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## **Health Policy Developments 13**

Focus on Health Policy in  
Times of Crisis,  
Competition and Regulation,  
Evaluation in Health Care

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# Preface

Dear readers,

At the time of writing (fall 2009), the global economy is beginning to pull out of a recession unprecedented in the post–World War II era, but the recovery is expected to be slow, according to the IMF World Economic Outlook update (October 2009). *Health Policy Developments 13* addresses this issue—showing the challenge that the crisis means for some health systems, but also asking to what extent it might provide opportunities for reform. An analysis of the implications of the current crisis for health policy has to take into account the effects on currency movements as well as on the prices of health-related goods and services. Furthermore, all health systems are facing declining budgets—be it because of a drop in tax revenue or because of rising unemployment.

Looking at responses to the crisis from our network countries, two main patterns emerge. Some countries have reduced their healthcare budgets. In Estonia, the government enacted dramatic cuts to the budget for the National Health Insurance Fund. In other countries, such as Austria or the United States, the crisis has exacerbated homegrown, decades-old problems, to which each government has responded with plans to boost public expenditure. In Austria, where rising unemployment is threatening to curb sickness funds revenues, the government is moving to create a new structural health fund endowed with tax money. In the U.S., President Obama has taken on the fight against financial disaster as a way of pushing solutions to the long-standing healthcare crisis. The nation’s recovery act, passed in February, 2009, included a substantial federal pledge toward investments in health IT and

**Health policy in times of crisis**

**Cutting or expanding the budget?**

comparative effectiveness research. Against fierce opposition, the Obama administration keeps on fighting for universal health insurance coverage.

**Balancing  
competition and  
regulation**

In spite of a current wariness when it comes to market mechanisms: One of the key assumptions of the contemporary health policy debate is that more competition between providers and insurers and more choice for informed consumers will help produce a system where resources are used more efficiently. The challenge is a huge one: As governments seek to enhance market mechanisms in health systems, regulation to successfully facilitate those changes becomes more complex. Chapter 2 shows how countries with health systems as diverse as Germany and the Netherlands on one end, and Singapore and the U.S. on the other, address this venture.

**Evaluation and  
its consequences**

Looking back can be ever so boring. But can we do without it in health care, while trying to improve patient safety and bring the best available care to individuals and populations? In medicine, very fortunately, the evidence-based approach is constantly gaining ground, with tools like Health Technology Assessment and comparative effectiveness research spreading from one country to another. At the same time, awareness has been growing that health system outcomes could be improved if policy decisions were also based on the best possible evidence. But while evaluating the effects of past reforms can no doubt inform reforms of the present, retrospective policy analysis is rarely done. And when we do take the time to understand the impact of policy change on the health system, we often do it very poorly indeed. Chapter 3 depicts examples of evaluations from six countries—some successful, some less so—and their respective consequences.

**Hospital care,  
prevention and  
health inequalities**

Furthermore, we provide insights from other major health policy areas—insights that matter even more in times of crisis than in times of economic growth. How can hospital care be coordinated with other sectors in the most efficient and patient-oriented way? Can we turn around unhealthy lifestyles in industrialized nations—poor diets, physical inactivity, substance abuse—to prevent as much morbidity and mortality as possible? How can we transform the rising concern with health inequalities into effective action? Chapters 4, 5, and 6 provide some answers to these questions.

The sources of information for this book were the expert reports of the International Network for Health Policy & Reform and other materials cited at the end of each chapter. The current volume presents the results of the thirteenth half-yearly survey which covers the period from October 2008 to April 2009.

**Reporting period**  
autumn 2008 to  
spring 2009

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Having started in 2003 as a rather small brochure, our book series *Health Policy Developments* over the years has developed into a full-scale half-yearly publication. Twice a year we have provided you with health policy updates and analyses from 20 industrialized countries around the globe. Covering all major health policy issues, we not only brought to you the most recent news from Austria to New Zealand. With topical introductions, we have also aimed to put this news into perspective, offering a broader and deeper view, as well as useful background information on worldwide developments. We owe great thanks to Ray Moynihan, Australia, who with his vast experience as a health writer and journalist has authored and enormously enriched the last issues of our series.

**Looking back,**  
**looking forward**

We thank you for your attention and hope that reading our books has been as informative and inspiring for you as producing these books has been for us. However, after six years we have decided to go new ways in communicating the key findings from the International Network Health Policy & Reform. We will take some time to work out how to build on the strengths of our books and explore new communication channels. Soon, we will provide you with a new source of information on health policy developments in industrialized countries. If you want to let us know your

**Book series**  
**to end ...**

thoughts or ideas on what would be most valuable to you, we'd be happy to receive your comments.

... yet the Health  
Policy Network is  
alive and well

The half-yearly reporting of the International Network Health Policy & Reform will of course be continued. Over the last seven years, we have successfully occupied a niche between health economics and public health, by closely monitoring the politics of health policy, windows of opportunity for reform, moving policy targets and shifting alliances in search of better care (or higher profits). Interest in our international and political angle of analysis has grown steadily, and we have all but good reasons to stay in our not-so-little niche.

As in the past, our Web site, the HealthPolicyMonitor ([www.hpm.org](http://www.hpm.org)), will provide you with free access to all half-yearly reports as well as other publications and information produced by our project. We will keep on informing you about the results of our work at conferences and meetings, international, regional or domestic, and we are available for presentations, interviews and networking, glad to join your event and inform your policy debates.

For now, we hope you enjoy the read and as always look forward to receiving your feedback and suggestions.

*Kerstin Blum, Reinhard Busse, Sophia Schlette*

# Crisis or opportunity?

## Health policy and the financial downturn

*Precisely as the need for state surveillance grew,  
the needed supervision shrank.  
There was, as a result, a disaster waiting to happen ...*  
Nobel Prize Winner Amartya Sen,  
March 2009

The disaster did of course happen. The global financial crisis that erupted in the United States housing mortgage market in September 2008 wiped trillions of dollars from the value of global assets within months, caused millions of people to lose their jobs and many more millions around the world to join the ranks of the working poor. Advanced economies experienced an “unprecedented” 7.5 percent decline in real GDP during the last quarter of 2008. Output is expected to decline in 2009 in countries representing three-quarters of the global economy (IMF 2009a). And although the global economy in October 2009 seems to be pulling out of this recession unprecedented in the post–World War II era, the recovery is expected to be slow (IMF 2009b). The combination of falling public revenues and rising public expenditure on rescue and recovery packages has further compounded the crisis. In many countries, collapsing currency values and rapid price increases are only exacerbating the problems that peoples and their governments are facing.

A preliminary review of evidence on the link between recessions and health presented in April 2009 suggests that in high-income countries, major health indicators such as all-cause mortality and life expectancy are unlikely to be negatively affected, and may even improve (Suhrcke and Stuckler 2009). However, the segments of the population hardest hit—notably those losing their jobs—will likely suffer health impacts in absolute and relative terms, compared to those who are wealthier. While these estimates suggesting a mixed picture are preliminary and tentative, they are echoed by other analysts as well. Writing about the potential impact of the crisis on health in the *BMJ*, Michael Marmot

**A disaster waiting  
to happen**

**Crisis will have  
mixed effects on  
health**

and Ruth Bell point to studies suggesting unemployed people have mortality rates 20 to 25 percent higher than other people in equivalent socio-economic groups (Marmot and Bell 2009). Interestingly, as many industries shed labor, the health sector is one area where employment prospects may remain stable, with many western European countries experiencing job growth in this sector in 2008 (WHO 2009).

**Falling currency,  
rising costs**

Any analysis of the implications of the current crisis for health policy also has to take into account the effects on currency movements and related impacts on the prices of health-related commodities. Since September 2008, according to the International Monetary Fund, the U.S. dollar, the euro, and the yen have all strengthened in real terms, and the Chinese currencies pegged to the dollar have also appreciated. At the same time “most other emerging economy currencies have weakened sharply” (IMF 2009a). Between summer 2008 and spring 2009, the Polish currency had lost more than a third of its value against the euro, while in the Ukraine the currency had lost almost two-thirds of its value against the dollar, and the price of pharmaceuticals there had risen by up to 30 percent (WHO 2009).

**Estonia feels  
the pain**

Like many other Central and Eastern European countries, the Baltic states are facing a “significant deterioration” of their fiscal balance sheets (WHO 2009), and Estonia is expecting a drop in GDP in 2009 of 10 to 15 percent (see report on Estonia, p. 20). This comes after an extended period of quite rapid growth in some of these nations, including an average real GDP growth rate of 8.2 percent per annum in Estonia between 2000 and 2007 (Statistics Estonia 2009). Responding to the crisis, the Estonian government is introducing a range of changes to try and balance its budget. They include dramatic cuts to the budget for the National Health Insurance Fund, whose revenues are already seriously threatened by the collapse in salaries within the private sector—social taxes on salaries make up the bulk of health expenditures in Estonia. Other unpopular measures include tax increases on pharmaceuticals, increases in workloads for some clinical staff without commensurate increases in pay, and increases in the number of unpaid sick days for all Estonians.

As in many other countries, in Austria the crisis is causing a massive rise in unemployment and a dramatic drop in the na-

tion's GDP, which is expected to contract by 2.7 percent in 2009 (see report on Austria, p. 23). Like Estonia and other nations with some form of social health insurance systems, a key consequence of this big fall in employment will be a drop in contributions to the revenues of sickness funds in Austria. In 2008, sickness funds in Austria reported an accumulated deficit of €1.2 billion—corresponding to about 8.5 percent of the annual sick fund budget—with another large addition to that deficit expected in 2009. Responding to both the historic problem of the sickness fund deficits and the current financial crisis, the Austrian government is moving to create a new structural fund endowed with tax money and write new laws to link payments to efficiencies, cost containment and a range of other health reforms.

**Austria: bigger government role in health insurance market**

The leaders' communiqué released after the G20 meeting in April stated: "Major failures in the financial sector and in financial regulation and supervision were fundamental causes of the crisis" (G20 2009). In its World Outlook released the same month, the IMF also described policy failures that were at the root of the market failure that led to the current crisis. "Financial regulation was not equipped to address the risk concentrations and flawed incentives behind the financial innovations boom" (IMF 2009a). The task now with respect to financial policies, said the IMF, was to "broaden the perimeter of regulation ...". Likewise the G20 leaders called for a stronger "supervisory and regulatory framework" from governments. Whether this new mood for regulation in the financial sector will impact debates about the nature of healthcare systems will be a fascinating feature of the coming times.

**Weak regulation a key cause**

At exactly the same time as the crisis has exposed "market failure" and legitimized calls for stricter regulation in the financial world, health policy debates are increasingly acknowledging the link between wealth and health, with some voices arguing that improving health-for-all requires a paradigmatic shift in economic thinking. In late August 2008, only a matter of days before the financial firestorm finally ignited, the World Health Organization released the report from the Commission on the Social Determinants of Health. The report produced evidence showing that the conditions in which people are born, grow, live, work and age are major determinants of their health (Commission on

**Health is socially determined**

Social Determinants of Health 2008). Writing in early 2009, the commission's chair, Michael Marmot argued that the financial crisis would increase that social injustice, with grave consequences for people's health, particularly in the developing world.

**A new economic order?**

Stressing the crucial and ongoing role of markets, Marmot criticized what he saw as the unfairness of current global trading arrangements, and an economic growth model causing environmental destruction and obscene inequalities within and between countries. He foreshadowed the need for a "new plan with equity at its heart" and a "new economic order" necessary to achieve a "fair distribution of power, money, and resources" (Marmot and Bell 2009). However, other observers of the complex relationship between health and wealth have responded differently.

**No need for "new capitalism"**

Reflecting on the nature of the current crisis, former Nobel Prize winner for economics Amartya Sen wrote that in his view the times did not call for a "new capitalism," but rather for a new understanding of older ideas about the economic system, including seminal ideas associated with Adam Smith (Sen 2009). He pointed out that contrary to common perceptions, while Smith valued "prudence" as the virtue most useful to the individual, Smith wrote that "humanity, justice, generosity, and public spirit are the qualities most useful to others." Moreover, Sen asserted, Smith's legacy had been distorted by those championing unfettered capitalism. In concluding a long essay on the crisis published in March 2009, Sen argued not for a new economic order, but rather for a more "clearheaded perception" of how the institutions of states and markets can both contribute to producing a more decent economic world.

**Opportunity for fixing the U.S. health system**

As a key example of the needed transformation towards a more decent world, Sen points specifically to health systems and the necessity of universal health insurance coverage (Sen 2009). He describes the failure of the United States market mechanism to deliver health for all as "flagrant" and argues that China's abolition of universal coverage in 1979 was associated with a sharp halt in progress on health status there. He contrasts the situation in China with the Indian state of Kerala, which in recent decades has continued affordable state-guaranteed health care for all and has since overtaken China in indicators including life expectancy and infant mortality. While noting that policy makers in both

China and the United States are trying to rectify their nation’s respective lack of universal coverage, “the rectifications have far to go, but they should be central elements in tackling the economic crisis ...”

As it turns out, the government in the United States has been forced into simultaneously facing up to the financial disaster and its long term structural healthcare crisis. And President Obama and his Democratic colleagues in Congress have in some ways used the fight against financial disaster as a way of helping to push through solutions to that healthcare crisis. A month after Sen’s article, the powerful Senate Finance Committee released a series of papers describing different health policy options for expanding insurance coverage, transforming delivery systems and financing comprehensive reform (Senate Finance Committee 2009a-c). Part of a much broader debate underway, the papers demonstrate that United States policy makers are under no illusions about the depth and breadth of the crisis in their healthcare system, and the urgent need for fundamental reform. “It has become increasingly evident that the way health care is paid for in our system does not always encourage the right care, at the right time, for each and every patient. Today’s payment system more often rewards providers for the quantity of care delivered, rather than the quality ...” (Senate Finance Committee 2009a).

The finance committee options papers note that the United States is already spending around 17 percent of GDP on health care, with credible predictions it will rise to 20 percent within the coming decade. Yet 46 million people are uninsured, another 25 million underinsured, and the nation “ranks low in many areas of quality” (Senate Finance Committee 2009a). In short, almost one in five dollars in the economy is being spent on health care in a nation where more than one in five people are still not adequately insured.

The reforms that are being floated and debated by the Senate finance committee and others come on top of major health system reforms included in the nation’s recovery act, passed in February (see report on the U.S., p. 26). Those reforms enact a number of pre-financial crisis commitments to improving quality and moving to universal coverage that flow from the presidential campaign of Barack Obama and his Democratic allies. In the area of

**US fighting financial and health crises**

**U.S. set to spend 20 percent of GDP on health**

**Health reforms part of U.S. recovery package**

information technology, the recovery act included over US \$19 billion for supporting the expansion of health information technology. This reform includes generous incentives to providers, who could earn up to US \$18,000 in the first year of implementing new systems, and many states are already gearing up to apply for demonstration grants available under the reform (Commonwealth Fund 2009).

**Comparative effectiveness research**

A highly controversial reform also included within the stimulus act involves expanding comparative effectiveness research to try to find out what works and what doesn't in health care. Though many players express strong support, drug and device manufacturers are wary about the impacts of this reform on markets for their products. The details of the reform include the creation of a council to foster research and an allocation of more than US \$1 billion to various healthcare agencies to expand this research, which could potentially see ineffective or harmful treatments de-funded. While not novel internationally, this rational approach to evaluation is a relative newcomer to the United States health system and has been sharply opposed by some conservative voices in the media.

**Finally universal coverage?**

Perhaps the most dramatic development in health policy in the United States has been the return of universal health coverage to the mainstream of political debate (see report on the U.S., p. 29). That the U.S. is facing the most serious economic crisis since the Great Depression has given an additional argument to the Democrats' push for healthcare reform: "Making sure every American has access to high quality health care is one of the most important challenges of our time. [...] A moral imperative by any measure, a better system is also essential to rebuilding our economy" (Organizing for America). With commitments from the incoming Obama administration to achieve universal coverage, there is a strong sense of urgency within the United States congress to create major healthcare reform in 2009.

**Public option— blessing or curse?**

Three proposals for health insurance reform have been put on the table for debate during the summer of 2009. Academic advisers and some left-leaning Democrats are strong advocates of extending existing public programs like Medicare to cover the whole population. Another proposal, also voiced by the political left, is to introduce a government-run insurance plan to induce

competition between private and public insurance plans. The expectation of proponents of such a public plan is that government, with its market power, could negotiate lower fees with providers, drive down prices overall and thus rein in healthcare costs in the long run. Moderate Democrats, however, support an insurance exchange similar to Massachusetts, where private insurance companies—closely regulated by the state—have to accept every applicant without considering health risks (“guaranteed issue”). This third option appears to be the most promising when it comes to devising a bipartisan compromise. In any case, the call for a public option, however designed, has taken an ugly note over the summer, and contributed to polarizing the debate on both sides of the political spectrum.

In mid-September, the Senate Finance Committee finally presented a long-expected draft law that sets the tone for all further debate among Democrats and Republicans who are willing to discuss health reform at all. Senator Baucus’ draft plans to introduce mandatory insurance for a basic package with a market of regulated competition among private insurers. The public option—which some observers say has been a bargaining chip meant to get Republicans to discuss mandatory insurance—is no longer part of the deal. Still, as a reaction to the economic crisis and to appease concerns of the political left, Medicaid is to be expanded.

While the United States system is often seen as largely market-based in fact roughly 50 percent of total health expenditure already flows through the public sector, via government programs like Medicare and Medicaid, the Veterans administration, and tax subsidies for expensive insurance policies. Concurrent with debates about how to finance an expansion toward universal coverage are debates about how to contain costs, expected to grow by more than 5 percent this year, at a time when GDP is predicted to contract.

At time of writing, the full extent and impact of the global financial crisis are unclear, and the consequences for health policy reforms uncertain. What is certain is that different nations are reacting differently. Two main patterns emerge: Estonia—along with other countries mainly in Central and Eastern Europe, such as Hungary, Latvia, Lithuania and Romania (WHO 2009: 8)—is reducing the size of its healthcare budget (or increase copayments as in Croatia or Latvia [WHO 2009: 9]), while in others,

**Public option is fading**

**The myth of a “private system”**

**Does the crisis affect health policy?**

such as Austria and the United States, the crisis has augmented an historic problem, and the governments in both countries—as well as others such as Germany—are planning to boost public expenditure, or have already pledged it in form of a reserve. Both camps are in search of a balanced budget, with the ability to put in extra money and the time horizon taken into consideration clearly varying. It remains to be seen which path the majority of countries will take—and which strategy is more successful economically and in terms of public health.

Moreover, in the United States the crisis has coincided with the arrival of a new president and a new Congress, apparently determined to try to fix fundamental problems in the healthcare system, in part by relying on the popular momentum generated by the gigantic recovery effort. Meanwhile, high-level international meetings of policy makers are taking place to specifically look at the consequences of the crisis for health systems and produce recommendations for ameliorating its adverse effects.

In survey round 14 of the HealthPolicyMonitor in October 2009, a number of network partners have again reported on effects of the economic crisis on their country's healthcare system and political reactions. All reports are accessible at [www.hpm.org](http://www.hpm.org).

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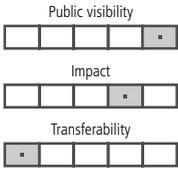
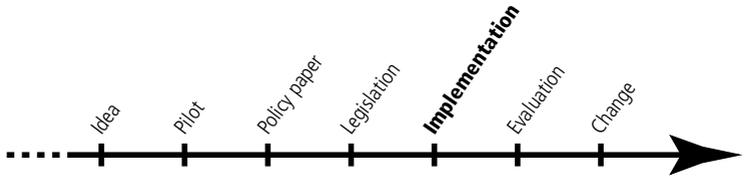
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## Estonia: Economic crisis shaping healthcare system



After a long period of rapid growth in its public sector, the financial crisis is causing Estonia to implement major cuts in public expenditure, directly affecting its health system. Facing a drop in GDP of up to 15 percent, a rapid rise in unemployment to perhaps 15 percent, and an estimated cut in private salaries of 20 percent, this Baltic nation that depends heavily on consumption taxes is confronting a major fiscal crisis. Driven by the strong desire to balance the budget, the Estonian government has in the space of a few short months introduced and implemented four major changes to the healthcare system, all designed to generate revenue or cut expenditure, and all both unpopular and controversial.

**Four big controversial changes**

In January 2009, the government raised consumption taxes on pharmaceuticals from 5 percent to 9 percent (while neighboring Latvia even went from 5 percent to 19 percent [WHO 2009: 11]). It has also legislated to increase the regular workload of clinical staff to eight hours a day, regardless of the specific field of work, and without any increase in pay. Thirdly, the parliament has passed a new act, significantly increasing the number of *unpaid* sick days.

The key part of its bid to balance the budget has been the cut of around 6 percent to the funds that flow from the government to the National Health Insurance Fund, which translates into a cut of €40 million. Following that cut, the government is now pushing for a further massive cut, inflaming existing controversy and raising fears of hospital closures and loss of essential health services.

**Increasing the price of medicines**

The increase in value added tax from 5 percent to 9 percent will obviously lead to a rise in the price of medicines, a phenomenon occurring in some nations as a result of currency depreciations associated with the financial crisis. As with all of the current changes, this one has not been accompanied by any analysis of

its likely impact or any plans to monitor or evaluate its consequences. Clearly this change will disproportionately affect those who consume more medicines, notably people over the age of 65 who constitute about 17 percent of the Estonian population.

The government's new laws on working hours have increased the working hours from 5 to 8 per day for those health sector workers exposed to radiation or doing very intensive work. This has occurred without any increase in salary or any increase in the budget, and it is causing complications as contracts with the many individuals affected will have to be renegotiated. The feared consequences are that some workers may be exposed to unacceptable levels of radiation and that patients may suffer because other staff—including surgeons for example—may be at increased risk of making mistakes because of fatigue.

**The crisis exacerbates labor-related health hazards**

Previous to the latest reform, the National Health Insurance Fund paid for sick days after the first day of illness. Under the latest changes, the fund will not start paying until day 9. The first 3 days will not be paid at all, and the sick person's employer will have to pay for days 4–8. One obvious consequence is that people will be more likely to go to work when they are sick, rather than miss out on their pay. Another consequence is that employers may be more likely to influence people to return to work earlier and not file sick-leave claims at all. The change has been introduced without any accompanying measures, such as tax exemptions on employer investment in worker's health.

**Increasing unpaid sick days**

Reducing the National Health Insurance Fund, which is used to pay for medical services in the country for every insured person, is the most significant of the changes introduced in the face of the financial crisis. The effects of the initial cut have been negotiated between the Fund and service providers and will translate into a € 40 million cut. As part of the negotiations this monetary cut would mean a 5 percent reduction in inpatient care cases. However, the government's desire to make further dramatic cuts is causing intense controversy in Estonia, which only spends 5 percent of GDP on health care and has a reputation for its systems' transparency and efficiency.

**Reducing the national insurance budget**

The government is seeking a further cut of € 45 million, but neither providers nor the Insurance Fund can see ways to implement such a change. Both parties suggest the government could

**Government seeking bigger cuts still**

use part of the Fund's reserves, which have built up in recent years. While the government is opposed to using the reserves—a move that could impair budget balancing—negotiations are continuing. The fear is that these further cuts could see the closure of small hospitals, along with reduction in ambulance services, emergency care for the uninsured and public health programs. The revenue problem for the Insurance Fund is compounded by falling salaries and growing unemployment, as almost two-thirds of total health expenditure is financed from earmarked social taxes on salaries.

**Bleak outcomes  
now, but new  
financing options  
may emerge**

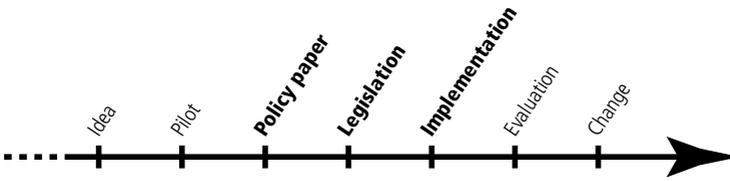
The intended objective of a balanced budget is likely to be achieved in Estonia, though the impacts of these changes on public health and the health system are not at all clear, and there is concern they will ultimately weigh particularly heavily on the more vulnerable segments of the community. An important worry is the major rise in unemployment and thus an increase in uninsured individuals who will have limited access to health services. People who can afford it will seek medical treatment in private settings or outside the country. Looking forward to elections in 2011, some parties are talking of increased and progressive taxation to fund social expenses, while others are pushing the idea of private schemes for health financing.

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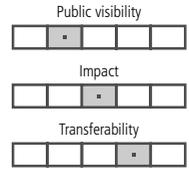
## Austria: Health policy response to the crisis



As the financial crisis unfolds in Austria and the debts of the nation's sickness funds balloon out of control, a new center-left government is attempting to link future funding with more government control over the way insurers operate. The accumulated deficit of the nation's social health insurance funds was approximately € 1.2 billion in 2008, but with falling GDP and rising unemployment, the current deficits for 2009 alone are estimated to reach € 600 million. A raft of immediate measures will see those deficits ameliorated, and significantly, the next step will be the creation of a new structural endowment fund for the sickness funds. While not novel internationally, the move is being seen as the Austrian government boldly signaling its attempts to play more of a governance role in the life of what has been considered an autonomous health insurance sector.

Austria's health insurance landscape consists of almost 20 funds, and almost another 20 small health welfare institutions that provide insurance to civil servants at the regional and local level. However, almost 80 percent of the insured population is covered by the nine regional funds, which range in size from 137,000 members to over 1 million. The funds cannot reject or compete for insurees, and insurees cannot choose which fund to join. Dealing with sickness funds' deficits and in particular the deficits of the regional funds has been on the policy agenda in Austria for years.

The problem of sickness fund deficits is not new in Austria, and through the 2000s there have been many attempts to help them meet revenue shortfalls. Those measures have included compensation for consumption tax outlays, raising contribution rates for blue-collar workers and pensioners, and unifying contribution rates for all salary earners. Despite these measures, expenditure continued to outstrip revenues and the accumulated deficits have grown now in excess of € 1 billion, with balance sheets



**Government increases its role in health insurance**

**Austria's complex social health insurance landscape**

**Historic problem of funds' revenue shortfalls**

looking sicker as a result of the financial crisis. Against this background, the newly elected government has injected money to reduce deficits in 2009 and to create the new structural endowment fund in 2010, with an initially small—but significant—investment of € 100 million.

**The new fund as a tool to increase government's role**

The subsidies that will flow from the new fund to the sickness funds will be linked to efficiency. However, it is as yet uncertain exactly what strings will be attached and how big the government's role will ultimately be in the governance of the formerly autonomous insurers. The draft legislation on the structural fund includes the following proposals:

- The structural fund will support balanced budgets for sickness funds
- The fund should help efforts to contain costs and support integrated care
- Ministries of health and finance are to issue guidelines for granting subsidies
- Reporting on cost containment will require viable cost-benefit evaluation criteria
- The Federation of Social Health Insurance Institutions will provide monitoring reports quarterly to the government
- The government may also authorize outside evaluation

**Cost containment measures will have uncertain impact**

Against a background of a predicted drop in GDP growth of almost 3 percent in 2009 and a high degree of uncertainty about future economic conditions, there are estimates that even with government increasing the revenues to the sickness funds, deficits will still be in the order of € 300 million in 2011. However, certain cost-containment measures could enable sickness funds to economize up to about € 300 million over the next four years. There are estimates that this kind of saving could occur if expenditure growth in the fields of ambulatory care, drugs and administration were matched to specified “benchmarks,” based on age-adjusted per-capita expenses. If hospital expenses were also included deficits could potentially shrink further. However, this detailed level of cost-containment reform is not yet being discussed by the Austrian government.

**Changing culture of governance**

While major cost-containment reforms are yet to materialize in Austria, the creation of the new structural fund can be seen as

a significant change in the culture of governance of health insurance. Although the initial figure of € 100 million of direct government revenue is only less than 1 percent of the total expenditure of social health insurers, it is likely it will grow in the future, in absolute terms and relative to other forms of revenue, namely contributions. As a result the fund may well become an important policy tool for the central government, engaging in monitoring and evaluating the performance of previously autonomous insurers.

Like many nations, Austria has taken quick steps to try to stimulate its economy. However there is a question about whether health and social investment was given a high enough priority in the recovery package, despite reductions in taxes on drugs, increases in long-term care allowances and additional investments in research and development. The question is resonating in other forums as well, as advocates see the response to the financial crisis as an opportunity for reform. A background discussion paper prepared for a meeting on the implications of the crisis for health in Europe describe the notion of missed opportunities: "... the opportunities offered by the first wave of economic recovery programs have been missed, as many of these have left health and environmental problems to be tackled at a later date" (WHO 2009).

**Stimulus package  
not stimulating  
enough?**

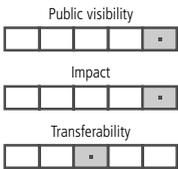
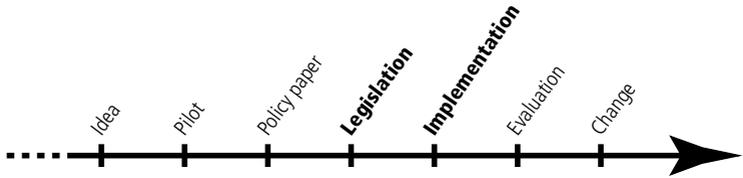
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## United States: Recovery act stimulates health IT and comparative effectiveness research



Two months after the onset of the global financial crisis in September 2008, the people of the United States elected a new president and Congress, dominated by representatives of the Democratic Party. The first act of the new Congress in 2009 was to pass the American Recovery and Reinvestment Act, also known as the stimulus act, which included key elements of healthcare reform that were part of President Barack Obama’s pre-crisis campaign platform. Among the health-related measures were significant new amounts of money to promote the introduction of electronic health records and to fund research into the comparative effectiveness of different treatments. Both reforms aim to reduce costs and increase quality, and while neither is novel globally, significant federal government action on these fronts is certainly unusual in the United States.

**\$19,200,000,000**  
for health IT

The plan in the stimulus package earmarks US \$19.2 billion to establish a nationwide health information technology infrastructure that can offer patients and providers access to compatible and standardized electronic health records. The aim is to facilitate access to these electronic records in real time, potentially reducing medical errors and unnecessary tests and other services, increasing responsiveness to patient needs and improving communication between providers. Until now, the uptake of this kind of information technology has been fairly low in both ambulatory care and hospital settings in the United States (Blumenthal 2009), and overall the hope is that this reform will ultimately reduce costs and enhance quality—though potential barriers to these aims remain, as we discuss below.

**Financial crisis offers fortuitous timing**

The expansion of health information technology initiated in the recovery act is very similar to other proposals that have been before Congress for a number of years. However, in this case, the

plan was attached to the historic “stimulus bill” and received strong support from the incoming president, making its passage much easier. Importantly, this version of the expansion of electronic health records was also supported by advocacy groups interested in privacy concerns. Notably the powerful American Civil Liberties Union supported the expansion of information technology because of language in the bill specifically addressing privacy and confidentiality concerns. Patient and provider groups are also largely supportive, though the stimulus bill was opposed by representatives of the Republican Party in Congress.

**Big carrots,  
little sticks**

Offering incentives is one of the key ways in which policy makers are encouraging uptake of new health information technology in the United States. Under the details of the new law, from 2011 through to 2015, providers can receive incentive payments if they become “meaningful” users of electronic health records and other information technology infrastructure within their practices. Early adopters could receive as much as US \$18,000 extra in the first year, going down to US \$2,000 in 2014. Providers who do not qualify as “meaningful” users by 2015 could see their government-funded reimbursement rates reduced by 1 percent a year until 2018, though the notion of “meaningful use” is still to be defined—one of the key challenges ahead.

**Potential problems  
in rollout of  
electronic health  
records**

The Department of Health and Human Services will oversee the expansion of health information technology, establishing standards, evaluating physicians’ offices for compliance, and disbursing incentives. It will also provide a standardized system if necessary, if the private market is not able to do so. Another barrier to implementation may be that providers simply do not take up the incentives, and then potentially oppose or ignore the penalties if they occur. Making sure that future electronic health records all connect with each other—and with existing systems—will also be difficult. Ongoing concerns about privacy and confidentiality may likely become more intensified during implementation.

**Building a better  
evidence base with  
“comparative  
effectiveness  
research”**

A second significant development in health policy included in the U.S. stimulus act is the expansion of “comparative effectiveness research,” which essentially compares the benefits and harms of existing tests and treatments or compares existing therapies with new ones. The aim is to strengthen the evidence base within

the health system and to make more meaningful knowledge available about what works and what doesn't, how well interventions work and what harms they have, compared to alternative approaches. This knowledge can then in turn better inform the decisions that providers and patients make about care. The act allocates US \$1.1 billion to expand this comparative effectiveness research, reflecting key messages in the health reform proposal of Barack Obama's presidential campaign. While the plan is widely supported by many different sectors within society, drug and device manufacturers are wary of the potential impacts on markets for their products.

**New research  
funding overseen  
by new federal  
council**

The bulk of the money will flow through existing public health institutions, including the National Institutes of Health and the Agency for Healthcare Research and Quality. However, a new federal council will be established to foster coordination of this research across federal agencies, reduce duplication efforts, and report regularly to Congress, providing public oversight of the new spending. The new council is explicitly prohibited from making decisions on whether a treatment is reimbursed, or making recommendations on coverage, assuaging concerns that providers would lose autonomy to outside organizations. In other countries, bodies like the National Institute for Health and Clinical Excellence in the United Kingdom or the Pharmaceutical Benefits Advisory Committee in Australia have been involved in using this kind of research to make coverage recommendations for many years. While considered commonplace now elsewhere, such evidence-based infrastructure is still regarded as highly controversial in the United States.

**Widespread  
support, but some  
controversy as well**

The government plan to expand research that compares the effectiveness of different treatments has unsurprisingly received widespread support from many players, including providers, patients and insurers. The main opposition has come from drug and device manufacturers concerned about the impacts on markets and from some conservative voices within the media. While the national body representing the pharmaceutical industry has publicly expressed support for this kind of research, it has been opposed to congressional action in this area. The concerns often focus on the possibility that treatment decisions could be removed from physicians and put into the hands of bureaucrats—

one of the often-heard concerns about the move toward an evidence-informed approach to decision making in health care.

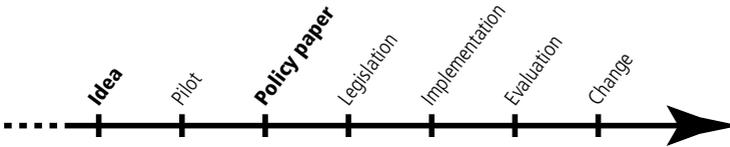
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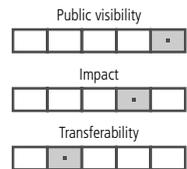
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### United States: Expanding Medicare for universal coverage?



In the lead up to the 2008 election, then presidential candidate Barack Obama campaigned on healthcare reform, calling for efforts toward universal insurance coverage. Despite the enormity of the parallel challenges of solving the financial and healthcare crises, there are great expectations that with Obama’s election, such fundamental reform might be initiated in 2009. While President Obama promised to expand a public system, there was no specific promise about exactly which system would be expanded or how universal coverage would be achieved. Expanding Medicare—an idea that dates back 40 years to the program’s inception in the 1960s and is still on the agenda—is one way of providing coverage to the 46 million uninsured. A key issue is the inclusion



of a public option in addition to private insurance in the mix of options that are available.

The idea of expanding Medicare is voiced mainly by left-leaning Democrats, who seem to be more enthusiastic about seeing their ideal come to life than about finding a feasible societal consensus that would gain support from Democrats and Republicans alike. Without a “public option” they have threatened to vote against any health care bill—no matter who might have entered it into the parliamentary process.

**A number  
of options**

Although the expansion of Medicare is part of the national debate about fundamental healthcare reform, it is only one among a number of options in a recent report on expanding coverage to the uninsured from the influential Congressional Budget Office (CBO 2008). Other options in the report include

- regulating insurance premiums and sales;
- reducing or eliminating the tax subsidy for employer-sponsored health insurance;
- establishing managed competition; and
- expanding access to the Federal Employees Health Benefits insurance scheme, which currently covers federal employees.

**Doing nothing isn't  
an option**

Democrats and the new president support expanding public programs, but not necessarily Medicare, while Republicans are likely to oppose it. Physicians and insurance companies, while both generally supportive of major healthcare reforms to deal with the problem of the uninsured, would both be concerned that a Medicare expansion could eat into their income streams, if cost-containment strategies involved reducing reimbursement rates to providers and if employers and individuals shifted their coverage away from private plans. Employers have mixed responses, and public opinion polls do not show an overwhelming majority support for Medicare expansion. Unusually, representatives of some of the largest sectors in health care—including insurance providers, drug and device makers, hospitals and doctors—have formed an informal alliance to engage with the President's reform plans. In all camps the sense is that doing nothing is not an option—the U.S. healthcare system is in desperate need for reform. The public is watching and no group is willing to take on the role of the villain hindering reform. In a letter to the President in mid 2009,

the group outlined plans to cut hundreds of millions of dollars from the costs of care while at the same time improving quality (American Medical Association et al. 2009).

In the first years of the Bush administration, the role of private health plans within Medicare was greatly expanded—the so-called Medicare Advantage Plans. Medicare raised the reimbursement to private plans to up to 114 percent of regular Medicare payments. These private plans in turn offered managed care type arrangements, rather than fee-for-service more regularly offered within Medicare. Higher reimbursement, however, does not mean better care for patients. Furthermore, since 2004, there are estimates that Medicare spending would actually be lower if all insureds were enrolled in the regular fee-for-service plans. In fact between 2004 and 2008, extra payments from Medicare to private plans amounted to US \$33 billion. Shortly after taking office, president Obama announced that he would reduce these on-top payments to providers from 114 to 105 percent starting in 2010. A bitter pill to swallow for private providers whose income would thereby be noticeably reduced.

**Medicare  
Advantage Plans  
controversial**

Unlike the small Baltic state of Estonia, where the government can swiftly act to introduce and implement significant changes, any major healthcare reform will have to make its way through the labyrinthine political structures in the United States, overshadowed by the power and influence of the professional and commercial interests. President Obama has established healthcare reform as a major policy goal in his first year, and he is being strongly supported by the powerful chairs of key congressional committees in both the Senate and the House of Representatives, where legislation is generated and debated. While Democrats have a majority in both houses, the strong desire is for some bipartisan support, as well as the engagement of physicians, insurers, industry and patients.

**Politics will  
be critical**

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# Balancing competition and regulation

As seasoned observers of health policy will know well, the governance of a national healthcare system is one of the most complex regulatory challenges everywhere. At the heart of that challenge lies one of the great policy paradoxes: As governments seek to enhance the role of market mechanisms in health systems, to encourage more quality-oriented competition and choice, the regulation required to successfully facilitate those changes becomes even more complex. Yet if regulation is “best seen as an ongoing balancing of competing forces and interests” (Chinitz 2002) then it is hardly surprising that regulating health systems can prove both extremely challenging and highly complicated.

One of the cornerstones of much contemporary health policy debate is a widespread assumption—among many analysts and policy makers—that more competition between providers and insurers, and the provision of more choice for informed consumers, will help produce a system where resources are used more efficiently—where we all get better “value for money”. Indeed it is this belief that is driving many key reforms, including the health system reforms large and small that we will deal with in this chapter. Weighed against the hopes for these market-based reforms are of course the fears of their unintended consequences.

Entrepreneurialism tends to segment markets, with entrepreneurs aiming primarily to find profitable niches rather than maintain a system designed to get the best-quality, most efficient care to the entire population. The problem is that healthy competition within healthcare systems can have decidedly unhealthy effects. Insurers naturally compete by seeking out the healthiest patients to insure, entrepreneurial doctors compete by maximizing their use of the most profitable interventions, and drug compa-

**Competition—  
part of the  
problem or part of  
the solution?**

**Competition's  
unhealthy  
consequences**

nies compete by pulling as many prescribers as possible into their giant webs of marketing influence. The challenge for successful regulation is to realize the hopes of market mechanisms by harnessing the positive impacts of competition while mitigating its much-feared side effects.

**“Fencing in”  
market forces with  
regulation**

As Saltman and Busse observe in an essay on balancing entrepreneurialism and regulation in European systems, “the market-style mechanisms that form the heart of entrepreneurial initiatives are inherently incapable, in themselves, of either comprehending or addressing the major normative goals that most governments posit for their health sector” (Saltman and Busse 2002). Those goals—universal access to effective and efficient systems responsive to their populations’ needs—are thus achieved by “fencing in” market forces with well-targeted regulation. And that regulation is undertaken by governments acting as “stewards” of the health system, rather than centralized planners (Saltman and Busse 2002).

**The challenge of  
“good regulation”**

As David Chinitz points out in his 2002 essay on good and bad regulation, good regulation is “not only a matter of technical tools but a question of ongoing managerial intervention.” (Chinitz 2002). It is about setting rules and monitoring adherence to them, while trying for consensus in implementing reform, relying on the trust and social cohesiveness that are the foundations of a health system. Others warn that monitoring the impacts of regulatory change, particularly reforms aimed at unleashing market forces and enhancing competition, is absolutely essential. “Regulation without systematic monitoring and enforcement may well be worse than no regulation at all, in that it engenders disrespect and ultimately delegitimizes state authority” (Saltman and Busse 2002).

**Regulatory reforms  
big and small**

In this chapter we look at the hopes and fears for pro-competitive regulatory reforms in Germany, as the nation implements a long-awaited reform—the centerpiece of which is the creation of a new health fund—aimed at containing costs and improving quality via enhancing competition between its still almost 200 sickness funds. We also learn about the early monitoring experiences in the Netherlands, where the major “regulated competition” reform designed to increase choice and competition is now three years young. In Singapore, where a strong centralized state

relies on a market-based approach to health care, it seems that doctors' fees may be re-regulated to some extent, after a brief period of deregulation. Similarly, an unexpected upsurge in new regulation is coming out of the United States, as policy makers try to manage the influence of drug companies on prescribing health professionals.

Against a background of rising healthcare expenditure and decreasing revenues from payroll-related contributions, Germany's reform is designed primarily to establish a more economy-independent, sustainable financing mechanism for the nation's health system (see report on Germany, p. 37). It includes three core elements: Since 2009, the government stipulates a uniform contribution rate rather than allowing sickness funds to set these individually; there is centralized pooling of all contributions to a nation-wide health fund; and the way of compensating sickness funds for the risks of their insurees has been expanded to include morbidity measures, rather than relying on age and gender proxies alone. This move has attracted criticism and controversy. Moreover, for the first time, the government will use taxation to establish new revenue flows into the new health fund. The aim is encourage sickness funds to compete in terms of quality and efficiency, rather than competing for healthy insures based on price and the expectation ultimately is to improve the quality and efficiency of the entire system.

**Germany's new health fund: more regulation, more competition**

The tightly regulated introduction of more market elements in 2006 has allowed hospitals and insurers limited autonomy in the Netherlands (see report on the Netherlands, p. 43). With the caveat that it is still too early to draw any firm conclusions, the tentative results are these:

**Tentative results of Dutch "regulated competition"**

- Almost one-fifth of consumers switched insurer in the first year of the reform. This rate plummeted soon after to the before-reform levels of 2 percent
- The number of people not paying premiums—because unable or unwilling to do so—has increased sharply, though consumer satisfaction generally seems high
- Employer-based groups and other group insurances have negotiated significant premium discounts
- Consolidations of insurers resulted in high market concentration

- There is some evidence of subtle risk selection as insurers now chase the healthy via complementary packages
- Administrative costs are overall lower, though still high for complementary insurance
- Differences between insurance plans are marginal; problems with transparency occur
- Effects on expenditure are uncertain; there are concerns regarding increasing volumes and expanding markets

**Singapore re-regulates doctors' fees**

In Singapore, the complex dance between regulation and competition has been played out in a different arena: the fees that medical practitioners charge their patients. In order to comply with new pro-competition laws dating back to 2004, the Singapore Medical Association in 2007 withdrew its guidelines for doctors' fees, essentially deregulating those fees. However, just two years later, the doctors' group has applied to the Competition Commission of Singapore to reinstate the fee guidelines, and the commission has agreed to consider the application (see report on Singapore, p. 47).

**United States: more doctor-drug company transparency**

Concern about increasing expenditures on pharmaceuticals has led policy makers in the United States to focus more attention on the influence of drug company marketing strategies and their impacts on prescribing behavior (see report on the United States, p. 49). While the relationship between doctors and drug companies is under increasing scrutiny globally (Moynihan 2009), the United States appears to be moving more quickly than other nations to regulate for more transparency. At a federal level, Congress is considering a bill to force drug and device makers to publicly disclose payments to doctors. In the state of Massachusetts, policy makers have already done as much, passing a bill in 2008 to create a new marketing code to be enforced by the state's public health authorities.

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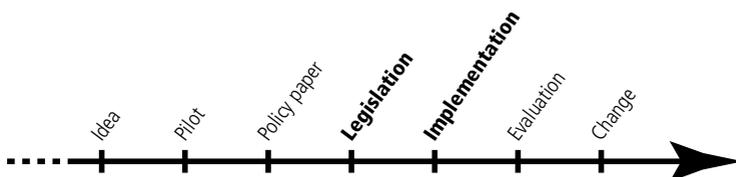
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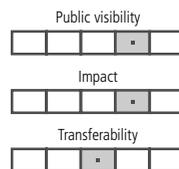
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## Germany: Major financing reforms now underway



The centerpiece of the health reform law passed by the German parliament in 2006 has in 2009 finally become effective, the three-year delay serving as an indication of the magnitude of the compromise and the controversy that have characterized these changes from the outset. Designed as a way of promoting more competition and choice in the system, the reform introduces a major new element of state infrastructure into the system: the new health fund which pools and allocates insurance contributions. The changes were born through a compromise between Germany's two major political forces, thrown together in a grand coalition seeking consensus, and as a result of the fundamental



**Consensus,  
compromise and  
controversy**

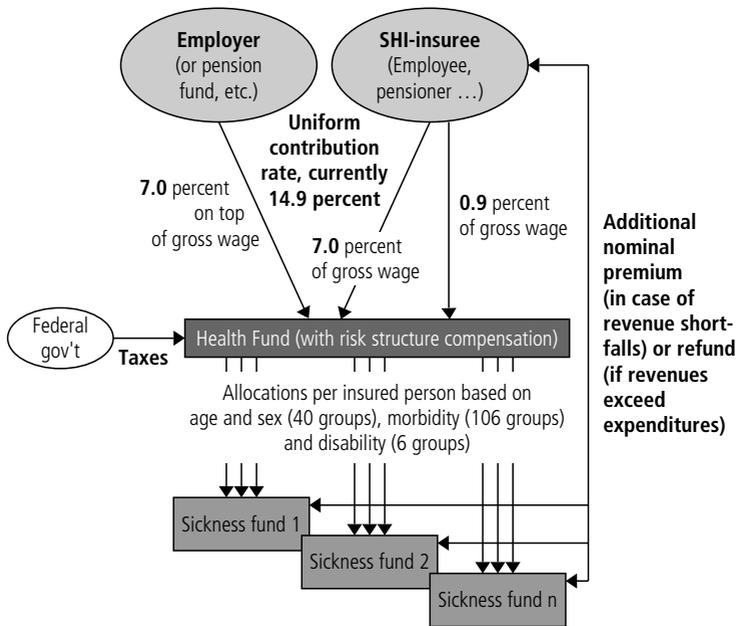
shifts in the status quo they entail, the reforms have proved controversial with every major stakeholder. In Germany though, they say that if in health care reform you managed to get every stakeholder against you, you must have gotten it right ...

**New health fund is the centerpiece**

The health fund constituting the centerpiece of the reform will be fed by a new uniform contribution rate for all sickness funds members, as well as from growing and increasingly significant levels of extra taxation revenues. In turn, the central health fund will feed the nation's many sickness funds with newly risk-adjusted payments for each of their members (see figure 1). The familiar hopes for the reforms are financial stability and an improvement in quality and efficiency. The fears include the possibility of manipulation—or gaming—of the complex new risk-adjustment scheme and, as a result, rising costs.

The combination of rising health expenditures and falling revenues were producing what was seen as an unavoidable financial

*Figure 1: Health fund with risk structure compensation in Germany*



Source: own illustration

crisis for the nation's 200 or so sickness funds (the number is decreasing due to ongoing mergers) that make up the social health insurance system. One reason for falling revenues—based on a proportion of labor incomes—has been rising unemployment. Another reason is that labor's share of the total national income has been shrinking, while the share of capital has been increasing, further causing a drop in revenues to sickness funds. And a third factor is that people above a certain high income level have been allowed to opt out of the solidarity-based social health insurance system and take out comprehensive private health insurance.

**Motivation was to avoid financial crisis**

The “grand coalition” government of Social Democrats and Christian Democrats declared healthcare reform a top priority for 2006, and despite their different approaches to reform and to financing in particular, they achieved it. The Social Democrats favored more solidarity, with contributions coming from all income including rents and capital investments, not just labor, and the inclusion of private insurers into the new health fund. The Christian Democrats favored more individual responsibility, with the same flat-rate premium for everyone and the retention of full-coverage private insurance.

**Reform emerged from “grand coalition”**

The consensus emerged in the form of the “Statutory Health Insurance Competition Strengthening Act” of 2007: the health fund as its centerpiece, a unitary contribution rate, and the retention of private insurance outside the new health fund. From the start of the reform process, the traditionally powerful private health insurers strongly opposed the notion of a central health fund and their inclusion in it. While the fund did emerge, the protests from private insurers proved successful to some extent in excluding the privately insured from the fund, at least for the time being. The current compromise is regarded as a stepping stone for further more partisan reform, whichever party takes power in future elections.

**Consensus as stepping stone for future reform**

The original idea for the health fund as a compromise solution and stepping stone for future reform came from an advisory committee reporting to the German Ministry of Finance. While it is a new approach within Germany, is it not new internationally: The insurance system in the Netherlands has been organized through a health fund for around 70 years. A key hope for the re-

**Hopes for more competition**

form idea was that the central health fund—and the associated reforms to risk adjustment discussed below—would ultimately help stimulate more competition among sickness funds on quality and cost, once their financing was unlinked from the direct contribution of their members.

**More choice driven  
by refunds and  
penalties**

Another key hope for the reform was that it would offer consumers more choice, as sickness funds would design innovative sorts of healthcare packages, including greater use of integrated and coordinated care. The reform also provides more autonomy to funds, so that they can negotiate with providers more vigorously on quality and cost parameters. Importantly, the reform includes provisions for sickness funds to offer refunds to members if revenues exceed expenditures, allows funds to charge extra if limited premiums to cover revenue shortfalls, and enables insureds to cancel membership and switch funds easily. These elements of the reform are hoped to push the sickness funds to provide better quality care at the best possible price.

**Fears of  
competitive  
disadvantages ...**

Sickness funds have already started to offer refunds, and there are expectations some funds may have to charge higher premiums in the form of surcharges—though the extra premium penalty is restricted to 1 percent of the insured's contributory income. Financial problems of funds are also expected to lead to market concentration, with 30 to 40 mergers expected among the currently approximately 200 funds. Another concern is that a fund with higher numbers of low-income earners could face a competitive disadvantage if it tried to introduce or increase premiums.

**... and lost  
opportunities for  
cost-savings**

Furthermore, the cost savings that could have emerged through lower administrative costs may not materialize: Originally it was envisaged that the new fund would collect contributions directly from members, but following protests from the sickness funds, the sickness funds will remain the primary collection point, at least temporarily.

**Changes to risk-  
adjustment at  
heart of reform**

At the heart of the reform is a new risk-adjustment system, designed to reduce "risk selection," the process of sickness funds cherry-picking healthier and wealthier insureds. Under the new scheme, the central health fund will transfer a standard amount to the sickness funds for each member, with the amount adjusted specifically for that member, depending on demographic characteristics and on their level of ill-health. In the past, there had

been limited risk adjustment on the basis of age, sex, health status, and participation in a disease management program. The new scheme greatly expands this process, in order to try to fairly allocate funds to the sickness funds for the true costs of the care of their members.

As an example of the new risk adjustment, for a healthy 24-year-old woman a sickness fund would receive less than the standard rate from the central health fund. However, if the 24-year-old is suffering from one of the diseases included in the new method of risk assessment, then the sickness fund will receive extra payments. The new method of assessing risk involves a list of 80 diseases, and because some diseases have different levels of severity there are 106 hierarchical morbidity groups now being sued to classify insurees (see figure 1, p. 38). Allocation of monies is prospective, in the sense that extra payments are determined by the predicted extra expenses in the year following an initial diagnosis. The aims are to prevent risk selection, improve care for the sick, and establish a level playing field for competition between funds. While other countries, notably the Netherlands, have introduced morbidity-oriented adjusters earlier, the German approach is—despite its limitation to initially 80 diseases—wider than in other countries. For example, even the Netherlands uses only 20 adjusters based on pharmaceutical prescriptions and 13 based on previous hospitalizations.

**Morbidity-based risk adjustment**

The new approach challenges the traditional strategy of sickness funds which has been to attract primarily healthy and wealthy insurees, and insurers can now profit from those who are sick. This paradigmatic shift could considerably improve the quality of care for patients with conditions included in the new scheme's list. Innovative approaches that may be stimulated by the reform include more integration and care coordination; more case management; selected contracts with providers for chronic care; horizontal, cross-sector partnerships of physicians and hospitals; specializing in insurance for patients with certain conditions (of those for which additional money is allocated to the sickness funds); and developing chronic care infrastructure.

**Hopes for innovative care for the sick**

One of the key fears that form the basis of criticism from many stakeholders is the possibility for manipulation of the assessment of a member's risk in order to gain additional alloca-

**Fears that adjustment may be manipulated**

tions from the central health fund. The concern is that a person's risk may be "up-coded," in other words members or patients may be made to look sicker than they are in order to improve the flow of money to the sickness fund. In fact, the Minister of Health has denounced alliances between physicians and insurers, where physicians are paid to review the diagnoses of the insurer's members, as corruption. The sickness funds officially disapprove of "up-coding" but use the word "right-coding" to describe efforts to improve the recording of existing but as yet unreported morbidity.

**Rising costs and  
other fears**

Another key concern is that basing payments to sickness funds on diagnosis, partly validated through pharmaceutical prescriptions, could act as a disincentive to cost containment. Critics argue that despite escalating costs of drugs and other services, sickness funds now have an interest in promoting these services in order to increase future allocations from the central health fund. Moreover, critics argue, the assessment process, whether "right-coding" or "up-coding," will tend to increase the reporting of the most cost-intensive and profitable diseases. The regulating authority responds that the financial endowment of the central health fund is fixed, so any increase in morbidity would simply reduce the value of additional payments. Other concerns include a move away from prevention and a focus on the 80 diseases on the list, at the expense of conditions not listed.

**Stakeholders upset  
by changing  
status quo**

Sickness funds and private insurers were both opposed to the idea of the centralized health fund, arguing it would increase bureaucracy and not make the system financially sustainable in the long run. In the end, private insurers, thanks to their lobbying, were exempt, and statutory sickness funds as quasi-governmental organizations have to adjust to the new law. On the new morbidity-based risk adjustment, the sickness funds are somewhat divided, depending on the risk profile of their members. Some physician groups originally feared the reform's effects on their incomes and have raised concerns about the potentially corrupt practice of "up-coding." Trade unions were against the central health fund, because they feared employees may bear the burden of rising costs. The strongest proponent of the reform has been the coalition government.

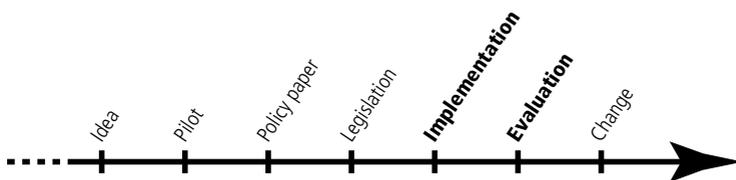
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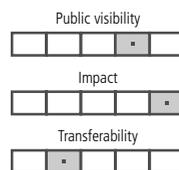
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## Netherlands: Early results of “regulated competition”



As in Germany, the major healthcare reforms in the Netherlands were informed by both sides of politics, finding a compromise between libertarian desires for more market mechanisms and social democratic demands to maintain solidarity and universal access. Also in the Netherlands, market-oriented reforms are based on the assumption that more competition and consumer choice will enhance both quality and efficiency. However, pro-competitive reforms have been accompanied by strict regulation to try to prevent any deleterious effects on solidarity, producing the notion of “regulated competition” (also see reports in *Health Policy Developments* 7/8 and 9).

Implementation of reforms began in 2006 and will continue until 2012. A key element of the reform has been integrating the former sickness fund scheme and private health insurance into a single mandatory scheme for all residents. Other important elements offer hospitals, providers and insurers more autonomy in



**The Netherlands implements “regulated competition”**

**Reforms are a work-in-progress**

how they behave and interact. Hospitals and other providers now have more room for decision making about their own capacity, and along with the financial institutions which fund their expansion they may now incur more of the risk involved in such investment. Insurers and hospitals now have more autonomy in negotiating prices, and importantly the ban on for-profit hospital care may be lifted in 2012. The changes are being monitored by several regulatory agencies.

**Choice?  
Which choice?**

Three years in, a number of reports have been published by the authority monitoring the reforms. While there are tentative results, it is considered too early to draw conclusions. As expected, the results suggest a mixed picture. For example, in regard to the expansion of consumer choice—a key aim of the reform—on the positive side, figures on health insurer membership showed an early flurry of consumer mobility, with up to one in five switching insurers in the first year of the reform, while consumer satisfaction seems high. However, mobility dropped sharply after 2006; differences between plans tend to be marginal, yet many consumers have complained they have great difficulty understanding and comparing their options.

**Defaulting appears  
to be a problem**

In 2008, there appeared to be a significant increase in the number of people not paying their premiums, with the number rising 16 percent to a total of 280,000—which translates to 2 percent of the country's population. Government and insurers agreed on a monitoring program to track defaulters, and several ways are being used and tested to compel people to pay their premiums. However, funds are not able to remove defaulters from their lists. At the same time, about 1 percent of the Dutch population has no health insurance at all, though this figure cannot be compared with pre-reform years because of reporting problems.

**Consolidation and  
concentration**

The reform eliminated the former distinction between sickness funds and private insurers. Consolidation was expected and has indeed happened. In 2006, the number of insurers fell from 57 to 33, though the number had been falling over the previous two decades as insurers sought greater administrative efficiency and effective risk pooling. Unsurprisingly, one result of the consolidation has been an increase in market concentration, with the four biggest insurance companies now having almost 90 percent of the total market. There is some concern, not shared by the reg-

ulatory authority, that this concentration may undermine competition and choice, particularly in certain areas of the Netherlands.

While the reform includes a formal ban on the practice of risk selection for basic health insurance, there may be some forms of this practice at work. For example insurers may deny a group a contract if they see the group having a predictable loss, though this has not been reported yet. In one case, an insurer launched a new plan attractive only to young healthy people, which contained a provision that people would have to switch plans in the case of an illness requiring frequent medical consumption. Importantly, complementary health insurance has no ban on risk selection, and almost half of all insurers are now asking applicants to fill in medical questionnaires. There is actually some evidence that some people may avoid switching plans for basic insurance, fearing they would not be accepted by the new insurer for complementary insurance, a problem that is potentially reducing choice.

A cornerstone of the new reform is the enhanced role of the insurer, expected to play a more active or “agency” role in purchasing health care on behalf of its members. In principle, insurers are no longer obliged to contract with each provider, and they can now selectively contract with specific providers to purchase certain services. However, this form of purchasing is still in its infancy for several reasons: The monopolistic position of some hospitals in some regions makes it impossible not to contract with them; insurers are concerned that selective contracting could damage their reputation; and steering patients is seen as extremely difficult, though incentives to members to seek care at preferred providers are now being offered.

One area where competition has emerged in the Netherlands is in the area of insurance premiums, particularly for those purchasing what are called group contracts, who have gained substantial premium discounts. The average discount for employer-based groups grew from 7 percent in 2006 to 8 percent in 2008, and some employers managed to negotiate a 10 percent discount. Patient organizations and smaller groups were less successful in negotiation, averaging discounts of just over 4 percent in 2007. Given changes in the market and the nature of plan packages, it is difficult to compare the standard costs of premiums for basic health insurance over a longer period of time.

**Not-so-subtle forms of risk selection?**

**New forms of purchasing and contracting slow to emerge**

**Premiums are competitive**

**Administrative costs have decreased**

Administrative costs taken as a percentage of total costs did drop significantly after the reform, as private insurers merged with sickness funds. The administrative costs of complementary insurance, however, while having come down since the reform was introduced, have remained much higher than for basic insurance. In 2003, the administrative costs for sickness funds were 4 percent, for private insurers 12 percent, and for complementary insurance even almost 23 percent. In 2007, post-reform, basic health insurance administrative costs were 4.6 percent, and complementary health insurance administrative costs were 14.6 percent.

**Expenditure growth may have flattened**

The growth of total healthcare expenditure in the Netherlands appears to have flattened in 2006 and may have actually fallen in 2007. Structural changes introduced as part of the reform and the concurrent shifting of some costs to local government, however, make it hard to be certain about the recent patterns of total expenditure, which should become clearer as time goes on and further elements of the reform are introduced.

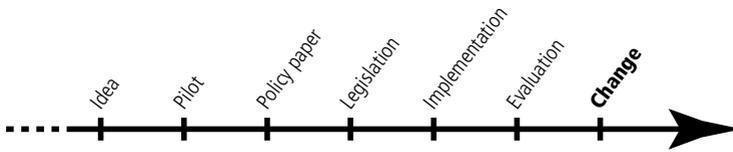
**Prices down, but fears volume may go up**

In terms of the prices of hospital care, there does appear to be some movement, with suggestions from the authorities that insurers' negotiating power has been reinforced, and signs that the hospital prices subject to competition since 2005 had declined by 2007. It is uncertain whether these effects will last, and there is concern that competition may have an upward effect on the volume of care. This is because of supply-induced demand propelled by competitive pressures and the interests of private investors to expand the market for health care. Despite the fact that the ban on for-profit hospitals is not yet lifted, two hospitals in financial trouble have been taken over by private investment companies.

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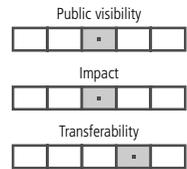
## Singapore: Re-regulating doctors fees



A very different relationship between regulation and competition has been occurring in Singapore, in relation to a professional association's nonbinding guidelines that recommend the fees doctors charge their patients for treatments and procedures. In March 2007, the Singapore Medical Association's annual general meeting decided to withdraw its fee guidelines for the nation's doctors, asserting that it was taking the action to comply with the then relatively new Competition Act of 2004. Two years later, in a surprise move, the doctors' group announced it wanted to reintroduce the guidelines, potentially re-regulating the fees to some extent.

The Competition Commission of Singapore has consistently expressed the belief that the fee guidelines—in place for 20 years—were generally harmful to competition, and that giving flexibility to practitioners to set their own fees would result in enhanced competition, therefore benefiting consumers. The Competition Act of 2004 did have exemptions, however, and the nation's Law Society was able to keep its recommended charges for conveyance work for lawyers. While the doctors' group had argued for an exemption initially, they did not pursue an application for exemption and dropped the fee guidelines in 2007.

Since early 2007, private doctors have thus been free to set their own rates, though under other laws they must inform their patients how much they will charge before treating them, and they must also provide an itemized bill afterwards. A 2008 survey by the Singapore Medical Association on fees charged by almost 80 specialists showed only a minimal increase in some charges since the guidelines were dropped, though there have been isolated reports of alleged exorbitant fees being charged. The Consumers Association shows that fee-related complaints against doctors almost doubled between 2007 and 2008, and there have



**The Competition watchdog's views on fee guidelines**

**Uncertain impact of deregulating fees**

been media reports that many doctors are not giving patients itemized bills.

**Surprise move to  
reintroduce  
guidelines**

In February 2009, the Singapore Medical Association filed an application with the Competition Commission to seek an exemption to the competition act and reinstate its fee guideline. In its application the association stated that the objective of its fee guideline was to “safeguard the interests of patients through greater transparency of medical fees to reduce the information asymmetry between patients and medical practitioners.” Moreover, the association took the view that there were “net economic benefits and public interest considerations” arising from the fee guideline. Notwithstanding the lofty rhetoric, it is important to remember that the original guidelines were nonbinding and carried no penalties for deviation, and that they served primarily to protect doctors from being accused of overcharging in the event of disputes.

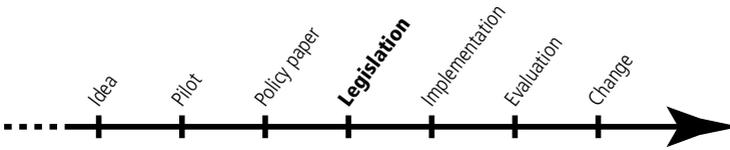
**The Competition  
Commission  
responds**

Despite its previous position that the guidelines were harmful to competition, the Competition Commission responded by undertaking a six-month study at taxpayers’ expense. The study will examine the local market for medical services, to see if there are special circumstances that justify any form of fee guideline. It will then decide if the old guidelines should be reinstated or newly set. It is believed there must be compelling reasons for this change of attitude within the commission, but those reasons have not yet been made public.

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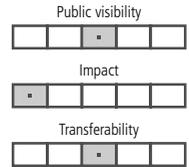
## United States: Shedding light on doctor—drug company connections



As elsewhere in the world, in many state capitals across the United States, policy makers are moving to throw some light on doctor-drug company relationships. As of July 2009 in the state of Massachusetts in the northeast of the United States, pharmaceutical and device manufacturers will be forced to publicly disclose all payments to healthcare providers, including physicians, hospitals, nursing homes, pharmacists, health plan administrators, and all other professionals authorized to prescribe, dispense or purchase prescription drugs or medical devices. The disclosure move by the state government is not innovative, but it is comprehensive. It's a move designed to contain the unhealthy influences of marketing on prescribers, in order to contain the costs of unnecessary and irrational prescribing. It has been taken against a backdrop of growing global scrutiny of these important relationships between professionals and industry (Moynihan 2009).

Three major reports in the United States are among many that have highlighted the need for greater independence between physicians and the pharmaceutical industry in light of a crisis of public trust over the issue. In 2008, the Association of American Medical Colleges, following a two-year investigation, called for an end to all industry gift-giving and urged universities to discourage faculty from being paid speakers for industry (AAMC 2008). The same year, a report from the Josiah Macy foundation called for a five-year phase-out of all industry funding of medical education (Fletcher 2008). And in 2009, the Institute of Medicine's report echoed calls for bans on gifts and meals, finding that financial ties "present the risk of undue influence" on doctors' judgments and may "jeopardize" scientific integrity, patient care and public trust (IOM 2009).

Rather than institute complete bans on financial ties, policy makers at the state and federal level in the United States are mov-



**Small state acts  
against backdrop  
of global debate**

**Three big reports  
call for more  
independence**

**Policy makers  
regulating for  
more transparency**

ing to regulate for more transparency in the relationship between health professionals and the makers of drugs and medical technology. Federal policy makers are considering the so-called Sunshine Bill, which if enacted would force disclosure of all payments to physicians nationwide, though thresholds for disclosure and penalties for noncompliance are currently being debated (Senate Finance Committee 2009). Following legislation already passed in 2008, Massachusetts will begin its new disclosure regime in July 2009, with any payments of US \$50 or more being revealed. Companies will be fined US \$5,000 per violation.

**Move is  
controversial and  
stakeholders  
are split**

Consumer groups have welcomed the new regulations but argued they could have gone further and instituted a complete ban on gifts from industry to prescribers. The biotechnology industry argues the new rules could stifle research in the state, and the local hotel and convention industry is also worried about declining revenues. So far, the regulations have meant that two major medical meetings have been moved to other states, according to media reports. Understandably, the national body representing drug companies is also strongly opposed to the reforms.

**Disclosure is part  
of wider state  
reforms**

The plan to force disclosure of all payments to doctors is included in a new marketing code of conduct, introduced as part of a wider state health reform bill with several measures aimed at curbing rising health costs, improving transparency, and boosting the efficiency of care. The bill established

- a new council to promote transparency of costs and quality;
- a state E-health institute;
- an education and outreach program to promote optimal drug use; and
- a measure allowing patients to choose nurse practitioners as their primary care providers.

**State reforms part  
of wider reforms  
across the nation**

At least six other states have enacted similar regulations on disclosure of financial ties between doctors and industry, but none have been as comprehensive. Two of the first states to move in this regard were Minnesota and Vermont. Interestingly, the new marketing code in Massachusetts is to some extent based on new codes of conduct promulgated by industry itself and by other institutions including universities, hospitals and professional associations. Healthcare organizations in Massachusetts have, for ex-

ample, recently placed restrictions on drug company sponsorship of medical education and banned company representatives from visiting doctors uninvited.

The new disclosure regime will be enforced by the state department of health, which will post all reports of payments from industry, but there is no formal plan for monitoring or evaluating this new regulation. Evidence from other states suggests these disclosure regimes may ultimately prove far less effective than policy makers envisage, with many payments from industry to doctors simply not being revealed (Ross et al. 2007). As others have pointed out, good monitoring can be critical to the success of reforms that seek to “fence in” entrepreneurial behavior, because a failure to carry through with enforcement “engenders disrespect and ultimately delegitimizes state authority” (Saltman and Busse 2002).

**No plans for monitoring and evaluation**

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# Evaluation: Still the poor cousin

So many reforms of the health system are launched with the laudable aims of improving quality, efficiency, and sometimes even access, but how many of them actually do? Despite wave after wave of reform in many nations, the costs of health systems inexorably increase, and in many places many people are receiving care they may not need, or not getting the care that might improve their health. Evaluating the effects of reforms is clearly an important aim but is often not undertaken. Governments come and go, policies change, and so do reform proposals, which sometimes are not even implemented—let alone evaluated. And when we do take the time to test the impacts of changes to the health system, we often do it very poorly indeed. Sadly, despite the love of all her relatives, evaluation remains the poor cousin in the health policy reform family.

The desire to evaluate what we do is an old one, which has received a new lease on life in recent decades with the rise to prominence of the “evidence-based” approach to medicine and health. In the 18th century, a ship’s doctor named James Lind famously conducted a controlled trial on a group of sailors suffering from scurvy during a long sea voyage, helping confirm the benefits of citrus fruits. Yet that example of evaluation is really only relatively recent. The James Lind Library in the United Kingdom—devoted to promoting the benefits of good evaluation—cites the use of an untreated comparison group in an experiment testing the effects of a treatment for meningitis, dating back to 10th-century Baghdad (Chalmers et al. 2008).

Since the 1990s, there has been a rapidly increasing appreciation of the importance of basing medical decisions on good evidence. The move towards an “evidence-based” approach to medi-

**Evaluation has a long history**

**Evidence-based medicine**

cine sprang from a growing awareness of the enormous variation in medical practice, and the fact that many treatment decisions are based on very poor evidence. As many readers will know well, the evidence-based movement has developed a “hierarchy” of evidence, with anecdote and opinion at the bottom and the systematic reviews of randomized controlled trials at the top.

**HTA: evaluation  
in action**

One area where evaluation has become firmly embedded in the infrastructure of health systems is health technology assessment, which is primarily focused on clinical care, not policy reform effects. Rising to prominence in Sweden, and then across Europe and the world, health technology assessment organizations are evaluating the benefits and harms of new technologies, and in some cases, the extent to which they offer value for money. International collaborations in this field are growing rapidly, in order to reduce duplication and strengthen the rigor of the evaluations (Velasco-Garrido et al. 2008).

**Evidence-informed  
health policy**

While pharmaceuticals are routinely tested before widespread availability, other interventions including surgical procedures, diagnostic technology and health system reforms are not. Evaluating the effects of a drug is much easier than testing the impacts of a system-wide change in policy, yet notwithstanding the methodological challenges involved, there is a strong view that policy reforms too “should be assessed in terms of their capacity to improve health” (Velasco-Garrido et al. 2008).

In recent years there has been a growing awareness that health systems could be improved if policy-related decisions were also based on the best possible evidence (Lavis et al. 2008, Moynihan 2004). One way to generate that evidence is to evaluate policy reforms as rigorously as possible, synthesize the results of those evaluations, and use the resulting knowledge to inform future policy decisions.

**Evaluations  
of quality  
improvement often  
poorly done**

Policy decisions, in all their many and varied forms, are informed and influenced by many different factors, and sometimes that includes good evidence, though certainly not often enough. Canada-based academics Kaveh Shojania and Jeremy Grimshaw have made the case that strategies being used to improve quality—whether that’s changing provider behavior or achieving organizational change—are in general being very poorly evaluated (Shojania and Grimshaw 2005). They write that “evaluations of

specific interventions often fail to meet basic standards for the conduct and reporting of research.” While they warn policy makers wanting to improve the quality of care that there are no “miracle cures,” they also stress the importance of conducting rigorous evaluation and systematically reviewing the results of evaluations. Moreover, they argue, the results of systematic reviews can show not only what interventions might work but also why and under what conditions they work.

An important part of the debate about evaluating policy reforms concerns performance measures, which are increasingly used to assess the extent to which a health system is meeting the objectives that policy makers lay down for it. In a recent report on the use of performance measurement to improve health systems, a group of researchers led by Peter Smith argue that part of government’s role as stewards of health systems is active leadership in performance measurement. They cite the World Health Report 2000 definition of stewardship as “defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information” (Smith et al. 2008).

Smith’s report, released under the auspices of WHO Europe, outlines several key domains of performance measurement, including population health, individual health outcomes, clinical quality, responsiveness, equity and productivity. The domain of interest will determine which instruments are used to measure performance. So, for example, a generic quality-of-life instrument called the EQ-5D can be used to measure patient outcomes following a wide range of treatments. Understandably, such measurement is controversial, particularly in terms of the extent to which outcomes of such evaluation should become public or remain confidential. The report also calls for caution in interpreting the results of measuring performance, particularly in attributing causality.

In this chapter we examine a range of reforms in light of attempts to evaluate their impact, and we find a very mixed picture, both in terms of outcomes and evaluation methods, which generally leave much to be desired. In Canada, there have been promising results from a controlled trial of integrated care in the province of Quebec, and concurrently there are moves in this direc-

**Evaluation is part of ‘stewardship’ by government**

**What are we measuring and how well?**

**Evaluations bearing fruit, though rarely sweet**

France, German  
and Israel evaluate  
reforms—though  
not rigorously

tion across the nation, with different experiences in different provinces (see report on Canada, p. 57). In New Zealand, evaluation of a primary care reform strategy finds it has enhanced the role of nurses (see report on New Zealand, p. 60), while an evaluation from California has stirred a debate in Pennsylvania and other U.S. states about whether boosting the ratio of nurses to patient really does improve care (see report on the United States, p. 63).

In France, a national cancer plan has been evaluated, exposing limited successes and, ironically, the poor quality of the evaluation (see report on France, p. 67). Meanwhile, evaluation of disease management programs in neighboring Germany suggests some improvement in the quality of care but only preliminary conclusions on cost-effectiveness (see report on Germany, p. 69), and a proactive approach to improving quality in Israel has led to improvement in some indicators such as mammography rates (see report on Israel, p. 73).

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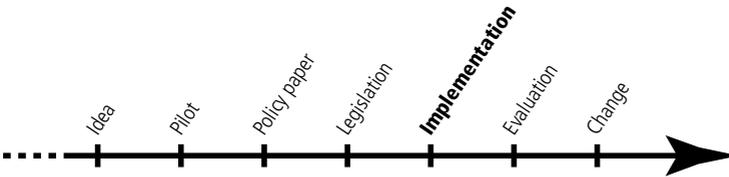
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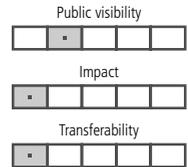
## Canada:

### Positive evaluation inspires wider rollout of integrated care



Provincial healthcare systems across Canada are now moving toward implementing a framework of integrated care for people with chronic illnesses. The aim is to improve the access to community care for people with chronic conditions, to improve patient outcomes, and to reduce avoidable utilization of hospitals and long-term-care homes. Many stakeholders within the system agree on the need for more home and community care and on the need for better integration to make that care work best.

Integration is a complex set of processes designed to boost coordination in health systems and reduce fragmentation, and it can occur at different levels. At a system level, a region, a province or a nation may integrate activities such as strategic planning, purchasing, or coverage. At an organizational level, integration implies vertical and horizontal coordination and management across different agencies engaged in (for example) the acute



**Integration:**  
**different levels and**  
**different forms**

care sector, primary care, and so on. At a clinical level, integration happens between different caregivers and professions for any particular individual (also see *Health Policy Developments* 6, p. 33).

**An example of integration from Quebec**

A high-profile example of integration has been underway in the Eastern Townships Region of the Canadian province of Quebec for several years, the “Program of Research to Integrate the Services for the Maintenance of Autonomy,” or PRISMA (see *Health Policy Developments* 12, p. 115). As we reported recently, the project is a collaboration of researchers, providers and managers designed to coordinate the care of frail seniors, and it has six essential elements:

- A single entry point for initial evaluation of need
- Involvement of a case manager who coordinates a multidisciplinary team
- An individualized care plan
- A needs classification system with standardized measurement of autonomy
- An up-to-date electronic medical record
- Coordination between institutions, involving new panels and committees

**Promising results of Quebec evaluation**

Another key characteristic of PRISMA is the long-term evaluation of the project, involving over 1,500 participants, roughly half of whom were in a control group and half in the experimental group receiving the integrated care. Four years of evaluation data suggest modest though promising results. The incidence and severity of functional decline was modestly lower in the experimental group, and there were positive effects on reported levels of satisfaction and empowerment. Importantly, the evaluation found reductions in visits to the emergency room and hospitalizations. These results, along with wider changes in health policy thinking, have led the Quebec government to instruct Regional Health Authorities throughout the province to adopt models similar to PRISMA.

**Systematic review suggests ingredients of successful integration**

As others have argued, it is important to know not just what works, but why, and systematic reviews of evidence can come in very handy when looking for answers to these questions. A recent systematic review found indications that some models of integrated care for the elderly can result in “improved outcomes, client

satisfaction and/or cost savings or cost-effectiveness” (MacAdam 2008). Four key elements of potentially successful approaches are

- Umbrella organization structures that ensure efficiency and accountability
- Multidisciplinary case management with a single entry point to the system
- Organized provider networks with standardized procedures and shared information systems
- Financial incentives to promote prevention and rehabilitation and enable integration

Few provinces have reached the level of integration being achieved in Quebec with the PRISMA reform, which brings together many different sectors (e.g., primary and acute care) into a collaborative governance model. However, a recent survey of provincial ministries of health across Canada found that all provinces are making some degree of progress in implementing system-wide home and community care strategies for those with chronic conditions, including frail seniors. The survey found most had moved towards implementing coordination features such as

- Single entry systems
- Standardized system-level assessment and care authorization
- Single system-level client classification system
- System-level case management and involvement with clients and families

The recent survey revealed that the provincial health authorities in Canada were less likely to have implemented integrated information systems, which are deemed necessary for good coordination between different parts of the system. The survey also asked ministries about how the home and community care sectors are linked with physicians, hospitals and other social and human services providers. It found that many provinces still have poor linkages, although some are adjusting remuneration packages toward more comprehensive care for the elderly, while others are adding case managers to primary care centers and hospitals to assist with discharge planning and diverting elderly people from emergency rooms.

**Recent survey finds provinces moving towards integration**

**Slowness on coordinating IT and other linkages**

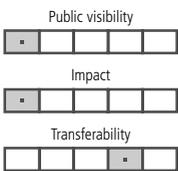
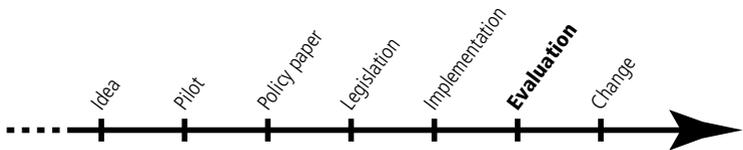
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### New Zealand: Evaluation of primary care reform finds enhanced role for nurses



A decade ago, when the PRISMA project was being initiated in Quebec, New Zealand embarked on its Primary Health Care Strategy. Shaped by a strategy paper released by the then incoming left-leaning government, the approach was discussed at more than 50 public meetings around the country. Following suggestions made in almost 300 written submissions and at the public meetings, the strategy was adopted in 2001, and an expansion of the role of nurses was seen as a crucial element of the new approach (also see *Health Policy Developments 1*, p. 55).

**Features of the  
Primary Health  
Care Strategy**

The PHC Strategy involved the creation of Primary Health Organizations, which would house multidisciplinary teams and would receive funding on a per capita basis, replacing the old fee-for-service approach. The underlying principles of the country-wide approach were to improve the health status of the disadvantaged

and to offer timely and equitable services regardless of the ability to pay. Key elements of the primary care strategy were a greater focus on prevention and population health and a desire to reduce patients' out-of-pocket co-payments while enhancing the cost-effectiveness of the system. As a result, nurses were seen as the entry point of contact, and the development of the nurse practitioner role was seen as critical to providing more cost-effective care.

**More waves of pro-nursing reforms**

In the years since the inception of the Primary Health Care Strategy, several concurrent reforms were aimed at widening the role and responsibilities of nurses in New Zealand (see *Health Policy Developments 7/8*, p. 154, and *Health Policy Developments 11*, p. 30). Increased budgets for nursing, better career opportunities and better training were all key objectives, as government wanted to see an expanded role for nurses in clinical work, prevention and health promotion. While the nurse practitioner was seen as critically important, the numbers of these positions in New Zealand stayed relatively small, with only 25 nurse practitioners in the mid-2000s.

**Nurse practitioners get a further boost**

Driven by an assumption that nurse practitioners could improve population health, the positions were first formally introduced in 2000, with limited powers to prescribe drugs. Five years later in 2005, the government greatly extended the prescribing powers of nurse practitioners, allowing them to prescribe for a range of chronic conditions. Concurrently there were moves to strengthen training and employment opportunities for nurse practitioners, against a backdrop of ongoing concern from the medical profession about the potential for overlapping responsibilities. As a result of all these incentives, the number of people enrolling as nurse practitioners began to expand rapidly.

**Evaluation of development of nurses' role**

Part of the evaluation of the broader primary health care strategy focused specifically on the development of the role of nurses. This part of the evaluation was based on interviews with personnel from the new Primary Health Organizations—which now number over 80 across both islands of New Zealand—, nurse leaders and other key stakeholders. Questionnaires were also completed by regular staff nurses, general practitioners and practice managers.

**Evaluation finds substantial growth**

Unsurprisingly, given the energy devoted to enhancing the role of nursing, the evaluation found substantial growth in the

in nurses' roles

development of the nurses' roles and capacities, especially with respect to the management of chronic conditions and of underserved or vulnerable groups. Two elements were important factors in this growth: special funding earmarked for nursing innovation—including involving nurses in governance and management, the development of nursing outreach clinics and mobile case management—and the emphasis within certain Primary Health Organizations on the need to improve population health. This resulted in more cost-effective services, growing acceptance among patients that nurses were the first point of contact rather than a doctor, greater choice for patients, freeing up of doctors' time, and greater job satisfaction among members of the multidisciplinary primary care teams.

**Downsides,  
barriers and  
recommendations**

The evaluation also found that current funding models do not promote autonomous provision of services by nurses, with some funding streams short term and ad hoc. Despite the rising numbers of nurse practitioners, the evaluation results suggested the need to establish more of these new positions. Moreover, the evaluation recommended more post-graduate education, more targeted funding and improved undergraduate clinical placements for primary health care nurses. It also recommended appointing nurse leaders within Primary Health Organizations, putting more emphasis on primary health care nursing as a career, and increasing the numbers of Maori and Pacific nurses and nurse practitioners.

**A new government  
commits to  
primary health care  
strategy**

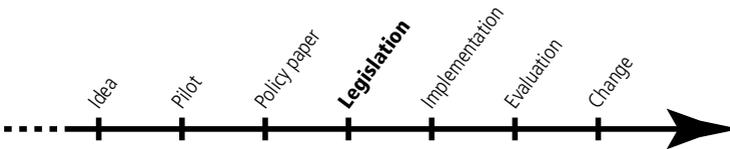
While the enhancement of nursing's role is predicated on the assumption that improved health will follow, the evaluation did not throw any light on this fundamental question. Nevertheless, the new centre-right government, elected in late 2008, looks set to continue the primary health care strategy initiated by their political opponents in 2001. The senior coalition partner in the new government, the National Party, has in fact criticized the former government for failing to deliver on some aspects of the strategy. The new government plans to accelerate change, especially in terms of expanding the range of services provided at the primary level, by devolving minor surgery and similar services currently usually provided in hospitals. This could well lead to a further expansion of the role of nurses in primary health care settings.

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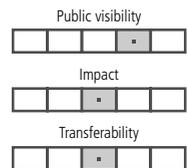
## United States:

### Does legislating nurse-patient ratios improve care quality?



Like many nations, the United States is in the middle of a major shortage of nurses, with estimates that 13 percent of nursing positions may currently be vacant and predictions that the figure will continue to rise. As in New Zealand, many states in the United States have taken action to try to fix the problem, making nursing more attractive by boosting training and professional opportunities and in some cases increasing salaries. Evidence suggesting that patient adverse outcomes are related to nursing shortages makes fixing the problem even more compelling and urgent, and one popular strategy is to introduce new laws mandating certain nurse-to-patient ratios within hospital settings.

California was the first state to introduce laws on ratios, drafted, as it happens, by the California Association of Nurses. Coming into operation in 2004, the laws mandated that all general wards in hospitals must have a ratio of one nurse to every six patients, improving to one to five the following year (also see *Health Policy Developments 2*, p. 67). Emergency wards were to have one nurse for every four patients, one for every two patients in maternity wards, and one for every five in medical-surgical units. The plan was to improve the working conditions of nurses and improve safety for patients. While organizations like Kaiser Permanente supported the new regime, nursing associations were split over the value of state legislated ratios, and are still.



**California leading on nurse-patient ratios legislation**

**California inspires  
action in many  
states**

California's new laws are said to have led to an increase of 100,000 registered nurses in that state, and they are inspiring action in many other states. In 2009, at least nine states are considering setting staffing ratios. One of those states is Pennsylvania, where there are predictions of a nursing shortage of 16,000 nurses by 2010. According to the Health Resources and Services Administration, the state could be facing a nursing-position vacancy rate of more than 40 percent by the year 2020.

**Pennsylvania  
debates different  
draft laws**

In 2009, three draft laws have been introduced into the legislature in the state of Pennsylvania, all designed to mandate nurse-patient ratios. One key aim of the draft laws is to reduce medical errors—which studies have associated with nurse shortages. Another aim is to reduce hospital infections that result from unsafe working conditions, in order to make the hospital workplace more attractive for nurses. A third objective is to cut back the expenses incurred by hospitals having to constantly recruit and fill nurse vacancies. The hope is that the new ratios will improve job satisfaction, nurse retention and the quality of care, and the experience in California is cited as a positive model.

**Nurses are split  
over state-  
mandated ratios**

Despite the worthy aims of the draft laws, nurses and their associations and unions are split over the strategy of state-mandated staffing ratios, the split mirroring the political divide within this professional group. This is the case both nationally and within Pennsylvania itself. Some nursing associations argue hospitals should set ratios, not the state, while others argue the state laws protect nurses from potentially dangerous decisions made by hospital managers to shed staff and cut back on costs. In Pennsylvania, some nursing groups support one of the draft laws being proposed by a Democrat—which calls for state-set ratios—while another key nursing association is supporting a Republican draft law, which would allow hospitals to set their own ratios. Both draft laws would introduce new whistleblower protections for nurses who “blow the whistle” on unsafe work practices.

**More nurses, fewer  
adverse events?**

Several studies have shown that higher rates of pneumonia, heart attack, urinary tract infection and other conditions occur in hospitals and wards with lower numbers of nurses on staff. One study published in 2002 found surgery patients had a 31 percent increased risk of mortality in hospitals with low numbers of nurses (Aiken et al. 2002). Another study from 2005, cited by Sen-

ator Leach when introducing his bill, suggested that keeping ratios at one nurse to four patients could potentially save 72,000 patient lives a year (Rothberg et al. 2005). A report in 2007 from the Agency for Healthcare Research and Quality linked increases in nurse staffing levels with decreases in “failure to rescue” and decreased hospital stays (Kane et al. 2007).

In early 2009, the California Health Care Foundation (CHCF) released a study suggesting the state’s minimum nurse-patient ratio had one positive outcome: the increase in employment for registered nurses, with a resultant increase in the “skill mix” in hospitals. The report also found that despite initial concerns, the ratios had not significantly affected finances, though some hospital administrators reported having to reduce other services and cut costs elsewhere in order to fund the expansion of nurse staffing.

Most importantly perhaps, the CHCF study found no evidence to suggest ratios altered the average length of stay or changed the frequency of many “nursing-sensitive” adverse events, including pneumonia and failure to rescue. Its authors recommended more detailed investigation to assess the full impact of the reform. Given that California is touted so widely as a model, this lack of evidence raises serious questions about the need for better evaluation of the impacts of significant reforms, such as nurse-patient ratios. While the highest profile draft law in Pennsylvania contains provisions to record daily statistics on a range of safety-related data, it has no mandated evaluation plan.

**Little impact on cost**

**Evaluation has not confirmed quality aspirations**

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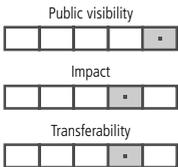
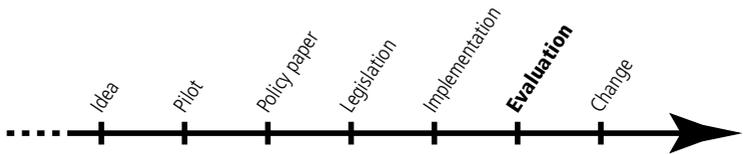
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**France:**  
**Evaluation of cancer plan reveals the need for better follow-up**



**France has high incidence of cancers**

**France launches major cancer plan 2003–2007**

Cancer is the leading cause of premature death in France, causing a third of male mortality and a quarter of female mortality. Over the past 25 years, cancer incidence in France has increased while the risk of mortality from cancer has decreased. Cancer survival rates in France are above the European average, but incidence rates are among the highest. The French system is not considered strong on prevention or coordination of care, and there are large social and geographic inequalities in both incidence and survival. Against this backdrop, France launched a major five-year strategy to fight cancer in 2003, a key element of which was strict follow-up and evaluation.

Cancer was described as one of the three top health priorities in 2001, and with backing from the then French president, the five-year plan was formally launched in 2003. The audacious plan had the ambitious aim of reducing cancer mortality by 20 percent. The plan hoped to create almost 4,000 new jobs and had 70 goals, clustered within six main priority objectives:

- Increasing primary prevention through better knowledge, fighting smoking and work-related cancer, and promotion of pro-health attitudes
- Improving screening, especially for breast, colorectal and cervical cancers, and improving early detection of melanoma
- Improving quality of care and focusing care on patients, with more equity of access to best treatments, more coordination and better information, and more money for new drugs
- Providing more humane and comprehensive social support structures
- Adapting training of professionals, by including cancer education in first stages of nursing and medical curricula
- Developing research by creating regional cancer centers and the National Cancer Institute, and encouraging collaboration and knowledge transfer

Despite widespread support for the initial plan, there were also important criticisms aired at that time. The most important criticism related to the insufficiency of measures addressing the prevention of environment and work-related cancers, which may constitute up to 20 percent of all cancers. The second type of criticism related to the unevenness in the budgets allocated to prevention versus care. Prevention, including screening, comprised only 13 percent, while care budgets were allocated almost 70 percent. There was also a degree of concern that the plan was unnecessarily oriented towards favoring the health industries, including drug and device makers.

An evaluation of the plan in 2004 focused mainly on process-related matters, across the six domains (Paris 2004). However, by 2009, two more comprehensive evaluations of the plan’s impacts had taken place. The first was from the Auditing Court, focusing primarily but not exclusively on the costs of the plan, and the second was from the High Council of Public Health, focusing more on the pertinence of specific actions, process and outcomes. Despite the fact that the actual plan called for strict annual follow-up of progress, this was not implemented during the five years that the plan ran. Furthermore, the research activities—one of the six key elements of the plan—could not be evaluated at all. Both reports deplored the difficulty of assessing the real outcomes of the plan, and the health impact was deemed impossible to assess.

**Support for and criticism of original plan**

**Evaluations could not find any quantifiable results**

**Evaluation finds  
lack of information  
on costs**

The real expenditure on the plan was not monitored separately by the Department of Health or the health insurance funds, and there was no formal agreement between the government and the new National Cancer Institute defining its objectives. The Auditing Court was very concerned about the lack of information on the real cost of the plan and about the difficulty of judging the results in the absence of precise indicators of performance. The court estimated the budget devoted to cancer has increased about 4 percent due to the plan; only half of the targeted increase in employment happened; and there were delays in acquiring diagnostic and treatment equipment. Results-based indicators were only partly developed, epidemiological data was not up to date, and it was therefore impossible to assess the real impacts of the plan. The court estimated that of the 70 original goals, perhaps one third were achieved, one third partly completed, and one third only just started or abandoned.

**Second evaluation  
similarly  
unimpressive**

Both evaluations found that prevention of tobacco use was an area of success, though like the first evaluation, the High Council of Public Health found the results available for evaluation were incomplete. This evaluation found that in the area of preventing unhealthy alcohol consumption and work-related cancers, there had not been much progress at all. Screening programs had been extended for breast and colorectal cancer, but participation rates were not at targeted levels.

**Both evaluations  
call for better  
follow-up in future**

Despite the problem with monitoring results and the negative findings, both evaluations considered that the plan played a significant role in improving prevention and quality of care for cancer, and in advocacy for prevention and treatment. Both evaluations also recommended a new plan be created, and asked for stricter follow-up of results, with one of them recommending separate work be undertaken to identify data needs and develop new information systems. The lack of measures in the 2003–2007 plan targeting social and geographic inequalities in cancer incidence and mortality was considered one of its biggest weaknesses, and one of the evaluations suggested that inequalities had probably increased during the 2003–2007 five-year period.

**A new cancer plan  
emerges**

The results of the evaluations of the first five years will contribute to the development of a new plan that will cover the period 2009–2013. The new plan will continue the work of the old, but

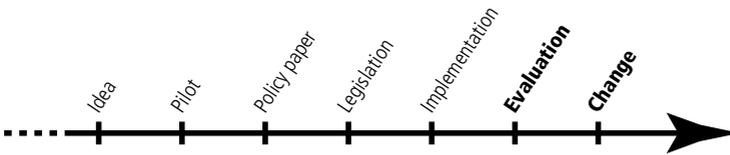
with stricter follow-up and some additional measures. The new plan will seek to improve coordination between hospitals and doctors in the ambulatory care sector. Importantly, it is informed by the need for tackling health inequalities, at a local and national level. Other elements include improving the lives of survivors by a range of measures such as encouraging more positive attitudes to cancer patients and providing better information about the consequences of treatment. The advisory report that has shaped the new plan reasserts that research should be driving innovation in this field.

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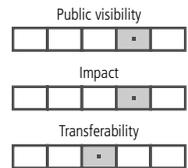
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**Germany: Time to evaluate disease management programs**



Modeled after similar schemes for the management of the chronically ill in the United States, disease management programs officially began in Germany in 2003 (also see *Health Policy Developments* 3, p. 32). Run by the nation’s statutory sickness funds, the disease management programs were enabled by new federal laws and were unable to operate until they were accredited by the German Federal Insurance Office. Disease management programs target those with chronic conditions, including diabetes, coronary heart disease, asthma, and breast cancer, and are currently being delivered to 5.5 million patients.



**Goal: Stop sickness funds chasing healthy**

Disease management programs were introduced into Germany as a way of compensating sickness funds for offering care to those with chronic conditions. As such it was a way of trying to work against “risk selection”, that is, the health insurers’ wish to insure the healthiest patients. Under the new Act to Reform the Risk Structure Compensation, sickness funds received special allocations for insurees enrolled in disease management programs, which were created by the sickness funds, accredited by the Federal Insurance Office and based on contracts with providers to provide the program’s care according to guidelines. Prior to 2002, risk-based compensation had been based on age, sex, and a measure of disability only.

**What exactly is a disease management program?**

Disease management programs are designed to improve the quality of care for those with selected chronic conditions and to contain costs at the same time, primarily by coordinating care, using good evidence and making the care patient-centered at the primary care level. Most programs share three key characteristics. First they have a knowledge base, with treatment flowing from evidence-based guidelines, using information technology. Second, the delivery system employs coordination of care and integrates different levels of the health system. Third, the programs offer incentives for payers, providers, and patients.

**Slow at first, but rapidly gaining popularity**

In part because of initial resistance from within the medical profession, who fiercely fought against “cookbook” medicine, disease management programs were cautiously introduced on a voluntary basis and thus at first grew very slowly in Germany. Moreover, the sickness funds themselves showed mixed reactions, the particular view of the fund contingent to the risk profile of its particular members. However, DMPs soon became very popular, and three years later, by 2006, almost 3 million people were enrolled. In 2009, more than 5.5 million patients were enrolled in disease management programs.

**Further changes to risk adjustment in 2009**

As we discussed in chapter 2, major changes came into effect in the German health system in 2009, including a new risk pooling system. For the first time, a detailed measure of morbidity is being used to assess risk, superseding in some way the use of disease management programs as a risk adjustment tool. Sickness funds no longer receive separate money for those enrolled in disease management programs, but according to a list of 80 chronic

and/or severe diseases, including those previously qualifying for DMPs. The new system removes the financial incentive to run DMPs, a strong driver for the establishment of these programs from 2004 till 2008. However, since 2009, DMPs will have to prove attractive and cost-effective in their own right in order to survive.

Evaluation of disease management programs is mandatory every three years in order for the programs to receive re-accreditation from the health authorities. The mandatory evaluations—commissioned by the Federal Association of Sickness Funds and conducted by independent scientific institutes—include an assessment of the achievement of clinical parameters, a review of process and documentation, observations of the rules of enrollment and examination of the costs of services. The study design used for the evaluation is an uncontrolled, non-randomized, prospective cohort study.

**Programs had mandatory evaluation**

According to the results, clinical parameters developed positively for type 2 diabetes and coronary heart disease, with evidence of decreasing blood pressure, fewer co-morbidities and stable blood sugar levels for those defined as having type 2 diabetes. A positive impact on smoking cessation and patient satisfaction was also noted. Effects on the patients' body mass index (BMI) and on the adherence to diabetic foot care could not be found. Evaluation results of the second generation of DMPs are expected to be published in 2009. None of the evaluation compared the costs or cost-effectiveness of the programs with standard care, because there was no control group. An overall impact on quality improvement thanks to "cross-fertilization" effects has also been observed, given that physicians who participate in DMPs begin to treat patients the same, whether the latter are enrolled in the programs or not.

**Promising results three years into DMP practice**

A separate large study that employed a cluster-randomized design found that over two and a half years the death rate was significantly lower among those enrolled in the diabetes disease management program, compared to a similar cohort receiving standard care. A recent review concluded that certain of these mainly U.S.-based and often older programs could improve the quality of care, as measured by the providers' increased adherence to evidence-based standards. However, effectiveness only re-

**Lower mortality rates in diabetes DMP participants**

ferred to structure and process, and no study found any impact on long-term health outcomes (Mattke et al. 2007).

**Evidence  
encouraging,  
but limited**

In summary the evidence—both in Germany and internationally—generally suggests improvement in important process outcomes, but there is no evidence yet that these programs, in place for only five years, are improving final patient-related outcomes—or that they are more cost-effective than standard care. As Shojania and Grimshaw wrote, “it seems that there is a pill called ‘disease management’ that produces promising results, but its active ingredients remain unclear ...” (Shojania and Grimshaw 2005). As for pills, emphasis on careful evaluation cannot be overemphasized. Both abandoning DMPs because of lacking evidence and continuing them in spite of lacking data would be a mistake.

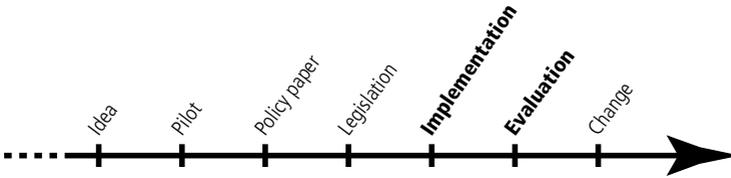
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## Israel: Evaluation of a proactive program for managing clinical quality

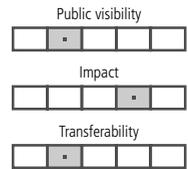


In 2007, Israel’s largest sickness fund and provider of health services, Clalit, initiated a new patient outreach program, aimed at both improving the care offered by its primary care community clinics and improving its own national quality indicators in comparison to other sickness funds. The first six months of the program were evaluated by comparing improvements in quality at clinics running the outreach program and at control clinics not running it. By 2008, the program was spreading rapidly, and it now operates in over 50 percent of the organization’s primary care clinics.

Clalit internally monitors 72 different quality indicators in its primary care clinics. The indicators cover primary prevention, in the form of vaccinations and other interventions, early detection of conditions including high blood pressure and high cholesterol, and treatment of chronic conditions including diabetes. In 2007, a program was initiated to reach out to patients listed on the organization’s database who scored low on these quality indicators. A list of patients was generated at each clinic taking part in the new outreach program.

In order to evaluate the impact of the new outreach program, the ten clinics taking part in the program were matched to another ten clinics with similar patient demographics. Using the list of patients that had been generated, the clinics invited people into the clinic for a special 20-minute consultation with a nurse and a physician. They were then assessed, sent for tests, and given information or other interventions deemed appropriate, including, for example, mammography or vaccinations. A follow-up visit was scheduled with the doctor or nurse, as needed.

The program is related to the National Primary Care Quality Indicators Program (also see *Health Policy Developments 4*, p. 51), which provides annual reports to each sickness fund in Israel com-



**Outreach to those with low quality-indicator scores**

**Outreach program simultaneously evaluated**

**Aim: Ranking high in National Program of Quality Indicators**

paring its performance to the national average. Even though comparative reports are not published, sickness funds try to improve their performance in order to rank favorably in national scores (Gross, Revital et al. 2007). In 2007, Clalit's national quality indicators were not high compared to other sickness funds, giving some background to the motivation behind this outreach program.

**Initial stakeholder concerns**

At first the participating clinics were ambivalent about the outreach program. It was a new approach that could mean more work and new ways of collaborating between different health professionals. Some clinics were willing to participate, some were not. Five districts within the organization chose to participate, but three districts strongly objected to the program and did not participate. However, despite initial concerns and opposition, it appears the program is now widely supported.

**Positive evaluation and further rollout**

Within six months, implementation was successful in four of the five districts in which it was tested, and there were apparently marked improvements in quality indicators compared to the control group. For example, the relative rates of mammograms improved by almost 18 percent in the intervention clinics, compared to almost 10 percent in the control clinics (and 7 percent in all clinics). In-depth interviews with staff members indicated their high satisfaction with the program. Within a year, 50 percent of Clalit's clinics voluntarily chose to use the care management techniques demonstrated in this program. The evaluation aspect of the project effectively lost its control groups, because those control clinics started to use the program as well.

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# Hospitals: Connecting with the community

*“...just as war is too important to be left to the generals,  
hospital care is too important to be left to  
hospital managers and health professionals.  
Martin McKee & Judith Healy, 2002*

One of the strongest messages emerging from the contemporary literature on hospitals is that while these institutions are critically important parts of the healthcare system, they must be integrated much better with that system's different components. For all their modern medical technology and high public visibility, hospitals are in fact very old institutions which face enormous challenges adapting to the demands of twenty-first-century health care. Today hospitals are very much in search of a new role (also see *Health Policy Developments* 9, p. 53–72); and predicting how best to define that role is a perilous process for policy makers everywhere. The key to connecting more with the communities of the future is building in a good dose of flexibility, along with the shiny new operating theatres and sumptuous rooms with a view.

Many hospitals can trace their origins to the Middle Ages, when many patients either recovered spontaneously from their conditions or died. Hospitals were more hospices than places where the sick got cured, often offering support and comfort, founded as part of religious establishments (Edwards et al. 2004). Even in the late 19th century, as Florence Nightingale reported, hospitals in London had mortality rates of more than 90 percent (Rechel et al. 2009). It was only following developments around the turn of the last century in anesthesia, infection control, medical science and technology that the modern hospital emerged, though it remained a place characterized by bed rest and convalescence until the 1950s.

Recent decades have seen tremendous growth in hospitals, with a recent survey in Europe offering some important observations (Chevalier et al. 2009). While per capita spending on hospitals has risen dramatically in absolute terms in the quarter of a

**Hospitals are very  
old institutions**

**Hospitals grow, but  
not as quickly  
as health care  
as a whole**

century to the mid-2000s, it has contracted as a proportion of total healthcare spending, which has of course swelled in many nations over that same time period. For example, in the Netherlands hospital spending decreased from 55 percent to 40 percent of total spending, in Italy from 47 percent to 44 percent and in Sweden from 70 percent to around 30 percent.

**Decline in bed numbers**

While there is much variation between countries in the nature of their hospital system and the number of beds per capita of population, overall there has been a decline in bed numbers over the past quarter century. In Europe, the figure has fallen from an average of six beds per thousand people in 1980 to just over four beds per thousand in 2004. Similarly, during the same time, the average length of stay in acute care hospitals shrank from eleven days to just under seven.

**Multiple trends affecting hospitals**

Despite the changing overall climate for health care that affects hospitals as well, including aging populations, shifting disease patterns, evolving workforce profiles, new technologies and new public and political expectations, there are some trends that are likely to continue. These include further shortening of length-of-stay, the growing use of market mechanisms, measures to improve care quality, and greater integration with other parts of the system, including greater use of ambulatory, home and community care (Rechel et al. 2009). While these trends will continue, other unexpected changes will occur and accelerate, leading informed researchers to conclude that a “key challenge for hospitals will be to incorporate a high degree of flexibility, so they can quickly adapt to changing needs and expectations” (Rechel et al. 2009).

**Hospitals are increasingly hazardous places**

Despite efforts to improve quality, hospitals are “increasingly hazardous places”—according to a concise, forward-looking analysis of how to configure these institutions for the 21st century (Edwards et al. 2004). The hazards come both from the growing risks of catching multi-resistant infections during a stay in hospital and from the epidemic of medical errors. One source of the error is the level of organizational complexity in contemporary care, combined with the fragmentation born of increasing specialization. Too many different professionals simply don’t talk to each other, and patients too often fall through the cracks of unhealthy professional division. Integration within hospitals, and between hospitals and the primary health care system and wider

community, will help ensure that only those who can benefit will be admitted, and that the care they receive during that admission will be optimal.

While only one fraction, hospitals have become a potent political symbol of the healthcare system as a whole, and they are highly prized in the public consciousness. Yet while the risky downsides of hospitals have increasingly become more commonly known, one problem has as yet received little public attention: the difficulty getting out of a hospital when you don't need to be there. "Hospitals typically have significant numbers of patients in acute wards who have ceased to benefit from medical care and round-the-clock intensive nursing care" (Edwards et al. 2004). Hard to believe, this Policy Brief estimates that 50 percent of patients in medicine and surgery wards may fit this description. The introduction of Diagnosis Related Groups (DRGs) in many countries has certainly led to significant changes here.

Many of the patients who end up admitted unnecessarily into hospital come through the emergency department, and these units are the focus of much reform activity. Many of the patients who present at emergency have a minor illness that can be much better treated elsewhere in the health system, via primary care units or stand-alone surgical centers that can be staffed by nurses, doctors and other health professionals (Edwards et al. 2004). Reforming emergency departments also means much closer links between hospitals and community and home care services: Contrary to the popular view, the aging of populations does not necessarily mean more pressure on hospitals, if enhanced social care can replace expensive and unnecessary hospital admissions (McKee and Healy 2002).

Against the background of these global policy debates, policy makers in Canada have embarked on a major reform of the nation's emergency departments, trying to reduce wait times, in part by diverting patients to more appropriate care pathways (see report on Canada, p. 81). And similarly, New Zealand's strategy to cut wait times includes a move towards more integrated care and strategies to reduce inappropriate patient presentation in emergency departments (see report on New Zealand, p. 83).

While in many countries hospitals remain largely a public endeavor, the reach of the private sector within hospitals is growing,

**Hospitals can be hard places to get out of**

**Emergency departments are problematic entry points**

**Canada and New Zealand reform emergency departments**

**More public-private ventures**

estimated to constitute an average of 20 percent across Europe's hospital sector, for example (Chevalier et al. 2009). One of the key developments in recent years has been the blurring of the boundaries between public and private hospitals and the rise of the public-private partnership, where the private sector can be contracted by the public sector to build, manage and maintain hospitals (Rechel et al. 2009).

**Privatization:  
politically  
welcomed, and  
rejected**

As we will read later in this chapter, South Korea is currently encouraging more private-sector involvement, by allowing its private not-for-profit hospitals to issue bonds in the capital market (see report on South Korea, p. 85). Denmark meanwhile is experiencing a government-backed rise in the use of private hospitals, enhanced indirectly as a result of a recent nurses' strike (see report on Denmark, p. 87). And in Poland, great political controversy surrounds a move to transform ownership of the state's hospitals, known also as health care units (see report on Poland, p. 90).

**Private sector  
involvement:  
not a cost-saver**

A recent report by the European Observatory on Health systems and Policies in cooperation with the European Health Property Network, called "Investing in hospitals of the future," canvassed several problems associated with this new blurring of the private-public roles and the rise of private-public partnerships (Rechel et al. 2009). The concerns raised include the significant time and money involved in the complex contracting process, the fact that long-term contracts tend to be incomplete due to a deficit of information, and the market reality that private partners are often reluctant to take on significant risks in capital projects. Another recent health policy document (Chevalier et al. 2009) cited an investigation of public-private partnerships by the National Audit Office in the United Kingdom, which found that the financial arrangement may ultimately be more expensive than conventional funding because of higher interest costs for the private sector and added contracting and compliance costs; buildings resulting from these arrangements are not necessarily of a better quality; and long term contracts are not flexible enough.

**Predictions are  
hard to make**

Whether private or public, planning the hospitals of the future requires dealing with a complex set of volatile factors (Rechel et al. 2009): Demographics are changing, exemplified of course by the aging process underway in many nations. Patterns of disease

are changing, with unhealthy lifestyles, poor diets, inactivity and climate change generating new pathologies. Technology too is transforming rapidly, with trends like miniaturization in surgery and diagnostics meaning much more can be done outside of the hospital. And inside the hospital, the workforce and its inter-relationships are changing, characterized by the rise of nursing, the expansion of multidisciplinary teams, and the still rare but vitally important championing of teamwork.

With so much change underway, the process of planning must be handled very carefully indeed. In this chapter, reports from two nations to some extent cover the process of planning. In Australia, a state government in trouble politically commissioned an inquiry into its hospitals, headed by a single lawyer (see report on Australia, p. 92). In Denmark, the government has engaged a multi-national team of specialists in a rigorous process of planning for future hospital needs (see report on Denmark, p. 87).

A study by WHO's Health Evidence Network in 2003 attempted to answer the question: "What are the best strategies for ensuring quality in hospitals?" (Øvretveit 2003). Despite the enormous public visibility of hospitals and the strategies to improve them, the review of the evidence found there was little good research assessing the effectiveness of one or more hospital or national quality strategies. This does not mean the strategies are ineffective, but rather that they are unproven. Moreover, as a team of high-profile researchers observed recently in relation to hospitals, "many traditional approaches to improvement are futile" (Rechel et al. 2009). This is because improving efficiency in one part of a highly complex system may have no effect in other parts, it may have adverse consequences, and it may create minimal value for patients.

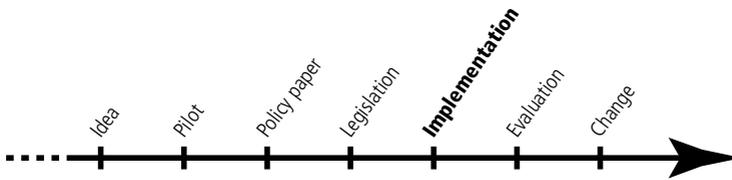
**Planning, not just political point-scoring**

**Many hospital reforms untested and futile**

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## Canada: Reducing emergency department wait times

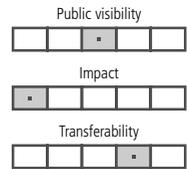


Unnecessary hospital admissions through a busy and already overburdened emergency department is a well recognized key problem in many nations. In Canada, about one in seven people received care for their most recent health problem via a hospital emergency department (ED). Of this population, just under a third was admitted to hospital, and these patients tended to be older and sicker than patients admitted through other means. Inefficient processes within EDs are believed to be one reason for long wait times and inappropriate admissions, and in the Canadian province of Ontario the government has introduced a range of initiatives to reform them.

In 2008, initiatives to improve processes and reduce wait times in Ontario targeted both hospitals and the primary care sector, in order to get better integration between the two, thereby reducing unnecessary presentations at EDs and the inappropriate admissions that can follow. Those initiatives included

- Targeting the 23 hospitals in the province with the greatest ED wait times
- Increasing home care services and enhancing integration between hospitals and the community
- Additional nurses for EDs
- Funds for local health integration networks to help provide community-based alternatives to hospital care
- Funds for nurse-led outreach to provide residents of long-term care facilities with care in-facility to avoid transfer to hospital EDs

One aspect of efforts to reform hospitals in Canada in the 1990s was to reduce inpatient beds because of a perceived over-capacity. Despite the reforms, problems in hospitals and primary care remain in the media spotlight and the subject of policy attention. A



**Multiple initiatives inside and outside hospitals**

**Unintended consequence of previous reforms**

study of the effects of hospital restructuring in Montreal found they were followed by marked increases in numbers of people turning up at emergency departments.

**EDs are victims of wider problems**

That study suggested some of the main reasons for the increases in ED visits: the community and primary care sector was unable to cope with the reduction in in-patient beds; access to in-patient beds had become more restricted to emergency department patients; and the average length of stay began to rise. In addition some hospitals were left with too few beds to respond to seasonal fluctuations in demand. Moreover, Canadian hospitals are also experiencing the increasingly recognized inability to discharge patients who no longer need to be there, estimated to be in the order of 20 percent of patients in Ontario hospitals. Ontario's 2008 initiatives, and further reforms in 2009, are designed to tackle this suite of problems, ultimately improving processes within, and taking pressure off, emergency departments.

**Ontario now setting targets for wait-times**

In 2008 the provincial government announced it would spend more than Can \$100 million (approx. US \$90 million, €63 million) on the suite of initiatives ultimately designed to improve performance within emergency departments. In early 2009, the government announced it would be introducing strict performance measures in the form of targets for ED wait times. For patients with minor conditions, the target is that 90 percent of patients will spend a maximum of 4 hours in the emergency department. Currently performance for these patients is 4.6 hours. For complex patients the target is that 90 percent of patients will spend a maximum of 8 hours in EDs, with current performance at 13.5 hours. Ontario is believed to be one of the first jurisdictions in North America to introduce strict ED wait times.

**Early successes at some hospitals**

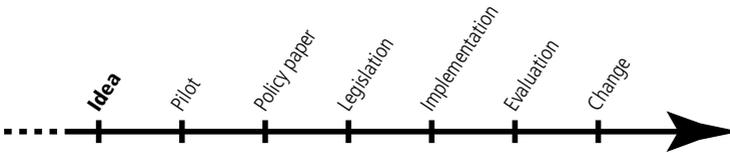
Early reports from some hospitals that have already tackled some of these issues indicate success in improving emergency departments. Some evidence suggests that within six months, ED wait-times for patients with both minor and complex needs can improve by up to 60 percent. Media have also reported that providing alternatives to hospital emergency departments can avoid ED visits for long-term care facility residents. While these initiatives have been popular with many stakeholders, it is unclear whether these early gains will actually occur across the province,

and as yet there has been no analysis of the cost-effectiveness of the new measures.

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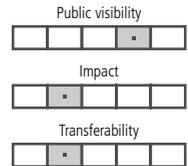
### New Zealand: Wait-time target of six hours for emergency departments



Like the Canadian province of Ontario, New Zealand is moving to implement strict targets for waiting times in its hospital emergency departments. Following the deliberations of an influential working group of clinicians, managers, ministry officials and an academic researcher, the new government in New Zealand has announced it will introduce targets for emergency department wait times.

The initiative—informed by similar reforms in the United Kingdom—will include a standardized measure of wait times and a target to treat almost all patients within a maximum of six hours. It will also include new accountability measures for District Health Boards—the public sector organizations responsible for the provision of hospital services—though it is unclear, and a source of disagreement, whether those measures will include punishments or give rewards for meeting targets.

Released in April 2009, a recent report highlights some aspects of the problem of wait times in New Zealand, specifically for the three categories of patients requiring very prompt attention. Patients with an obvious life-threatening condition, described



**6-hour ED wait-time target**

**Recent report highlights wait-time problem**

as Triage 1 patients, are seen immediately in all public hospital EDs. However, only 5 of 21 District Health Boards were meeting existing targets for seeing Triage 2 patients, those needing attention within ten minutes or less. For Triage 3 patients who should be examined within 30 minutes, only 4 of the 21 boards were meeting this target.

**A change of government is part of the context**

While the need to improve ED performance was certainly on the political agenda, a recent change of government in New Zealand has been an important context for the new wait-time targets. The proposal to introduce the new policy was one of the first major initiatives flagged by the new Minister of Health, within three weeks of the election in 2008. Replacing a long term center-left government, an incoming center-right coalition had as part of its election manifesto a pledge to deal with long waiting times at hospital emergency departments.

**Working group developed the initiatives**

In May 2008, a large gathering of 70 senior District Health Board clinicians, managers and Ministry of Health officials set up a “Working Group for Achieving Quality in Emergency Departments.” The group was charged with refining recommendations from the meeting and contributing to a government review of hospital-based emergency services. Reporting to the new minister in 2009, the working group recommended a standard approach to measuring wait times and a target for the numbers of people treated within six hours, to be introduced after a year of no targets, thus enabling the collection of baseline data. Highlighting the connections between problems in EDs and elsewhere in the healthcare system, the report also called for the creation of a national clinical network to continue working to reduce inappropriate patient presentations to EDs and a national, integrated acute care plan.

**Stakeholder support for wait-time targets**

Most prominent stakeholders have expressed in-principle support for the introduction of targets, which have been championed by the incoming Minister of Health. Organizations representing health professionals have all expressed broad support, though a nurses’ group has sought to define the problem in terms of inadequate nurse staffing levels, asserting that wait-time targets are a means to an end, not an end in themselves. There is, however, still a level of disagreement within New Zealand about the extent to which the new targets should be accompanied by rewards or punishments for those accountable.

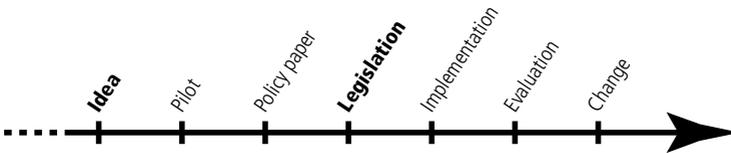
The new Minister of Health has signaled a preference for “hard targets” and said that the government “will be holding District Health Boards and management accountable for meeting these targets.” Ministry officials and the working group are more ambivalent about how “hard” the targets should be. Importantly, the working group identified the possibility that targets could have unintended consequences and lead to “gaming”—an example of which is holding patients in ambulances outside hospitals in order to meet wait-time targets inside. The group argued that unintended consequences could be minimized by maximizing organizational buy-in and using targets for internal improvement rather than as triggers for rewards or punishments by external bodies.

**How much carrot,  
how big a stick?**

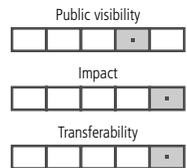
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**South Korea: Private nonprofit hospitals to raise funds through capital markets**



As in New Zealand, the people of South Korea in 2008 elected a new, more pro-market government. One of the plans of the new government is to enable the nation’s not-for-profit private hospitals to raise funds through issuing bonds in the capital markets, not just through loans from banks. The rationale is that this would allow an expansion of available funds for private hospitals, with the expressed hope of having more competition within the health sector. There will be regulations on the maximum amount



of funds hospitals will be allowed to raise through issuing bonds, based on the net value of their assets, and in addition there will be some broad limitations on how the money is spent.

**The backdrop of South Korea's healthcare system**

With an aging population of around 50 million, the Republic of Korea spends just over 6 percent of GDP on health care (WHO 2009). While the public share of total expenditure is more than 50 percent (channeled through the national health insurance system), the role of the private sector is prominent, with the vast majority of hospitals and clinics run privately. Private for-profit hospitals are technically not allowed in Korea, but not-for-profit hospitals are regarded as actively involved in profit-making. Private hospitals have big outpatient clinics which compete with physician clinics.

**Over-reliance on private sector?**

There are concerns that the proposed reforms will exacerbate what is seen by some as an existing over-reliance on private care, and that they will increase the profit-making behavior of private hospitals, unnecessarily inducing demand and causing health cost inflation. While the new policy may well enable increased funding for private hospitals and potentially improve quality as a result, some observers are worried that the growing privatization may see cost-cutting directed at maximizing profits, with potentially deleterious effects on care and equity.

**Ministries have differences over the plan**

The proposal has not yet been passed as legislation, and there are different positions among ministries. The Ministry of Strategy and Finance is regarded as preferring a radical change in the system that would see the introduction of for-profit entities into the hospital sector. By contrast, the Ministry of Health and Welfare is considered to be worried about the political feasibility of such a radical change. Instead, it is proposing to allow hospitals to seek funds by issuing bonds in the capital markets. The Ministry of Strategy and Finance is understood to think this is too marginal a departure from the status quo.

**Doctors and progressive groups opposed, hospitals divided**

Doctors and progressive groups in civil society are opposed to the plan, though for very different reasons. The Korean Medical Association is opposed as it could increase the competitive advantage of the hospitals vis-à-vis physician clinics. Progressive civic groups are opposed because they see it as aggravating profit-making behavior in hospitals and as the start of a major contracting of the public sector in health care. Hospitals are divided be-

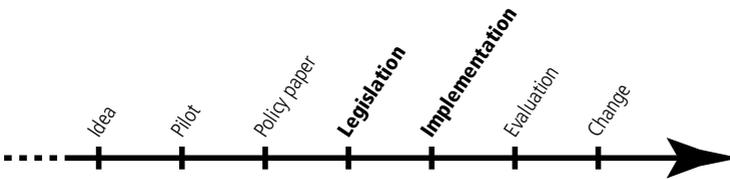
tween small and large hospitals, with large hospitals strongly supporting the idea. For their part, small hospitals are worried that they will have limited access to extra capital, and that the plan may leave them weaker in terms of competition with their big sisters.

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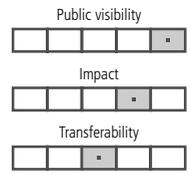
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**Denmark: Hospital privatization and long-term restructuring**



A very different form of privatization from that being planned in South Korea is underway in Denmark, enhanced in this latter case by a strict and controversial hospital wait-time guarantee that has been introduced incrementally over the past decade.

Under the wait-time guarantee, very different from that being promoted in emergency departments in Canada and New Zealand, patients in Denmark who cannot be treated at a public hospital within one month are able to seek treatment either in a public hospital in a different region or in a contracted private facility, at public expense. Initially the period was two months, but it was tightened to one month in 2007 by the liberal-conservative government. Critics argued the new time period of one month was too short and could be costly for the regions, which are involved in delivering care in Denmark. Political opponents argued the



**Wait-time guarantee spurs privatization**

moves were ideologically driven attempts to expand the market for private health care.

**Tax subsidies  
helped  
privatization**

A second key policy that has encouraged privatization involved changes to tax laws to encourage the takeup of duplicate private health insurance. This particular sort of insurance covers people for care and services received from private providers that is also available in the public sector. A relatively new form of insurance coverage, it is now used by 13 percent of the Danish population. While promoted by the government and popular with private providers and insurance companies, a recent survey found that six out of ten Danish people see this insurance as problematic because it undermines equity of access.

**Nurses' strike  
creates backlog of  
patients**

Into the middle of these policy changes came a major two-month-long nurses' strike in 2008, which helped fuel a rapid increase in waiting times at public hospitals. As a result, the one month wait-time guarantee was suspended between November 2008 and June 2009. However, the government and the regions agreed that they would work toward eliminating the expanded waiting list—by then numbering 400,000—by using total hospital capacity, including both private and public hospitals—indirectly giving an added boost to the private sector.

**Concerns  
privatization may  
drain staff**

As reported previously, there have been concerns for some time that the growing privatization may be helping to drain professional energy from the public sector (also see *Health Policy Developments* 10, p. 125). Doctors are allowed to set up dual practices, and there are worries some specialists may devote greater energy to their more lucrative private practice than their responsibilities in the public hospital sector. However, evidence is unclear about exactly what is happening in Denmark in this regard.

**Private hospitals  
paid too much?**

Under the wait-time arrangements, Danish regions were obliged to pay private hospitals at the same rate as public hospitals using standard pricing. However, because private hospitals do not have the same responsibilities as public hospitals—for example with regard to acute care or teaching activities—there is a view that private hospitals have been significantly overpaid, as part of a pattern of favorable treatment they have received from the Danish government, for ideological reasons. As it happens, since November 1, 2008, the regions have negotiated greatly reduced prices with the private hospitals. And importantly, a 2009

report by the National Auditors criticized a former health minister for allowing inflated prices to be paid to private hospitals from public funds.

Following reform of the Danish regions in 2007, major hospital restructuring and planning is now underway, running concurrently with the policy changes encouraging privatization. Under the regional reform, 14 counties were abolished and replaced with five new regions (also see *Health Policy Developments 4*, p. 79). Around the same time, the National Board of Health issued guidelines requiring a serious reduction in the number of acute admission hospitals in Denmark. This created a need for a major new plan looking at future hospital building and renovation needs, and a group of experts was appointed to make recommendations about how to spend € 3 billion allotted for these activities.

**Fewer acute admission hospitals**

The planning panel included three Danes, a Norwegian and a Swede, with backgrounds in the private and public hospital sector, medicine, industry and architecture. The group found considerable uncertainty surrounding projected treatment needs, given that some of the new hospitals would not be completed for a decade. Following its investigations and deliberations, the group decided to work with assumptions of an overall 50 percent growth in outpatient treatment and a 20 percent reduction in the number of beds. The panel's detailed recommendations caused some disagreement from individual regions, but the government has accepted all of them.

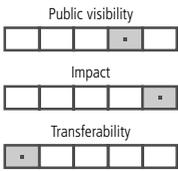
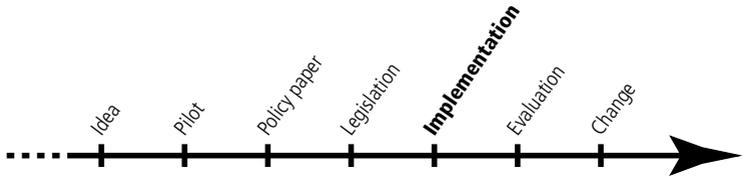
**Will outpatient treatment go up 50 percent?**

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**Poland:**  
**Tumultuous controversy over “privatization” of public hospitals**



Hospitals in Poland are in the midst of legal and political transformation. A new law introduced in 2008 would have seen health-care units—which include hospitals—move from state ownership to more of a market-based company structure. However, the proposed changes were highly controversial, with strong differences between parliamentary parties, and they were seen by some as an unhealthy form of privatization that could only favor the wealthy. Poland’s president in particular was a key opponent, and he ultimately vetoed the new legislation which introduced the reforms.

**Part of wider reforms**

The law on healthcare units was prepared by the parliamentary health commission and the Ministry of Health. It was part of a package of five health bills passed by the Polish parliament in 2008. The other bills included laws on patient rights, national and regional consultants, accreditation in health care and the working hours of health professionals. The main purpose of the reform package was to replace an older law on health care units from 1991 and to introduce a new legal framework and status for healthcare units, mainly hospitals.

**Moving from state-ownership ...**

A key element of the planned reforms was that hospitals would be obligatorily transformed from state-owned units into companies governed by legal provisions. If hospitals did not transform their legal status in this way by a certain time, they would be liquidated. According to one version of the proposed law, buildings and lands were to be handed over to the new company, though this proposal also met with serious opposition and was later changed from company ownership to a form of lease from the state.

**Proposed changes were highly controversial**

Wide discussion within the media, fueled by opposition from leading political voices, has given these proposed changes very high public visibility. A key argument was that the changes would

be a form of privatization. However, another set of arguments suggested that the laws were inadequate and even included wrong legal concepts and legal solutions. For example the responsibilities, or liabilities, of key stakeholders including healthcare professionals were not defined precisely enough, with a lack of information about issues including organizational structures and doctors' working times.

Very early on in the development of the proposed law, the president of Poland, Lech Kaczyński, expressed his strong opposition, and this understandably became a very important aspect of the political context. He argued the changes would essentially mean hospital privatization and that the consequences would not be acceptable to most of the Polish population. At the first opportunity, the president announced his intention to veto the proposed laws and instead suggested a referendum that would ask people's opinions on the reconstruction of public hospitals.

Apart from the president, two other key actors in this drama have been the Minister of Health and the Social Democrats group within the parliament, though the cast of players is long, including provider groups, local communities, the scientific community, lawyers, the media and local authorities. The Minister has been very active in promoting the planned changes and she has initiated many discussions and consultations with different bodies and groups. The Social Democrats have also been very influential, opposing elements of the changes, and suggesting amendments. While they are technically part of the opposition, their votes are necessary if the government is to get the 60 per cent of votes necessary to overturn a presidential veto. Up to summer 2009, the presidential veto has put any implementation of the reform on hold.

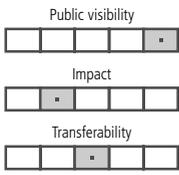
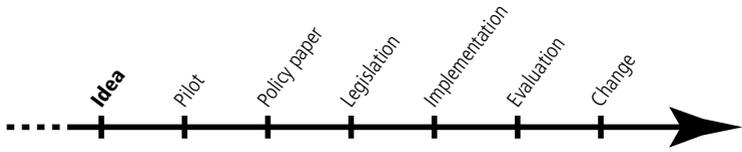
**President in strong opposition**

**Several actors in a complex political drama**

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## Australia: Hospital reform in New South Wales



In contrast to the planning process in Denmark mentioned previously in this chapter, the government of the Australian state of New South Wales recently created a one-person inquiry to examine the safety and quality of its hospitals. In Australia, notwithstanding a healthy private sector, healthcare expenditure is predominantly public. In terms of public hospitals, spending flows via taxation from the national government to state governments who are responsible for hospitals in their state.

### Controversy as background to inquiry

The center-left labor party has been in power in the state government in New South Wales for more than a decade. It has become increasingly unstable, with major changes at the executive level in recent years and widespread perceptions of incompetence from traditional opponents and party supporters alike. After several months of sustained public interest in problems at public hospitals, the government appointed an inquiry to investigate the safety and quality of the state's hospitals. Some observers thus see the inquiry as serving a political objective namely to demonstrate to a growing number of critics that the government was doing something.

### Legal approach for inquiry

The government chose a single lawyer to run the inquiry, rather than a team with any experience or background in the health sector. The lawyer gathered information by visiting public hospitals and hearing verbal evidence from individuals as well as receiving written submissions. Evidence was in the form of witness statements that can be seen as being taken at face value, from a legal perspective, rather than from a health perspective. He also received extensive briefings from health department officials and attended two conferences, and his inquiry was supported by a small secretariat from within the health department.

### Inquiry makes 139 recommendations

In summary, the inquiry found the state's hospital system was good by world standards but unable to deal with sudden in-

creases in patients, the rising costs of treatment, and pressures on staff that were too thinly spread and too poorly supported in terms of their administrative tasks. The inquiry made 139 recommendations across a wide range of health areas, including staffing, safety and quality, bullying, funding and clinical records. It also called for the creation of several new agencies, including a Clinical Innovation and Enhancement Agency, the Institute of Clinical Education and Training and the Bureau of Health Information.

The government responded by convening a forum of representatives from the community, health managers, clinicians, and unions, to prioritize the recommendations. It then formally accepted 134 of the 139 recommendations, but there is a degree of cynicism from some observers as to how many of the “accepted” recommendations will be implemented. For example, in its formal response the government says many of the accepted recommendations will first be subjected to a further loop of review and that many have already been implemented or are in the process of being implemented.

Three of the most contentious issues in the state are not yet resolved: how to manage low-risk pregnancies; the amalgamation of current pediatric services; and the processes for treating patients in EDs. The state government has committed to reviewing every public hospital in the state in terms of safety and viability, and this could lead to recommendations to downgrade or close some small rural hospitals. The inquiry also recommended that there be an independent oversight report four times a year to the government on the progress of the reforms, but at time of writing it was unclear if this was going to happen.

**Accepted, but also implemented?**

**Ongoing controversies**

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## Prevention: Yes, now, but how?

*“... the costs of most unhealthy activities impact in the future, whereas the benefits from them occur in the present.”*

Health England Report, 2009

Poor diets, physical inactivity, car travel, cigarette use and alcohol abuse... these are both the hallmarks of our high-flying twenty-first-century lives and the well-known causes of so many of our premature deaths. Working out how to change our lifestyles and prevent as much morbidity and mortality as we can is becoming more and more of a priority for policy makers everywhere (also see *Health Policy Developments 7/8*, p. 193). So while prevention still plays a very small part in the great drama of health care, its role is slowly growing, as evidenced by the slight upward trend in its share of total expenditure in OECD countries in recent years, seen in the graphs below (see figure 2. data should be interpreted with caution due to differences in definition and measurement). In Denmark, the political commitment to prevention now includes a target to extend life for citizens by three years in the coming decade, though already the strategies are being watered down (see report from Denmark, p. 101).

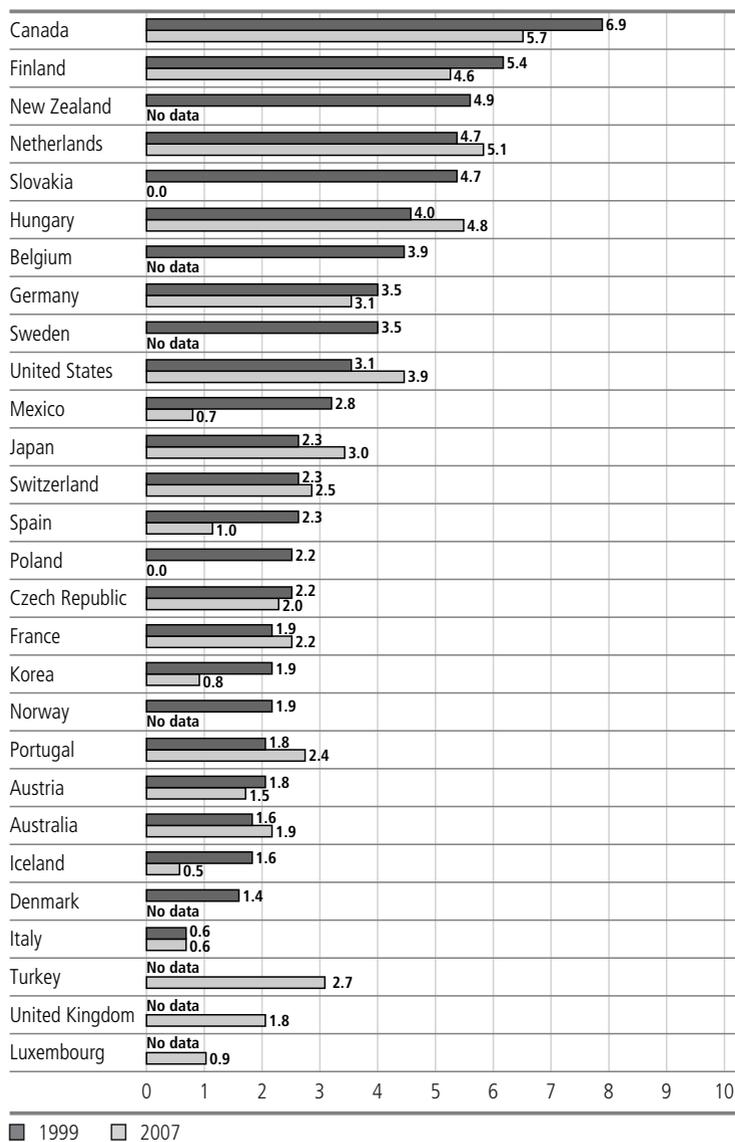
As many people have observed, the health costs of many unhealthy behaviors occur in the distant future, while the pleasures are received immediately in the present. The fear of an illness many years down the track can easily fade in comparison to the joy of an excessive smoking and drinking session with friends. Conversely, the costs to policy makers and taxpayers of trying to prevent unhealthy lifestyles take place in the present, while the benefits of these policy changes may not be reaped for decades (Le Grand and Srivastava 2009).

One way of trying to encourage more healthy behavior is to provide incentives for that change, or disincentives for unhealthy behavior, and this approach is receiving increasing policy interest. The aim is to bring some of the costs of that unhealthy behav-

The “pleasure now pain later” paradox

Incentives receiving increasing policy attention

Figure 2: Expenditure on prevention and public health (percent of total health expenditure), 1999 and 2007



No data available for Greece, Ireland. Portugal data from 2000; Australia, Portugal, Japan from 2006.

Source: OECD Health Data 2008.

ior into the present, and conversely to bring some of the potential benefits of policy changes into the present, to make them more attractive to those designing and managing the system. A recent report from Health England analyzes a range of possible incentives to encourage prevention, targeting individuals, healthcare providers and policy makers at different levels of the system. It finds a mixed picture in terms of the tentative evidence relating to the potential effectiveness of different strategies (Le Grand and Srivastava 2009).

As the Health England report points out, the evidence for offering incentives directly to individuals is equivocal (Le Grand and Srivastava 2009). Some reviews find evidence of effectiveness, but other reviews don't find enough evidence to prove that incentives can bring changes necessary for long-term lifestyle change. Examples of existing incentives can already be found in different countries, including Germany, where people can earn points for taking part in prevention activities, which can be later redeemed as sports equipment or books. A number of controlled trials are underway which should improve the evidence base for this approach. In the United Kingdom, a range of initiatives are being launched, to reduce alcohol problems and generally encourage more healthy lifestyles, though the incentives are being offered at the local government level (see report on the United Kingdom, p. 103, also see *Health Policy Developments 12*, p. 20).

Framing public health challenges as problems of individual behavior rather than social conditions is of course contentious. Depending on cultural views and values, different nations will give different importance to environmental and social conditions vis-à-vis individual behaviors and risk factors (also see *Health Policy Developments 5*, p. 43) In relation to obesity, for example, some argue the “blame” does not lie with the individual for excessive behavior, but rather with obesity-creating social structures and environments. Others, however, argue that a structural analysis is limited, and that individual behaviors can and do change (Le Grand and Srivastava 2009).

While there is evidence that increasing taxes and raising prices can act as a disincentive for unhealthy behavior—as for example with alcohol or tobacco—the strategy is not without controversy. Along with traditional concerns that conventional health

**Evidence is equivocal about incentives**

**Unhealthy behaviors or unhealthy societies?**

**Tax increases as classic but controversial disincentives**

promotion strategies tend to widen health inequalities, there are added concerns that tax increases on alcohol or cigarettes could be inequitable in the sense that they disproportionately hit people on lower incomes, who are already at risk of worse health outcomes. Controversy also surrounds the impacts of tax increases on domestic industry. In Finland for example, the interest of the domestic industry was a key factor when the government supported alcohol tax decreases in 2004 (see *Health Policy Developments* 5, p. 59). Currently, like many nations, Finland is introducing tougher regulation of tobacco as a means of preventing its unhealthy effects (see report on Finland, p. 106), while in Israel a health fund is opting for its providers to use computerized behavioral prescriptions to encourage smoking cessation (see report on Israel, p. 108).

**Tax increases on  
unhealthy food?**

While there is evidence that tax and price rises can reduce tobacco or alcohol consumption, the picture is different when it comes to tax increases on unhealthy food, being considered in places including Denmark. A short review of the evidence by the World Health Organization's Health Evidence Network in 2006 found "no direct scientific evidence of a causal relationship between policy-related economic instruments and food consumption, including foods high in saturated fats" (Goodman and Anise 2006). The review finds indirect evidence suggesting a link is plausible, but—as so often with such interventions (see chapter on Evaluation, p. 53)—no evidence from rigorous studies. Interestingly, it finds a small body of evidence that reducing the price of fruits and vegetables and healthy snacks can increase their consumption. Importantly, it warns that price increases, without complementary interventions such as subsidies for healthful foods, "may be viewed as inequitable."

**Japan: incentives  
to attack  
waistlines**

Japan is using financial disincentives for companies and local governments as a strategy for fighting the problem of overweight and obesity and its associated conditions (Onishi 2008). Under a new law introduced in 2008, companies and local governments face financial penalties if they do not meet specific targets for measuring the waistlines of people aged between 40 and 74. Individuals found to exceed very strict waistline thresholds will be offered dieting guidance and other intervention. The government hopes the new approach will save money in health costs, but crit-

ics say the guidelines are too strict, too many people will be labeled, and overmedication and rising costs could result instead (Onishi 2008).

The discussion in Japan about whether prevention activities will lead to unnecessary prescriptions is part of a wider debate about the blurring of preventive and curative medicine.

Policy makers who presume that investing in prevention will save costs should be cautious, particularly in light of the growing number of expensive medications prescribed long term to large proportions of the relatively healthy population in the hope of preventing illness in the future. Costly long-term pharmaceutical therapies including cholesterol-lowering drugs, anti-hypertensives, bisphosphinates for osteoporosis, and drugs for type 2 diabetes can potentially be cost-effective for those at high risk of future illness, but for those at lower risks, the drugs may be useless, harmful, and cost-ineffective compared to non-drug approaches to prevention (Moynihan 2005). In any case, a careful technology assessment of such interventions should seek to differentiate between different population groups.

Much of the contemporary prevention activity covered in this chapter and underway in many nations targets young people, with the aim of reducing smoking and excessive drinking, at the same time as increasing physical activity and healthy eating habits. Schools are an obvious site for this health promotion activity, and a synthesis looked closely at the relevant evidence (Steward-Brown 2006). It found that long-duration, high-intensity programs were effective, and multifactorial interventions were effective in promoting healthy eating and physical activity. However the synthesis also found that programs trying to reduce drug and alcohol use and abuse were largely ineffective, a finding which calls for renewed creativity from policy makers seeking this aim.

**Unhealthy blurring  
of preventive and  
curative medicine**

**Schools as a  
setting for  
prevention**

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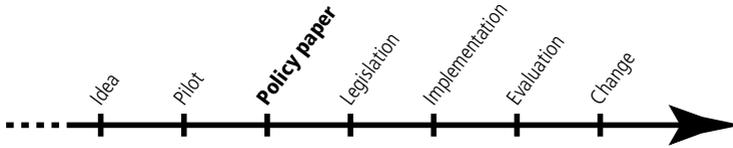
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## Denmark: Increasing life expectancy through prevention

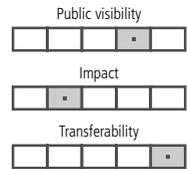


A fascinating analysis of public health policy within Scandinavia found important differences in approaches and strategies between Denmark and its northern neighbors, Norway and Sweden (Vallgarda 2006). While the Danes tend to stress “the importance of individual behavior, responsibility, and autonomy,” Norway and Sweden emphasize social relations, living conditions, democratic participation, and political responsibility for the health of the population, in addition to behavioral factors.

Against this background of a more individual-liberal-behavioral approach, the liberal-conservative government has set a target to increase full life expectancy in Denmark by three years, within the next decade. The government appointed an independent commission, which made recommendations, some of which have already been rejected as politically unpalatable. Because of major political reforms affecting the entire public sector, local municipalities now have responsibility for prevention and health promotion, and along with legislative changes that may occur, local government will play a big role in trying to reach the national targets.

Denmark ranks at number 20 in terms of life expectancy within the OECD, largely—it is argued—because of life-style issues relating to smoking, drinking, nutrition and exercise. The main problem is smoking, though Denmark also has one of the highest alcohol intakes within the OECD, particularly among the young. Similarly, the consumption of sugar and fat is very high in Denmark compared to its peers, though the intake of fruit and vegetables has increased in the last few decades. An astounding 40 percent of Danes are employed in jobs that do not require any physical activity.

The ten-member prevention commission was asked to come up with cost-effective prevention activities, and the main focus of



**Three more life-years within a decade**

**Danish lives are rather short**

**The commission makes 52 suggestions**

its 52 recommendations not surprisingly concerns smoking, alcohol, poor nutrition and inactivity—responsible for an estimated 40 percent of all premature deaths. Some of the recommendations included

- Extending tobacco taxes and smoking bans, placing warnings on cigarette packs, offering courses in smoking cessation
- Raising the alcohol age threshold from 16 to 18, banning all alcohol advertising
- Increasing activity in schools, promoting activity in local district plans
- Increasing taxes on chocolates and sweets, offering fruit in schools

The commission also recommended actions concerning the early discovery of illnesses, workplace changes and prevention research.

**Government rejects some key recommendations**

The Ministry of Health has rejected raising the age threshold for buying alcohol from 16 to 18—fearing that it will be highly unpopular among the Danish population. The Ministry has also rejected increasing cigarette taxes and extending the smoking ban to all indoor locations, while the Prime Minister has rejected the cigarette tax increase on grounds it will increase cross-border shopping. Other stakeholder groups including provider and patient advocacy groups welcomed the commission’s recommendations.

**Political differences over tax strategies**

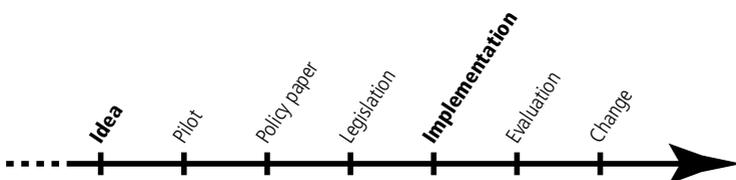
While there is political consensus about the aim of focusing more on prevention, there is political disagreement over the extent to which the state should use economic levers like taxes to change individual behavior. The Social-Liberal party supports the increased taxes on chocolates and sweets, and the Social Democrats generally support increases in taxes on unhealthy foods. The Liberals, by contrast, prefer to try to change behavior without using tax instruments, for example by constructing different types of playgrounds or more bike paths.

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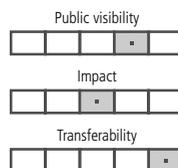
### United Kingdom: Encouraging healthier behavior



The government in the United Kingdom has introduced a suite of initiatives to encourage healthier behavior, focusing on reducing binge drinking, increasing physical activity and boosting healthy eating habits. In terms of the initiatives aimed at increasing exercise and encouraging better eating habits, the main motivation is tackling rising obesity rates, particularly among children, and they are targeted at nine “healthy” towns. For alcohol, the initiatives involve both new regulation and education, and again the focus is on young people and their binge drinking.

In November 2008, the government announced it would spend 6 million pounds (approx. US \$10 million, € 7 million) on tackling excessive drinking in 20 areas with the most severe alcohol problems. Regional alcohol managers have been employed to promote treatment and advice at the local level, and simple advice relating to appropriate use has been issued. Given what we know of providing information alone, this particular investment may ultimately produce little change in the nation’s drinking problem.

The government has also proposed a range of measures to better regulate the sale of alcohol, including



**Targeting 20 problem drinking areas**

**Tougher regulation of alcohol**

- Banning “all you can drink” offers in pubs
- Banning promotions to certain groups
- Banning discounts on large purchases
- Training for sellers
- Requiring pubs to offer medium-sized glasses
- Increasing fines for public drinking
- Tougher punishment of those selling alcohol to underage drinkers
- Strengthening police powers to confiscate alcohol

**Teen drinking is another focus**

In early January 2009, a further set of less-regulatory measures were released by the government for public consultation, specifically relating to teenagers. The key recommendation was that children aged under 15 should avoid alcohol completely. Additional recommendations include that 15–17-year-olds should not consume alcohol more than once a week, and that parents should be aware that anything in excess of this could be damaging to their children’s health. Moreover, parents should be made aware of the influence of their drinking on their children. Increased availability of services for children with alcohol-related problems was also part of the plan.

**Nine towns selected to be “healthy towns”**

In late 2008, the government announced that nine towns would receive special funding of 30 million pounds (approx. US \$49 million, € 35 million) to promote what’s known as the “change4life” initiative, essentially designed to encourage more healthy behavior. The nine towns include Halifax, Sheffield and Manchester, and many are disadvantaged. The main aim is to promote physical activity and healthier eating habits, and the towns have agreed to provide matching grants to the government investment.

**Bikes, green spaces and vegetable and fruit growing**

Examples of the initiatives being funded under the new scheme are

- A loyalty scheme in Manchester that rewards people with free activities or healthy food if they take exercise
- A scheme in Thetford to encourage more cycling and bike maintenance
- A new urban garden in Tewsbury to encourage fitness and rebuild green space
- A grow-your-own-vegetables scheme for public housing tenants in Halifax
- A scheme to make the city of Sheffield breast-feeding-friendly

The government is also seeking to gain the commitment of the private sector—not threatening fines as in Japan—but by encouraging companies to sell healthier products and provide healthier work environments to their employees. A number of examples have already started to occur, including

- Two giant retailers, collectively serving 36 million customers, have agreed to communicate to customers and workers the benefits of healthy eating
- The main commercial television station will run campaigns to encourage people to lose weight
- A soft-drink manufacturer will fund advertising to promote the benefits of an active lifestyle.

**Private sector also involved in initiatives**

One of the key criticisms of the new suite of initiatives to promote healthier behavior is that they are being insufficiently and inadequately monitored for their level of effectiveness. It seems the government may believe that by doing many things, something is bound to work, and that providing information where there are information deficits is a worthwhile thing to do. So if these initiatives are not evaluated, as is often the case with many policy reforms, it will be very hard to know what impact, if any, they have had in terms of preventing illness and premature death.

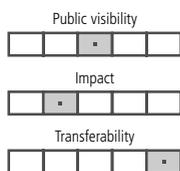
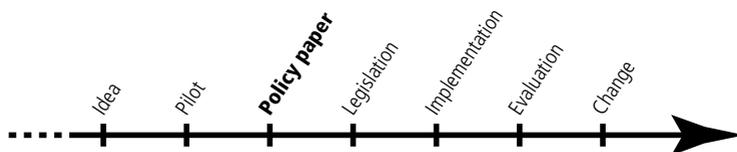
**Evaluation, as ever, the poor cousin**

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## Finland: Tightening tobacco legislation



As in Denmark, a recent set of recommendations on how to prevent illness from a government-appointed body has been watered down by that same government. In the case of Finland, the government had appointed a working group specifically to look at how to reduce the harm associated with tobacco. As elsewhere, smoking is a major cause of disease and premature death in Finland, with estimates that it may induce about 5,000 premature deaths annually. The latest round of reforms comes more than three decades after the first major attempts to wind back tobacco use.

**Long history of attempts to reduce smoking**

A law in 1977 initially banned the advertising of tobacco products, and gradually since then, legislation has become increasingly stricter. In the last ten years the most significant reform was the 2007 change which saw smoking severely restricted in bars and restaurants (see *Health Policy Developments 7/8*, p. 216). Under this change, smoking could only take place in closed areas where no eating or drinking was occurring. The reform was unpopular with bar owners but popular with a majority of Finnish people. In that same year, the government appointed a working group to investigate further measures to reduce smoking.

**Working group has broad representation**

The Ministry of Social Affairs and Health nominated a working group with broad representation from different stakeholders. It included representatives from the Ministry of Social Affairs and Health and the Ministry of Finance, a cancer society, the National Public Health Institute, a grocery trade association and the hotel and restaurant association. The WHO Framework Convention on Tobacco Control and previous national policy documents played an important role in the development of the working group's proposals.

**Several measures recommended**

The working group reported in December 2008 and proposed several measures, as well as expanding sales of nicotine replacement products to pubs and restaurants:

- To ban brand names and logos of tobacco products from retail outlets
- To widen the ban on smoking in public places (e.g., to ban smoking in hospitals even in dedicated smoking rooms or outside areas)
- To totally ban importation of snus (addictive oral tobacco product used by about 5 percent of Finnish men and popular in Sweden)
- To ban possession of tobacco by under-18s, and have four-year jail sentences for those supplying under-18s
- To ban importation and sale of products imitating tobacco products (e.g., cigarette-shaped chocolates)
- To ban sales of tobacco products from vending machines

The associations representing the grocery, hotel and restaurant industries did not accept all the measures proposed by the working group. They opposed the plan to ban brand names and logos from retail outlets. The grocery association also saw the punishments for violating proposed regulations as too severe, and opposed the plan to ban snus importation, which became a key topic in public discussion. The Swedish People’s Party, which is one of the parties forming the current government, also opposes restrictions on snus importation, as the use of these products is believed to be more common among the Swedish-speaking minority in Finland.

**Industry and political opposition**

Following the criticisms of the working group’s proposals, a new revised plan has been released by the government, with several measures diluted. The proposed legislation currently includes these changes to the working group’s proposals:

**Legislative proposals dilute recommendations**

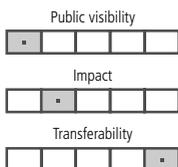
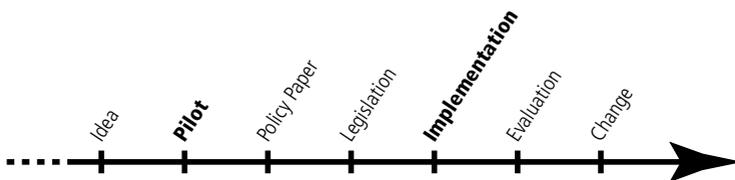
- The smoking ban is not extended to healthcare facilities
- Importation of snus remains legal, limited to 30 boxes for personal use
- Possession of tobacco by under-18s will not be banned
- Sale violations would have maximum punishment of six months
- Importation and sale of imitative products will not be banned

Even a more than 30-year-old commitment to reducing the harmful effects of tobacco on population health in Finland obviously does not mean that the means are uncontested.

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## Israel: Computerized smoking cessation programs



An innovative strategy being used to try to reduce smoking rates in Israel involves a behavioral prescription for smoking cessation. The strategy has been initiated and is being implemented by the smallest health fund in Israel, Leumit Health Fund, which has 700,000 members and a market share of about 10 percent. Patients who have an interest in quitting smoking will receive the behavioral prescription, generated through their electronic medical record, which will serve as a tailor-made informal contract with their doctor.

### Origins in a behavioral psychology

The origin of the idea is the behavioral psychology approach described as Short-term Family Therapy in Ambulatory Medicine. This approach suggests that certain strategies from cognitive behavior therapy, hypnotherapy and other psychological interventions can be adapted and used in primary care settings, even in short 10-minute office consultations. A text book co-written by a physician and a psychologist outlines the approach, which has inspired the behavioral prescription for smoking cessation. One of the book's authors presented the idea to his colleague, the medical director of Leumit, and ultimately it received backing from the most senior levels of the organization and is being rolled out in all primary care facilities. The behavioral prescription for smoking cessation is in line with Leumit's vision and mission emphasizing health promotion and health education for its members.

The national context for the smoking cessation program is the “Healthy Israel 2020” program initiated by the Ministry of Health (Rosen et al. 2006). The program was developed by a large pool of leaders within the health system, who analyzed evidence, set targets and outlined strategies to achieve them. The program was part of Israel’s commitment to develop a “Health for All” program, under the auspices of the WHO program. It is also a manifestation of the Ministry of Health’s interest in increasing the attention given to population health, health promotion and disease prevention.

**Smoking cessation part of national strategy**

The smoking cessation plan has been widely supported both by providers and by different departments within the health fund. Physicians are not yet being offered financial incentives but are rewarded by positive feedback from their patients. Patients sign a contract with their doctor which is thought to create a psychological commitment to quitting. For its part, the insurance fund, Leumit, has a long-term incentive to promote the program in that it has the potential to reduce the costs of caring for those with smoking-related illnesses in the future.

**Incentives for providers, patients and insurer**

At time of writing, the behavioral prescription for smoking cessation is not yet widely used by doctors, though an intensive dissemination plan is set to begin later in 2009. Possible obstacles to widespread use include a lack of awareness about the new tool, low motivation to invest the effort required to use the new tool, and a perceived lack of time to use it. Continuing medical education and even material incentives may be considered as ways of changing physician behavior and encouraging use of the new tool, and an evaluation is being planned to assess its effectiveness.

**Possible obstacles**

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## Equity: Always the goal, but how serious are we?

On average, being wealthy in Europe can give you an extra decade of health, compared to those from different socio-economic backgrounds (EUROTHINE project 2007). The facts of health inequalities are now well known everywhere, and many nations have decided to make the fight against inequalities a key objective of their health systems. Yet as we are reminded again by the policy developments reported in this chapter, the mountain of concerns about health inequality appears to have produced little more than a molehill of effective action. In Singapore, for example, recent reforms mean that the wealthy—in addition to their extra years of healthy life—will now be able to legally buy kidneys from the poor (see report on Singapore, p. 114).

A report published as early as 1980, the Black Report, documented widening health inequalities in the United Kingdom, despite the advances of the nation's post-war welfare state and its publicly funded universal system of health care. Until today, that report is still credited with being highly influential internationally, essentially putting health inequalities on the policy agenda to one degree or another in many nations (EUROTHINE project 2007). By the late 1990s, many countries were generating their own data and were trying to close the health gaps that characterized their populations' health status (Hogstedt 2008).

More recently, a major European project involving 50 researchers from over 20 nations reported on efforts to tackle inequalities (EUROTHINE project 2007). It found that countries differ strongly in terms of the diseases making the largest contribution to health inequality and also differ strongly in the specific health determinants that make the largest contribution to explaining that inequality. Despite the challenge, it found that effective action is

**Three decades of worrying about inequity**

**Health inequalities can be reduced ...**

feasible, but it should be comprehensive, sustained and systematic, addressing both the “upstream” determinants, and mid- and downstream causes.

... if we choose to

Further findings included the importance of tackling health-related behaviors like smoking or excessive alcohol as a way to reduce inequalities, the critical role of access to good care, and the value of setting quantitative targets for reducing differences in health indicators. The report concluded optimistically that “health inequalities can be reduced if we really choose to.”

UK: Evaluating a decade of action

Subsequent to the Black Report, the Acheson report in the United Kingdom in 1998 made many recommendations to fight inequalities in health. A just-published evaluation of ten years of action in the United Kingdom found significant improvements in the health of the population, including the health of disadvantaged groups. However, the gap between the average and the worst off did not narrow (McDaid 2009). While welcoming encouraging overall improvements, in his foreword to the report, Sir Michael Marmot reminds us that we need to look beyond the health system to fix inequities in health because “if the causes of health inequalities are social, economic, cultural and political, then so should be the solutions” (McDaid 2009). As it happens, the government in the United Kingdom has invited Marmot to chair a fresh review of how to tackle health inequalities, to help seek those solutions (see report on the United Kingdom, p. 116).

Improving health can have unfair outcomes

Another of the classic paradoxes of public health policy is the danger of simultaneously improving health and harming equity. A paper in *Health Affairs* analyzed an immense health-promotion and disease-prevention project in the United States called “Healthy People 2010” (Keppel 2007). As in the United Kingdom, many of the indicators—including heart disease deaths, for example—for the overall population health are improving, but disparities between racial and ethnic groups are not. In some cases where there was overall improvement, disparities ended up being worse. The authors concluded that the aim of enhancing quality and life expectancy does not necessarily coincide with eliminating disparities, and special strategies may be required. In France, one such special strategy is the Urban Health Networks, focusing on improving access to health services in the nation’s most disadvantaged communities (see report on France, p. 119).

System-wide health reforms can have differential impacts on different groups, with obvious consequences for improving or worsening health inequities. A review of the evidence about how reforms might affect gender equity, conducted by the Health Evidence Network, found that expanding private insurance, out-of-pocket costs and privatization may impact negatively on existing gender inequities, as women tend to have fewer resources and make up a larger proportion of the patient population (Ostlin 2005). In South Korea, concerns that out-of-pocket payments disproportionately hurt those on lower incomes has motivated a move to introduce graduated thresholds or ceilings on out-of-pocket costs, dependent on a person's income (see report on South Korea, p. 121).

**Health reforms can affect different groups differentially**

Meanwhile a review for the Scottish government examined the effectiveness of interventions aimed at tackling inequalities in the first years of life (Hallam 2008). A key finding was that even for health programs that are effective, they are often less effective, or ineffective, for the most disadvantaged groups. The report concludes that it may not be enough to target deprived areas with programs to improve parenting in the first year of life, but rather we may need to specifically target the most disadvantaged families within those deprived areas—using innovative interventions designed and delivered by mothers living within the target communities: “Mothers targeted by the intervention may find it easier to trust their peers” (Hallam 2008).

**Involving the target community**

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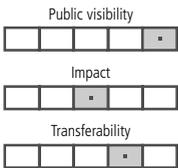
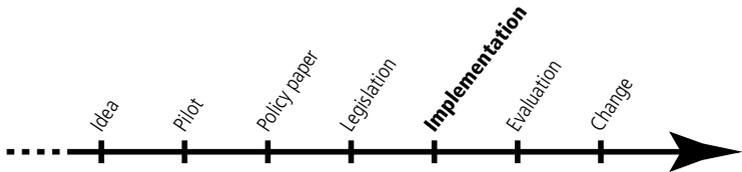
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## Singapore: A legal trade in human body organs?



Though the practice was previously illegal and for many unimaginable, the government of Singapore has recently amended its laws to allow people to be “reimbursed” for the direct and indirect expenses relating to donating an organ. It is not clear yet what level of payment will be allowable, though already the possibility of a six-figure sum has been mooted. The government argues that the reform will allow organ donors to be properly remunerated, while critics are concerned it could be the beginning of a legal organ trade and even transplant tourism in Singapore.

**Big demand  
for kidneys**

Unmet demand for kidneys is one of the driving forces behind the changing legal picture in Singapore. An important develop-

ment took place in 2004, when the government made it legal for the first time for a living person to donate an organ. The living donor had to be related to the recipient, and there could be no emotional coercion or financial inducement influencing the decision-making process. Then in 2008, political debate began about further liberalization, sparked in part by a high profile case of a potential sale of a kidney, from a donor from Indonesia, to a wealthy Singaporean businessperson. The 2009 changes allowing “reimbursement” followed.

While organ trading remains illegal, there is concern that legalization of the “reimbursement” will essentially allow wealthy people to buy organs from poorer people, making acceptable a trade that currently occurs only in the black market. Importantly, the Minister for Health has publically moved in recent years in his position on organ trading, from one of moral condemnation to outright openness, saying it is an option worth studying. In relation to equity, the Minister is reported as saying that the current reform could enhance equity by enabling the rich to subsidize the poor in obtaining their organs.

During the debate in 2008, the Singapore Medical Association made very strong statements opposing the sale of organs, saying that the sellers are almost always desperately poor, that donors could be abused and exploited, and that donors face a range of short and long-term risks after donating an organ. However, their position later softened, and they are not opposed to the current change in law. A number of different views have been expressed in the wider public debate in recent years, with some arguing that a legal trade would save the lives of those waiting for organs, and others arguing that donors might be best reimbursed in nonfinancial ways.

One of the concerns is that Singapore may now be on a slippery slope towards becoming a capital of “transplant tourism.” During the parliamentary debate, the government had said that for the sake of fairness the new law should apply equally to Singaporeans and foreigners—opening the door to allowing poor foreigners to sell organs to Singaporeans and vice versa. However, the Minister for Health later clarified this position, saying that in the implementation of the new law only Singaporeans would be reimbursed, though payments would be extended to foreigners after enough “confidence” had developed in the scheme.

**Will legalization replace black-market?**

**Doctors' position softened**

**Singapore: capital of transplant tourism?**

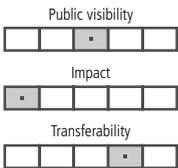
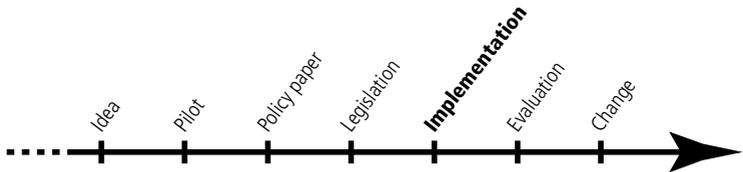
**When is an reimbursement an inducement?**

One of the biggest questions surrounding the new law—perhaps even a rhetorical one—is when does reimbursement become an inducement? Heavy reliance is being placed in hospital transplant ethics committees to help resolve this question, yet they are not empowered to investigate and discover the extent to which a donor is being coerced, financially induced, or emotionally pressured. Nevertheless, the National Medical Ethics Committee has endorsed the change that allows the reimbursement of kidney donors, saying this does not amount to payment, and that it rights a wrong, as donors face the risk of higher healthcare costs in the future as a result of the donation.

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**United Kingdom: Health inequalities—reports, reviews and re-evaluations**



While some within the government in the United Kingdom have declared that the aspiration of an egalitarian society is now redundant (Wintour 2009), the official goal of reducing inequalities in health remains in place, notwithstanding the challenges of realizing it. A recent review of ten years of action found little progress on inequality, as mentioned earlier, though there had been improvements in population health overall (McDaid 2009). Between 1995 and 2005, life expectancy overall increased by 3.1 years for men and 2.1 years for women, and in disadvantaged areas the increase was 2.9 years for men and 1.9 years for women. Similarly,

infant mortality fell by the same amount overall and for those in disadvantaged areas, meaning that existing disparities have held tight on both major indicators over that ten-year period.

Motivated in part by the failure to shift entrenched inequality in health status, the government has appointed Sir Michael Marmot to chair a fresh review of how to make genuine progress. Marmot was the chair of the World Health Organization's Commission on the Social Determinants of Health, which reported in 2008, drawing global attention to the issue of health inequality and social injustice. His fresh review will look at how the recommendations of that report can be taken up in the United Kingdom, via work with local and national stakeholders. It will also seek out the evidence on what strategies to adopt and show how that evidence can translate into policy.

**The new Marmot Review**

The political context for this fresh review is a long-term Labour government fighting for its political life. The leader, Gordon Brown, is considered a little more left-leaning than his predecessor Tony Blair, perhaps predisposing the government to take health inequalities a little more seriously. With elections due in 2010, it is unclear how the results of the Marmot review will impact on policy, as a future conservative government may be less inclined to implement them.

**A government fighting for its life**

Despite being seen to be concerned, the current government has allotted only very small amounts of funding to specifically fight inequalities in health. For example, in late 2008 it announced new funding to improve the health of people in disadvantaged areas. The funding would be spent on local initiatives to improve parenting and healthy eating, for example, in more than 80 local communities, and on strategies to improve knowledge on these issues at the local government level. The amount of funding attached to this announcement was 13.5 million pounds (approx. US \$22 million, € 16 million).

**Small funding to fight inequality doesn't match rhetoric**

At the same time, the government announced that a program called Pacesetters would be extended. Initially introduced in 2007, this program is aimed at improving health and wellbeing in deprived areas. Examples of initiatives include trying to increase breast screening rates and the hospital experiences of those with learning disabilities, and according to the Department of Health the program had already achieved some success. The

**Pacesetters program targets deprived areas**

**Parliamentary  
report calls for  
better evaluation**

new extended program will target families affected by serious and chronic conditions, including cancer and heart disease.

The reported success from the Pacesetters program should be treated cautiously, because it did not arise from the results of a rigorous, controlled evaluation. In fact, a lack of rigorous evaluation of strategies to tackle health inequality has attracted political attention. A parliamentary report on health inequality, published in early 2009, concluded that the government's efforts were "being held back by inadequate policy evaluation" and "money has been spent on initiatives that might not even work" (House of Commons Health Committee 2009).

*Sources and further reading:*

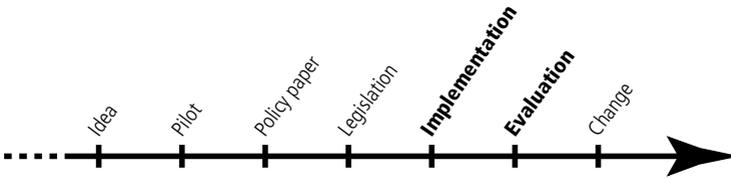
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## France: Urban Health Networks work against inequalities

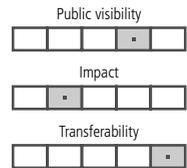


Seen as something of an icon of urban policy, there are now 300 Urban Health Networks active in France. These locally-based networks of health and social actors aim to improve both access to health services and general wellbeing for the residents of low-income neighborhoods and, as such, reduce inequalities in health status, which are particularly marked in France. Critically, the networks aim to involve the communities themselves in identifying both problems and solutions and to integrate preventive and curative care services. While they are popular, they are still plagued by inadequate and irregular funding.

The current version of the networks has its roots in policies from the 1990s, and they were first officially created by government decree in 2000. Pilot networks were introduced into several areas in 2001, and following positive evaluations in 2003, they grew rapidly in other areas across France. Another government decree in 2006 consolidated the legal and financial framework. By the mid-2000s, the official government objective was to establish 300 Urban Health Networks in low-income neighborhoods, which has been achieved, despite ongoing concerns about the insecure nature of the funding arrangements which primarily flow from the state.

Under French law, the Urban Health Networks have several key objectives, including

- Identifying local health needs and risk factors
- Mobilizing and coordinating different actors into medical-social networks
- Making sure those in need have access to services
- Developing active participation of the local population in all phases of the project, including identifying problems, defining priorities, creating plans and evaluating them.



**Networks were slowly strengthened**

**Targeting needs and engaging people**

This participative approach is seen as critical to the operation of the networks.

**More than 750 disadvantaged neighborhoods**

The majority of what are regarded as disadvantaged neighborhoods are city housing developments, where income and schooling levels are low and unemployment is high. These are classified officially as critical urban areas, and there are more than 750 of them across France, with a population of about 4.5 million residents. More than a quarter of the residents in these areas live in the Paris metropolitan area. The repeated failure of centralized measures for improving health in these areas gave rise to the integrated locally based initiatives.

**Toulouse: helping senior immigrants**

As an example of how these projects operate, the network based in Toulouse identified access as a problem for elderly immigrants and created an information campaign for them. To improve the quality and efficiency of care at home for the elderly, the Toulouse network put in place a training course for nurses and prepared and distributed a list of local available providers. To fight rising obesity, local actions are organized, including picnics, cooking lessons and sporting activities. However, as with many other networks there is little hard data about how effective these measures have been in shifting health statistics and ultimately reducing health inequalities in France.

**Evaluation suggests improved access**

Specific participative evaluation processes are supposed to be in place at the local level, to accompany evaluation measures at the national level. An official report of the overall outcomes of the Urban Health Networks, completed in 2007, found that despite big differences in projects, the networks in most cases had positive results in terms of improving services provided to local people. In general, the players involved, perhaps not surprisingly, saw that the networks made a unique contribution. The participative nature of the program seems to be well appreciated, and in some cases regional public health programs were influenced by the local diagnosis of problems and the resulting setting of priorities.

**Little quantifiable evaluation results**

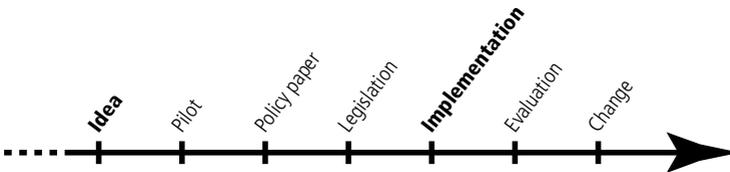
Notwithstanding the generally positive assessments and welcome signs of collaboration and integration, there is no framework for the many networks to present results and compare their actions. Despite much material now available, it is difficult to get a sense of any final results of evaluation efforts. Importantly, there

are few quantifiable results. While continuous evaluation is seen as valuable, particularly in order to inform future strategies, there does not seem to be much central support for it at this time.

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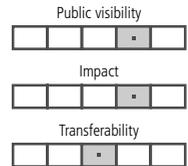
**South Korea: Differential out-of-pocket ceilings**



In a move seen as making the nation’s health system more equitable, the government in South Korea has decided to introduce differential ceilings on cumulative out-of-pocket costs, dependent on the person’s income. The new policy aims to reduce the financial burden or catastrophic effects of illness for those on lower incomes. It arose in response to concerns that the previous policy of one ceiling for all—independent of ability to pay—was limited, because it was a much heavier burden for the poor than the better off.

In order to reduce the financial burden on patients, the government introduced the original ceiling in 2004. The ceiling for cumulative out-of-pocket costs was set at US \$2,000 over a six-month period. However, the ceiling was criticized for having only a limited effect on reducing financial pressure on the worse off who have high medical costs. Thus in 2009, a new system was introduced, with three different out-of-pocket cost ceilings, dependent on the income of the insured person.

Following research by the National Health Insurance Corporation, the Ministry of Health and Welfare separated the ceiling



**Original ceiling dates back to 2004**

**Three new ceilings in 2009**

into three different levels. The new ceilings on cumulative out-of-pocket payments were set at

- US \$4,000 in one year for the top 20 percent of the insured population, in terms of income
- US \$3,000 in one year for the middle 30 percent
- US \$2,000 in one year for the bottom 50 percent of the insured population

**General support  
for reform**

The reform has been welcomed by different players and is strongly supported by the government, health services researchers and progressive civic groups. The view from those who support the reform is that it is a legitimate way of increasing financial risk protection and reducing the catastrophic effects of major illness. The previous flat ceiling was seen as inequitable. One issue which may arise in the future is exactly how to measure the ability to pay of some insured people, particularly the self-employed.

*Sources and further reading:*

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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	National Institute for Health and Welfare (THL), 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 Epidemiology and Public Health, 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	CAPSE—Consorti d'Atenció Primària de Salut de l'Eixample Universitat de 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	Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore; Center for Health, Culture and Society, Rollins School of Public Health, Emory University, Atlanta

## Survey preparation and proceedings

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

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

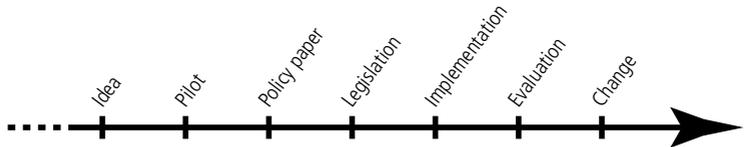
## Reporting criteria

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

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

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

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



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

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

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

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

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

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

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

## Policy ratings

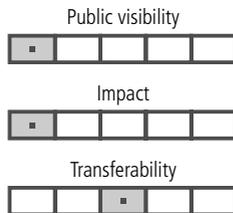
A second figure is used to give the reader an indication of the character of the policy. For this purpose, three criteria are shown: public visibility, impact and transferability.

*Public visibility* refers to public awareness 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 twelve and the thirteenth survey round can be looked up and researched on the network’s Web site, [www.healthpolicymonitor.org](http://www.healthpolicymonitor.org). Both these reports and this publication draw upon the partner institutions’ reports and do not necessarily reflect the Bertelsmann Stiftung’s point of view.



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