health and social services within the remit of a single organization, it is expected to close gaps in the provision of care and improve coordination between the various services.</p>
Mandatory registration for all service providers	<p>All service providers in the healthcare and social sectors will be required to register with the new regulatory body in order to be able to offer their services. Registration will depend on the adherence to unified quality standards and this will first be assessed through a process of consultation. The standards themselves are to be formulated as patient-oriented standards which also give service providers clear and standardized guidelines.</p>

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Oliver, Adam. The Health and Social Care Bill. *Health Policy Monitor*. April 2008. www.hpm.org/survey/uk/a11/1.

Estonia: New centers assume responsibility for primary care

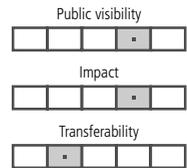


The government of Estonia has set itself the target of improving primary health care by 2015 and to this end aims to establish a system of combined social and health care centers. In addition, regional coordination units will be responsible for the central planning and administration of primary care in regions with an average of 40,000 inhabitants. A plan to this effect was published in April 2008 after two years of deliberation.

In recent years, there have been a number of attempts to improve primary care in Estonia. In 1993, family medicine was designated and recognized as an independent medical discipline. By the end of 2001, there were 557 family doctors with a diploma in family medicine and by 2003, this number had risen to about 800, almost enough to care for the entire population. Since 1998, they have been remunerated through a mix of capitation (approx. 73 percent), fee-for-service (approx. 15 percent) and additional allowances (Koppel et al. 2008: 87).

The Estonian network of family doctors covers the whole country and provides adequate access to care in all regions. The family doctor has been established as a gatekeeper within the system, but one who is also responsible for preserving the previous high quality of care. Surveys reveal that patients are satisfied with the results, with 91 percent of respondents giving the care provided by family medicine a positive rating.

A further improvement in primary care is due to the creation of a central telephone hotline which the national health insurance fund had previously set up in August 2005. Since then, it has handled an average of 9,000 incoming calls per month from patients who receive advice from general practitioners and nurses. The hotline serves above all to ensure that primary care reaches the less wealthy sectors of the population and inhabitants



Mixed remuneration system for family doctors

The family doctor system covers the entire country

of remote areas. In addition, it bridges the gaps between normal consulting hours (see *Health Policy Developments* 7/8, p. 124).

Still no central coordinating body

In spite of all the progress that has been made, Estonia still has no sole institution which is responsible for the planning, organization and supervision of primary care. As a result, the responsibilities are dispersed among several institutions and there is a great deal of ambiguity about the coordination of actions and even the allocation of resources. The latest reform project is the result of several years of consultation. The concept had been under development since 2006. During the course of this, it became increasingly clear that primary care in Estonia had been too narrowly defined. There was hardly any integration between the social services, which unlike health care are funded from municipal budgets, and specialist medical care. The Ministry of Social Affairs had summoned a broad working group and actively sought to reach a consensus.

New health care centers ...

The proposal that has been developed now asserts the key role played by primary care in maintaining a healthy population and involves establishing two new institutional forms. Between 46 and 184 health care centers are to be set up as the primary point of entry for patients. These centers will be formed around existing family doctor practices and complemented by additional components such as nursing, mental health care and social services. These centers will adopt regional responsibility for a wide range of health and social services and may also work in cooperation with existing small hospitals.

... and regional coordination units with full responsibility

Secondly, it is intended to establish regional coordination units, each responsible for about 40,000 inhabitants. There will be fifteen of these throughout the country and a further two in the major cities of Tallinn and Tartu. The coordination units are to be responsible for ensuring the provision of medical care at county level. They will enter into contracts with the health centers and individual service providers. The precise nature of how these coordination units are to be organized has not yet been clearly defined. According to the draft policy paper, both single cooperative business entities and voluntary networks of independent providers are possible.

Implementation in 2009

The first stages of implementation are expected to take place in 2009. It remains to be seen what the effects of the proposed

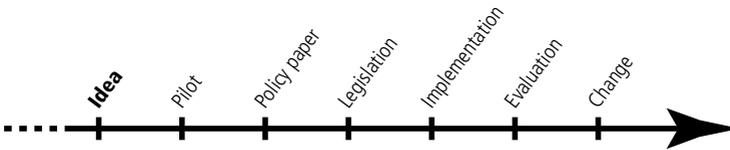
closer cooperation between health service providers and regional authorities will be. After all, the plan involves integrating areas which have so far been funded from completely separate budgets.

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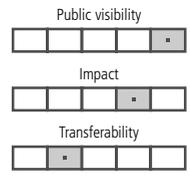
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Austria: Ambulatory care centers on hold



Policymakers in Austria have failed in their attempt to radically restructure the system of providing health care outside hospitals. A proposal to this effect was turned down within a week of its publication in the face of fierce opposition from physicians. So-called ambulatory care centers were to have been established as an additional pillar of the health service. It was hoped that the proposed measures would make the health service more patient-centered and introduce greater flexibility in management and contracting. Now the government has called a halt to the process and has instead charged a working group with drafting a new proposal to be presented by the end of 2009.



In 2005, the ratio of beds to inhabitants in Austria was 6.1 acute care beds per 1,000 inhabitants. The average for the EU in the same year was 4.2 beds per 1,000 inhabitants. Compared to

High rates of admission in Austria

other European countries, the hospital admission rate in Austria is also very high, with nearly 28 admissions per 100 inhabitants in 2005. The introduction of DRG-based hospital financing in 1997 had helped to reduce the average length of stay but had at the same time led to an increase in admission rates. It is therefore one of the main aims of current Austrian health policy to relieve the hospital sector and improve outpatient care. While the federal states (“Länder”) are responsible for hospitals, primary care is financed mainly through the 21 individual sickness funds and on the basis of regional location plans which, however, are not fully coordinated. Also, the Main Association of Austrian Social Security Institutions (Hauptverband der österreichischen Sozialversicherungsträger) has only little to say in this context.

**Three pillars of
ambulatory care:
local physicians, ...**

Currently, the provision of outpatient care is organized in three pillars. Firstly, there are some 19,000 independent physicians who are self-employed and mainly work in solo practices. A legal framework permitting group practices was established in 2001 but currently only two percent of contracted physicians take advantage of this.

**... hospital
outpatient
departments, ...**

The second pillar of ambulatory care in Austria consists of hospital outpatient departments. Almost all nonprofit public and private sector acute hospitals operate outpatient departments, mainly specialist ones. These primarily provide emergency and first aid services as well as pre-treatment and post-treatment care for hospital patients. (Federal Ministry of Health, Family and Youth 2008: 6).

**... and outpatient
clinics**

Thirdly, there are about 840 outpatient clinics. These are a mixture of hospital and private practices and are mainly run by private individuals or social insurance institutions. These clinics can employ physicians but do not have to provide round-the-clock care and are therefore under no obligation to offer emergency services. They are well established in the diagnostic and treatment segments, which either call for an integrated and interdisciplinary team of physicians or require a large number of nonmedical personnel. Of these clinics, 64 percent are dental outpatient clinics.

**Care centers for
contracted
physicians only**

In October 2007, a draft proposal was released by the Austrian Ministry of Health advocating the creation of new ambulatory care centers. The proposed centers were to be regarded as a spe-

cial type of outpatient clinic and would therefore fall under the regulatory remit of the federal states. Only physicians who maintained a contractual relationship with the sickness funds (social health insurance institutions) would be able to purchase equity in these ambulatory care centers. The draft proposal also foresaw the possibility of converting existing hospital outpatient departments into ambulatory care centers.

The proposal to establish a system of ambulatory care centers was intended to pursue three main policy objectives:

- to enhance cooperation between sickness funds and the state health funds
- to make the provision of health care more patient-centered
- to ensure better access to healthcare services through extended opening hours, the integration of different health professionals and improved communications between service providers in the various sectors

Objective: reduce the number of hospital admissions

Overall, the ambulatory care centers were conceived as a way of reducing the number of acute hospital admissions without compromising the quality of health care.

The proposed model was very innovative for Austria and the resulting controversy correspondingly fierce. Health care researchers were impressed by some aspects of the draft proposal. They would have expected the ambulatory care centers to fundamentally change the landscape of health care in Austria. Hospital outpatient departments and the ambulatory specialist care provided outside hospitals would have gradually merged. This would have represented a significant step towards the seamless delivery of care at the crossover points between the different sectors. Treatment in the ambulatory care centers would have been provided in compliance with national quality standards. This in turn would have led to a greater focus on quality throughout the entire health service, even in the case of physicians who are not contracted by the sickness funds.

However, the proposed ambulatory care centers posed a threat to contracted private practice physicians. Physicians’ representatives complained of a looming “nationalization of health care” and the “end of free choice of medical practitioners.” They condemned the proposal as “a dismantling of doctors in their own

Physicians fear the specter of nationalization

practice” and even saw the proposal as an attempt to “expropriate doctor’s offices.” In the face of this vehement opposition, the proposed bill was reduced to a single paragraph in a current agreement (15a BV-G Vereinbarung). A working group consisting of representatives of all relevant stakeholders has now been entrusted with the task of proposing ways to improve ambulatory care and make it more patient-centered. This concept should also identify gaps in the existing system and offer suggestions for closing these gaps through organizational and structural change.

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Professions in primary care

A second, frequently debated topic in the area of primary care is the roles played by the various health professionals and the future division of labor between physicians and nonmedical health professions. In many developed countries, new forms of cooperation between the professions or new professional models are being investigated in order to improve the coordination of care and minimize inefficiencies arising from the interfaces between the various sectors (see also *Health Policy Developments* 7/8, p. 159). It is above all in the primary care sector with its focus on coordination and communication that these new concepts of professional roles and of the cooperation between professions are possible and indeed needed.

In recent years, New Zealand has developed new models for primary care, placing nursing at the centre of the health system, alongside medical care. This system of primary health care (PHC) nursing is the result of a process of reorientation in primary care which was launched some years ago and now offers a broad range of population-based services. In 2001, the key Ministry of Health goal was the further expansion of nursing in primary care. Subsequently, in 2003, the ministry, following the recommendations of an expert advisory group, allocated funds to eleven nursing projects in primary care over three years and contracted a team to evaluate them (see the report on New Zealand, p. 30).

In France, similar projects aimed at improving cooperation between the various health professions have also been implemented and evaluated. Here, the education and training of health professionals is undergoing a process of fundamental reform (see the report on France, p. 32). Since physicians have in fact already been delegating many medical tasks to other professionals, it is really only a matter of creating a formalized regulatory

**New Zealand:
Primary health
care nursing**

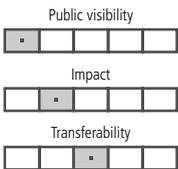
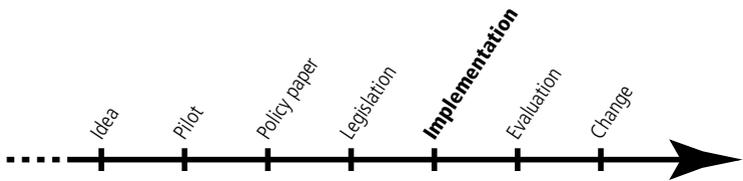
**France: New roles
for non-medical
personnel**

framework for these services. Experts in France believe that future challenges can be met only if nurses, midwives and other health professionals are offered attractive career opportunities.

**Japan considers
introducing
general physicians**

In Japan, on the other hand, government, health insurers and service providers are intensely pursuing a quite different aspect of reform. The issue here is a number of proposals for establishing and consolidating the profession of general physician as a central point of contact for patients and acting as a coordinator within the health service (see the report on Japan, p. 35). So far, there has been no clear distinction in Japan between general practitioners and specialists. Most physicians are trained as specialists by teaching hospitals and there is effectively no established discipline of general practice. The proposed reforms have the long-term objective of reducing the frequency of treatment carried out by specialists, establishing general physicians as an independent discipline and assigning to them the role of gatekeeper within the health service.

New Zealand: Positive experience with primary care nursing



In recent years, New Zealand has developed new models of primary health care (PHC) nursing. The current concept of PHC nursing is the result of a program of reorientation in primary care which commenced some years ago and which is intended to be more population-based and offer a wide range of services. The key goal of the Ministry of Health in 2001 was the further expansion of nursing in the primary care sector. In 2003, following the recommendations of an expert advisory group, the ministry allocated funds to 11 primary health nursing initiatives to run over a period of three years and contracted a team of nursing researchers and consultants to conduct an evaluation of the projects between January 2004 and mid-2006.

The model projects focus on initiating a far-reaching change in the health service by making greater use of the skills of generalist and specialist nursing staff and other health professionals in primary care. New forms of nursing are directed at those patients who have difficulty accessing existing services or whose needs are currently not being well met.

**Improving
accessibility
and outreach**

Several new forms of primary nursing care have now been established throughout the country. The reorganization of the provision and scope of PHC nursing has received broad acceptance. In some cases, however, observers claimed that there was insufficient buy-in from nursing professions and other service providers who were not really assuming responsibility for the tasks entrusted to them. A further barrier noted by experts was that the new PHC nursing models fell under the auspices of networks of primary health providers known as Primary Health Organizations (PHOs). Establishment of PHOs only commenced in 2002 and they are therefore themselves still in a very early stage of development (see also *Health Policy Developments 1*, p. 55 and *Health Policy Developments 7/8*, p. 154). As relatively new non-profit health service organizations, they ensure that primary care reaches those citizens registered with them and are funded by flat-rate per capita charges. Furthermore, many nurses are already involved in other health initiatives and there is in particular a shortage of suitably skilled nurses of Maori and Pacific origin.

**Reorganization
widely accepted**

The projects were most successful when more than one of the following success factors were present:

Success factors

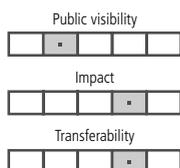
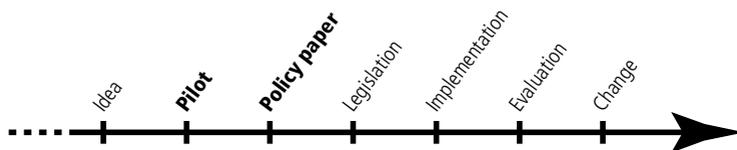
- Broad-based support for the initiatives from a variety of institutions
- Embedding of primary health care in the regional health authorities (District Health Boards and PHO governance)
- Effective communications systems and the inclusion of local nursing forums
- Clear clinical leadership, well-developed policies and protocols, investment in IT services
- Attractive career pathways for the nursing professions

In the future, it is to be expected that further nursing services will be incorporated into new models of primary care.

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France: National recommendation for a professional skill mix



In France, the National Authority for Health (Haute Autorité de Santé, HAS) and the National Observatory of Health Professions (Observatoire National de la Démographie des Professions de Santé) are calling for reforms in the education and training of health professionals. A number of different projects have been piloted and evaluated over a period of four years and national recommendations were published in April 2008. The recommendations also set out the regulatory framework and the key arguments in support of new forms of cooperation in the health service.

Nurses to replace physicians

The main objective of the recommendations is to combat an anticipated decrease in the number of physicians by transferring a limited number of medical tasks from physicians to nurses and other paramedics. Experts regard it as one of the main tasks to open up new attractive career pathways for nursing staff and other health professionals by establishing master's degree programs at universities, thereby creating new job opportunities in health care. Furthermore, it is intended to introduce greater flexibility into the remuneration system in both the hospital and ambulatory sectors.

Shortage of physicians in rural and poor areas

In France, the main tool of medical supply regulation is a *numerus clausus* which limits the number of students entering medical studies and had been reduced steadily between 1971 and 1998.

Although between 1998 and 2008 the number of students was increased from 3,500 to more than 7,000, this will not compensate for the shortage of doctors because of the long duration of medical studies. Moreover, the introduction of the 35-hour workweek, the legislation of the European Union on working time in hospitals, an increasing share of female doctors (60 percent of students entering medical studies in 2002 were female), and a change in the young professionals' attitude towards professional involvement lead to a reduction in doctors' working time. The result is a relative shortage of doctors particularly in rural and economically deprived areas.

Experts believe that future challenges can only be met by providing attractive career perspectives for nurses, midwives and other health professions. Some years ago, France had already launched a number of initiatives aimed at securing adequate human resources in the health service. In 2003, the National Observatory of Health Professions was set up to document the development of human resources in the health service in cooperation with regional institutions (see *Health Policy Developments* 6, p. 76).

The National Observatory of Health Professions has played a key role in developing the present initiative. Its president, Professor Yvon Berland, has from the outset been one of the project's main supporters and has provided continuity while the position of health minister has changed hands every year. In 2006, responsibility for running the project was transferred to the National Authority for Health. It is this body that has developed the national recommendations for policymakers and health professionals. The reorganization of training and education is also linked to the Bologna process, which provides an incentive to introduce new university degrees for different healthcare professions.

The paper is based largely on the results of pilot projects during which it became evident that certain medical tasks had in fact already been transferred to different health professionals and that a legal framework was now required to formalize this practice. Examples of this are imagery technicians carrying out abdominal echography and nurses performing ambulatory chemotherapy for patients with brain tumors and providing follow-up treatment for those with hepatitis.

In all, there were a total of 16 pilot projects, all of which were carried out under clinical supervision and performed on a volun-

New career perspectives for nurses

Initiative linked to the Bologna process

In practice, many tasks are already being delegated

tary basis over a limited period. The majority of these pilot projects involved introducing new technical procedures, organizing follow-up treatment for patients with chronic conditions or developing preventive measures. The evaluation of these projects has been discussed in detail with physicians and representatives of other professional groups. However, there is currently no specific policy initiative in place for implementing the recommendations.

**Possible opposition
from the Ministry
of Education**

The Ministry of Health announced that some of the recommendations are to be implemented in a number of different laws, but at the moment very little is known about the precise content of this legislation. This lack of transparency arouses the suspicion that the Ministry of Education will attempt to block the proposals, since its representatives were not involved in the foregoing deliberations.

**Providers divided,
patients supportive**

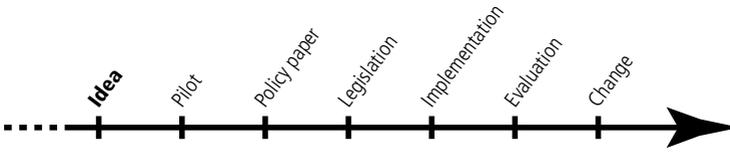
The opinions of service providers are divided; while the chamber of physicians, for example, would prefer to retain the existing system, physicians in private practice are at least partly in favor of the proposed changes. General practitioners also support the project, whereas medical specialists have not yet taken a unified stance. The National Health Insurance Fund, however, fears that expenditure may increase as a result of tasks being duplicated rather than supplemented or transferred. Patients and consumers support the initiative.

For the recommendations to be implemented in practice, three key stakeholders need to be brought on board: the physicians' and nurses' associations, the French parliament and the Ministry of Education. The formalization of new skills and qualifications and the introduction of new levels of competence and new professions can contribute significantly to the development of new models of healthcare delivery, promote equal access to care and have a beneficial effect on the overall quality of care.

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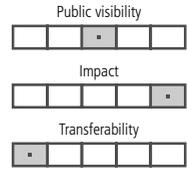
Japan: The “general physician” as a new profession?



Government, health insurers and service providers in Japan are working intensely but in parallel on concepts designed to develop and establish general physicians as central points of contact and coordinating agents for patients within the healthcare system. In Japan, the idea of the general physician as a gatekeeper and “pilot” of the patient through the system is new and is receiving the support of government and health insurers. Following in-depth deliberations in recent years on ways to make the Japanese health service more efficient, the government has been examining new models of role distribution and division of labor in health care since 2007.

So far, there has been no clear distinction between general practitioners and specialists in Japan. Most physicians are trained as specialists by teaching hospitals. The notion of general medicine as a discipline requiring different areas of competence and experience to those provided by specialist training is largely unknown in Japan. This has made it virtually impossible to coordinate treatment through the practice of gatekeeping in the Japanese healthcare system.

The Medical Ethics Council of the Ministry of Health, the body responsible for the training and certification of physicians, has now begun to formulate the roles which could be assigned to general physicians. According to the proposals, general physicians would become the primary interface between patients and the healthcare system, provide all primary healthcare services and refer patients to specialists and hospitals. In this model, future general physicians would need to possess a broad spectrum of knowledge of health care and illnesses and also be in a position to utilize community resources for the benefit of the patients. To this end, the government is considering the option of establishing



There are no general physicians

Coordinating community resources

a system of systematic training for general physicians.

**New profession,
new system of
remuneration**

The health insurers are likewise recommending the establishment of a new professional group of general physicians. In addition, they propose developing a new system of remuneration to do justice to the general physicians' new range of responsibilities. This could be included in the next revision of payment structures in the health service, which the government has scheduled for 2010.

The Japanese Medical Association supports the notion of physicians as gatekeepers but rejects the government's proposals to establish a new professional group of general physicians and a new remuneration system. Instead, the association argues that the required certification and training should be provided within the existing medical training curricula.

**Training so far
entirely voluntary**

So far, the debate has focused mainly on the issue of systematic training for general physicians, an idea which in itself is not really new. Indeed, some medical societies and associations have already developed their own curricula on the basis of international experience. However, such training has always been organized on a purely voluntary basis without being linked to the health insurance system or having any effect on remuneration. Generally in Japan, physicians who pass the national examination for certification have to go through two years of training with a healthcare provider accredited for teaching. After that, all training is voluntary.

**Physicians oppose
structural changes**

More than other industrialized nations, Japan finds itself confronted by the demographic problem and consequent challenge of an aging population with a growing demand for complex health and social services. Government and health insurers expect physicians to act as agents of integration and coordination as well as efficient service providers, and see the introduction of general physicians as a step in this direction. The physicians themselves remain opposed to the proposals, as was the case with previous measures. A recently introduced remuneration system for treating patients with chronic conditions, which would result in physicians receiving a fixed per capita fee for patients for whom they entered into a long-term care plan, was likewise opposed by physicians.

This policy proposal is still in its infancy and is highly contro-

versial. If implemented, it would radically change the nature of the health service in Japan. But it remains to be seen whether the concept of the general physician will take hold in Japan, and if so, in what way.

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Caring for the chronically ill

Demographic change and the concomitant increase in chronic conditions make primary care an ever more important focus of attention for health research and policy development. In their efforts to adapt care structures to the changing patterns of medical needs, health experts from all over the world are banking on closer integration and enhanced cooperation between different sectors and service providers (see also *Health Policy Developments* 6, pp. 33–1252).

In Germany, for example, the Advisory Council on the Assessment of Developments in the Healthcare System (SVR) has provided an impetus for the care of the chronically ill. Faced with an increase in the number of older and multimorbid patients, the SVR recommended in its 2007 expert report “adopting the principles of the Chronic Care Model to improve outpatient care in Germany” (SVR 2007: 23). The Chronic Care Model was first developed in 1996 by Ed Wagner, director and founder of the MacColl Institute for Healthcare Innovation in Seattle. This model serves as the basis for reforming clinical care and realigning it to better suit the needs of chronically ill patients in the primary care sector. It regards physicians, practice professionals and patients as partners and promotes patient self-management. It provides the template for optimizing medical care and integrates the whole system of service providers, social services and local resources. The workflow is improved by means of decision-support tools and health information technology (see also *Health Policy Developments* 10, pp. 35–1248).

Health policy in Denmark is likewise seeking to adopt the Chronic Care Model. It is hoped that this model will improve disease management for chronically ill patients within the context of

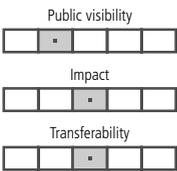
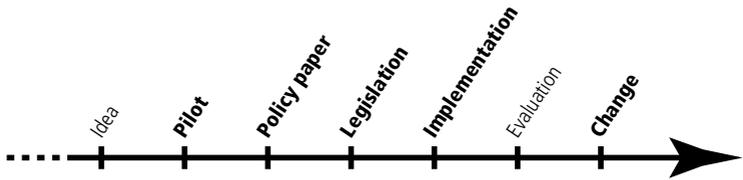
Denmark:
Support for self-
management

primary care. For this purpose, the National Board of Health has drafted a strategy paper which is still in its early stages. The key principles of the policy are initiatives to support self-management by the patient and strengthen the central role played by general practitioners (see the report on Denmark, p. 40).

Singapore: Disease management programs expanded

In Singapore, the coordination of care for patients with chronic conditions is to be extended. The government has expanded the range of the existing structures of care programs. Now, chronic asthma sufferers and those with chronic obstructive pulmonary disease can also register for these programs. It is hoped that patients with chronic conditions will in future be more likely to consult a general practitioner than turn directly to a specialist or a hospital outpatient department (see the report on Singapore, p. 43).

Denmark: Importing the Chronic Care Model



In Denmark, the Chronic Care Model is to be adopted to improve care for patients with chronic conditions. The National Board of Health has drafted a strategy paper to this effect. The initiative is still in the early stages of implementation but experts expect it to have a major impact on the nature of health care in the long term.

Patient-centered care, Kaiser Permanente as a model

The Chronic Care Model (CCM) provides a basis for restructuring clinical care and aligning it more closely to the needs of patients with chronic conditions within the primary care system (also see p. 39). The fact that CCM has been greeted with widespread support in Denmark and elsewhere is due to its systemic holistic approach which places individual patients at the center of activity and optimizes the management of care. Furthermore, it is a model which has already been implemented and of which first-hand experience can therefore be gained. For example, Kaiser Permanente, a managed care organization in California, has success-

fully been implementing CCM for years. In recent years, about 130 representatives from Danish healthcare institutions have visited Kaiser Permanente, among them the Minister of Health, members of parliament, politicians from the regional and local level, groups of health professionals and administrators. This has had a considerable influence on mindsets and policy developments within the Danish public healthcare sector.

Inspired by the visits to Kaiser Permanente, Danish policy-makers drafted a strategy paper accordingly. The cornerstones of this policy are as follows:

**Comprehensive
strategy paper**

- Emphasis should be given to establishing programs which support self-management by the patient. Currently, this is taken to mean systematic patient education and additional rehabilitation initiatives.
- The healthcare system should be adapted to support the provision of a continuum of services delivered to people living with chronic conditions, whereby primary care is to play a key role.
- Greater use must be made of available decision support tools such as disease management programs.
- The role of local authorities and municipalities must be strengthened.
- Health information technology should be expanded.

The main challenges faced by this policy initiative lie in the creation of regional coordination units, the formation of interdisciplinary teams and the allocation of a coordinating role to general practitioners. Furthermore, it is still not clear which financial and nonfinancial incentives could facilitate the process. In addition, case managers are to be assigned to patients who are in need of special support and are not capable of self-management. Patients must therefore be grouped according to needs and the respective diagnosis and medical condition. The patients should then be assigned to a group according to the available evidence and care provided with the support of a disease management program.

In order to promote the implementation of the policy idea, the National Board of Health has introduced a number of incentives. The municipalities, which in Denmark are responsible for social services and prevention, are to receive additional financial incentives for introducing health promotion and preventive services.

**Incentives for
municipalities and
physicians**

General practitioners are to receive a fixed annual payment for treating patients with diabetes type 2. This flat fee covers recording of the diagnosis in question, provision of recommended care and follow-up as described in the disease management program. As an incentive to improve quality, the Board of Health intends to set up clinical databases for the purpose of benchmarking service providers.

Regional and local authorities to participate

Since the regional authorities and municipalities are expected to participate in the scheme, it follows that their representatives must be included in the planning and implementation. The same applies to patients' associations and voluntary workers who may assist in the management of patients with chronic conditions. The underlying objective of the proposal is to improve the quality of health care at a cost-effective level.

Main actors must seek mutual interests

The main impact of this restructuring will be on the health professions in hospitals, general practitioners, and employees working in healthcare centers and in the health departments of municipal councils. Hospital employees are somewhat reluctant to take a stance, since they are uncertain how the policy initiative might affect their daily work. General practitioners in private practice are concerned about the new demands that might be placed on them, especially with reference to documentation duties and quality management. One of the greatest challenges will probably be that their care will have to comply more closely with the recommendations of the disease management programs. Until now, they have enjoyed a high degree of autonomy and professional discretion.

The success of the policy initiative and its implementation now depends on the local and regional authorities and the general practitioners developing mutual interests as a basis for professional collaboration.

Outcome still undecided

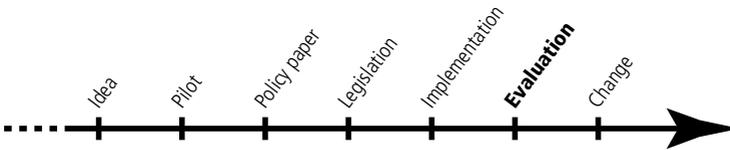
The responsibility for implementing this new healthcare concept resides with the regions, which among other things are responsible for primary care and the remuneration of physicians. The key question is whether all concerned will accept their new roles and carry them out to the extent necessitated by the current prevalence of patients with chronic conditions and the financial constraints involved. Estimates indicate that about 1.5 million Danish citizens out of a total population of approximately 5.5 mil-

lion currently suffer from one or more chronic conditions and it is evident that this prevalence is set to increase further. The chronically ill currently account for about 70 percent of the total cost of the health service. If the quality, patient-centeredness and efficiency of care for the chronically ill at Kaiser Permanente are taken as a yardstick, then the policy initiative could considerably improve the quality of provided care in Denmark.

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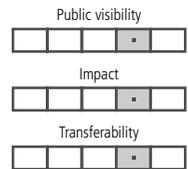
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Singapore: Successful DMP for the chronically ill



In Singapore, the government has incorporated two additional conditions, namely asthma and chronic obstructive pulmonary disease (COPD), into the existing disease management program (DMP). It had been encouraged by the results of the Program following its first year of implementation.

The DMP Program aims to improve the care for patients suffering from common chronic diseases by encouraging early treatment and sustained follow-up according to established disease management protocols. At its launch in January 2007, a financial incentive for both patients and providers was provided through the “Medisave for chronic disease management program”, which basically loosens the restrictions on the use of personal medical savings accounts (Medisave), so that patients with one of four eligible chronic conditions (i.e. diabetes, high cholesterol, high blood



Medisave credits for ambulatory treatment

pressure and stroke) could then withdraw 300 Singapore dollars per year from their Medisave accounts to pay for outpatient treatment (see also *Health Policy Developments* 7/8, p. 66 and p. 109). Previously, these funds had been available only for hospital treatment.

Some 70,500 patients have so far taken part

According to the Ministry of Health, about 70,500 patients have withdrawn approximately 15 million Singapore dollars (about €7.7 million) to pay for ambulatory care in the first year of implementation. In the first phase, about 80 percent of patients suffered from more than one chronic condition. Some two thirds were diabetics and 90 percent were over 50 years old. The patients used about a third of their withdrawals to consult specialists in hospital outpatient departments, about half was spent on treatment in government-run polyclinics, and another 20 percent was used to pay for treatment by GPs.

GPs are nearer

Patients have not only welcomed this new financial freedom, they have also praised the program for quite practical reasons. Patients report that the additional allowances enable them to choose to travel shorter distances to see their neighborhood GP instead of making the journey to a hospital. In many cases, they also felt better cared for by continuing to see a general practitioner because they found that GPs took more time to talk to them. They also found that their overall relationship with their GP had improved.

Chronic conditions more under control

The government carried out further evaluations of the DMP. According to the findings, 19 percent of diabetics had all the required tests done and 27 percent of stroke sufferers had undergone a risk assessment for thromboembolism. About 62 percent of hypertensive patients and 77 percent of those with high cholesterol had had all the necessary check-ups. Some 70 percent of diabetics had their condition more under control. Half of diabetics with lipid disorders achieved an ideal cholesterol level. The Ministry of Health has welcomed these findings as a vindication of its policy and expects to see further improvements over time. Since April 2008, it has added asthma and chronic obstructive pulmonary disease to the list of eligible conditions which can be treated through this disease management program.

Apart from encouraging early treatment while reducing the financial burden of patients with chronic conditions, a longer term,

secondary objective is to encourage the shifting of such treatment from hospital-based specialists to general practitioners (GPs) working within the primary care sector. It does this by offering GPs who participate in the DMP additional training designed to upgrade their knowledge and increase their expertise and capability in the treatment of chronic illnesses. It also publicizes this fact in the hope that patients will change their perception of GPs as “only good for coughs and colds” and increasingly turn to them for continuing care of chronic conditions. Participating clinics are identified by a prominent display sticker and also listed on the Ministry of Health website. General practitioners have welcomed the intensive training they receive in caring for chronically ill patients. They acknowledge that not all GPs really know how to properly perform certain common tests such as eye and foot check-ups for diabetes patients.

Special training in caring for the chronically ill

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Appropriateness, Fairness and Transparency

How can the benefits of medicine be assessed with a view to ensuring that available resources are allocated appropriately and on the basis of sound information? How can suitable analytic procedures be developed that are both transparent and comprehensible to all concerned? Appropriateness, fairness and transparency form the central focus of the health policy reforms described in this chapter.

The World Health Organization (WHO) defines appropriateness in health care according to three characteristics: an intervention must be effective, it must be efficient in the sense of cost-effectiveness and finally it must be based on ethical principles (WHO 2000). Appropriateness therefore clearly signifies more than mere efficacy. A further prime consideration is the benefit for the individual and for the community.

Health policy makers in all industrial countries increasingly need to address the issue of appropriateness. They are the ones responsible for the budgeting of healthcare services and medical advances. How can health care be distributed fairly in the face of ever more chronic illnesses, an aging population and the continuous development of innovative forms of treatment and care? The policy makers have to determine and agree upon which medicines, treatments and interventions are to be financed through health insurance or tax funds and which are not.

In evaluating medical products and treatments, many countries observe the principles of Health Technology Assessment (HTA). The process was first introduced in 1975 by the Office of Technology Assessment (OTA) in the United States. Nowadays, HTA reports are regarded around the world as one forum for for the faster transfer of knowledge—next to the publication of scien-

Appropriateness: effective, efficient, ethical

Budgeting for progress

HTA reports speed up the transfer of knowledge

tific studies, clinical guidelines and information for patients. If a country sees fit to have its medical procedures and technologies systematically analyzed with regard to the provision of health care for its population, it must first establish suitable structures and then train its staff in HTA methods.

In Slovenia, HTA is being used to control costs, ...

In this chapter, we report on newcomers as well as old stagers in the field of HTA. Slovenia has been under considerable financial pressure for many years and has set its sights on regulating expenditure on pharmaceuticals. In spring 2008, a commission was set up to establish the principles of cost-benefit analysis. In this endeavor, the country is receiving the support of EUnetHTA, the European network for HTA (see the report from Slovenia, p. 51).

Poland is striving for greater transparency ...

Poland presents a further example of the importance of information exchange and assistance from abroad (see the report from Poland, p. 53). Establishing HTA, and in particular attaining transparency in pricing policy, is proving to be a major challenge in this country. In a Franco-Polish partnership project, partly funded by the European Union, officials are receiving advice on the compilation of HTA reports, while members of staff are being trained in the use and evaluation of HTA information.

... and Australia for cost control

In Australia, a pioneer of HTA, there has also been a new development (see the report from Australia, p. 56). A local health authority in the federal state of New South Wales has developed an HTA initiative in accordance with a central directive, the first such initiative to examine cost-effectiveness at local level.

MUMM: Increasing equity in service provision in Finland

The Finnish health service, characterized by a highly decentralized structure, also faces difficulties when it comes to the nationwide implementation of HTA decisions. There have been considerable differences among the hospital districts as regards which treatments were included in the benefit basket and which were not. Finland is therefore introducing a procedure to be known as MUMM, or Managed Uptake of Medical Methods, to evaluate the cost-effectiveness of new methods of treatment (see the report from Finland, p. 60). MUMM will make recommendations at national level and is supposed to ensure that assessment methods everywhere are based on the same standards.

Informed patients take control

Apart from questions of cost and effectiveness of the technology in general, appropriateness in health care is really about the

individual patient: patients' needs, desires and experiences are increasingly gaining attention. More and more countries try to increase user competence—the ability of patients to express wishes, needs and expectations, to obtain information, to choose and to decide—to put patients in a position to make informed decisions regarding their health care.

This can be the conscious decision for or against a treatment. In Australia, the federal state of New South Wales is attempting to curb the number of unnecessary cesarean sections by means of a new public information policy. It is mainly patients with private supplementary health insurance who tend to opt for this operation even in the absence of sound medical grounds for the intervention. It not only a matter of patient safety but also a financial issue, since a cesarean section costs almost twice as much as a normal delivery (see the report from Australia, p. 63).

Australia:
Informing about the risks of cesarean sections

Not only medical products and treatments have to face the test for cost-effectiveness. Increasingly, providers are supposed to prove their efficiency. In Denmark, efforts are continuing to introduce performance measurement procedures. A corresponding initiative was launched as early as three years ago. Now specialist hospitals and even individual hospital departments are to have their productivity assessed (see the report from Denmark, p. 61).

Denmark:
Transparent hospital performance

When it comes to choosing a provider, patients are also increasingly making their own decisions. Data on quality and performance is not only being collected for the purposes of benchmarking service providers against one other but is being made available to the public. Examples of this are an Internet database on hospital infections in France (*Health Policy Developments 7/8*, p. 115) and Internet portals designed to enable patients to access quality-related data when searching for a suitable hospital or service provider. In Germany, the Internet platform “Weisse Liste” (www.weisse-liste.de), launched in June 2008 by the Bertelsmann Foundation, provides users with transparent and comprehensible information on the quality of hospitals. Similar platforms exist in Denmark (Møller Pedersen 2006), Great Britain (www.nhs.uk/England/Choice) and the Netherlands (www.kiesbeter.nl).

A quality-orientated information culture

In the Netherlands, not only performance data of hospitals are being published on the Internet, but also user experiences with different health insurers and long-term care institutions. This is

The Netherlands:
User experiences on the Web

intended to stimulate managed competition and improve the quality of service in the long term. This type of information policy is innovative in that it actively engages patients and members of health plans in the development process. The process is due to be evaluated in 2009 (see the report from the Netherlands, p. 10).

**IT for appropriate
use of pharma-
ceuticals**

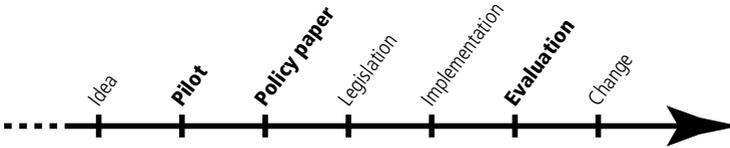
Even with patients increasingly acting as informed consumers in the healthcare sector, a certain amount of control is still needed to ascertain appropriate care. Healthcare policy makers in South Korea and France are trying to use information technology to monitor the use of pharmaceuticals more closely and thereby to ensure greater safety for patients. The Ministry of Health and Welfare in South Korea has ordered a database to be set up for use by physicians and pharmacists (see the report from South Korea, p. 13). In France, a similar task has been entrusted to the pharmaceutical association. Pharmaceutical files designed to identify iatrogenic risks from prescriptions are currently being tested in eight French departments (see the report from France, p. 15).

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Slovenia: First steps towards Health Technology Assessment

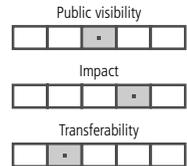


In early 2008, the Ministry of Health in Slovenia took several decisions aimed at firmly anchoring Health Technology Assessment (HTA) in the health system. The government hopes that a systematic evaluation of medical procedures and technologies can be used to bring rising healthcare expenditure under control and to safeguard or even improve the efficiency of medical treatments.

As far back as the early 1990s, the country had found itself under pressure from high expenditure on health care. Following independence in 1992, the health service, which under Tito had been funded by taxes, reverted to the original health insurance system introduced in 1888 on the lines of the German model set up by Bismarck, albeit with additional voluntary insurance elements. Today, Slovenia faces problems similar to those of other EU states in that members of health insurance schemes and patients are calling for new types of treatment, innovative drugs and new technologies while the budget is inadequate to provide the range of healthcare services sought after.

Just over two million people live in Slovenia. The proportion of GDP spent on health care has been increasing steadily since the beginning of the 1990s and amounted to 8.7 percent in 2004, the year in which Slovenia became a member of the European Union. In 2006, Slovenia joined EUnetHTA (European network for HTA). The network's aim is to assist those responsible for introducing HTA in the member states and this support includes facilitating cooperation between EU states. The network was initially set up for three years and, apart from the EU states, its members also include Norway, Iceland and Switzerland as well as four further states outside Europe, namely the United States, Canada, Australia and Israel.

Meanwhile, a number of shortcomings in terms of medical equipment, particularly in the fields of diagnostics and therapy, have become apparent. The government's aim is now to develop



1992 return to Bismarck-style health insurance

Support from EUnetHTA

EUnetHTA tool proves its worth

an HTA agency in order to prepare the groundwork for the evaluation of new medical treatments and technologies. These tasks have previously only been carried out by stakeholders from the private and public sectors. Now the Ministry of Health has decided to adopt the instruments developed by EUnetHTA for use in handling future proposals for new diagnostic techniques, treatments, procedures and therapies. With the aid of this procedure, applications for new diagnostic techniques and therapies can be submitted to the Health Council in standardized form.

The Health Council is the highest advisory body within the Ministry of Health. It is responsible for deciding which services are to be paid for out of public funds. Adopting the EUnetHTA tool has considerably speeded up the introduction of HTA in Slovenia. The tool has therefore proved its worth. The goal is now to implement HTA throughout all levels of the healthcare system.

**Cost-benefit
analysis of
pharmaceuticals**

One of the most pressing problems in the country's healthcare system is the matter of paying for pharmaceuticals. In the past, the government has made several attempts to regulate expenditure on drugs through the prescription of alternative preparations and generic drugs. In the end, however, these political initiatives have only resulted in provoking heated public debate. In April 2008, a commission was set up to establish the principles of cost-benefit analysis applicable to pharmaceuticals. The Ministry of Health charged the commission with drawing up pharmacoeconomic guidelines in accordance with EU requirements. With this new commission in place, the government is now well on the way to achieving its goal of creating more transparency in the pricing of pharmaceuticals.

**State institution
required**

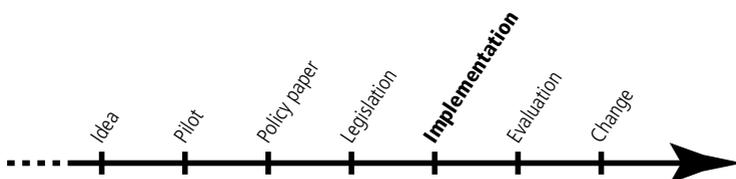
The developments described clearly indicate that the government is increasingly taking charge of the healthcare system in Slovenia. Until now, initiatives to introduce HTA into the country have been based largely on vested interests, often on the part of pharmaceutical companies. Although this is completely legitimate, it has nevertheless become increasingly apparent that a state institution is necessary to carry out the work in line with international standards. This may materialize soon as a result of parliamentary elections in September 2008. The new government of Prime Minister Borut Pahor promises to institutionalize HTA, possibly within the Health Insurance Institute of Slovenia.

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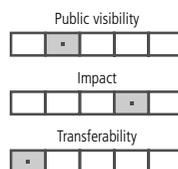
Poland: Major challenge for Health Technology Assessment



Poland is still struggling to establish Health Technology Assessment as a permanent fixture within its healthcare system. The state HTA agency AHTAPol was founded in 2005 and has since had to face numerous challenges (see *Health Policy Developments 6*, p. 24–26).

The current situation is that the agency's funding has so far been too meager to overcome all these obstacles. In particular, the procedure for laying down the prices of pharmaceuticals has attracted considerable criticism in recent years. However, a project entitled Transparency of the National Health System Drug Reimbursement Decisions, which was completed in spring 2008, specifically aims to resolve these issues.

After the reorganization of the market in the early 1990s, the Ministry of Health came under tremendous pressure from the pharmaceutical industry, which wanted to see its products on the reimbursement list. As a result, the Ministry of Health resolved to strengthen the HTA agency and decided to bring foreign experts into Poland. In October 2006, representatives of the government signed a partnership project with France that was cofinanced by the EU. Together with experts from France and a further five



**Making decisions
more transparent**

**Talks about an EU
partnership project**

EU states (Austria, Germany, Latvia, the Netherlands and Great Britain), representatives from the Polish Ministry of Health and from AHTAPol set about laying the groundwork for the short-term implementation of HTA. The main aim was to ensure that the measures developed in Poland comply with EU directive 89/105/EEC. The directive lays down the rules of transparency to be applied by EU member states in deciding on the reimbursement of pharmaceuticals.

France is providing advice and training

The Franco-Polish partnership project had two central components. The first was to provide advice to those responsible for legislation, organization and process quality, and the second was to train staff in national and regional health facilities in matters of evidence-based medicine and HTA. Approximately 30 employees were trained to produce HTA reports themselves and another 300 employees were taught to analyze and utilize HTA information in their work.

Political tension over HTA

Establishing HTA in Poland has taken place in an atmosphere of considerable social tension. The government is under tremendous pressure to make the pricing of pharmaceuticals transparent. In this process, it is being backed mainly by The National Health Insurance Fund hoping to reduce future expenditure. By contrast, service providers are forever trying to undermine the sought-after transparency, since the industry sees the initiative as an assault on its economic interests. Finally, media reports about corruption in the health service are unsettling consumers and patients alike.

Project enhances self-regulation in the marketplace

Given this state of tension, experts consider the transparency project to be successful for two reasons. Firstly, the adopted policy of making pharmaceutical price regulation more transparent has been taken a stage further. The true test will follow when the process is implemented, since this could give rise to renewed pressure from the pharmaceutical industry. The Ministry of Health has already announced plans to introduce a regulatory and monitoring system to place the activities of the various stakeholders under particular scrutiny. The transparency achieved could cause those drug manufacturers who support the decisions to drive opponents of the new assessment practice out of the industry. The project therefore also encourages self-regulation in the marketplace.

Secondly, Poland has great hopes for staff members who are now better trained in administering HTA measures. They are now able to make the necessary decisions in the interests of the general public. The benefits to the public from greater accountability, more transparency and a more comprehensible system of making approval and pricing decisions would still appear to be largely unappreciated in Poland.

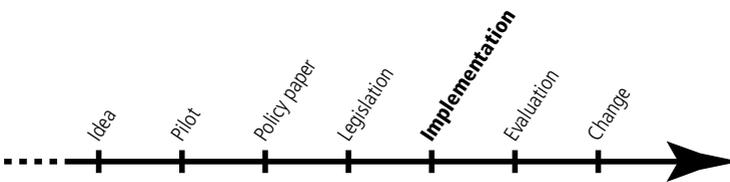
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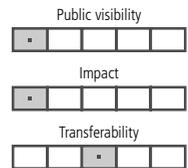
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Australia: Health Technology Assessment at local level



In Australia, a local health authority in the federal state of New South Wales has now developed a procedure to facilitate the implementation of Health Technology Assessment (HTA) at the local level. The aim is to make it easier to decide whether new treatments should be introduced or inefficient technologies abolished. The core criteria for this process are effectiveness, safety and efficiency, i.e., cost-effectiveness. A further aim is to ascertain the amount of organizational effort required to introduce the new technology.



HTA formally integrated at national level ...	Australia was one of the first countries to formally integrate HTA into the decision-making process at the national level. Nevertheless, attempts at implementing HTA still remain fragmented and appear uncoordinated. Both the individual federal states and the Australian central government have responded by setting up new institutions and committees to facilitate the assessment of a broader range of procedures.
... but adapted to local requirements	As far back as 2003, the New South Wales Department of Health issued a general directive on the introduction of new medical interventions. The directive is designed to standardize the concepts of HTA for all Area Health Services (AHS). The core aim is for the AHS to set up processes to help select those interventions and methods that have been proven to be effective, safe and efficient and that can also be financed within the budget. However, the general directive is intended only as a guideline and is therefore not binding on the individual AHS. On the contrary, the document emphasizes that each region should adapt the prescribed measures in the light of local requirements and contexts.
AHS in charge of health care in public hospitals	In federal states such as New South Wales, the Area Health Services are responsible for providing medical care for their inhabitants. For this, the state government provides funds at a previously agreed level and ensures that the budget is adhered to. If new medical procedures are adopted, then these normally have to be financed out of the funds already available to the AHS. This practice is a constant source of financial constraint and underlines the need to set priorities at the local level.
Local health authority develops own HTA program	NSCCAHS (Northern Sydney Central Coast Area Health Service), a local health authority in New South Wales (NSW), has now developed its own HTA procedure in accordance with the general directive. The core criteria of the assessment procedure are effectiveness, safety and efficiency, together with the impact on personnel, the need for training, the size of the patient group and the additional service involved. HTA is applied to all new medical procedures, programs, medical devices, appliances and equipment. Only pharmaceuticals are excluded since these are already covered by existing decision-making strategies at the local level.
Local HTA committee	The HTA initiative was implemented in 2006 when the AHS founded the NSCCAHS Health Technology Assessment Commit-

tee to evaluate medical procedures, chaired by an independent person with a background in health economics. In the first 15 months after the committee was founded, 14 applications were received. Of these, nine were approved with reservations, two are still pending, one was withdrawn after the preliminary hearing on the grounds of insufficient documentation and two were rejected.

The process starts when a health facility submits a proposal. The facility itself provides the basic information on the nature of the procedure and the expected benefits. The local HTA team then examines the proposal. If relevant HTAs from other establishments already exist, these are included in the decision-making process; otherwise research literature is consulted. The committee then calls for further information concerning target population, organizations and patients in order to ascertain the safety, effectiveness and efficiency of the treatment should it be adopted locally. The next step is for the assessment to be presented to the local HTA committee, which then issues a recommendation for the executive of the local health authority. If the new procedure is adopted, it must be financed from the funds already available to the local AHS.

In this way, the NSCCAHS aims to ensure that funds are used only for technologies and procedures that actually lead to a qualitative improvement in care. The HTA procedure is also designed to ensure that the decision-making processes are fair, just and transparent and to prevent any individual sectors or healthcare providers from receiving preferential treatment.

The explicit adoption of cost-effectiveness as a criterion at the local level is a genuine innovation. The local initiative could even have an effect on the approach taken by the local health authority, assuming that service providers take advantage of the assessment procedure described above and abide by the recommendations given.

The development and implementation of the NSCCAHS HTA initiative did not receive coverage in the media or attention from the public. In interviews, conducted as part of a base case evaluation, officials from the regional authorities criticized the decision-making process as unsatisfactory. They complained that cost issues and the effects on the budget had been seen as the ultimate deciding factors.

Results of other studies combined with local data

Cost-effectiveness as a criterion at local level

Critics demand more say for stakeholders

Stakeholders were keen for as many participants as possible to be involved in the new initiative and for full details of new procedures to be disclosed in order to keep health service employees informed. The interviews also showed that those involved are fully prepared to accept changes, provided that new strategies address the needs of hospital physicians and require a minimum of administrative effort.

**The districts still
need to prove
themselves**

One of the key aspects of the initiative is that it aims not only to assess the safety and effectiveness of a technology but also to determine whether it is appropriate to roll out a new procedure in the health district concerned. For example, it is necessary to determine whether employees have received sufficient training. These questions must be answered in order to ascertain whether the local Area Health Service is actually in a position to implement a new application. A further aspect of the assessment process is that it takes cost-effectiveness into account, while the initiative can also extend the scope of local decision-making to include not only cost factors but also benefits.

Although there is much that can be achieved by a strategy such as this, there remain two main risk factors that could stand in the way of its success. For one thing, it is not clear to what extent the participants will accept the process and its results and for another, the districts still need to prove that they can perform high-quality assessment procedures efficiently and in a cost-effective manner.

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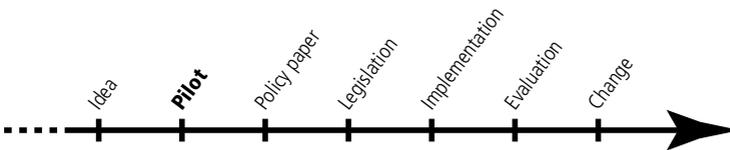
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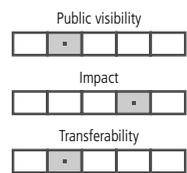
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Finland: More cooperation to assess new medical methods



How can treatment methods be assessed quickly and effectively? And which approach is the right one locally? Finland's answer to these questions is a new procedure based on cooperation between national and local actors. Working together with FinOHTA, the Finnish Office for Health Technology Assessment, the representatives of the 20 hospital districts are developing a systematic process called Managed Uptake of Medical Methods (MUMM) to investigate and introduce new medical treatments in secondary care. Hospital physicians are responsible for producing systematic reviews, on which officials in hospitals and municipalities can base their decisions. Launched in September 2005, MUMM is primarily intended to improve the management process when adopting new methods and was not specifically set up to limit expenditure in the health service.

The Finnish health service is characterized by its highly decentralized structure. Officials in the more than 400 towns and municipalities decide which health services their inhabitants can access. Besides providing primary medical care, prevention, rehabilitation and dental treatment within its borders, each municipality is a member of one of the 20 hospital districts, which in turn are responsible for the provision and coordination of specialist medical care (secondary care) in their catchment areas.



Decentralized health service structure

The national government prescribes the legislative framework for the health system. A number of institutions are directly subordinate to the government, and they in turn monitor the implementation of the guidelines and the quality of care. One of these institutions is STAKES, the National Research and Development Center for Welfare and Health. The Finnish Office for Health Technology Assessment (FinOHTA) is an agency which comes under the auspices of STAKES.

FinOHTA has been assessing treatments and therapies in the health service since 1995. However, so far there has been no standardized process to enable officials at the national level to coordinate and regulate the various assessment procedures for the adoption of new treatments in the municipalities and health districts. Consequently, there have been considerable differences among the hospital districts as regards which treatments were included in the benefit basket and which were not. This structural problem of the decentralized Finnish healthcare system is now to be tackled by FinOHTA working together with officials from the hospital districts. MUMM's goal is to develop a system and structure for the uptake of new treatment methods, in particular with regard to secondary care. MUMM will then be in a position to make recommendations at the national level. In addition, this process should ensure that assessment methods everywhere are based on the same standards.

MUMM is structured in such a way that the hospital districts first of all produce joint systematic reviews and then make a suitable recommendation at the national level. This process is coordinated by a full-time employee at FinOHTA. The reviews are written by different groups consisting of one or two assessment experts and one to three clinical specialists. As part of the system, each hospital nominates representatives to work on the MUMM committee for a period of three years. The committee is always chaired by the medical director of a university teaching hospital.

The main forum for this cooperation is a half-yearly meeting of the members of the MUMM team. Here the results of the reviews are discussed and joint recommendations drafted. The reviews are published in the Finnish Medical Journal and on the FinOHTA Website. This preliminary work then forms a basis for hospital representatives and local health authority officials to adopt

**Districts with
different health
baskets**

**Half-yearly forum
for the exchange
of views**

new methods of treatment in their catchment areas. MUMM therefore helps hospital administrators to make more careful evaluations before they propose new procedures for addition to the health basket. And furthermore, the process makes the expertise of hospital physicians available to the entire health service.

The collaboration changes the decision-making culture in Finland significantly. Hospital administrators had previously opted for new procedures on the basis of their own criteria. Isolated critics of MUMM now fear increased bureaucracy. Others see the need for a reliable and standardized procedure.

Since 2000, there have been repeated discussions about how new medical procedures could be assessed and introduced in a standardized and coordinated manner. Hospital directors and medical superintendents, especially in university teaching hospitals, have joined in the debate. It seems that there has been a widespread tendency in the health sector to assert the right to use new technologies, even if no genuine innovation was involved.

MUMM enables the uptake of new methods of treatment or forms of therapy to be more closely monitored and made more systematic. Above all, greater importance is being attached to the aspect of patient safety. In future, there is an increasing likelihood of such decisions being made centrally, resulting in a greater consistency of the quality of care in all regions. (Similar initiatives have been documented in Sweden, Denmark and Spain.) The first step is now to develop procedures for the uptake of new treatments and new technologies for secondary health care. These structures can then be extended to primary care at a later stage.

In the government's program for 2007, the Ministry of Health resolved to make more use of the findings of evidence-based medicine (see Vuorenkoski, 2007). The aim is to ensure that the methods applied are effective, sustainable and safe. At the national level, this entails breaking new ground in order to issue joint recommendations. The result is expected to be an improved and fairer allocation of resources and a much more measured uptake of new medical procedures.

Not every new development is a genuine innovation

New initiative to issue joint recommendations

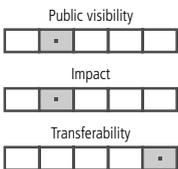
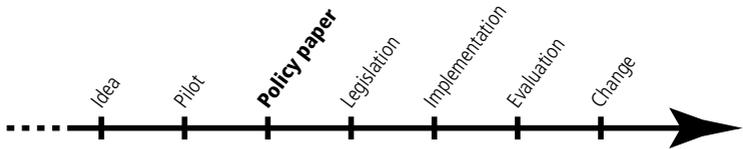
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Australia: More information to reduce number of cesareans



In Australia, the federal state of New South Wales (NSW) is attempting to curb the number of unnecessary cesarean sections by means of a new public information policy. It is mainly patients with private supplementary health insurance who tend to opt for this operation even in the absence of sound medical grounds for the intervention. At present, one in three of all births in Australia is performed by cesarean section.

Number of cesareans on the increase

There has been a marked increase in the number of cesareans in recent years, rising from 19.5 percent in 1995 to 30.3 percent in 2005. In 2005, cesareans accounted for approximately 28 percent of all births in New South Wales, whereas four years previously this figure had been 23.6 percent. NSW is Australia’s most populated state. Approximately one third of the 20 million Australians live in this region on the southeast coast of Australia and in its capital, Sydney.

Now pregnant women in New South Wales are to receive comprehensive information about the risks and consequences of cesareans. Above all, the information campaign will point out that even cesareans which are indicated on medical grounds should not be carried out before the 39th week of pregnancy unless this is absolutely unavoidable.

Surveys carried out among physicians revealed that many women wanted a cesarean for personal reasons. The phenomenon is so widespread that a new term has been coined to describe those prospective parents who consciously choose to give birth by cesarean section, namely “too posh to push.”

Is the cesarean a fashion statement among the upper classes? Figures released by the health insurance industry seem to support this assertion. Australia’s insurance statistics provide further evidence that cesareans are much more common among mothers with supplementary private health insurance than they are among those covered only by the state Medicare scheme. There were, however, other views expressed by observers. Health experts suspected that expectant mothers might have been persuaded to have a cesarean. They questioned whether relatives, family members or interest groups such as hospitals or physicians had granted mothers-to-be sufficient freedom to make the decision for themselves.

Up until now, cesareans have been regarded as a safe intervention with few risks for mother and child. However, a glance at the data reveals that this is not the case. An epidemiological study in the United States that looked at 5 million births shows that infant mortality for cesarean sections is 2.9 times higher than for vaginal deliveries (1.77 deaths per 1,000 live births). It is important to note that while the study controlled women’s initial risk, it did not control for complications that may arise during labor leading to a cesarean section. This means that the initiative taken by the Australian politicians is also a response to the growing number of babies placed in intensive care after a cesarean. Particularly intensive medical care is required in the case of preterm cesarean sections. The insistence on waiting until the 39th week of pregnancy before performing medically indicated cesareans is based on this epidemiological data and is intended to reduce the health risk to the baby.

Cesareans as an expensive fashion statement ...

... for women with private health insurance

Cesareans entail health risks

After cesareans, mothers and babies have to stay in hospital much longer than after normal births and as a rule they also need extra nursing and medical care. And finally, the period of postnatal care at home lasts many days longer than is necessary after vaginal births.

**Normal births cost
half as much**

An analysis of the Australian data shows that elective cesareans and the potential complications associated with the intervention, when taken together with the increased need for aftercare, are presenting a major challenge to Australia's mainly tax-funded health service. The cost of a cesarean is almost twice that of a vaginal delivery. Elective cesareans can place an enormous burden on a healthcare system that is already under heavy financial pressure. In 2005, the total number of births in Australia was 259,800, about 90,000 of which were in New South Wales. Any further increase in the number of cesareans, even if only by one percent, means more days spent in hospital and the diversion of even more hospital resources.

**Government
information
campaign**

The authorities therefore saw a pressing need to take action to combat the rising number of cesarean births in NSW. An information campaign targeting expectant mothers aims above all to inform women of the risks associated with the procedure. The information provided was collated from evidence-based studies and is intended to help expectant mothers to make an informed choice. Ideally, it should encourage discussion about the benefits and risks of cesarean sections and vaginal births. On the basis of evidence from studies by the Royal Australian and New Zealand College of Obstetricians and Gynecologists, it was also shown that even if a cesarean is indicated, a mother should be able to carry her child until the 39th week of pregnancy without fear of additional risks.

**More monitoring
of timing and
frequency**

The NSW initiative has received a mixed reception from the stakeholders concerned. The Australian College of Midwives and patients' organizations have welcomed the directive. Only individual health experts have conjectured that the directive could fail in its objective if the government does not at the same time look into the financing of maternity care and the nature of the treatment provided. In any case, the directive specifies that the Area Health Services should monitor the timing and frequency of cesareans in NSW. Furthermore, in the case of preterm cesareans

the week of pregnancy is also to be recorded in the annual New South Wales Report, which collates data from all the hospitals in its catchment area.

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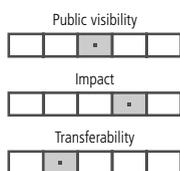
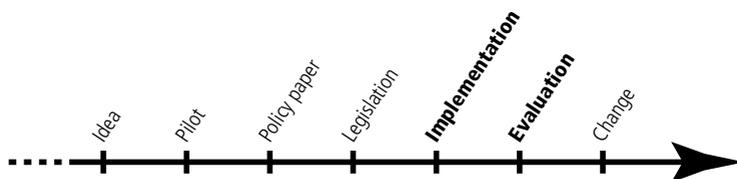
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Denmark: Further development of performance measurement



In December 2007, the Danish Ministry of Health published its third annual report on hospital performance. The government's policy goal is to further refine performance measurement procedures for the health service and to supplement them with further productivity indicators. The previous publications have helped to make policy goals aimed at promoting greater efficiency in the health service more detailed and more ambitious.

Performance data for the various hospitals are now to be collated and extended to include, for instance, labor productivity and psychiatric care. There are further plans to develop Web-based solutions for performance management which makes it easy and simple for citizens, physicians and hospital owners, among others, to follow developments in productivity.

Hospital departments under scrutiny

Since the previous report on performance measurement (see *Health Policy Monitor* 6, p. 30–31), the Ministry of Health has published further systematic analyses of hospital performance at the national, regional, county and hospital level. These publications are the result of negotiations between central government and the regions on the precise nature of the data to be included. A working group consisting of representatives from central health authorities (Danish Ministry of Finance, Danish Ministry of Health and the National Board of Health) and hospital owners has now been set up. According to the political agenda, its meetings have played a decisive part in ensuring that the reports contain more detailed data on productivity.

Productivity being measured

Data for the years 2003 and 2004 first became available in 2005 on productivity at national, regional and county levels. In 2006 and 2007, the performance indicators for individual hospitals were also published for the first time. Furthermore, the government and the regions agreed in 2007 to supplement the reports with selected productivity indicators and parameters for individ-

ual hospital departments. In addition, the report for 2007 will reveal how the regions and hospitals themselves have utilized the productivity measurements. In 2008, the working group plans to continue to develop the measurements at both hospital and hospital department levels.

The reports show that performance rose by 1.9 percent at the national level between 2005 and 2006. The result therefore exceeds the target of 1.5 percent that the government and the regions had agreed upon. In the regions, significant variations in productivity were recorded, with the range extending from 1.4 to 2.7 percent. A central problem at the local level is that different approaches have been used to enter the data on costs and inpatient treatment within the DRG (Diagnosis Related Group) system.

A study into the quality of the data entered in the county of North Jutland also came to the conclusion that additional training is needed at various levels. In 37 percent of the cases, registrations were found insufficient or incorrect. The experts recommended that physicians and their assistants receive ongoing training in the use of the DRG system to ensure that diagnoses, treatments and patient progress are entered correctly. At the national level, they also called for more precise recommendations to ensure unambiguous data capture for secondary care. The conclusion reached by the authors of the study therefore indicates that the recorded variations in productivity could also be due to the lack of standardization in entering the data.

Nevertheless, the government has used the previously published reports as a basis for setting general productivity targets for all hospitals. Some regions have even set different targets for individual hospitals on the basis of the data. Basically, all participants accept that performance measurements are necessary. The government and the regions therefore intend to extend the system even further.

In future, comparable productivity measurements for both hospitals and individual hospital departments will continue to be published. The Ministry of Health and Welfare aims to focus more on the efficiency and cost-effectiveness of treatments in the Danish health sector. According to the Minister of Health, this is a necessary step in light of the shortage of physicians, the increasing number of elderly patients, more highly skilled physicians,

**Regional variations
in performance**

**Was DRG data
entered
incorrectly?**

**Comparisons based
on productivity
measures**

new treatments and limited budgets. Greater efficiency also means that additional funds can be released to treat patients.

The chairman of the Danish regions has stated that the regions intend to publish benchmark examples of high productivity and possibly to reward hospitals for their efficiency. He claims that it currently takes too long for examples of good practice to become more widely known.

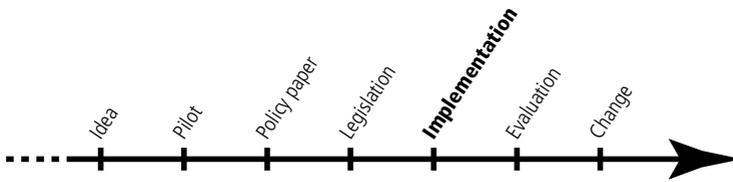
**Further
refinements
expected**

In its reports from 2005–2007, the working group itself had repeatedly called for performance measurements to be standardized at the national, regional and county level, and for each individual hospital as well. The working group would like to introduce further refinements to the system of data collection. It even plans to develop new productivity measurements below the department level. In the coming years, performance measurement techniques are expected to be increasingly used by government, regions and hospital management to improve efficiency, and contain costs. The effect this will have on quality is uncertain. After all, performance measurement puts considerable pressure on service providers. It could in fact give rise to false incentives and thereby fail in its objective of becoming a useful instrument applicable to all hospital activities.

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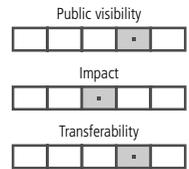
Netherlands: User-based information on health care



The Netherlands is seeking to further stimulate managed competition in the healthcare system. For a system of managed competition to work, transparent information on the performance of both health insurers and service providers is necessary. As a first step, since November 2005 experiences of patients and the insured with different health insurers have been systematically collected and published on a Website (www.kiesbeter.nl). Today, other patient experience data available on Kiesbeter relate to nursing homes and homes for the elderly, home care organizations and organizations for people with handicaps. Furthermore, public performance information relating to hospitals in the Netherlands is provided, based on indicators developed by the Health Care Inspectorate (Inspectie voor de Gezondheidszorg—IGZ). Kiesbeter is supposed to support patients in making decisions for or against medical service providers on the basis of sound information.

The disclosure of performance information is regulated by the Law on Managed Competition (Wet marktwerking gezondheidszorg). Article 38, section 4 of this law obligates hospitals and clinics to disclose information on the quality of their services. Article 40, section 1 lays down similar stipulations with regard to the insurers who fund the health service.

Data is collected by means of a standardized questionnaire known as the Consumer Quality Index (CQI). CQI was developed by the Netherlands Institute for Health Services Research (NIVEL) and the Department of Social Medicine of the Academic Medical Center, University of Amsterdam, on the basis of the U.S. survey tool CAHPS and its Dutch equivalent “Quote.” It was originally developed for specific sectors within the health service such as nursing homes and homes for the elderly, but also for hospitals and specific services such as cataract surgery. The Centre for Consumer Experience in Healthcare (Centrum Klantervaring Zorg—



Hospitals and insurers disclose quality data

Consumer Quality Index

CKZ) was founded in December 2006. The main aims of the CKZ are to coordinate the development of the questionnaires, to supervise the measurement of consumer experiences and to guarantee comparable information.

Transparency to stimulate managed competition

Government policy sees the publication of performance information as a central tool for stimulating managed competition. The mechanism is designed to ensure that health insurers compete with each other as they would in a free market. The ultimate goal is for patients to be able to make an informed choice between health plans and health care providers in the expectation that the quality of service will improve as a result of increased competition for customers.

Market gradually adapting

The government is now publicizing the homepage, and its approach is relying on self-regulating forces within the health service. There are no financial incentives for insurers or health care providers to participate in the collection of data or to disclose their own data. Some insurers have opted to publish user experiences, thus placing competitors under pressure to similarly make their data available in the marketplace. As soon as a certain number of providers and health insurers publish their performance data, they will be followed by others who do not want to miss the opportunity of attracting patients or who do not want to be perceived as unwilling to participate.

Consistent continuation of health policy

It is remarkable that this change in information policy has received a broad social consensus. Patient organizations, traditionally a powerful force in the Netherlands, immediately lent their support to the public disclosure of information. The government is therefore continuing on the course it embarked upon with its 2006 reform. At that time, the Ministry of Health had called upon the main actors in the health service to take responsibility for the process of developing and implementing the policy.

The origins of this reform are threefold.

- The Ministry of Health reformed the Dutch health insurance system by setting up a new “Market and Consumers” directorate to stimulate and coordinate such policy initiatives.
- Some proactive insurers identified the need to obtain reliable information for their own portfolios and funded relevant studies to develop reliable and comparable questionnaires for measuring user experiences.

- Umbrella organizations introduced benchmarking projects which likewise collected information on user experiences. Even though this information was not originally intended for public disclosure, public pressure eventually led to this.

It is expected that the public disclosure of performance information will be extended in future. In this sense, the new information policy has successfully been implemented. However, it is much more difficult to say whether all the goals will be reached. This will depend on the extent to which patients and the insured make use of the information disclosed and on whether health insurers and healthcare providers respond accordingly. The unintended effects of disclosing performance information have already been studied and discussed in other countries, such as the United States. Experts use the term “performance paradox” to indicate that quality and cost-effectiveness are dependent on many factors, not solely on the disclosure of data. It is therefore difficult to say what the influence of this policy will be. A first evaluation of the Centre for Consumer Experience in Health Care will take place in 2009.

Will patients actually use the information?

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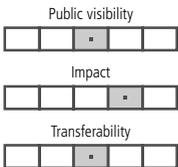
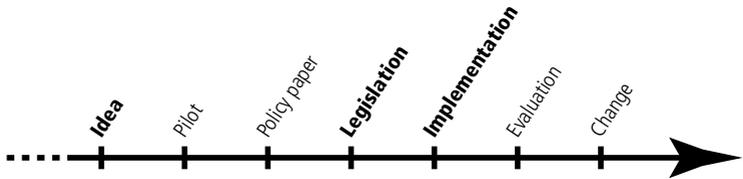
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South Korea: Database for Drug Utilization Review



South Korea has set its sights on combating the inappropriate use of pharmaceuticals. The Ministry of Health and Welfare has therefore required physicians and pharmacists to make use of a database. This procedure is designed to detect prescriptions for drugs that are unsuitable or that should not be combined with other medications. The database will also indicate if any drugs should not be prescribed for those under a certain age. The technology is designed to alert the physician to potential errors at the time of prescription. If the physician nevertheless proceeds to prescribe the drug in question, both the patient and the Health Insurance Review Agency (HIRA) are informed.

List of dangerous combinations

In 2004, the Ministry of Health and Welfare had published a list of drugs that presented a health risk if used together. In addition, the publication contains information about drugs which should not be prescribed under a certain age. Although physicians and pharmacists had researched and developed the publication on behalf of the government, incorrect or unnecessary drugs continue to be prescribed. The health authorities record approximately 20,000 cases of inappropriate prescriptions each year.

By obligating those concerned to utilize the existing database, South Korea is endeavoring to improve on the previous review system. In the past, HIRA had detected inappropriate prescriptions during the process of claim review and reimbursement and subsequently informed the patient. However, this information often came too late, as the patient had long since taken the drugs. The Ministry of Health and Welfare therefore decided to restructure the system so that patients and insurers are informed of inappropriate prescriptions on a real time basis. The Korean Medical Association vehemently rejects the new directive, entitled Drug Utilization Review. It maintains that the policy would unfairly restrict a physician's autonomy in matters of prescriptions. The association is also concerned that the database could be extended to restrict the physicians' freedom to issue prescriptions even further.

Patients to be alerted earlier

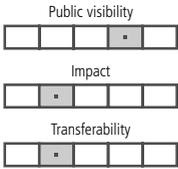
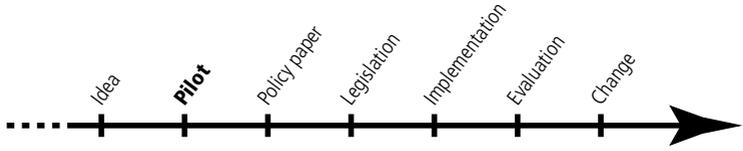
The physicians' strong opposition is receiving little public support, mainly because the new policy is based on scientific evidence and provides information on the side effects of certain combinations of drugs and on drugs intended for specific patient groups. Furthermore, health insurers will in future no longer reimburse physicians who do not use the software. The physicians are therefore expected to relent and conform to the new policy before long. The Ministry of Health and Welfare is actively advertising the benefits of the new policy by issuing a series of patient-oriented publications.

Ministry advertises benefits

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France: Electronic pharmaceutical records for patients



Using pharmaceutical files to monitor consumption

In 2007, the French government authorized the creation of electronic pharmaceutical records for patients. The pharmaceutical association was entrusted with the task of implementing the project. This followed a similar proposal previously made by the association. Only pharmacists are to have access to the patients' electronic pharmaceutical files.

The data contained in the files lists all prescription and non-prescription drugs the patient has bought in the previous four months. When a medication is purchased, the pharmacist can quickly check the pharmaceutical file to establish which tablets, pills, drops, injections or suppositories, if any, the patient has taken in the preceding weeks and months. This enables iatrogenic risks and contraindicated drug combinations to be identified at an early stage, since the unintentional interaction of different medications can trigger adverse reactions in patients. This in turn often necessitates further medical treatment which could have been avoided.

High levels of drug consumption in France

Drug consumption in France is among the highest in the world, irrespective of the field of medicine. When patients take a number of medications at the same time, this may result in an unnecessary consumption of drugs but more importantly, it may present health risks. From a societal point of view, excessive drug consumption is becoming a serious problem. According to estimates, 130,000 hospital admissions amounting to over a million hospital days a year can be attributed to the incorrect or inappropriate consumption of drugs. Reviewing medications not only enhances the quality of care for each individual patient but also contributes to greater efficiency in the deployment of health care funds.

Patients have access to their data

In France, the plan is to set up an individual electronic pharmaceutical file for each insured person, subject to the patient's

consent to their data being collected. The data in the pharmaceutical file identifies the medications, prescribed doses and the date on which each item was dispensed. Neither the prescribing physician nor the drug manufacturer can be identified from the file. Patients can have the file closed at any time or can deny access. They can request a printout of the file's contents, for instance in order to pass the information on to healthcare professionals in the event of hospitalization. The patient can also refuse to allow certain information to be recorded in his or her file. In this case, a comment is added to the file to indicate that the data is incomplete.

The collection of patient data requires the authorization of the central French data protection agency. The digital files are not maintained by either druggists or pharmacists but by suitably qualified IT service providers. Each pharmacist can only record in the file such information as relates to the products purchased from his pharmacy. The pharmaceutical file may only be accessed in the presence of the patient. The patient's electronic health insurance card, together with the pharmacist's professional e-card, serves as an access key.

At present, the project is being tested in eight departments. If the test phase is successful, then pharmaceutical files will be introduced throughout the whole of France. The long-term goal is to integrate the pharmaceutical files into the patients' personal medical records (PMR) (see *Health Policy Monitor* 6, p. 61). At the moment, it is still not clear how patients who refuse to open a pharmaceutical record can be encouraged to participate. So far, there have been no particular financial incentives for them to do so. On the contrary, penalties in the form of reduced reimbursement are currently being discussed as a means of encouraging patients to make use of personal medical records.

The main concern of pharmacists in France is to enhance the role they play within the health service. The pharmaceutical files present them with an opportunity to draw upon their expertise to contribute to the quality of healthcare provision. In the health insurance reform of August 2004, it was announced that a personal medical record (PMR) was to be set up for every insured person. However, this project, which was originally planned to be rolled out in 2007, has not yet been implemented. This will prob-

An additional aid to disease management

So far no incentives to participate

Pharmacists are keen to strengthen their position

ably take several years more due to the conceptual, technical and financial problems involved. Thus, the pharmacists now see the introduction of pharmaceutical files as a simple first step towards its implementation.

At the same time, pharmacists have been under extreme pressure to consolidate and justify their role and task description within the healthcare system ever since it was proposed to open up the market for OTC products. A law promulgated in April 2008 obligates pharmacists to display a list of nonprescription OTC products. However, this also means that customers must have free access to these products and be able to compare the prices of OTC medications, a market which has not yet been regulated.

**Trials under way in
eight departments**

The pilot project for the introduction of pharmaceutical records was launched in May 2007. The technology is currently being tested, as is the acceptance of the system among pharmacists and patients. Pharmacists participating in the trial phase confirm that the technology and the data transfer between pharmacists are working well. Approximately 14 percent of the pharmacists taking part were in six departments. Adapting the technology proved to be a relatively simple matter, since the pharmacists were already using software applications to distribute their goods, for stock control purposes and to transmit their data on prescription drugs to the regulatory authorities.

**Physicians feel
excluded**

Patients expect to derive benefits from pharmacists having access to more information on medications, since this may help to avoid adverse side effects. According to data supplied by the pharmaceutical association, approximately 80 percent of patients in the pilot regions are taking part in the project. Health insurance funds and health facilities are supporting the project not only at the level of legislation but also with funding. They anticipate on the one hand a qualitative improvement in the use of drugs and on the other hand a reduction in expenditure. By contrast, healthcare professionals remain skeptical. They feel excluded from the initiative. The French Medical Council (CNOM) objected to an additional patient file on pharmaceuticals being set up separately from the personal medical record. The Council also demanded that physicians be granted access to the data, but so far they have failed to achieve this objective.

The greatest challenge now is to adequately incorporate the patients' self-medication into the database. In order to record such products, the patient's insurance card would need to be presented, which until now has only been necessary when purchasing prescription drugs. Patients often fail to take the card with them when they purchase nonprescription drugs. Furthermore, medications are often purchased by women acting on behalf of their partners, children and other family members. In such cases, it would hardly be possible to allocate any particular drugs to a specific member of a family.

Not clear how self-medication is to be incorporated

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National Strategies

Health policymakers need objectives as a basis on which to work together with the players concerned to select suitable forms of implementation and to allocate available resources appropriately. An obligation to guarantee an accessible, (qualitatively) appropriate and needs-based system of health care, which not only delivers the necessary services but is also cost-effective (see previous chapter), and to ensure financial security in the event of illness is laid down in the legal codes of the vast majority of countries. The most frequently cited objectives in international literature relate to quality, accessibility, equity, cost containment and cost-effectiveness. In the 1980s, the member states of the World Health Organization (WHO) published a catalog of targets in the document *Health for All*, which on the one hand expressed their commitment to a policy of health promotion extending to many areas of policy, but on the other hand refrained from formulating targets for healthcare systems in a specific sense. Many countries have therefore paid little or no attention to the more narrowly defined healthcare system in their catalogs of health targets (Busse and Wismar 2002). Health targets can, however, provided that they are systematically pursued, result in a shift away from previous health policy, since they are based more on health outcomes (longer life and improved wellbeing) than on structural indicators (e.g., the number of hospital beds or the number of physicians working in the ambulatory sector).

It was not until its *World Health Report 2000* that the WHO looked in depth at health(care) systems and their targets. In this report, three main objectives, together with a number of indicators derived from them, were presented to the general public for debate: (1) attaining a level of good health, (2) responsiveness to

**Health policy
needs targets**

**WHO health
system targets**

the expectations of the population in regard to non-health matters, e.g., reducing waiting times and (3) fairness of financial contribution, i.e., all persons contribute an equivalent percentage of their income to the health system.

Individual strategies ...

All countries have independently pursued different strategies in health policy and its reforms—including decentralization, the introduction or strengthening of the autonomy of service providers (see *Health Policy Developments 1*, p. 25) up to total privatization, patient-centeredness and patient participation (see *Health Policy Developments 3*, p. 16, and *Health Policy Developments 7/8*, p. 119) as well as freedom of choice and competition. However, it is not often clear which of the broad health policy objectives referred to above are pursued through such strategies. Additionally, there is often no empirical evidence by which to determine whether the strategies concerned have attained them.

... if they conflict with each other ...

It must also be remembered that different countries choose very different paths, i.e., both decentralization and (re)centralization may be considered (see *Health Policy Developments 3*, p. 46) and that some countries (such as South Korea) are merging their sickness funds in the interests of improved efficiency and greater social justice, while other countries (such as the Netherlands or Switzerland) are promoting competition between health insurers, which on purpose also involves different levels of contribution. The third aspect is that certain strategies pursued within a given country may even be in conflict with each other. For instance, a consistent process of decentralization such as in Spain can find itself in direct conflict with the goals of cost reduction and social justice.

... do not produce an overall strategy

In the face of catalogs of health targets which partly ignore the health systems and individual strategies pursued uncoordinated side by side and in some cases even in conflict with each other, national governments are increasingly recognizing the need for a truly comprehensive strategy which not only specifies targets, identifies the key players and designates effective and appropriate individual strategies, but also considers both implementation and evaluation. In the following sections, we report on two such comprehensive strategies, one from Slovenia and one from Finland, and two rather less comprehensive strategies on e-health and competition, from Switzerland and the Netherlands respectively.

Slovenia has been without an overall strategy for health policy since 2004. There was no general program, neither for funding, nor for the deployment of human resources, nor for dealing with the consequences of demographic change. Local experts saw the numerous shortcomings as the result of a lack of direction. The introduction of a national health plan for the years 2008–2013 was intended to address a number of issues in a coordinated manner, e.g., by developing the IT infrastructure, human resources planning in secondary care, quality assurance and reorganization of the healthcare infrastructure. The Health Ministry’s bill passed parliament in July 2008. However, a number of points were still matters of debate—most of all the plans to continue privatization of the healthcare sector. A change of government in September 2008 meant the end of the “National health plan 2008–2013.” Experts expect the new government to bring in an alternative proposal in 2009 (Albrecht 2008).

Slovenia: National health plan

Finland intends to strengthen the cooperation between national government, the municipalities, the regions and other stakeholders in the health system. A new health plan has now been developed setting out the overall targets and the measures for implementing them over the next four years. The main focus is on quality of service and equal access to health care. Plans involve changes affecting health professionals, health promotion and prevention, greater integration of primary and secondary care and the development of the IT infrastructure (see the report on Finland, p. 82).

Finland: Four-year plan sets out health policy targets

In Switzerland, a number of cantons have independently been developing and piloting the use of information technology for health care applications. Now, a national e-health strategy is to provide the framework for implementing these techniques nationwide. A current strategy paper released in April 2008 lays down the groundwork for this and consolidates the previous initiatives into the overall concept of a Swiss e-health strategy. A new coordination group based at the Federal Office of Public Health (FOPH) has been set up to overview the implementation of the strategy. The new electronic network is to be developed nationwide by 2015 and is to include electronic patient records and an online health portal (see the report on Switzerland, p. 85).

Switzerland: National e-health strategy

Ever since its last major structural reform of 2006, the Dutch government has been actively pursuing a policy of fostering com-

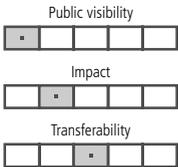
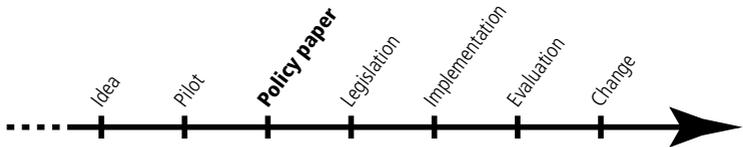
**Netherlands:
Competition in
secondary care**

petition among insurers and service providers as a means of improving quality and providing more efficient care. Competitive-ness is now being increasingly introduced in secondary care through the creation of new specialist treatment centers, which will provide a secondary care structure operating in parallel to hospitals. This is intended to put pressure on hospitals to become more innovative, more efficient and more patient-centered (see the report on the Netherlands, p. 81).

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**Finland:
National Development Program for Welfare and Health Care**



The Finnish government has drawn up a new health plan defining the overall targets of health care policy and the measures to be taken to achieve them over the next four years. The National Development Program for Social Welfare and Health Care (Finnish acronym KASTE) sets out targets and the procedures for regulating cooperation between the government, the municipalities and other key players within the health service.

This program was previously known as the Social Welfare and Health Care Target and Action Plan. Upon its election, every in-

coming government develops such a program for the following four years. In 2007, a parliamentary resolution reformed the structure of these programs with KASTE as the result. The objective of the reform was to further strengthen the steering function of the program, for example by providing direct state funding for local authorities. The state is to allocate € 25 million per annum to local healthcare projects.

The program defines targets and measures

The three main objectives to be pursued by this new development program are (1) to reduce social marginalization and inequity among the population, (2) to enhance general wellbeing and quality of life in all sectors of the populace and (3) to ensure high quality, effective care and accessibility on a nationwide scale. These broadly defined objectives were then broken down into specific areas of action and detailed, quantifiable targets. Alcohol consumption is to be reduced to the level of 2003, the proportion of people of working age with a body mass index (BMI) of over 25 is to be brought down to the level of 1998–2001, the proportion of smokers aged 16–18 years is to be reduced from 22 percent to 17 percent and the mobility and health of elderly people are to be improved. The number of home and leisure-time accidents is to be reduced by 10 percent through preventive and public information measures. In terms of health care, waiting times are to be kept within the limits permitted by law. The shortage of physicians and regional differences in the density of secondary care are also accepted as challenges and are to be combated in the long term.

Objectives: equity, quality of life and high quality care

The development plan also sets out measures to reach these targets, including

Implementation

- Strengthening health promotion structures
- Improving services for children and adolescents
- Securing sufficient human resources for social and health services and further strengthening the competence of personnel
- Improving the professionalism of management in the social and health care sectors
- Empowering patients
- Strengthening primary care and in particular promoting greater integration of primary and secondary care
- Creating a good practice network for disseminating information on new care initiatives

- Further development of information and communications technology
- Further development of national quality guidelines

Municipalities consulted in five regional meetings

The program was prepared by the Advisory Board of Social and Health Care. The board is chaired by the Minister of Health, who also takes on the leadership role. The board also consists of representatives from regional and local authorities, the Ministry of Education and the Ministry of Employment and the Economy. The board is active at three levels, those of state administration, regional level and civil society. In addition, there are five regional steering groups who share responsibility with the board for implementation and follow-up at regional level.

The new KASTE development program is the result of detailed preparation and consultation in which all players were involved. For example, five regional meetings were arranged to allow the municipalities to express themselves in detail.

The individual activities of the program are to be documented and monitored annually. This will enable further measures to be adopted, if deemed necessary.

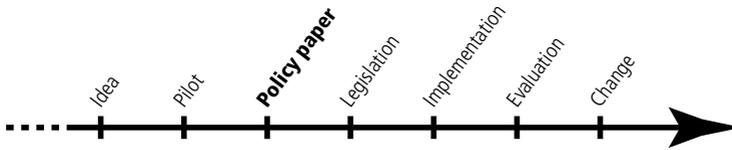
State funding increases chances of success

A key component of the program is the annual contribution by the state of €25 million to fund local development projects. This is in contrast to the previous program and considerably increases the chances of the measures and instruments being implemented and the stated targets actually being reached. The municipalities and regional authorities have a key role to play in implementing the program, but no penalties are foreseen if the program is not implemented as planned.

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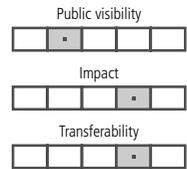
Switzerland: National e-health strategy launched with e-card



Switzerland is set to introduce an electronic insurance card in 2009. Initially, this e-card will contain emergency data, organ donor status and information on drugs taken by the patient and will serve to simplify administrative processes. In the long term, however, the intention is to develop the e-card into a detailed electronic patient record. It is a component of the Swiss e-health strategy adopted in 2007 which is to be implemented nationwide by 2015.

There are two main pillars to the Swiss e-health strategy. Firstly, an electronic patient record, providing all patients with Internet access to their own health records, as held by different providers. This includes data on illnesses and health complaints, care status, check-ups, preventive measures and information about the patient's insurance status. Secondly, a central online information portal is to be set up to make health information from international organizations available to the national government, the cantons and the municipalities. The Swiss vision for 2015 is an ambitious one. Using their e-card as the key to an online information portal, all citizens are to be given permanent access from wherever they are to their personal health data and personalized, quality-assured health information. Electronic prescriptions, tele-diagnostics and teleconsultations will by then become standard practice.

The use of e-health applications will enable all patients to actively manage their treatments and to participate in decisions on matters of therapy. Information technology is to be used to inform patients about how they can help to plan their own therapy, for example by deciding which data is to be stored and which is not. Special training programs are to be set up to ensure that health professionals and patients will be in a position to make full and efficient use of the technology by 2015.



Electronic patient records and online portal

Special training for patients and professionals

Pilot projects in the cantons	<p>The legal framework for the e-health strategy was created by the 2004 Federal Health Insurance Act (FHIA). An initial pilot project to test the application of electronic health care was launched in the canton of Ticino in November 2004. The main players in the health system (physicians, pharmacists, health insurers and patients) had agreed upon a concept and worked closely with partners from industry through a steering committee. In addition to Ticino, the canton of Geneva had also launched its own pilot project. There, an electronic patient record was set up under the name “e-toile” and gradually expanded into an electronic health network. At that time, an overall strategy for introducing telematic applications was already being discussed (see <i>Health Policy Developments</i> 6, p. 56f).</p>
Separate initiatives to be woven into a comprehensive concept	<p>The strategy paper of April 2008 now consolidates the previous initiatives into an overall concept. The Swiss Confederation and the cantons have set up an e-health coordination group at the operative level with a three-member team based at the Federal Office of Public Health (FOPH). The equally new e-health steering committee set up by the national government and the cantons has already allocated subprojects.</p>
Opposition from physicians	<p>The e-health initiative has come in for sharp criticism from some stakeholders within the health service. Speakers for the Swiss hospitals, for example, have expressed the view that what Switzerland really needs is an overall healthcare strategy, rather than a concept aimed specifically to promote e-health. They also regard a coordination office for the cantons and the Confederation as superfluous. The physicians, furthermore, fear that the database may not be adequately protected, for example from the interests of health insurers. They evoke the specter of a “glass patient.” The insurers largely welcome the e-health strategy, but are calling for greater transparency and clarity in terms of how the implementation of the project is to be funded.</p>
Citizens favorable to the notion of e-health	<p>The general public, on the other hand, mostly welcomes the project. From the point of view of Swiss citizens, there is no contradiction between confidentiality and the efficient transfer of data. The majority of a focus group questioned in a survey carried out by the Center for Technology Assessment (TA-SWISS) was in favor of the electronic patient record. The Swiss people regarded greater transparency and access to comprehensive documenta-</p>

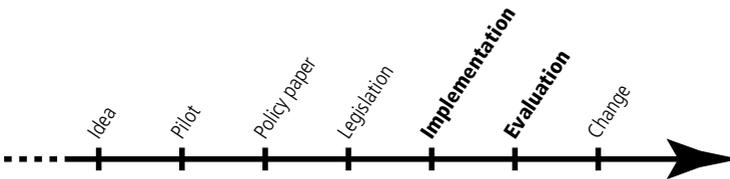
tion of their entire health history as more important than potential cost-savings (Rey 2008).

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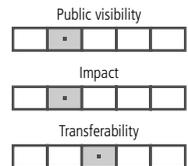
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**Netherlands:
Rise in the number of independent treatment centers**



In the Netherlands, there are now 180 independent specialist treatment centers for ambulatory care (Independent Treatment Centers or ITCs). The number of these has risen rapidly since the year 2000 and now exceeds the number of hospitals by a factor of two. The background to this is a radical shift in healthcare policy in the area of specialist medical care. Even at the time of the 2006 structural reform, it was central to the government's political strategy to strive to contain increases in the cost of health care and promote better quality of care through enhanced competition among health insurers and service providers. Now, greater atten-



tion is also to be paid to fostering competition in the secondary outpatient sector.

**Government seeks
to foster
competition**

Only a few years ago, the government had rather sought to discourage the setting up of ITCs, for example through negative incentives in the remuneration system. The reason given at the time was that the existing capacity for specialist care was already far more than adequate. However, this policy changed fundamentally during the late 1990s and above all in the early 2000s. Now, these ITCs are increasingly being seen as instruments for promoting competition in the hospital sector. The government is speculating that increasing the number of ITCs will improve the quality of care in the hospital sector and reduce waiting times. Competition is also expected to make hospitals more efficient and more patient-driven.

**Fewer restrictions
for ITCs**

Some of the former highly restrictive regulations which had been in force since 1998 were abolished some time ago. This included the precondition of waiting lists existing for the respective indications in the region, the stipulation that a center must cooperate with a local hospital and the requirement for the province concerned to approve the setting up of an ITC. With the introduction of a follow-up law in 2006 (the Health Care Providers Permit Act), even greater freedom was introduced. Since then, ITCs have even been able to admit patients for overnight stays.

The funding arrangements have also been reformed and a system of fixed case fees, known in the Netherlands as Diagnosis Treatment Combinations (Dutch acronym DBCs), adopted. While fixed prices exist for the majority of DBCs, certain ones can be negotiated freely between hospitals and health insurers. The new centers are therefore operating in direct price competition with the hospitals. In 2006 and 2007, the proportion of fully negotiable prices amounted to 10 percent of the total expenditure on hospital care, and this rose to 20 percent in the first half of 2008.

**Insurers must enter
into contracts with
ITCs**

There are now a total of 180 new centers, most of which are dermatology clinics (45), followed by ophthalmology (29), general surgery (20), orthopedics (11), radiology (13), cardiology (10) and dialysis clinics. They offer comprehensive routine care. The remuneration is regulated by the health insurance law. This means that a patient has access to a given ITC if his insurer has entered into a contract with the center in question. Most ITCs are founded

by medical specialists, often in collaboration with the hospital with which they are affiliated, and a private investor. Hospitals are now increasingly tending to found their own centers in order to forestall any loss of market share. The overall cost of services provided by ITCs currently accounts for about one percent of the total expenditure on hospital care. The number of employees in the centers seldom exceeds four or five; many specialists only work part-time in the ITCs and spend the rest of their working time at the hospitals to which they are attached.

Whether this opening up of the market will have a positive effect on cost-efficiency remains to be seen. Firstly, there is a serious risk of overcapacity, and secondly, savings made in this sector could lead to cost increases in another sector. On the whole, however, independent experts take a positive view. The ITCs will give patients more choice of where they are treated and health insurers will have more alternative contractual partners to choose from. Experts see the potential gain through ITCs less in the leveraging of market share and more in the positive impact that this new element of competition might have on the services and quality of care offered by existing hospitals (Maarse and Bartholomé 2008: 191).

**More freedom for
all concerned**

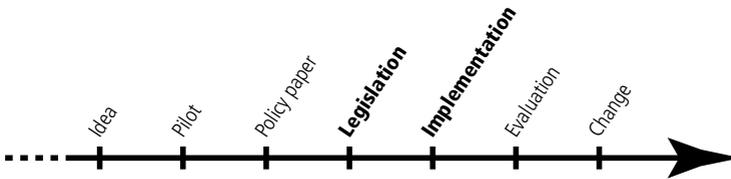
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Updates

Estonia: National health information system launched

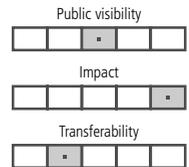


Estonia continues to pursue its ambitious plans for setting up a national health information system to be implemented nationwide by 2013. Following a number of successful pilot projects carried out since 2007, the main components of the Estonian Health Information System (EHIS) were introduced on a national basis in the fall of 2008. These consist of digital health records, a digital imaging database, digital prescriptions and an online appointment management system.

The Estonian government has been working towards a comprehensive health information system since the year 2000. The goal is to set up a central database using unified IT standards which will enable all participants to exchange data within the healthcare system. The central institution is a private, nonprofit foundation, the Estonian eHealth Foundation (EHF), which was established by hospitals and professional associations at the end of 2005 (see *Health Policy Developments* 6, p. 62–64).

Four major subprojects were launched by September 1, 2008:

- A digital health record (DHR) as the backbone of the system. This is where all providers will store their data



Digital health records: the system's backbone

- A digital image database to archive all diagnostic images of he patients and make them available through a single online portal
- A digital registration and referral system to manage appointments for patients and service providers
- A digital prescription database to store information on individual prescriptions for the use of physicians, pharmacists, patients and the foundation

**EU funding ran out
in summer 2008**

Providing the necessary professional training for employees within the health service turned out to be problematic. Litigation over the legality of the procurement process delayed the launch of the training program. As a result, every one of the approximately 9,000 potential users in Estonia had to be trained between April and August 2008. There was a good reason for this urgency, since the European Commission had allocated about € 640,000 to fund the training program, but this source of funding was set to dry up in August 2008. All in all, 85 percent of the total project costs of € 2.6 million was financed out of EU structural funds.

**Implementation
anchored in law**

The main challenge for the future is the question of sustainable financing for the project. If the government has its way, all service providers will pay a fee to the system operators. The providers, however, oppose this idea and insist that the state should bear the costs of implementing and running the system.

In order to ensure that the database is introduced, the government has embedded it in legislation. At the end of 2007, parliament approved an amendment to the Health Services Organization Act, legally defining the need for a health information system and making it mandatory for all healthcare providers in Estonia to join the information system.

**Physicians uneasy
about transparency**

Whereas the government is pressing ahead with the introduction of the EHIS, the opinions of other stakeholders are divided. Providers oppose the idea of their services being monitored through an online portal. They are also uneasy about an excessive degree of transparency towards the patients, a concern which has found its way into the new legislation, since physicians can now restrict a patient's access to information for six months if they consider its release to be a threat to the patient's life or wellbeing.

Whether service providers support or oppose the health information system may depend on whether or not the institution con-

cerned is a member of the board of the system's coordinating body, the Estonian eHealth Foundation (EHF). The Estonian Medical Association (EMA), for example, is not a member of the EHF board and is harsh in its criticism of the project. It fears that physicians will be required to update and manage the data, which would occupy too much of their time and consequently lead to a deterioration in the quality of health care. The Estonian Hospitals Association, on the other hand, is a member of the EHF board and is supportive of the project. Nevertheless, the association is critical of the speed with which the system is being implemented and is concerned that staff may not be fully trained in using the system.

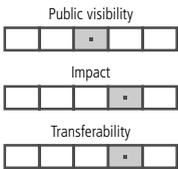
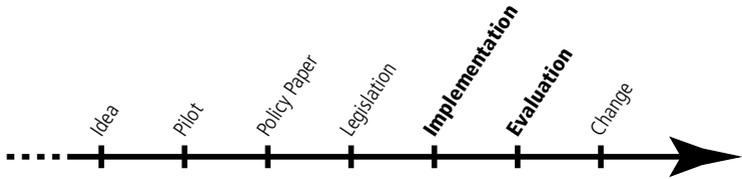
The Estonian Health Insurance Fund, a member of the EHF board, fully supports implementing the system. Above all, the insurer expects to benefit from greater transparency of the services provided. Patients and insurance beneficiaries also welcome the new information system. In a nationwide survey, 75 percent of the respondents believed that the health information system could be expected to improve coordination between the different sectors and service providers, speed up processes and reduce errors in treatment. Despite all obstacles, Estonia is at the forefront of European e-health initiatives.

**Insurer welcomes
greater
transparency**

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Austria: Code of reimbursement contains cost of pharmaceuticals



Austria has been successful in its efforts to contain expenditure on pharmaceuticals. Between 2000 and 2006, the average cost increase per annum amounted to 4.8 percent. In absolute terms, expenditure on pharmaceuticals rose from €1,644 million in 2000 to €2,180 million in 2006. However, if allowance is made for the harmonized index of consumer prices (HICP), which includes not only prescription drugs but also OTC products, non-prescription drugs and homeopathic medicines, then expenditure rose in real terms by an average of only 2 percent per annum over this period.

In 2004, the former Index of Medicinal Products was replaced by the Code of Reimbursement (German acronym EKO) which regulates the reimbursement of pharmaceuticals and generic medicines. This took place against a background of drastic increases in expenditure on pharmaceuticals. These costs had increased from € 715 million in 1990 to € 1,553 million in 1999, in other words they more than doubled. The health policy goal was therefore to roughly halve the annual expenditure growth rate of 9 percent.

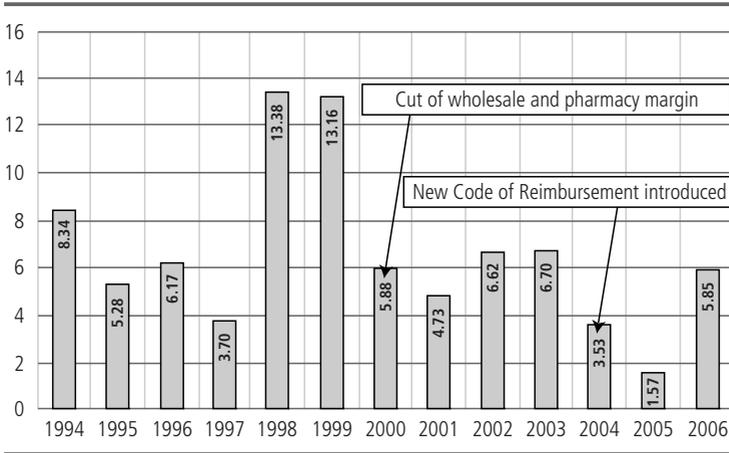
EKO achieves its goals

The introduction of EKO has played a major role in containing costs (see figure 1). In 2005 and 2006, expenditure rose by only 2.9 percent per annum. The main policy goal of an annual increase of between 3 and 4 percent was therefore reached. Furthermore, the second policy goal was also achieved, namely to increase the use of generic products to approx. 20 percent in volume terms.

Reimbursement according to traffic light system

The introduction of the new Code of Reimbursement in 2004 was the main project of recent years. This is a mechanism by which reimbursement is determined by means of a color code assigned to each pharmaceutical product. The green box contains

Figure 1: Nominal annual growth rate for health insurance expenditure on pharmaceuticals



All data in percent

Source: Bittschi et al. 2008

all pharmaceuticals which are automatically reimbursed. The yellow box contains those which offer an additional therapeutic benefit above and beyond conventional products. This is divided again into a dark yellow box containing products which are only to be reimbursed if prior approval is given by the physician responsible at the health insurance fund and a light yellow box containing drugs which are subject to approval after treatment. The red box contains all drugs for which reimbursement applications are pending. Finally, there is a 'No' box. This contains medicines which are licensed in Austria but not eligible for reimbursement by health insurance funds (see also *Health Policy Developments 2*, p. 57f).

Pharmaceuticals are assigned to their color-coded boxes chiefly on the basis of economic factors. Innovative products normally land straight in the dark yellow box. The main point of reference for pricing is the average price of the product in the EU. Products in the yellow box must not under any circumstances be more expensive than the EU average, while those in the green box must be priced below the average for the EU. Generics are approved

Cost-effectiveness is the main criterion

according to a system of price tiers which is similarly based primarily on cost factors. This means that the price of the first generic product must be 48 percent less than the cost of the original patented brand. Each subsequent generic must be offered at a price less than its predecessor, initially by 15 percent, then by 10 percent, always compared to the immediately preceding generic product.

**Cap on
co-payments**

Patient co-payments currently amount to about 20 percent of the total cost of pharmaceuticals. In absolute terms, this means that in 2006, patients contributed € 371 million towards the cost of pharmaceuticals out of their own pockets, either in the form of co-payments or by paying outright for medicines. In 2000, this figure had been only € 271 million. This increase led the government to introduce a cap on co-payments as from January 2008. Since then, co-payments may not exceed 2 percent of gross annual income, whilst prescription charges are fixed at € 4.80 per item. These measures are intended to ensure fairness and equality in the provision of care.

**Rate of VAT
on pharmaceuticals
reduced**

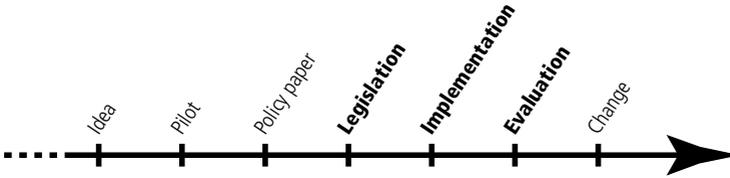
The current debate on the cost of pharmaceuticals also raises the issue of the rate of VAT on medicines. Both the health insurance funds and the Austrian Chamber of Pharmacists considered the current 20 percent rate of VAT to be too high and advocated cutting it to 10 percent. When compared to other EU member states, only Denmark (25 percent) and Bulgaria (200 percent) had higher rates of VAT for prescription drugs than Austria (European Commission 2008). On 24 September 24, 2008, the issue was decided by the National Council: As from 1 January 2009 onwards, the VAT rate on pharmaceuticals in Austria has been reduced to 10 percent.

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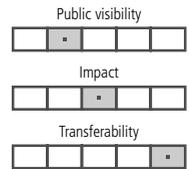
United States: Evaluating pay for performance initiatives



In the United States, Medicare, the federal health insurance scheme for the over-65s, has recently expanded its pay for performance (P4P) initiatives. The new arrangements apply primarily to hospitals. Authorized by the 2005 Deficit Reduction Act (DRA) with implementation beginning October 2008, Medicare will no longer reimburse hospitals for avoidable complications ensuing during a hospital stay.

First the DRA created greater incentives for hospitals to report quality data. Hospitals face financial penalties if they do not report their data. Until 2007, hospitals would in such cases face a 0.4 percent reduction in their annual payment update from Medicare funds, but with effect from 2008, this reduction has been increased to 2 percent. The DRA has also ordered the Centers for Medicare and Medicaid Services (CMS) to draw up a purchasing plan for the hospital sector. This plan is to be based on the quality data collected and is to come into force in 2009. The quality data will also be published on Compare, the Internet-based hospital comparison list developed under the auspices of Medicare (see also *Health Policy Developments* 5, p. 39). These new initiatives mean that Medicare is increasingly taking on a leadership role within the P4P program.

Improving the quality of care remains a key concern of American health policy. Each year, thousands of medical errors and preventable deaths are documented. Only about half of adult pa-



Quality data systematically collected and publicly disclosed

Quality of care linked to financial incentives

tients receive evidence-based treatment. It is also well established that there are wide regional variations in health care and that existing payment mechanisms have so far offered little incentive to improve the quality of available care. Measures introduced under the heading of P4P employ a system of financial rewards and penalties to encourage health care providers to continuously improve the quality of their services. This link between quality and money also forms the basis of the Medicare initiatives (see Fenley 2006).

P4P since 2002

In 2002, the state of California became the home of the first P4P initiatives to become legally binding. The stakeholders, i.e., insurers, physicians, researchers and experts from industry, had previously negotiated standardized success indicators. In addition to clinical quality, these also included patient evaluations. This agreement served as the basis for the subsequent allocation of funds (see *Health Policy Developments 1*, p. 44f).

**About 60 percent
of HMOs use P4P**

In the last five years, P4P has become widely implemented. About 60 percent of all private Health Maintenance Organizations (HMOs) have a P4P program. California still counts as the pioneer of the P4P movement and also boasts one of the most far-reaching cooperative arrangements between purchasers (health plans), providers and employers. But other countries are also experimenting with quality-based reimbursement (see Koppel et al. 2007 on Estonia and Oliver 2007 on the United Kingdom).

In 2004 and 2007, the first generation of P4P initiatives were evaluated on a series of process measures, and the results showed that in most cases incentive programs had been set up to encourage providers to improve their quality of service. Early P4P programs measured only discrete indicators in health care, such as vaccination rates. Then in 2007, the catalogs were expanded to include health outcomes, cost-efficiency, patient satisfaction and the use of information technology. Initially, these programs were directed mainly at primary care physicians, but later specialists, above all those working in group practices, were also included.

**High expectations
not always fulfilled**

Only 7 percent of P4P projects have so far been evaluated in terms of the quality improvement they were intended to achieve. In 38 percent of the cases evaluated, quality improvements were reported, in 42 percent there were mixed results and 20 percent showed no change. Probably the most heavily anticipated evalua-

tion of Medicare's P4P Premier Hospital Quality Incentive Program indicated an improvement in the quality indicators of all clinical specialties under evaluation. This evaluation led to the enactment of the DRA in 2005.

The bottom line, however, is that most of the P4P programs have so far failed to achieve improvements in the quality of care to the extent that had been anticipated five years ago. Nevertheless, the evaluations of the first generation of P4P initiatives enable conclusions to be drawn about how programs can be made more effective and more closely interlinked. On the basis of these evaluations, the following areas of action can be identified:

**Promoting
continuous
improvement**

- First, providers receive a bonus based on absolute or relative quality data. Those providers already above the threshold can receive bonuses by continuing their current practices. They have no need to invest in quality improvement. Similarly, an incentive to achieve a continuous improvement in quality has no effect on providers who fall short of the threshold and lack the resources to ever move above it (Rosenthal et al. 2007). A system based on relative performance, on the other hand, promotes competition among providers, but does not encourage them to share their insights and jointly develop effective programs. Processes which reward improvements also have their drawbacks. Even top performers often find themselves unable to make quality improvements which are large enough to earn them a significant bonus (Rosenthal et al. 2006).
- Second, the size of the bonuses varies greatly and so far most do not have a significant impact on the providers' income because the amount of money being distributed is small. In addition, since most providers have contracts with several insurers, P4P rules may only apply to a small number of patients from any given health plan, thus rendering the bonus payments largely insignificant (Trude, Au and Christianson 2006).
- Third, the insurers use very different quality indicators in their programs. Providers often complain that they must familiarize themselves with different methods of measurement and different incentive systems, which in turn increases the administrative burden. Furthermore, they also report that different plans can give conflicting scores for the same basic conditions (Trude, Au and Christianson 2006, Mehrotra et al. 2007).

In summary, it can be said that P4P is increasingly being seen as a necessary first step towards reforming the whole system of remuneration and improving quality. Many actors in health policy are keeping a very close eye on how Medicare uses this new instrument.

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United States: Can the Oregon Health Plan be rescued?

In January 2008, the government of the state of Oregon made a further attempt to tackle the problem of the uninsured and to rescue the Oregon Health Plan (OHP). The founder of the Oregon plan, John Kitzhaber, was among those trying to rescue this ambitious and much respected health insurance program for citizens on the poverty line and those with low incomes.

Kitzhaber, a qualified physician and former Democratic governor of Oregon, introduced the OHP during his term of office and is still an ardent champion of health service reform in Oregon. To this end, he founded the Archimedes Movement, an advocacy project operating under the auspices of the Foundation for Medical Excellence. Further stakeholders include current and former OHP enrollees, hospitals and managed care providers, taxpayers, charities, the state government and the federal government. It is noteworthy that many different stakeholders are involved in the process and strongly support the restructuring measures. In addition to Kitzhaber, these include the current governor, Ted Kulongoski; senators Alan Bates and Ben Westlund, all three of them Democrats; advocacy groups representing the uninsured and a number of advisory boards.

In 1989, the west coast state of Oregon became one of the first states to receive a waiver to restructure the its state Medicaid pro-

**Renewed support
for OHP**

Oregon: pioneer of general insurance cover age gram, which it did by creating the Oregon Health Plan (OHP). Some 120,000 low-paid workers were enrolled and the number of uninsured persons fell from 18 percent in 1994 to 10 percent in 1998. From that moment on, Oregon counted as a pioneer among the federal states, since it had succeeded in improving access to health coverage. But in the ensuing years, OHP was repeatedly restructured in order to put the plan on a sound financial ground, and political support for the OHP initiative began to wane at the end of the 1990s.

Cuts made from 2003 With the onset of the economic downturn, the benefit basket was gradually reduced from 2003 onwards (see also *Health Policy Developments* 3, p. 60). The state government increased premiums, introduced co-payments and cut a number of benefits, such as dental coverage and mental health care. This streamlined insurance plan was given the name OHP 2 and was later subdivided into OHP Plus and OHP Standard. OHP Plus was targeted at those who qualified for Medicaid and remained largely untouched by the restructuring. OHP Standard was intended to provide coverage for all those who had been reached by the extended criteria of the first Oregon Health Plan. As a rule, this meant people who were living on the poverty line, but whose income was too high for them to be eligible for the nationwide Medicaid program.

Higher premiums and co-payments The monthly premiums for health coverage under OHP Standard lay between US\$6 and US\$20. There were exceptions for the unemployed and the homeless, but the costs were still beyond the budget of many Oregonians. Furthermore, co-payments were introduced in 2003, amounting to at least US\$5 for each visit to a doctor and as much as US\$250 for a stay in hospital. Anyone who missed a payment had to wait six months before they were entitled to re-enroll in the program. In addition, physicians and pharmacists were allowed to deny services to patients who were unable to make the co-payments.

Still too many uninsured, even in Oregon As a result of these draconian measures, some 615,000 residents of Oregon once again found themselves without insurance in 2008. This corresponds to about 17 percent of the population. The number of those insured by OHP Standard had fallen dramatically over the years. Whereas there were about 88,000 persons enrolled in March 2003, by early 2008 the plan had only about

18,000 members (see table 1). Studies carried out by the Oregon Health Research and Evaluation Collaborative (OHREC) show that the cuts in OHP often had serious consequences for the former insured. The result was that they had virtually no access to health care, experienced serious financial difficulties and finally suffered a general decline in health.

Table 1: Number of persons enrolled in OHP Standard, 2003–2008

Month/year	OHP Standard enrollees
03/2003	88,874
09/2003	50,000
10/2004	46,520
Early 2005	38,000
Late 2007	19,000
Early 2008	18,000

Source: Conis 2008

There is a pressing need for new initiatives. In 2006, Oregon responded by creating a new advisory body, the Oregon Health Fund Board, tasked with developing a plan to reduce costs, ensure quality and provide at least a minimum for coverage to all Oregonians. At present, the board is collecting information from various state agencies and holding a series of community meetings to obtain the views of the public.

In January 2008, the government decided to allow new members to enroll for OHP Standard. 3,000 new members were to be enrolled in March and a further 3,000 in April, with admissions to be decided by means of a lottery. The hope of improving one’s social status through health insurance coverage is evidently widespread. More than 83,000 residents of Oregon entered their names in the lottery.

The health plan, however, continues to face fiscal challenges and will likely continue to face restructuring. A 2008 change in federal law forced Oregon to reconfigure a tax on health care providers that had been used to fund the state plan. In November 2008, the state’s Health Fund Board presented the governor with

Advisory board to develop sustainable concepts

Insurance coverage by lottery

a new set of recommendations to further reform the state's health care system and continue to expand coverage of the uninsured.

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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

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

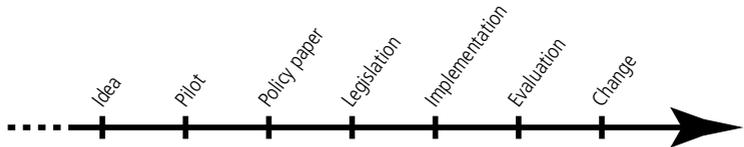
Reporting criteria

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 towards legal and professional implementation and adoption of a policy. Implementation does not necessarily result from legislation; it may also follow the evidence of best practices tried out in pilot projects.

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

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

Policy ratings

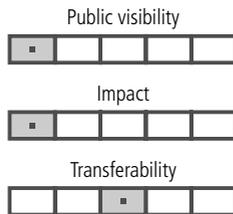
A second figure is used to give the reader an indication of the character of the policy. For this purpose, three criteria are shown: public visibility, impact and transferability.

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

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

Transferability: This rating indicates whether a reform approach could be adapted to other health care systems. Our experts assess the degree to which a policy or reform is strongly context-dependent (on the left) to neutral with regard to a specific system, that is, transferable (on the right).

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



Project management

The Bertelsmann Stiftung’s 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 ten and the eleventh survey round can be looked up and researched on the network’s Web site, www.healthpolicymonitor.org. Both these reports and this publi-

cation draw upon the partner institutions' reports and do not necessarily reflect the Bertelsmann Stiftung's point of view.

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