

*Reinhard Busse, Annette Zentner,
Sophia Schlette (eds.)*

Health Policy Developments

Issue 6: Focus on Continuity in Care,
Evaluation Techniques, IT for Health

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Introduction

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

The International Reform Monitor (www.reformmonitor.org), initiated in 1999 and now in its sixth year, is one example of this benchmark expertise. It primarily covers social and labor market issues. An example of the Foundation's expertise in comparative health policy research is "Reformen im Gesundheitswesen" (Esche, Böcken and Butzlaff (eds.) 2000), a study that compared health policy reforms in eight countries.

The success of both projects underscored the need and the potential demand for timely and regular information on health policy issues in countries with similar socioeconomic patterns. To this end, the Foundation established a separate monitoring tool, the International Network for Health Policy and Reform.

The International Network for Health Policy and Reform

Since 2002, the International Network for 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 looked for countries with reform experience relevant for Germany.

Partner institutions were selected on the basis of 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 and in international comparative research.

Australia	Centre for Health Economics, Research and Evaluation (CHERE), University of Technology, Sydney
Austria	Institute for Advanced Studies (IHS), Vienna
Canada	Canadian Policy Research Networks (CPRN), Ottawa
Denmark	Institute of Public Health, Health Economics, University of Southern Denmark, Odense
Estonia	PRAXIS, Center for Policy Studies, Tallinn
Finland	STAKES, National Research and Development Center for Welfare and Health, Helsinki
France	IRDES, Institut de Recherche et Documentation en Economie de la Santé, Paris
Germany	Bertelsmann Stiftung, Gütersloh; Department of Health Care Management, Berlin University of Technology
Israel	The Myers-JDC-Brookdale Institute, Smokler Center for Health Policy Research, Jerusalem
Japan	National Institute of Population and Social Security Research (IPSS), Tokyo
Netherlands	Institute of Health Policy and Management (iBMG), Erasmus University Rotterdam
New Zealand	Centre for Health Services, Research and Policy, University of Auckland
Poland	Institute of Public Health, Jagiellonian University, Krakow
Singapore	Department of Community, Occupational and Family Medicine, National University of Singapore (NUS)
Slovenia	Institute of Public Health of the Republic of Slovenia, Ljubljana
South Korea	School of Public Health, Seoul National University
Spain	Research Centre for Health and Economics (Centre de Recerca en Economia i Salut, CRES), University Pompeu Fabra, Barcelona

Switzerland	Institute of Microeconomics and Public Finance (MecoP), Università della Svizzera Italiana, Lugano
United Kingdom	LSE Health & Social Care, London School of Economics and Political Science (LSE)
United States	The Commonwealth Fund, New York; Institute for Global Health (IGH), University of California, Berkeley

Survey preparation and proceedings

Issues were jointly selected for reporting according to what the network partners identified as the most pressing issues for reform.

Subsequently, the issues were arranged into clusters:

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

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

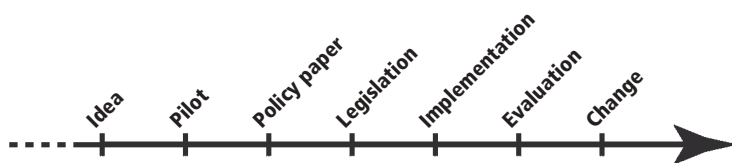
Reporting criteria

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

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

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

The process stage of a health-policy development is illustrated with an arrow showing the phase 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 approaches voiced or discussed in various 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 the growing acceptance of an idea within a relevant professional community.

Legislation covers all the 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 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, falls under this heading.

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

Policy ratings

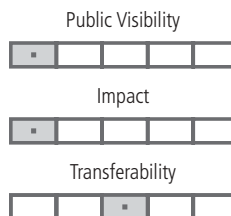
A second figure is used to give the reader an indication of the character of the policy. For this purpose, three criteria are shown: public visibility, impact and transferability.

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

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

Transferability: This rating indicates whether a reform 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 and average on transferability.



Project management

The Bertelsmann Stiftung's Health Program organizes and implements the semiannual surveys. The Department of Health Care Management, Berlin University of Technology (TU Berlin), assisted with the development of the semi-standardized questionnaire. We owe special thanks to Celia Bohannon for her thorough proofreading and to Matthias Dehn (TU Berlin) and Ines Galla (Bertelsmann Stiftung) for managerial and editorial support.

The results from the sixth biannual survey, covering the period from May to October 2005, are presented in this book. Out of 68 reported reforms, 30 were selected.

Although we describe current developments from the reporting period in detail on our Web site, we chose a somewhat different approach for presenting the findings in this report. Criteria for selection were scope, continuity and presence in public debate during and beyond the reporting period proper. With this in mind, we looked at topics from the first five surveys independently of their present stage of development or implementation.

This sixth issue of Health Policy Developments devotes special attention to four concurrent health-policy topics, all of them high on agendas in several developed countries:

- Evaluation in health care
- Continuum of care
- Information technology
- Human resources

In line with the Health Policy Network's news and monitoring function, the last chapter, "News Flash," reports on policies to improve the safety of cosmetics in the United States, recent developments to extend the health-benefit basket in South Korea, pharmaceutical policies in Finland, and progress toward reducing waiting times in England and Wales.

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

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

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Comments and suggestions on this sixth semiannual report are welcome. This series will continue to evolve, change, and, we hope, improve. Any input, therefore, will be helpful.

Reinhard Busse
Annette Zentner
Sophia Schlette

Evaluation in health care

Evaluation involves the description, analysis and assessment of programs, projects, services and organizations. It can relate to the structure, the process and the results (Bowling and Shah 2005). In contrast to basic research, evaluation addresses the specific questions of decision makers. Key aspects of evaluations relating to health policy are efficacy, cost-effectiveness, and equity. It is necessary to draw on a broad spectrum of methods in order to be able to provide useful information within an acceptable period of time.

Frequently, no scientific evidence is available to support decisions on health policies (Murray and Evans 2003). But since the end of the 1990s, the situation has begun to change.

In many countries, greater effort is being made to evaluate medical technologies and procedures. Many countries have created health technology assessment (HTA) institutions. HTAs carry out evaluations to provide a basis for health planning and control (table).

Trend toward an evidence-based policy

Evaluation of medical technologies and procedures

Table: Health technology assessment institutions

Australia	Australian Safety and Efficacy Register of New Interventional Procedures – Surgical	ASERNIP–S
	Medicare Services Advisory Committee	MSAC
Austria	Institute of Technology Assessment	ITA
Canada	Agence d’Evaluation des Technologies et des Modes d’Intervention en Santé	AETMIS
	Alberta Heritage Foundation for Medical Research	AHFMR

	Canadian Coordinating Office for Health Technology Assessment	CCOHTA
	Medical Advisory Secretariat	MAS
Denmark	Danish Centre for Evaluation and Health Technology Assessment	DACEHTA
	Danish Institute for Health Services Research and Development	DSI
Germany	German Agency for Health Technology Assessment at the German Institute of Medical Documentation and Information	AHTA@DIMDI
Finland	Finnish Office for Health Care Technology Assessment	FinOHTA
France	Haute Autorité de Santé	HAS
	Comité d'Evaluation et de Diffusion des Innovations Technologiques	CEDIT
Israel	Israeli Center for Technology Assessment in Health Care	ICTAHC
Netherlands	College voor Zorgverzekeringen/ Standing Committee for Health Insurance	CVZ
	Gezondheidsraad, Health Council of the Netherlands	GR
	Netherlands Organization for Health Research and Development	ZonMW
	The Netherlands Organization for Applied Scientific Research	TNO HTA
New Zealand	New Zealand Health Technology Assessment	NZHTA
Switzerland	Swiss Network for Health Technology Assessment	SNHTA
Spain	Agencia de Evaluación de Tecnologías Sanitarias	AETS
	Andalusian Agency for Health Care Technology Assessment	AETSA
	Galician Agency for Health Technology Assessment	AVALIA-T
	Catalan Agency for Health Technology Assessment	CAHTA

	Basque Office for Health Technology Assessment	OSTEBA
	Unidad de Evaluación de Tecnologías Sanitarias	UETS
United Kingdom	The NHS Centre for Reviews and Dissemination	CRD
	National Coordinating Centre for Health Technology Assessment	NCCHTA
	National Horizon Scanning Centre	NHSC
	National Institute for Health and Clinical Excellence	NICE
	National Health Service Quality Improvement Scotland	NHS QIS
United States	Agency for Health Care Research and Quality/Center for Practice and Technology Assessment	AHRQ
	Department of Veterans Affairs (VA)/Technology Assessment Program (TAP)	VATAP
	Centers for Medicare & Medicaid Services	CMS

Source: www.inahta.org

In this issue of Health Policy Developments, we report about Poland, which is about to establish a national Agency for Health Technology Assessment (see page 24). In Switzerland, complementary medicine was recently excluded from the health insurers' benefits catalogue on the basis of an extensive HTA evaluation program (see page 21). In issue 2, we reported on the National Institute for Health and Clinical Excellence, which can draw on many years of experience in the evaluation of health technologies (see issue 2, "Health technology assessment and the National Institute for Clinical Excellence").

It has only recently been widely accepted that the systematic assessment of health-policy reforms must be a central concern of a modern health system. The evaluation of the intended and unintended consequences of reforms is extremely important. In some countries, the evaluation culture is already advanced. We have reported about Israel, which recently analyzed the effects of

Evaluation of programs and reforms

co-payments for visits to specialists and for medication, and in particular possible negative effects for vulnerable groups, such as the poor and the chronically ill (see issue 4, “Co-payments, access, equity”). In this issue, we report on the evaluation of the diagnosis-related group system and electronic records for patients in Danish hospitals (see pages 29 and 60).

It is not always the case that an evaluation is based on appropriate parameters and indicators. The evaluation of HealthConnect, the Australian program for a network-based health record, has been criticized. One of the reasons is that it does not include a cost-benefit analysis (see page 19).

**Evaluation of
hospitals and
physicians**

When it comes to the evaluation of organizations and providers, different countries adopt different approaches. The Netherlands and South Korea have recently introduced an obligatory external quality evaluation for hospitals. South Korea assesses structural indicators and publishes the results of the best hospitals (see issue 4, “Evaluation of hospitals”). The Netherlands has developed a comprehensive benchmark strategy that assesses inpatient procedures on the basis of efficiency, quality and patient satisfaction (see issue 2, “Quality management more compulsory”). In the United States, Medicare publishes data on its Web site Hospital Compare about the quality of treatment for almost all 4,200 general hospitals. This transparency is intended to motivate the hospitals to base the treatment they provide on evidence-based recommendations and thus to improve the quality of their health care (see issue 5, “Hospital Compare”).

In Israel, quality audits are obligatory for hospitals. Only if they meet minimum standards for structural and process quality indicators set down by the ministry do the hospitals have their license renewed (see page 26). In New Zealand, the pilot project Performance Evaluation Programme is examining whether a questionnaire method imported from Canada is suitable in combination with audits for improving the quality of care provided by medical practitioners (see page 27).

**Developing
an evaluation
culture**

Evidence-based evaluation and quality development ensure transparency in health care and provide the conditions necessary for rational health planning and control. Systems and approaches differ in many ways among countries. Nevertheless, there is now extensive knowledge about what works in health systems and

what does not, providing an opportunity (which, in many cases, is still underutilized) to learn from shared experiences.

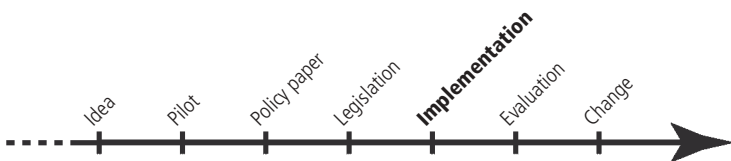
Sources and further reading:

Bowling, Ann, and Shah Ebrahim. *Handbook of Health Research Methods. Investigation, Measurement and Analysis*. Berkshire: Open University Press, 2005.

International Network of Agencies for Health Technology Assessment. www.inahta.org.

Murray, Christopher J. L., and David E. Evans (eds.). *Health Systems Performance Assessment. Debates, Methods and Empiricism*. Geneva: World Health Organization, 2003.

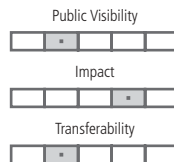
Australia: Evaluation of HealthConnect



HealthConnect, the Australian pilot project for network-based health records, has been subject to comprehensive evaluation since 2001 (see issue 5, “HealthConnect”). The method of the evaluation commissioned by the Australian government and the regional health ministers has been criticized from various sides.

In the opinion of the Productivity Commission, a government advisory body on microeconomics, key aspects needed to assess the success or failure of the ambitious IT program have not been considered. In its report “Impacts of Advances in Medical Technology in Australia” (August 2005), the commission finds that the benefits of the HealthConnect project bear no relation to the high investment and maintenance costs involved.

Other fundamental aspects were included in the evaluation only at a late stage, if at all. In agreement with some scientists, the commission criticized the fact that the outcome “health” was not considered. There was also no consideration of the suitability of



No cost-benefit evaluation

No evaluation of the IT standards

the IT standards specified by HealthConnect in order to ensure the compatibility of regional and local IT solutions. The commission feels that HealthConnect does not provide adequate coordination of the many models for electronic health records. They are concerned that this might mean that the major investment in new information and communications technologies will not be used efficiently and that HealthConnect will not realize its potential.

**HealthConnect
Phase I
(2001–2003)**

The evaluation program of HealthConnect is intended to provide the basis for decisions by the Australian government and the health ministers of six states and two territories on the introduction of network-based health records. It is divided into two phases. The first phase, which lasted from 2001 to 2003, was dedicated to research and development. It tested the technical feasibility of the network, which is intended to allow health data to be registered, stored and exchanged between providers of health services with the patient's permission.

**HealthConnect
Phase II
(2003–2005)**

The second phase began in 2003. In this phase, four states (Tasmania, South Australia, New South Wales and Queensland) and the Northern Territory are testing how HealthConnect can be used in the everyday provision of medical care. They are also assessing the acceptability of HealthConnect among users.

**Open questions
about data
protection**

The evaluation is also considering how the electronically stored patient data are protected against unauthorized access. The program office of HealthConnect has already identified a number of legal aspects that need clarification. However, doubts about data protection remain. The federal privacy commissioner is worried that HealthConnect could be introduced on a broad scale before suitable control mechanisms have been put in place to protect the privacy of the patients.

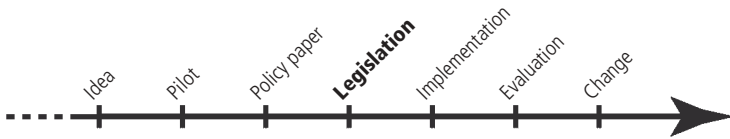
Despite the widespread criticism, experts do not expect the national government to modify the evaluation remit for HealthConnect. The long-term benefits and the cost-effectiveness of the ambitious project will remain unclear.

Sources and further reading:

Australian Government—Productivity Commission. Impacts of Advances in Medical Technology in Australia. Research Report August 2005. www.pc.gov.au/study/medi

caltechnology/finalreport/medicaltechnology.pdf.
 HealthConnect. A Health Information Network for all
 Australians. www.healthconnect.gov.au.

Switzerland: The evaluation program of complementary medicine

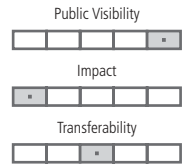


Since 1 July 2005, homeopathy, phytotherapy, traditional Chinese medicine, anthroposophical medicine and neural therapy are no longer included in the health benefit basket in Switzerland. This governmental decision was based on the findings of an extensive evaluation program of complementary medicine.

In 1999, the five types of complementary medicine were included in the health benefit basket in Switzerland for an initial five-year period. Costs were reimbursed only if the physician providing the treatment held an appropriate certificate. If complementary medicine were to remain in the benefit basket it would be necessary to demonstrate its efficacy, appropriateness and cost-effectiveness.

For this purpose, the federal government set up an evaluation program for complementary medicine (PEK) that was implemented from 1998 to 2005. In a consensual process, which was not without its difficulties, representatives of complementary medicine and conventional medicine and methodologists agreed on a two-stage approach.

The first stage considered the provision of complementary medical services in Switzerland. According to a survey, 10.6 percent of the Swiss population had made use of at least one of the five complementary methods in 2002. Homeopathy was mentioned most frequently. Patients treated by complementary



**Complementary
 medicine—subject
 to evaluation**

**PEK—Program to
 Evaluate
 Complementary
 Medicine**

**Stage 1: The state
 of complementary
 medical care**

medical physicians tended to be younger, female and better educated, and they were also more likely to have a chronic and severe form of their disease. Patients treated in practices oriented towards complementary medicine reported greater satisfaction with the treatment than patients in other practices. With the exception of phytotherapy, fewer patients suffered from side effects of treatment than patients using conventional therapy.

Costs comparable with conventional medicine

When adjusted for factors such as age and sex, the total costs per patient were not significantly different from those for conventional treatment. Consultation costs were higher, but medication costs were lower. The real increase in costs from 1998 to 2002 proved to be considerably lower than expected when the five complementary treatments were introduced (additional health insurance expenditure of CHF 35.9 million [23.3 million euros] instead of the predicted CHF 110 million [71 million euros]).

Stage 2: Systematic analysis of the literature

An important role in the decision to exclude complementary medicine was undoubtedly played by the second stage of the PEK project: the systematic analysis of literature on efficacy, safety and cost-effectiveness of the five procedures.

The scientific evaluation report reached a positive assessment regarding the efficacy and risk profile, with certain limitations concerning the safety of neural therapy and traditional Chinese medicine. Because of the lack of data, the scientists could not make any reliable statements about cost-effectiveness.

Results in part contradictory

For homeopathy, phytotherapy and traditional Chinese medicine, a group of epidemiologists from Berne conducted a meta-analysis of placebo-controlled clinical trials. Until that time, not enough studies had been published on anthroposophic medicine and neural therapy. The authors concluded that homeopathy was not better than placebos. The meta-analysis showed a positive result for phytotherapy. Regarding traditional Chinese medicine, no clear conclusion could be reached.

Ambiguous evidence—unambiguous political decision

Although the final PEK report in April 2005 noted the limitations of the evaluation method and the scope for scientific interpretation of the results, which were in part contradictory, this had no influence on the political decision-making process. The Swiss government decided to exclude all five forms of therapy from the benefit basket, despite vocal criticism from the professional associations and the media.

Experts see this as a clear signal that the government wants to put a stop to all additions to the benefit basket that are not backed by firm scientific evidence.

Little effect, but a clear signal

It is still not clear whether patients in Switzerland will have to pay for complementary medicine themselves (either out of their own pockets or through additional private insurance coverage). An initiative “Yes to Complementary Medicine” is calling on the federal government and the cantons to ensure that complementary medicine is taken fully into account within their sphere of responsibility. But even if a majority of the Swiss population supports the proposal in a referendum, it will remain up to politicians to decide whether complementary medicine is once again included in the health benefit basket.

Initiative “Yes to Complementary Medicine”

Sources and further reading:

Bundesamt für Gesundheit. Programm Evaluation Komplementärmedizin (PEK). www.bag.admin.ch/kv/forschung/d/PEK.htm (in German).

Busato, André, Andreas Dönges, Sylvia Herren, Marcel Widmer, and Florica Marian. Health status and health care utilisation of patients in complementary and conventional primary care in Switzerland—an observational study. *Family Practice* (23) 1 2006: 116-124. <http://fampra.oxfordjournals.org/cgi/reprint/cmi078?ijkey=xLy16EcmKV0fFTW&keytype=ref>.

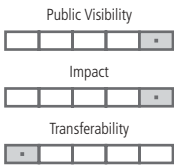
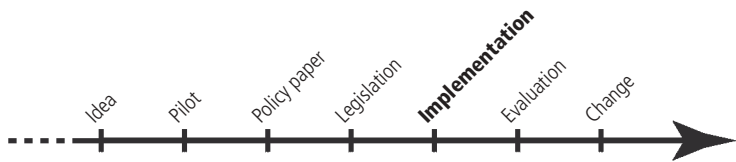
Crivelli, Luca, Domenico Ferrari, and Constanzo Limoni. “Il consumo di 5 terapie di medicina complementare in Svizzera. Analisi statistica sulla base dei dati dell’Indagine sulla salute in Svizzera 1997 e 2002”. www.bag.admin.ch/kv/forschung/d/2005/Gesundheitsbefragung-KM.pdf (in Italian).

Eidgenössische Volksinitiative “Ja zur Komplementärmedizin” (Initiative “Yes to complementary medicine”) September 2005. www.admin.ch/ch/d/pore/vi/vi331.html (in German).

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Poland: Agency for Health Technology Assessment



**Evidence-based
regulation of new
technologies**

Shortly before the elections in September 2005, the left-wing minister of health issued a decree that envisages the establishment of a publicly funded but politically independent institution to evaluate medical procedures and technologies.

The goal is to enable decision makers to make rational decisions, backed up by evidence, within the health system; to increase control over the implementation and financing of new technologies; and to improve the quality of medical care.

In the past, it has been possible for new therapies and technologies to be introduced in Poland without their effectiveness and costs being taken into consideration. The positive expectations of physicians and patients and pressure from the manufacturers were sufficient to advance the introduction of the technology. Experts see the rising expenditure on medications and the growing debts of hospitals as a direct consequence of the unrestrained dissemination of new medical procedures.

**Resistance from
industry and
health insurers**

For more than eight years, there were discussions in Poland about the creation of an agency for the assessment of health technology that could provide the health ministry with scientific advice for decisions concerning health policy. Tensions arose between the government, which was the driving force behind the

agency, and Poland's health-insurance fund. The National Health Fund demanded that it have control over the agency and that the agency not be allowed to work independently. There was also resistance from powerful interest groups, namely the pharmaceutical industry and the medical technology industry, because both feared that their profits would be hit.

It was only in 2004, after the passing of the Public Funding of Health Services Act (which contained a provision for the establishment of a state HTA agency), that the Ministry of Health was able to conclude the process by decree, that is, without further parliamentary debate.

The former left-wing minister of health had an open dispute with the pharmaceutical companies and other companies in order to overcome open and concealed opposition. The current conservative government has adopted a more conciliatory approach. Experts are worried that the ministry is prepared to renegotiate the structure and function of the agency and thus also its future influence. In contrast to the original proposal, the agency could be used solely as a clearinghouse for HTA reports produced by medical committees or the pharmaceutical industry. Recommendations to the Ministry of Health would not be made on the basis of the agency's own evaluations. Time will tell whether (and if so, to what extent) the agency is able to fulfill the intended controlling function.

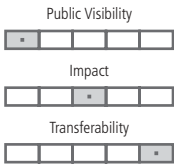
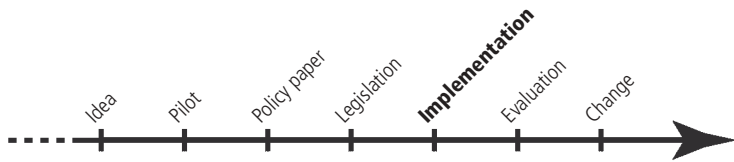
**New government
ready for
discussions**

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Kozierkiewicz Adam, Wojciech Trabka, Artur Romaszewski, Krzysztof Gajda, and Dariusz Gilewski. Definition of the "health benefit basket" in Poland. *European Journal of Health Economics* 6 Suppl 1 2005. 58–65.

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Israel: Audit for hospital licensing



License only after successful audit

Structure and process parameters, outcome parameters planned

Confidentiality of results

In August 2005, the Israeli Ministry of Health concluded the first round of the hospital-evaluation procedure introduced in 2003. Audits were carried out to check that quality standards were met in hospital care.

All general hospitals in Israel must undergo an external audit. The extension of the hospital's license is extended for a further one to three years only if the audit results are positive.

The hospital is visited for a day by an auditing team made up of 20 specialists from various disciplines (medicine, nursing, social work, physiotherapy, environmental medicine, information technology, and security). Working through a checklist of structure and process parameters, the auditors determine whether standards defined by the Health Ministry are met. For example, the structured audit form includes six categories for nursing care: personnel (number of qualified nurses, nursing assistants, and untrained staff), documentation (presence of nursing records and reports), drug supplies (secure storage, medication in original packaging, checks of dangerous drugs at the start of every shift, checks of the legally required drug documentation), patient surroundings (access to alarm and oxygen, bed safety), resuscitation (training measures), and human resources development (personnel evaluation and further training). For the future, it has been planned to include outcome parameters in the audit checklists.

The Ministry of Health evaluates the audit and sends the hospital management a formal report that includes details of any shortcomings to be made good. To encourage cooperation from hospitals and to prevent inappropriate media access, the findings are kept confidential. The ministry is planning a comparative evaluation of the hospital data in order to identify generally problematic areas (e.g., in physiotherapy).

The biggest problem with the evaluation process so far has been the recruitment of auditors, because they receive no financial compensation or time off work during the audit. Auditors come from the Ministry of Health or are volunteers from hospitals. In some cases, the auditors are in retirement. Their sole motivation is the gain in prestige and the possibility of acquiring insights into structures and procedures in other hospitals.

Lack of auditors

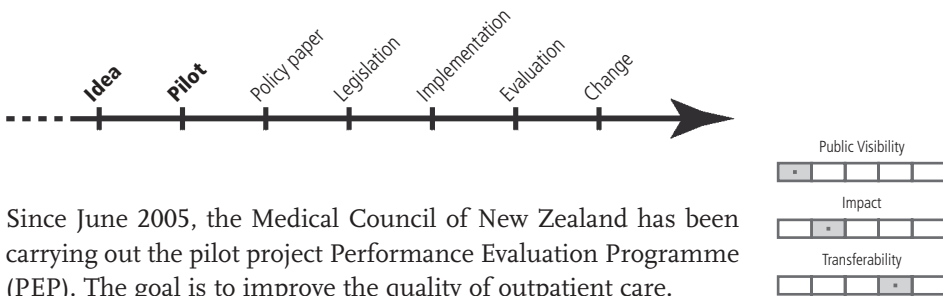
Hospital managers have an ambivalent attitude toward the audit procedure, the second round of which recently began. A successful audit can be useful for image enhancement or as an argument for more resources if some points have been criticized. But the managers also complain that the hospital license is no longer extended automatically. However, because the ministerial audit procedure only inspects minimum requirements, experts expect that quality improvements will be limited.

Minimum standards

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New Zealand: Performance Evaluation Programme



Since June 2005, the Medical Council of New Zealand has been carrying out the pilot project Performance Evaluation Programme (PEP). The goal is to improve the quality of outpatient care.

**Performance
Evaluation
Programme**

The Medical Council is legally responsible for the accrediting of general practitioners and specialists and ensuring and maintaining their medical competence. The 12-month pilot Performance Evaluation Programme consists of two parts. First, the Medical Council checks 10 percent of all practitioner physicians in detail to establish whether they meet the requirements of continuing professional development (CPD). This is the precondition in New Zealand for granting the license to work as a physician.

**Continuing
professional
development**

The doctors must show that once every year they have been through a clinical audit and at least 10 hours of peer review by independent colleagues. They also must prove that they have undergone 20 hours of continuing medical education (CME). The Medical Council expects that 10 percent to 20 percent of the randomly selected doctors will not meet the CPD requirements.

**Evaluation by
patients and
colleagues and
self-assessment**

In the second part of the PEP, the physicians are asked for a self-assessment of their performance based on a questionnaire. They also nominate eight colleagues, eight other medical personnel, and 10 patients willing to be interviewed. These colleagues and patients are then asked on the telephone or online about the medical, organizational and social competence of the doctor. The results in comparison with other physicians are reported back to the physician in an anonymous form.

**Measures for
shortcomings**

If the report shows shortcomings, the physician is expected to take part in further training and seek the advice of colleagues. In the case of serious deficiencies with an increased risk to the health and safety of patients, the Medical Council can carry out a detailed assessment of the performance of the physician.

**Criticism from
the medical
profession**

The pilot project is to check by mid-2006 whether the PEP method is suited to maintain the competence of physicians and to identify those who need support in order to improve their qualifications. Many doctors in New Zealand complain about the time needed to find patients, colleagues, and care personnel for the interviews. And they feel that the evaluation can raise doubts among patients about the competence of their physician. Experts, however, note that patients and colleagues may want to avoid openly criticizing the performance of the physician. The results may then be affected by a positive bias.

**Canadian program
as model**

The program in New Zealand has been developed along the lines of the Physician Achievement Review (PAR) of the College

of Physicians and Surgeons in Alberta, Canada. The Canadian experience during the first three years was largely positive. Of the 255 physicians taking part, 66 percent made use of the survey results to improve the performance of their practices. Patients have shown strong support for the PAR approach. However, the program does not seem to be appropriate in all cases, and it might be misused for disciplinary purposes. Experts expect that the results of the project in New Zealand will be similar.

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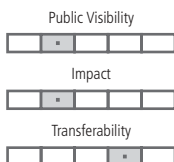
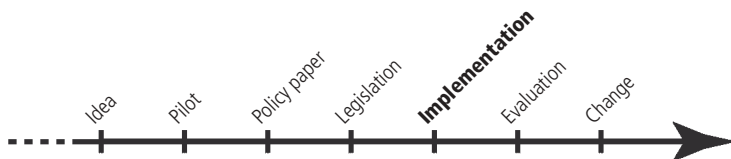
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Johnson Lannes. Hells bells are we guilty until proven innocent. *New Zealand Doctor*, May 2005.

Kumar Rajesh. Docs Performance under scrutiny. *New Zealand Doctor*, May 2005.

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Denmark: Evaluation of DRG system



Three years after the introduction of performance-related payments in Danish hospitals, the Ministry of Health has conducted its first review. In May 2005, together with the Association of Counties, it published an evaluation of the effects of the DRG (diagnosis-related groups) system on the health care of inpatients.

The evaluators concluded that the stepwise introduction of DRGs improved the productivity and capacity of the hospitals and reduced waiting times. In comparison to the former global payments, the introduction of DRGs has not led to a pronounced increase in expenditure. It was not possible to identify any deterioration in the quality of care. However, experts have remarked that because of the lack of comprehensive quality measurements, the final statement is based only on patient satisfaction as an indicator.

Delayed introduction of DRGs

Denmark was a late starter with a performance-related payment system. In a country that often looks askance at market-oriented reforms, hospitals were funded until 2002 through prospective global budgets. Hospital managers negotiated the annual global budget for their hospital with their county authority on the basis of past performance, additional needs and new responsibilities. Global budgets were regarded as an effective instrument for keeping costs down. From the point of view of critics, however, the system was inflexible and offered no incentives for efficient hospital management.

Counties reject DRGs

In order to increase the productivity of hospital care, the government in 2002 made an additional budget available for the annual negotiations, under the condition that this would be distributed on the basis of performance. This ad hoc initiative met with little support in the 14 counties, which are responsible for the management and financing of hospital care in Denmark. The

counties remain critical of the DRG system because they fear the loss of financial control. Nevertheless, in 2004 the central government decided that at least 20 percent of hospital payments must be performance-related. It is planned that this proportion will rise in the coming years to 50 percent.

The government evaluation draws the conclusion that there was a continual increase in productivity in Danish hospitals from 2000 to 2003, although the increase was smaller than expected. The main reason for the limited effect of the DRG payments is that there is not enough competition among the counties. Experts note that the official figures have not been adjusted for “DRG creep“, that is, the trend toward optimized coding. They are critical of the results and see virtually no effects on hospital productivity.

The official evaluation is the joint work of the central government and the Association of Counties. Experts interpret this as an indication that the latter is prepared to accept the demands for structures that allow more competition.

**Increase in
productivity less
than expected**

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Indenrigs- og sundhedsministeren. Evaluering af taksstyring på sygehusområdet. www.im.dk/publikationer/eva_takststyring/index.htm (in Danish).

Continuity in care

In many countries, health care has been highly segmented. The divisions in the financing and control of health and social-care services are not appropriate for the needs of the elderly, the chronically ill and people with physical or mental disabilities. This situation is only made worse by the fact that health systems in most countries are oriented toward the treatment of acute medical conditions.

This chapter looks at creative approaches in various countries. The goal of these approaches is increased continuity in care—either with models of integrated care or of disease management.

Concepts of integrated care

Models of integrated care are rooted in the strategies of managed care from the United States. In North America, and increasingly in Western Europe and Australia, a variety of forms of organization and management have been developed.

Distinctions are made between horizontal integration within one level of care (e.g., within primary care providers or facilities) and vertical integration across various levels of care (primary, secondary and tertiary care providers or facilities). It is possible to find both forms coexisting, as for example in the Canadian province of Ontario, which has chosen to promote networks of family doctors (family health groups and family health networks) and local health integration networks. (See issue 3, “Primary care reform”, and page 44).

In Germany, the Social Code Book defines “integrated care” as contracted models that include at least two entities from

**Horizontal,
vertical and
extended
integration**

different health-care sectors or interdisciplinary collaborations (see page 45).

Extended integration, finally, refers to complete care provided from one source. This includes population-oriented strategies, which may be regionally based, with the goal of achieving complete health care. Catalonia, a region in Spain, has been operating a pilot project of this type for many years (see issue 1, “A pilot project for integrated care in Catalonia”). In this issue, we report about the Spanish region of Valencia, which since 1997 has been testing local, population-based integration models in three areas (see page 48). In the Netherlands, integrated-care models concentrate on the needs of the elderly, and since the 1980s large nonprofit organizations have arisen that cover all key areas of care (see issue 2, “Integrated care for the elderly”).

**Managed-care
backlash**

The traditional U.S. managed-care model of the health-maintenance organization seemed best suited to meeting the needs for continuity in care. However, after the optimistic assessments at the end of the 1980s, problems became apparent. The focus on cost effectiveness led to a decline in the quality of care and proved to be less compatible than expected with the objective of coordinating care. Funding by capitation with inadequate risk adjustment was a considerable disincentive to insure chronically ill persons, whose treatment costs were above average (Guterman 2005). The experience resulted in an increasing rejection of the managed-care model in the United States. It became known as the “managed-care backlash“.

**Searching for the
right payment mix**

As a response to this development, a reorientation has been taking place since 2002 in the United States and in other countries, with modification of the managed-care instruments and forms of organization, and combination with traditional strategies, such as reimbursement by fee for service. We report about seven pilot programs in the United States that Medicare is currently carrying out with the aim of optimizing care for the chronically ill (see page 36). In Switzerland, too, the government hopes that new models of managed care will prove more successful (see issue 4, “Relaunching integrated networks of care”).

Disease management strategies

In many strategies, the classic concept of disease management is central to the optimization of the care of the chronically ill. A disease-management program covers all relevant aspects and levels of care for a given disease, from prevention and medical therapy to rehabilitation and social care (Busse 2004). However, these single-disease oriented programs have increasingly come under pressure. In fact, physicians and researchers admit having focused on a simple disease-management approach for reasons of simplicity—knowing that a chronic condition typically doesn't come alone.

For some years, HMOs in the United States have successfully been evaluating routine data in order to identify groups of illnesses for which a specific disease management program can be developed. With 46 disease-management organizations, the United States has a flourishing health-care industry for the chronically ill. In the United Kingdom, the successful U.S. programs United Healthcare Cooperation and Kaiser Permanente have been used as the basis for NHS programs (see issue 3, “The management of chronic disease”).

Physicians have normally played a key role in guiding patients through a system. However, physicians are neither trained nor prepared for that, nor are they reimbursed to assume such coordinating activities. In the care model of the Spanish region of Castile and Leon, a lack of qualification to assume such roles was found to present a significant obstacle to the integration of medical and social services (see issue 2, “Second plan for integrating health and social care in Castilla y León”).

In order to make physicians better coordinators and patient managers, Australia, the United Kingdom and the Scandinavian countries make use of the collaborative methodology as an instrument for managing change (see issue 3, “Primary care collaboratives“, and page 39). This generic learning system developed in the 1990s by the U.S. Institute for Healthcare Improvement promises prompt, locally relevant improvements to the care provided in a specified area, such as in the management of asthma patients.

**Selecting diseases
and populations**

**Key position
of physicians**

**Patient
empowerment**

Finally, the active participation of patients in the care process is increasingly integrated into the process of management. In Australia, a recently published Senate report, “The Cancer Journey: Informing Choices“, focuses on the need to inform patients fully about the diagnosis, conventional and alternative therapies, and the options for treatment and care, and to empower them as responsible participants in the decision-making process (see page 42).

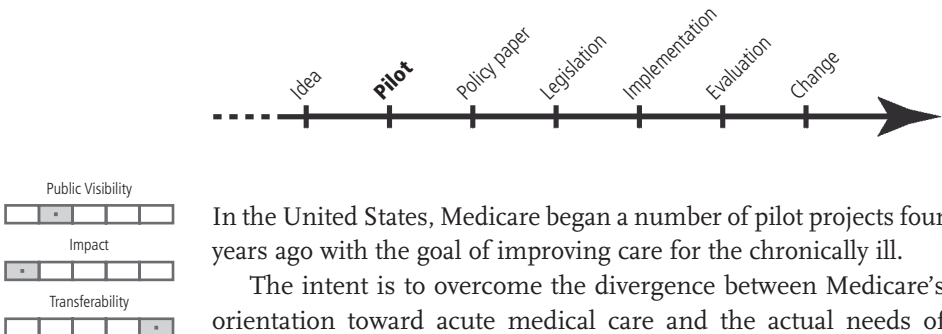
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Wolff, Jennifer L., Barbara Starfield and Gerard Anderson. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Archives of Internal Medicine* 162 (20) 2002. 2269–2276.

USA: Medicare pilot projects for the chronically ill



In the United States, Medicare began a number of pilot projects four years ago with the goal of improving care for the chronically ill.

The intent is to overcome the divergence between Medicare’s orientation toward acute medical care and the actual needs of their insured, who often are suffering from chronic conditions.

As a consequence of the 1997 Balanced Budget Act and the 2003 Medicare Modernization Act, five programs are already in the test phase, and two are about to be launched. A wide range of incentive and steering options are being examined, as well as disease- and case-management strategies.

Does fee-for-service lead to better health care for the chronically ill compared to capitation payments, without resulting in higher costs? This is the question addressed by the Medicare Coordinated Care Demonstration, which has been conducted since 2002 with some 15,000 patients in 16 states.

**Payment options:
fee-for-service,
bonus payments,
capitation**

The financial strategy of the Physician Group Practice Demonstration provides physicians with bonus payments when they improve the coordination of the care for their chronically ill patients, as measured by various quality indicators. The level of the bonus payments at the 10 multidisciplinary group practices, which have been participating since April 2005, depends on the savings achieved in comparison with the standard Medicare services.

Another project (End Stage Renal Disease Management Demonstration) is intended to consider the feasibility of per capita payments in the care of patients with chronic renal disease. Organizations that not only provide dialysis but coordinate all further necessary Medicare services for the variety of medical problems faced by these beneficiaries receive a fixed per capita payment each month.

The Medicare Voluntary Chronic Care Improvement Program focuses on diabetes mellitus and congestive heart failure. The participating organizations operate at nine locations in the United States. Since late 2005, they have been responsible for the improved implementation of evidence-based medicine and the avoidance of unnecessary hospital stays and visits to the emergency facilities over an entire geographic region (i.e., for a total of 180,000 patients).

**Disease and case
management for
diabetes and
heart disease**

Related to this project is the planned Care Management for High Cost Beneficiaries Demonstration, which will analyze case-management models at six localities for patients whose care is associated with exceptionally high costs.

The Medicare Disease Management Demonstration, with some 30,000 beneficiaries in California, Arizona, Texas and Louisiana, is investigating programs for the chronically ill. It

**Drugs and
information
technology**

focuses on the effectiveness of prescription drugs in the context of the Medicare programs.

Planned for 2006, the Medicare Management Performance Demonstration is intended to provide financial incentives for physicians to optimize procedures in their work and to improve the coordination of the care for their chronically ill patients through the use of information technologies.

All seven pilot projects are backed up by comprehensive internal or external evaluation. The results obtained will determine whether the U.S. Congress will launch the national implementation of new strategies for the Medicare program.

The search for new or modified models of care for the chronically ill finds broad support in the United States. This is primarily because the hopes placed on managed care have not been fulfilled. In the early 1990s, its organizational and financing models, with gatekeeping, capitation payments, and an emphasis on primary care, seemed much better suited for the care of the chronically ill than the traditional fee-for-service system with free choice of physicians. However, without adequate risk adjustment, health insurers often had little interest in insuring the chronically ill, let alone setting up specific programs for them. An additional problem was that until the end of 2005, health insurers were prohibited by law from offering programs only for defined groups of Medicare beneficiaries.

With the Medicare Modernization Act of 2003, this situation has changed greatly. Since 2006, so-called special-need plans have been permitted, and starting in 2007 these will also allow for the risk adjustment of beneficiary morbidity.

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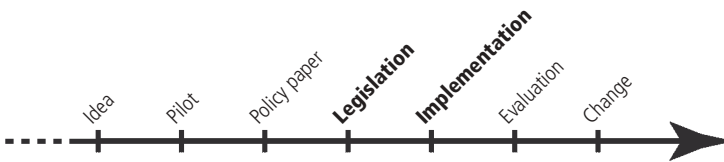
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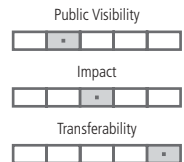
Australia: Chronic care collaboratives



Throughout New South Wales, chronic care collaboratives were established between February 2004 and March 2005. These are teams of general practitioners and clinicians formed to provide improved care for their patients with heart failure or chronic obstructive pulmonary disease.

The approach draws on the collaborative methodology developed in the 1990s in the United States by the Institute for Healthcare Improvement as a quality and change management instrument. The generic learning system is successfully implemented there, in the United Kingdom and in Scandinavian countries for the primary care of patients with asthma, diabetes, heart disease and cancer (see “Primary care collaboratives” in issue 3). The goal is to achieve locally relevant changes in health care quickly for these patients.

Four team meetings (one orientation session and three learning workshops) are held over a period of about 12 months. At



Collaborative methodology

Learning workshops and PDSA cycles

**Government
support**

each meeting, the teams are presented with examples of good practices in diagnostics, therapy and patient management that have proved successful elsewhere. The participants present results from their own work and plan further changes in accordance with the PDSA quality management cycle “plan, do, study, act“.

The NSW chronic care collaboratives are part of the NSW Health Chronic Care Programme, with which the most populous Australian state aims to improve the health outcomes for the chronically ill. Each health area involved in the development and implementation of the collaboration is provided by the New South Wales authorities with Aus\$26,000 (16,000 euros).

By now, 22 teams in all 18 area health services have completed the one-year change management program. The results of the evaluation are being awaited with interest. They should show whether the expectations in the concept have been fulfilled, and whether there has been a reduction in hospital stays or readmissions. The second question will then be whether the chronic care collaborative approach can be transferred to other chronic diseases.

Sources and further reading:

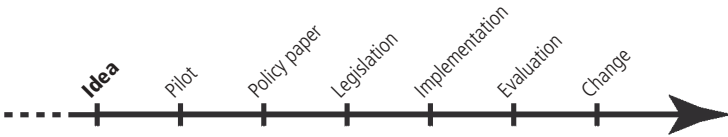
Institute for Healthcare Improvement. The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. 2003. www.ihl.org/NR/rdonlyres/3F1925B7-6C47-48ED-AA83-C85DBABB664D/0/TheBreakthroughSeriespaper.pdf.

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England and Wales: Reforms in social care



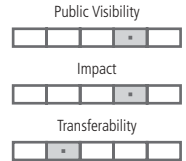
In July 2005, the British government announced three initiatives aimed at optimizing social care and improving its integration with the health sector. The intent is to come closer to the vision of a comprehensive care system.

So far, only the broad outlines of the reforms are known. Models tailored to meet regional needs aim to improve the social care of the elderly, the terminally ill and patients with physical or mental disabilities. Second, a working group will identify obstacles that restrict cooperation with the health sector. And finally, the government will work with the Department for Education to obtain an overview of options for the development of human resources.

Details of the plans are to be specified in a white paper after comprehensive consultations with consumer associations, care services and social services, among others.

The care services minister has already announced a series of specific measures. These include an investment of £140 million (210 million euros) so that vulnerable people can be supported by the social care system to live more independently. In particular, increased funding will be made available for the palliative care of cancer patients, so that more people can spend the last part of their life in their own home. Further, it is planned that people will be allocated an individual budget, thus putting them in the position to manage their own care according to their needs. Finally, the criteria for entitlement to public support for home care are to be standardized throughout the country, eliminating regional differences.

For years, the British government has been criticized for failing to invest enough in social care. The accusation applies particularly to England and Wales, where expenditures are lower than in Scotland. As in many other countries, another criticism is



Reforms of social care announced . . .

. . . plans remain to be specified

Increased investments and patient autonomy

Underfunding and inadequate integration

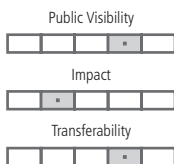
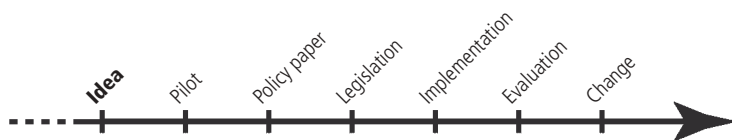
that the health system and the social system have operated more or less independently from one another. And each sector is very protective when it comes to guarding its funding. If the government envisages transferring resources from the health system to the social sector within the framework of the proposed reforms, then it is likely to meet with considerable resistance.

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Australia: Options for cancer treatment



In June 2005, the Australian Senate Community Affairs Committee published a report on improving the health care of cancer patients.

Cancer patients require various types of care and treatment over a long period. In a fragmented health system such as that in Australia, this often leads to problems with the quality of treatment and the accessibility of services.

Lack of coordination and information

Physicians and patients frequently have different views about the appropriate treatment for cancer. Physicians tend to offer

scientifically based procedures, whereas patients are often more interested in therapeutic methods that are based on personal preferences or that (according to the media) promise the most success. But the lack of data relating to alternative therapies and their costs often generates frustration and insecurity among patients.

This situation was the reason for the commissioning of a nonpartisan Senate committee that investigated the care of cancer patients in Australia and evaluated both conventional and complementary methods in the treatment of cancer. It received more than 100 statements from organizations, individuals and regional ministries. The report, “The Cancer Journey: Informing Choices“, made 33 recommendations about how to improve the treatment outcome of cancer patients.

The committee called for the mandatory accreditation of institutions treating cancer patients. The application of clinical guidelines should be a key criterion for the quality assessment.

**Promoting
multidisciplinary
care**

Another recommendation is that effective financial incentives should be provided to improve the coordination of care. For example, the committee recommended that physicians and hospitals be paid fee-for-service if they actively support a multidisciplinary approach to care.

One of the core demands of the report is that consumers be provided with more information about the diagnosis of cancer, the treatments that can be provided, and possible care providers, for example with lists of addresses. Many of the recommendations in the report relate to the promotion of research into complementary medicine and support measures not provided by physicians, such as psychosocial services. The fact that the report came out clearly on the side of the consumers generated a strong positive echo in the media.

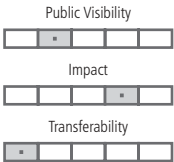
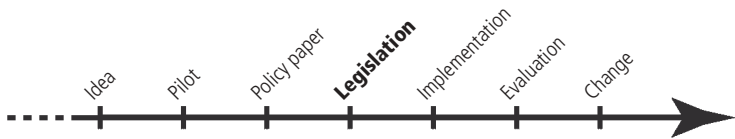
**Patient
information
in focus**

The medical profession was slower to present an official response. However, if conventional medicine representatives feel that their status or their earnings are threatened, it will be difficult to bring about any changes. It is now expected that the government will make clear whether and how it is going to implement the proposals.

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Canada: Local health integration networks in Ontario



Continuity and integration with local structures

Worries about democracy and jobs

Since mid-2004, the Canadian province of Ontario has been revising the administrative structure of its health-care system.

The seven health district councils were finally abolished in March 2005 and 14 local health integration networks set up in their place. The mission of the local care networks in Ontario is to improve the planning, coordination and integration of health care. It is expected that, being local organizations, they will be much better placed to respond to the needs and priorities of the geographic region for which they are responsible. The administrative structures in local health facilities such as hospitals, medical centers, care homes and social services remain unchanged. In contrast to the approaches adopted in other Canadian provinces, patients remain free to choose the area of care.

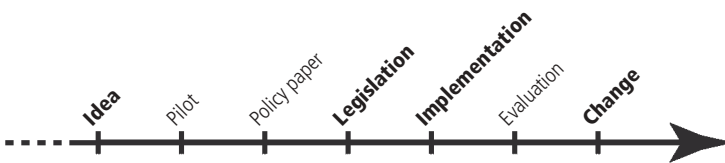
According to the health ministry, most interest groups, professional associations and hospitals support the strategy. But civil-rights groups have raised objections, saying that the structure of the integration networks is undemocratic. The boards consist of seven to nine health experts and administration specialists, all appointed by the provincial ministry. Trade unions fear that the care networks could be a step toward cutting back employment and the levels of services in the local authorities and could advance the privatization of the health sector.

After consultations with the local authorities, the ministry defined the geographic borders of the local health integration networks. It was also determined that each network has to reach an agreement with the Ontario health ministry every year about the services to be provided. The exact role of the integration networks is still not known, nor is it known what responsibilities they will have for the 12 million inhabitants of Ontario. For example, a decision has yet to be reached about whether the local health institutions should only be coordinated by the local health integration networks or also financed by them. At this stage, it is not possible to assess whether the networks will be able to fulfill their mission of improving the continuity of care and access to the system.

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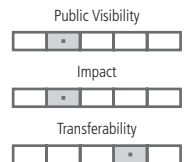
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Germany: Integrated-care contracts



The Statutory Health Insurance Modernization Act of 2004 improved the conditions for health-insurance funds to build integrated-care networks based on selective contracting in Germany. As a result, 841 integrated-care contracts had been signed by June 2005 . By March 2006, that number had risen to about 2,200.

In the German health-care system, ambulatory care (general practitioners, specialists in private practice) and acute hospital care are provided separately, as are rehabilitative care and



Segmented care is standard

long-term care. This segmentation leads to the duplication of services; it limits the quality of care; and it adds to the rising costs of health care.

One approach for the reorganization of care in Germany, the 2000 Health Care Reform Act, introduced the model of integrated care based on selective contracting. However, at that time take-up of the policy failed because too many legal and organizational obligations were still in place. The act called for the regional physicians' associations to be one partner of the integrated-care contracts, a major challenge. This required trilateral agreements among physicians, regional physicians' associations, and the health insurance funds—a complicated arrangement with many conflicting interests.

**Stronger
incentives for
integrated care**

In 2003, the Red-Green government, still in favor of integrated-care contracts, initiated substantial changes to which the Christian Democrats agreed during the negotiation process for the 2004 Statutory Health Insurance Modernization Act. First, integrated-care contracts no longer need to include regional physicians' associations as a partner. Second (and a major improvement): This reform introduced a financial incentive scheme to promote the integrated-care approach. Between 2004 and 2006, 1 percent of the total payments for physicians and for hospitals were earmarked for investment into integrated-care projects. This is a reallocation of around 680 million euros a year from the conventional system toward integrated care.

Finally, the reform introduced the possibility of health insurance funds signing contracts with management organizations to manage integrated-care networks. Possible partners of these management bodies are all the institutions or individuals the SGB V defines as “providers of care”: physicians, dentists, hospitals, institutions for inpatient or outpatient rehabilitation, and groups of these providers.

**Status of
integrated-care
contracts in
Germany**

The associations of health-insurance funds, the German Hospital Federation and the Federal Association of Statutory Health Insurance Physicians, established a joint registration office to monitor the evolution of integrated-care contracts. According to this data, by June 2005 the health-insurance funds had signed 841 contracts covering 2.2 million members (i.e., 3 percent of insured persons in Germany). However, there is a

remarkable variety in type, coverage and funding of contracts. For example, the majority were signed in the state of Baden-Württemberg (148 contracts), but these cover just 7,600 fund members. The 46 contracts signed in Saxony-Anhalt include 530,000 insureds. Baden-Württemberg consumes 20 million euros in incentive financing per year, the same amount as the region Westphalia/Lippe, which reported 38 contracts for almost 100,000 insurees. In seven regions, fewer than three contracts were signed.

Most of the contracts are related to a specific indication (e.g., stroke) or a medical procedure. For example, all regions reported contracts dealing with hip replacement or other orthopedic procedures. So far, no population-based approaches have become operational. (A “population-based approach” is a management organization or a network of providers assuming responsibility, including financial responsibility, for the organization of care for an entire region.)

Among providers, acute-care hospitals are involved in more than 65 percent of all integrated-care contracts. They partner with ambulatory-care physicians in 20 percent of all contracts and with rehabilitation institutions in 18 percent. In 29 percent of the contracts, hospitals represent the single type of provider. Agreements that include more than two sectors, such as those with physicians, hospitals and rehabilitation facilities, account for only 5 percent of all contracts. This may indicate that the contracts are covering a relatively low level of vertical (i.e., cross-sector) integration of care. However, the data may not reflect all the providers involved, since the primary contracting partners may have signed subcontracts with other providers. Overall, start-up financing was not completely used by health-insurance funds in 2004, and the same trend seems to have persisted in 2005.

In the last three years, new models have been introduced to promote the better integration of care. These include disease-management programs (see issue 3, “Disease management programs combine quality and financial incentives”), care models centered on the family physician (see issue 4, “Family doctors as gatekeepers”), and medical care centers (polyclinics with general practitioners and specialists under one roof). Thus, assessments of the long-term successes and failures of the German integrated-care

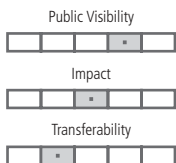
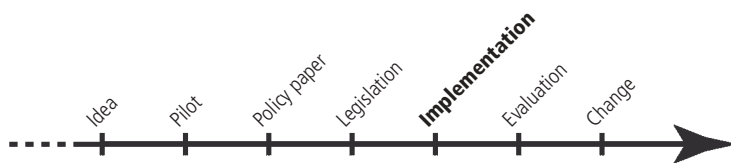
**Multidimensional
approach to
promote
continuum of care**

policy will need to take into account that the approach for a better continuum of care is multifaceted.

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Spain: The Denia model



Private health management of a complete town

Spain aims to promote cooperation between the public and private health sector by awarding fixed-period concessions to private health-care companies. The program will test care models intended to offer advantages to both sides.

In 2005, for example, the region of Valencia awarded the private health insurer DKV Seguros a 15-year license to manage all public health facilities in Denia, a city of 160,000 residents. The Spanish subsidiary of the Deutsche Krankenversicherung set up the operating organization Marina Salud, in which Spanish banks have a 35 percent holding.

Funding by capitation

To finance its operations, Marina Salud receives a fixed annual sum per resident from public funds. In 2005, this per capita payment was 411 euros. If patients from other areas want to be treated in Denia, they must first obtain the approval of the local administration. The costs will be charged to the patient's place of residence.

Legal claims to services are unchanged

DKV Seguros must guarantee the health services included in the public benefit basket. This includes care by general

practitioners and specialists, in the hospital, and at home. It also includes prevention programs. However, it is also possible to offer additional services, such as a single room in a hospital, in order to generate additional income.

The reform is part of the “Valencia model“, by means of which the region has decentralized health care in 20 areas, in three cases by transferring management to private companies. In Alzira, which has 230,000 residents, responsibility for all specialist centers was transferred in 1997 to a private operator for a period of 10 years and in 2002 extended as an integrated-care model to primary-care centers.

The Valencia model

Torreveija, population 130,000, was the location for the second concession awarded to a private health-care company in 2001 to manage the integrated health care. And finally, Denia was transferred to private management in 2005. For the first time, this also included an existing hospital.

Integration and decentralization

Because the conservative Partido Popular was in power in 2004 both at the national level and in Valencia, the political situation was favorable for such cooperation between the public and private sectors. Even so, a number of conditions were attached to the privatization. In Denia, DKV Seguros is obliged to invest at least 96.6 million euros to renovate buildings and build a new hospital with 240 beds, among other projects. The existing clinic will be converted into a care home. Investment plans must be made public. The license can be extended by five years, but after it expires the entire infrastructure reverts to public ownership. A further condition is that the private company must reinvest any returns on investment in excess of 7.5 percent.

Despite the restrictions, the proposition remains strategically attractive for the private companies because they will have an active role in restructuring the Spanish health market and will be able to enter into close cooperation with the public sector. In addition, the region of Valencia is financially interesting because tourism increases the population in the summer months. Finally, the Spanish experience with integrated-care models is regarded as being valuable for subsequent projects in other European markets.

Attractive despite conditions

The public sector also regards the restructuring as offering many opportunities and few risks. First, the financial and operative risk for the health care is transferred to the private

Many opportunities —few risks

Public service—
private
management—
not popular
everywhere

health-care company. The regional administration expects that this will offer a basis for planned health costs, and that debts can be avoided, with cost increases borne by the concession holder. Second, the refurbishment of buildings and the establishment of a new hospital will enhance the prestige of the region considerably. It may also be possible that the improved care standards associated with private services, such as shorter waiting lists, may find their way into the public health sector. Nevertheless, the public administration retains the structural and qualitative control of health care and the power to define the benefit basket and the insured population.

In the future, health personnel in Denia will answer functionally to the private operator but will remain public employees. It is expected that about 40 percent of the trained personnel will make use of the offer from DKV Seguros to work as private employees for the duration of the concession. Attractive training courses and other extras have been offered to persuade them. But the trade unions and the personnel representatives in the local authorities fear possible disadvantages for the employees, for example when it comes to payments.

Shortages of resources, inefficient management, and a lack of customer-oriented care are currently the main problems in the Spanish health system. Many view the long-term cooperation between the public and private sectors as an important step in the further development of the system. It remains to be seen whether Valencia will go ahead as planned and open up four more areas for private involvement.

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Information and communication technologies

There is international consensus that the widespread introduction of modern information and communications technologies (ICT) in health systems will lead to a more effective use of resources, improve the quality of care, and make it possible to pay greater attention to the needs and wishes of patients.

Initiatives undertaken by the European Union to promote the development of the information society—for example, within the framework of the eEurope action plan—have spurred many countries to take appropriate steps (eEurope 2005). In the health sector, the EU’s action plan eHealth encourages member states to develop their own e-health strategies and to establish international standards for the exchange of health data (European Commission 2004).

Today, information technologies are an integral part of hospitals and primary-care units (Dubois et al. 2006). ICT instruments find a wide range of applications. These include administrative support programs for patient data, appointment management and invoicing. In addition, information systems can be used to document and access medical knowledge, for example by means of online literature databases and registers of diseases, services for experts and patients on the World Wide Web, and rule-based systems to support clinical decisions, illustrated in the reports from New Zealand (page 68) and Australia (page 70).

There are also a number of IT solutions for the control and documentation of clinical treatment procedures. These include information systems for specific medical disciplines and for nursing, as well as for laboratories, radiology departments, operating rooms and intensive care.

Finally, ICT systems are used to inform the general public about the performance of the health system. For example, a U.S.

**eEurope and
eHealth**

**Varied IT
landscape**

Web site, Hospital Compare, provides data about the quality of patient care in almost all general hospitals (see issue 5, “Hospital Compare”). For two years, the Ministry of Health in Singapore has been publishing hospital charges on its Web site for frequent medical diagnoses and procedures (see issue 5, “Internet transparency reduces hospital bills”).

Individual solutions instead of standard approaches

Generally speaking, the approaches are island solutions. Interface management is insufficient; data transfer is not facilitated among disciplines or sectors. This is the problem addressed by holistic information and communications systems, which have the goal of providing smoother data exchange among physicians, hospitals, pharmacies, care institutions, health insurers and public administrations.

Electronic health cards being tested worldwide

Many countries are setting up such models for the future, with electronic health cards, records and networks. In order to test the electronic health cards, many countries—for example, Austria, Canada, France, Germany, Italy, Japan, Switzerland and the United States—have set up model regions.

With its “Rete sanitaria” strategy, the Swiss model region of Ticino has adopted a system similar to the one being tried in Germany, with two cards forming the key elements to providing access to the electronic health network. One card is for beneficiaries, and one is for health professionals (see page 56).

Electronic health records (EHR)—vision and reality

Cross-sectoral electronic health records (EHR) are a form of electronic communication envisioned for health systems in many countries. They are the goal of their health-policy ICT strategies. The EHR is expected to allow the long-term collection and documentation of all relevant patient data. In addition to personal data, it contains a wealth of medical information, such as the medical history of the carrier, important laboratory results, physicians’ letters and records of operations, and digital data from investigations.

Electronic health records in Israel, Denmark and Estonia

Israel’s largest health insurer, Clalit, introduced in 2005 a general system of electronic medical records covering its hospitals and community clinics. The technical advantage of this strategy is that the system links existing hospital and clinic software pragmatically via the Internet. Compatibility problems are largely avoided (see page 58).

Progress on the introduction of electronic medical records in Denmark's hospitals has been disappointing. The Ministry of Health was unable to implement the IT strategy by its deadline of 2005. Technical obstacles and resistance in the counties have made the process more difficult (see issue 3, "Electronic patient records in hospitals," and page 60).

**No e-health
without e-culture**

In comparison with other countries, the approach adopted by Estonia seems particularly ambitious. The country plans a national medical-information system that goes beyond the concept of electronic medical records. A central database, to be set up by 2008, will register health information for all 1.35 million Estonians from birth to death and make the data accessible (see page 62). However, the project is under considerable time pressure. Also, clarification is needed regarding both funding and concerns about data protection.

**From cradle
to grave**

It is widely accepted that, if patients are to accept the new electronic systems, it is essential to ensure data protection and to make personal data fully accessible to them. The high priority placed on the protection of personal data in the health systems of many countries was reflected in the Health Telematics Act passed in Austria in early 2005 (see page 65). This law primarily addresses the requirements for data security relating to the electronic transfer of medical information, a measure that many of those actively involved considered long overdue.

**Protecting
sensitive data is
very important
and ensures
acceptance**

The example of Austria also emphasizes a further objective of health policies relating to telematics that previously had been neglected. Evaluations of the implementation of ICT in health services have tended to adopt a partial or project-related approach. The Austrian government aims to perform a comprehensive analysis of the effects of utilizing ICT for the health-care system. It also intends to establish a monitoring system.

**Evaluation of
health telematics**

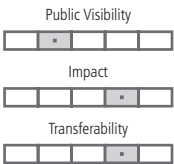
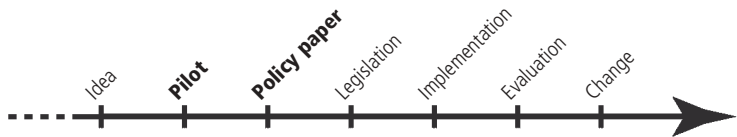
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Switzerland: Electronic health card and health network—the model project in Ticino



In the Swiss canton of Ticino, some 1,000 insurance beneficiaries are using an electronic health card. This is part of the model project “Rete sanitaria” which began in November 2004 in the Lugano area after a six-year period of preparation. The long-term goal is to establish a local electronic health network whose core elements will be two electronic cards.

**One system,
two cards**

The health cards (Carta Sanitaria) have been developed in accordance with international standards. The cards make it possible to store administrative data and additional medical information. The latter includes emergency data about allergies, vaccinations, blood group and current medication. It is also possible to store data on medical history, such as information relating to diagnosis, laboratory results or a list of x-rays.

The second card (Carta Professionista) is for health professionals working in pharmacies, practices, hospitals, emergency clinics and long-term care institutions. The clearly identified operator can access the protected information and make additions and updates. Patients express their consent to this by entering their personal access code.

In order to fund the project, the legislature of the canton of Ticino agreed unanimously in March 2003 to provide a loan of € 1.4 million and to contribute € 900,000 toward wage costs. It is planned that by June 2006, some 2,500 beneficiaries and 600 health personnel will be participating in the test of the health cards.

Starting in 2007, these cards will open up access to the electronic health network “Rete sanitaria,” which in a second five-year implementation phase will include online services such as electronic prescriptions and an electronic medical record. On the basis of the success of the model trials, the government of the canton will decide whether to introduce the network and the cards to the rest of Ticino.

Although implemented by the Ticino Health and Social Department, the pilot project is the result of a bottom-up consensus reached with the main actors in the health sector, such as physicians’ associations, pharmacists, health insurers and patient organizations. Their 10 representatives worked together closely with business representatives. The industrial partners support the project on such matters as hardware, communications infrastructure and network architecture.

The Ticino model has already had an influence on national legislation. In October 2004, the Swiss Parliament passed an amendment to Article 42a of the Health Insurance Act for the implementation of a national insurance card. After its introduction in 2006, it will store administrative data such as name, age, sex and insurance number, meeting the EU requirements for a European insurance card. In the longer term, the act also allows the storage of medical data.

However, a national strategy for the introduction of IT procedures is made more difficult by the fact that health care in Switzerland is the responsibility of the autonomous cantons. Nevertheless, the cantons have begun to make efforts to harmonize their telematic initiatives.

Card as key to the electronic health network

Bottom-up consensus and public-private partnership

Swiss national insurance card

Federalism requires coordination of IT initiatives

**Cooperation with
"e-toile" project
in Geneva**

As one example, the Ticino project is in close contact with the pilot project "e-toile" in the canton of Geneva. Initiated by the University Clinic Geneva, this project involves gradually expanding the electronic patient files to form a regional IT health network. Here too, a card is used to control data access.

**Data protection
strengthens
patient
participation**

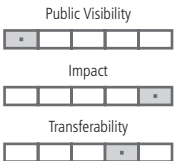
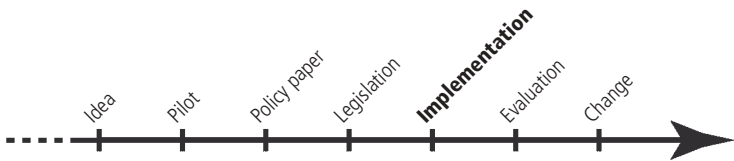
For many experts, the real innovation in the Swiss models is not so much the development and implementation of the technology but rather the cultural changes they bring about in the handling of health data. The strategies give the patients the responsibility for deciding what information is stored electronically, who can have access to it and who can make changes. The regulations to protect privacy could revolutionize the role of patients in the health system.

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Israel: Institutions sharing electronic medical records



**Retaining the
local software
programs**

Clalit Health Services, Israel's largest health insurer and its largest provider of health-care services, introduced a common electronic medical record for all its hospitals and medical centers in 2005.

A special technical feature of the system is that it can be applied irrespective of the software programs used by the various institutions. Medical information from the local systems is linked together in real time to form a medical record for the patient.

Compatibility problems are largely avoided. The commercial software developer dbMotion has constructed the system in such a way that the only technical requirement is that each workplace computer has Internet access. There is no need for any additional hardware or software installations. The protection of personal data is ensured because each physician can only access the information about his patients.

With a common medical record shared by the sectors, Clalit is following the goal of improving the quality of health care. By making available to physicians information about the latest treatments, it is possible to avoid medical errors such as prescribing contraindicated medications. The health insurer also hopes to cut costs by eliminating duplicate investigations carried out as a result of the gaps in information among the various providers. Clalit has 15 hospitals and more than 1,200 primary health-care facilities. Each has a fixed budget, creating a considerable incentive for the various institutions to realize substantial savings by using the electronic medical records. Experts expect that the project will meet with broad support.

One problem that experts envisage is that the electronic medical records will work only if all service providers enter the information completely and promptly into their computer. The results of laboratory analyses are already included automatically in the files. Physicians, however, will have to enter the latest diagnoses and therapy data manually. Because they were worried that the electronic documentation would lead to a considerable increase in workload, representatives of the medical profession argued that Clalit should not introduce the electronic medical records. Clalit responded by claiming that physicians would actually save time because they would be able to receive the latest treatment data about their patients without delays.

Although the electronic medical-records network has been implemented for all Clalit institutions across the country, so far only some of the physicians actually use it. Experts say one key reason for this is that the physicians have not yet been sufficiently informed of the program's potential benefits. Rejection by the medical profession would scuttle the project. Only if the records are updated regularly will it be possible for the program to succeed. The task facing Clalit is to convince the service providers

**Improved quality,
reduced costs**

**More work
for physicians?**

**Success will
depend on degree
of acceptance**

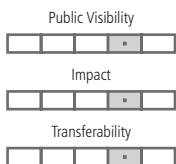
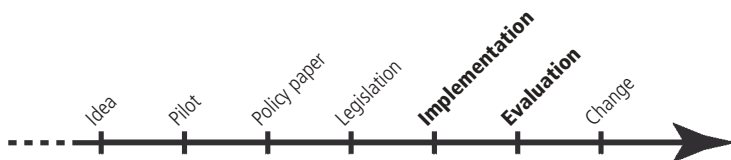
about the electronic medical records in a broad campaign over the coming months.

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Denmark: Sobering evaluation of electronic patient records in hospitals



Objectives of the electronic record system for patients

The goal of implementing electronic patient records in all Danish hospitals by the end of 2005 was not reached. Having failed to meet its own deadlines, the Ministry of Health will have to extend the time frame for the introduction of the hospital IT system by at least three years.

The introduction of standardized medical records in hospitals is intended to assemble all data for a patient electronically. In the long term, the information will also be available to other health-care providers. For the Danish Ministry of Health, a comprehensive IT strategy will make it possible to improve patient orientation, continuity in care, and systematic quality assurance. It will also promote the efficient use of health resources. The electronic records play a central role (see issue 3, “Electronic patient records in hospitals”).

There is consensus in Denmark among politicians and interest groups about the goal of introducing a nationwide system of electronic records for patients. So far, however, the actors involved view the results variously. The Ministry of Health and the county representatives explain the collapse of the timetable by pointing out that implementing the system turned out to be much more complicated than the project planners had assumed. Because Danish hospitals use various computer systems, compatibility problems have led to unexpected delays. However, some politicians blame the minister of health himself. According to the opposition, he did not provide sufficient information about the technical problems. This lack of information, they say, lengthened the delays.

**Ministry of Health
blames complexity**

Experts also attribute part of the delay to the fact that some of the 14 counties had already developed a joint system for electronic patient records—one that is incompatible with the system used in other counties. They suspect those counties of seeking to exert leverage on other counties and the national government. Additionally, county administrations might obstruct the national implementation of patient records to restrict the mobility of patients. They will have to transfer payments to other counties if their residents make use of health services outside their hospital district.

**Power games
between counties**

Overall, Danish health experts are critical of the project to create electronic records for patients. They view the failure of the IT strategy as a waste of resources. They go so far as to demand that the case be put before the National Audit Office to determine whether it constitutes a waste of public funds.

**Delays waste
public resources**

A further important point, in the view of the specialists, is the loss of credibility by the Ministry of Health. Representatives of the ministry have been trying to attribute the problems to structural obstacles instead of acknowledging their own shortcomings. By rejecting the accusations, the minister of health, who demanded more transparency from all the actors in the health service when he came into office in 2001, has made it less likely that others will be prepared to admit difficulties in public.

Loss of credibility

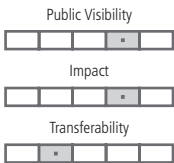
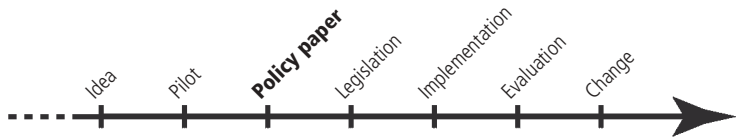
It remains to be seen when standard electronic records for patients will be introduced in Denmark. A recently published evaluation report suggests that, in the worst case, nationwide implementation could take until 2020.

**Will rollout be
possible by 2008?**

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Estonia: National health information system



By the end of 2008, Estonia plans to have established a comprehensive medical-information system that will make all the health data about every Estonian available electronically.

The plan anticipates a centrally administered database, accessible nationwide. Uniform IT standards will allow the exchange of information across the country among physicians, hospitals and other providers of medical services.

Ambitious program

Both in scope and timing, the program, which the Estonian government has been preparing since 2000, is ambitious. Between 2005 and 2008, a system of electronic records is to be developed for all 1.35 million Estonians. The system will contain the most important health data. There will be a range of data components, among them systems for digital appointment booking, electronic prescriptions, IT-supported billing of services, and databases for medical images and blood banks. The components will be linked electronically and administered centrally. Finally, the existing medical registers are to be harmonized, and some new elements (for example, a national accident register) are to be established in electronic form.

The government has estimated that the program will require an investment of 2.6 million euros, of which 85 percent will come from European Union Structural Funds. In addition to the necessary technical developments, the funds will also support intensive training programs, primarily for physicians and nurses, and a comprehensive PR campaign.

Responsibility for implementation has been entrusted to a private, nonprofit foundation, set up by the hospitals and professional associations in October 2005 following an initiative of the Estonian Ministry of Social Affairs. In order to increase efficiency and expand technical expertise, the foundation has called for tenders for IT solutions from private providers.

**eHealth
Foundation**

With the backing of the European Commission's eEurope initiative, the Estonian government coalition has placed considerable importance on the promotion of information technologies. The objective of the Center Party, Reform Party and People's Union is to make the health-care system more effective, safer and closer to the patients. The eHealth strategy was anchored in the Health Project Estonia 2015. Since 2003, a department of the Ministry of Social Affairs has been supervising further development.

Estonia and its people have a very positive attitude toward new developments in information technology, and the government's approach has received support from many sides. In public-opinion polls, respondents place the expansion of IT applications high on their wish list for the health service.

Innovative Estonia

However, the patients and the consumer association have scarcely been involved with the development of the system. For example, they have no representatives on the committee of the eHealth Foundation. This is remarkable, especially since the government is planning substantial changes to the legislation on data protection in order to allow the exchange of medical information among the various participants. Estonia's privacy laws are relatively restrictive. For example, no register of diseases is allowed to make data about individuals available for research without their written consent.

**Public support
without
participation**

All previous attempts in Estonia to reach voluntary agreements on shared standards for electronic data exchange have fallen short. Since the early 1990s, physicians and clinics have used a

**Generally positive
reactions from
physicians and
clinics**

wide variety of IT systems and databases. For some years, however, interest has concentrated on the billing process, because since 2002 the national health insurance has accepted relevant data only in electronic form. Family physicians now hope that the national health-information system will shift the emphasis to the patient-oriented treatment process: Information is less redundant, time-consuming paper documentation is reduced, and receiving a second opinion is easier. Less enthusiasm is shown by specialists and nursing personnel, who have been working for a long time with their own information systems and see few benefits for their daily work.

Experts consider Estonia's eHealth strategy ambitious. A system of medical information that registers all the health data of every Estonian from birth to death is without any international precedent. However, time will tell whether Estonia can overcome the funding obstacles, time pressure and concerns about data protection to implement the project successfully.

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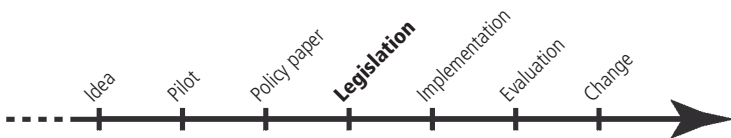
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Austria: Health Telematics Act

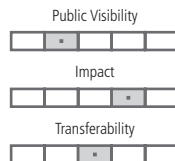


In Austria, the Health Telematics Act took effect on January 1, 2005. It governs the utilization of information and communications technologies in the health system.

The 20 paragraphs of the law contain regulations for improving security when health data are being transferred electronically. The law also introduces more detailed, uniform IT standards. Other key elements are the monitoring of IT developments in the health system and the provision of modern information services.

Progress toward an information society has been growing in political importance in Austria since the mid-1990s. A wide range of state-funded programs aims for the systematic, long-term implementation of efficient information and communications technologies in education, science, culture (eLearning, eFit), business (eBusiness) and public administration (eGovernment). Key impulses come from European Union initiatives within the framework of the eEurope action plan.

A first step in the health sector was the appointment of the STRING Commission (Commission on Standards and Guidelines for the Use of Computer Sciences in the Austrian Health System) in 1995 by the Federal Ministry Social Security Generations and Consumer Protection. In 2000, scientific experts and representatives of professional associations, social security systems and the public administration formulated the “MAGDA-LENA recommendations” (medical-administrative health data exchange—logical and electronic network Austria). These established broad technical and organizational framework conditions for an Austrian “logical health-data network.” This provided the basis for the draft of the Health Telematics Act.



**Data security,
electronic
standards and
information
services**

**Austria as an
information
society**

**STRING
Commission and
MAGDA-LENA
recommendations**

Focus on data protection

In line with the MAGDA-LENA recommendations, data protection and data security are particularly important in the new law. For example, health data may be exchanged in electronic form only when the identity and authorization of the communication partner have been established by a certificate or electronic signature. Service providers may provide authorization separately or by enrolling in a new eHealth registration service. The goal is to implement the data-security measures by the end of 2007. Unsuitable hardware should be replaced and software adapted by that time. However, the law offers no prospects for financial support.

eHealth registration service

The eHealth registration service is intended to list all individuals and institutions participating in the electronic exchange of health data in Austria. This will lead to the systematic localization and unambiguous identification of service providers. At the same time, a statistical evaluation of the register can be used for planning purposes or for filing reports, for example to the European Commission.

Monitoring IT developments

In the past, the fragmentation of the health system and the provision of services in Austria meant that it was not possible to obtain national information about the classification and the numbers of those taking part in the electronic transfer of data. There has also been a lack of reliable data on the current levels of equipment for information and communications technologies, as well as on economic figures, such as expenses as a proportion of the gross domestic product. In order to improve the basis for decision making at the national level, the law proposes market observation and analysis by the federal ministries for technology and for health and women. The goal is to establish a standardized reporting system that takes into account the data contained in the eHealth registration service.

Positive judgment by the OECD

In its Information Technology Outlook 2004, the OECD evaluated Austria's initiatives in the field of health telematics positively. The report drew attention to the fact that government, insurers and business have all committed to agreeing to a joint strategy for implementing information and communications technologies in the health system.

Is the Austrian IT strategy coherent enough?

However, some national experts say that several factors stand in the way of a modern and coherent IT strategy in the Austrian health system. For example, the Health Telematics Act does not

clearly define the role of the health insurers, although they will play a key part in financing the technical infrastructures and ensuring that data are protected. Critics note that the government has given relatively low priority to modern information and communications technologies in comparison to other health-policy topics. In addition, this field impinges on the responsibilities of a number of federal ministries, in particular those for health and women, social security, generations and consumer protection, and transport, innovation and technology. Their actions are not always properly coordinated.

Testing the e-card

One example of this is that the introduction in May 2005 of the electronic health-insurance card was not expressly synchronized with the Health Telematics Act. Austria is currently testing the e-card in 13 regions. It will replace the existing health-insurance form and, by including the European Health Insurance Card on the reverse side, will also replace the E 111 form. In addition to administrative information, it is planned that medical data will also be stored.

Data protection, which is now covered by the Health Telematics Act, has been a major cause for concern. Many stakeholders (e.g., the Austrian Medical Council) considered the legislation long overdue and blamed politicians for unnecessarily delaying it.

Despite the criticism, responses to the Health Telematics Act in Austria generally have been positive, because it offers the opportunity to improve the transparency, quality and efficiency of the health-care system and to promote responsibility among its participants.

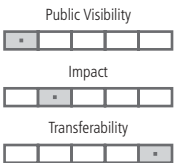
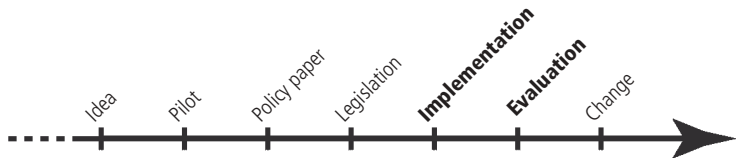
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New Zealand: Electronic support for clinical decisions



The computer program PREDICT offers New Zealand’s physicians in hospitals and primary care facilities the opportunity to assess the risks of their patients for heart disease and diabetes mellitus and to develop appropriate preventive and treatment programs.

Individual prevention and treatment

Linked to an electronic medical record, the program analyzes the patient’s medical history and clinical data and generates a risk profile. Within that framework, it provides recommendations for preventive measures and therapies suited to each patient. The program is based on guidelines developed in accordance with the principles of evidence-based medicine. Because the IT tool is linked to the Internet, the recommended preventive measures and treatments can be updated regularly to take into account the latest scientific developments.

The program was developed at the University of Auckland with the software company Enigma Publishing Limited. As well as providing support for the physicians in their daily work, the system can generate high-quality epidemiological data—an advantage, its developers say, that makes it possible to develop targeted prevention programs for populations at risk.

Population data for targeted campaigns

PREDICT-CVD, which appeared in 2003 and was the first version of PREDICT, was developed for patients at risk of cardiovascular disease and was used in an outpatient context. Soon afterward, the heart clinic of a major New Zealand hospital adopted the program. An evaluation showed that high-risk patients in particular benefit from the electronic decision-making support for physicians. A problem, though, was that the system had been developed without an Internet link. This meant that it was not possible to obtain direct updates for the clinical treatment guidelines. In the new PREDICT version 2.0, provisions have been integrated for a monthly online update. The program has also been extended to include risk analysis for patients with diabetes.

Previous version very successful with high-risk patients

There is no specific legislative framework for the program, although the Ministry of Health places the highest priority on the fight against heart disease and diabetes and is supporting the further development of the project. There have also been positive reactions from the national heart foundation, as well as from physicians and hospitals.

Broad support for the project

The developers are worried that the program could fail through lack of funding. The continuous maintenance of the system is vital—and expensive. In addition, not all physicians have a broadband Internet connection for the online use of the program. A further problem is achieving compatibility with the various software packages used. Thus, despite the initially positive results, the long-term success of the project is still uncertain.

Problems with funding and technology

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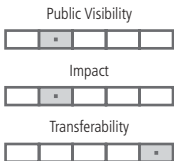
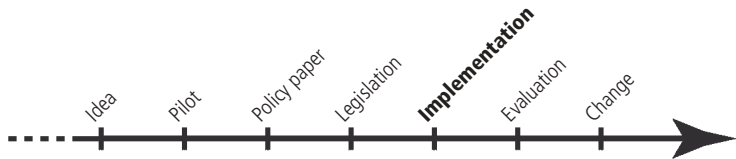
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Australia: Guideline database for cancer therapy



Internet protocols for evidence-based cancer treatment

With the goal of standardizing medications for the treatment of cancer patients, the Cancer Institute New South Wales created an Internet database in 2005 with detailed treatment guidelines for chemotherapy procedures.

The recommendations for clinical treatment have been developed in the form of protocols using methods of evidence-based medicine. The protocols contain information about the current evidence on the effects and undesirable side effects of chemotherapy. They list the potential applications of various combinations of drugs and the dosage patterns, and they propose an appropriate sequence for the treatment.

In addition to scientifically based approaches to treatment, alternative therapies are also included. The database is updated once a month. New developments are included promptly and can be accessed immediately by participating physicians.

Access for doctors, nursing personnel and patients

The protocols are intended for use by oncologists and nursing personnel as well as by patients and their relatives. On the Web site, physicians can access a full range of detailed procedures for

medical treatment, but the information for patients and nursing personnel is limited to the most important guidelines relating to chemotherapy.

The protocols have been developed by the state-funded Cancer Institute New South Wales with the support of oncologists, nursing staff, pharmacologists and representatives of patients. They have taken similar projects in Canada and Great Britain as references.

Currently, the Cancer Institute is mainly occupied with technical problems arising from the widespread implementation. Not all Australian physicians have permanent Internet links. In rural areas in particular, the database is not continuously available. The researchers are also worried that the complexity of the information could cause physicians to reject the system. Nevertheless, the Cancer Institute hopes that advertising in specialist journals and at conferences will reach a large number of potential users and convince them that the basic structure of the database is simple.

In the future, an evaluation of the user profiles and the ease of use of the system will provide information about the acceptance of the database. For example, planners intend to analyze the visits to the Web site and the numbers of hits via the various Internet search engines over a specific period. It is hoped that this will show whether the guideline database is achieving its goal of standardizing chemotherapy treatment and thus of improving the quality of care for patients with tumors.

Acceptance still unclear

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Human resources for health

Human resources are a key element in the health-care sector, which faces profound changes and a range of challenges.

Longevity and chronic illnesses increase the complexity of health problems and the provision of care. The potential of modern medical therapy and highly developed technologies calls for new occupations and qualifications.

Patients' expectations are also changing. People are increasingly well-informed about their illnesses, and they are no longer prepared to accept patterns of care uncritically.

Other important factors are the effects of demographic developments on human resources in health care, changes in career cultures, and increasing international mobility. In many countries with low birth rates, the working population will decline steadily over the coming decades—with repercussions on the recruitment of newly trained professionals in the health sector.

In Europe, 77 percent of health-care personnel are women, and the figure is rising, even in traditionally male-dominated areas. A growing proportion of medical students and physicians are women. In many countries, rigid structures and conventional gender roles are obstructing the introduction of more flexible work models and comprehensive child care. As a consequence, women are very likely to interrupt their career or to work only part time.

Men are also looking for a new balance between work and their private life. The traditional gender roles and attitudes toward work are changing. And in many cases, demands are being voiced for improved working conditions and better salaries.

Finally, the promotion of increased mobility in the work force is a key element of European Union policies and is important to

Complex illnesses and technologies

The well-informed patient

Shortage of health professionals

Feminization of the medical profession

Changing professional attitudes

International mobility

its single market. But as some Western European countries actively recruit personnel in new Eastern member states such as Slovenia, Poland and the Baltic countries, there has been a migration of doctors and nursing personnel from those countries.

Demographic and technical developments, changes in career structures, and migration are leading to a serious imbalance in supply and demand for qualified medical staff (Dubois et al. 2006).

**Shortage of
objective
demographic data**

However, opinions about the urgency of reforms and the extent of the shortage in human resources frequently differ. Therefore, France established a national project in 2003 to bring together all national and regional data relating to the demographic development of health professionals in order to create an objective basis for the regulation and control of human resources (see report, page 76).

**Redistributing
professional
responsibilities**

Many countries are becoming convinced that the traditional demarcation lines between health professions—for example, between physicians and nurses—stand in the way of optimal health care, and they are beginning to redistribute responsibilities. Thus in the United Kingdom, the United States and the Netherlands, a new career, “nurse practitioner,” has been established. These university-trained professionals not only carry out nursing duties, but they also assume responsibility for tasks that would traditionally be viewed as the responsibility of the physician (see issue 2, “Nurse practitioners”).

**Trend toward
group practices**

There is a broad trend away from single practices with general practitioners working in isolation toward more patient-oriented and cost-effective group practices. Canada is currently conducting 11 pilot projects to see how health professionals can acquire communicative and other skills to prepare them for teamwork (see report, page 78). Israel plans to transfer part of the specialist training from hospitals to community health centers, in order to make the medical qualification more practical and better suited for future care models (see report, page 80).

**Flexible contracts
and working hours**

Other countries are turning to flexible employment models, which are increasingly replacing a lifelong career in a single organization. Slovenia, for example, now allows specialists to enter into contracts with several hospitals, and it is relaxing its rigid regulations on working hours (see report, page 81).

Many countries are show considerable differences in the regional availability of physicians. Above all, there are shortages of general practitioners in rural areas. Internationally, there is a range of responses to this shortage of physicians. The medical profession in France is calling for the removal of restrictions on the numbers of medical students and trained specialists. The Ministry of Health, on the other hand, wants to provide financial incentives in order to make it more attractive for physicians to work in rural areas. Another government proposal envisages requiring physicians to complete thorough training in general medicine before they go on to qualify in a specialty (see report, page 76).

The National Health Service in England and Wales is focusing on disadvantaged areas. In a pilot project, it will be employing more general practitioners and establishing health trainers (see report, page 83). Singapore is attempting to keep pace with the developments in other countries and wants to put general medicine on a par with other medical specialties (see report page 85).

In view of the shortage of nursing personnel in public hospitals, the Australian state of New South Wales is making it easier for trained nurses to return to their vocation. The state has set up a program of practical refresher courses (see issue 2, “Retaining nursing personnel”).

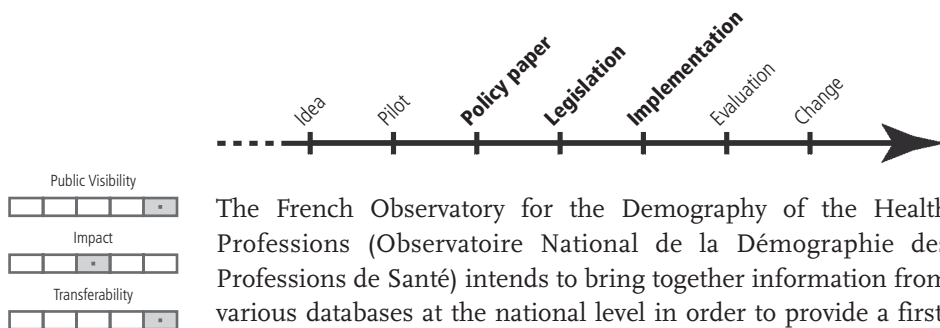
A common feature of virtually all these strategies is that those who seek to implement them must first overcome considerable opposition generated by conflicting interests and structural constraints. Here too, the health professionals are the key to success and must be fully integrated into the reform process.

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France: Observation and monitoring of health professionals



The French Observatory for the Demography of the Health Professions (Observatoire National de la Démographie des Professions de Santé) intends to bring together information from various databases at the national level in order to provide a first, objective analysis of the problem of the shortage of human resources in health care, on the basis of which specific solutions can be proposed.

**Shortage of
physicians
expected**

According to experts, France will be facing a marked shortage of physicians over the next 10 years. Already, the density of physicians in the north of the country is only 60 percent of that in the southern regions. The impact on the availability of general practitioners in rural areas will be particularly severe.

However, there is a shortage of reliable figures and forecasts. Information is in part contradictory and drawn from a range of sources: the health insurance funds, the Ministry of Health and the regional administrations, and the National Medical Council (Conseil National de l'Ordre des Médecins).

**Shorter working
hours and EU
limitations**

A number of factors contribute to the shortage of physicians in France. The introduction of the 35-hour work week and the EU Labor Directive increased the need for doctors. At the same time, the increasing feminization of the profession (women make up 60 percent of French medical students) and the changing attitudes of medical graduates to their vocation mean that the number of clinically active physicians is declining.

It is undisputed in France that there is a need to improve the data situation for planning for future needs and controlling the supply of physicians. This is the mission of the National Observatory for the Demography of the Health Professions. Founded in 2003, the organization is cooperating with regional institutions to document and analyze the development of human resources in the health system.

There is less agreement about how to respond to the shortage of medical professionals. The Ministry of Health argues in favor of transferring some functions from physicians to other health personnel. The associations representing hospitals and some of the nurses support this proposal. The medical profession is divided on the issue, with specialists in some fields fearing a loss of income and criticizing the lack of clear definitions of professional competence.

Transfer of professional responsibilities

Another recommendation that receives little support from the medical profession is the proposal to shift training in medical specialties outside the academic institutions and to support the development of comprehensive training in general medicine.

Strengthening general medicine

As a counterproposal, the Medical Council would like to increase the number of medical students by relaxing admission restrictions.

More medical students

Providing financial incentives to attract physicians to areas facing shortages is not a new strategy in France. The public hospitals offer premiums, and the state offers tax rebates for general practitioners. The ministry has declared that it wants to provide income incentives in particular for general practitioners, although it has not yet specified this further. In its recommendations in 2005, the observatory emphasized that no limitations should be imposed on a physician's freedom to choose where to work.

Financial incentives for physicians

The general goal of the ministerial model for human resources development is to work through all the various recommendations and approaches, to provide information, and to resolve the controversies.

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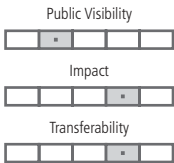
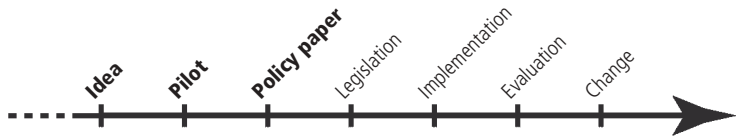
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Canada: Interprofessional education



**Interdisciplinary
teams are the
model of the
future**

In May 2005, the Canadian Ministry of Health made funds available for 11 research projects on interprofessional education to qualify health professionals to work together in interdisciplinary teams.

A core component of the Canadian health reform is to provide an alternative to general practitioners operating in a single practice. The aim is to develop collaborative practice models in which physicians work in a team with nursing personnel, social workers, psychologists, dieticians, midwives and physiotherapists. The objective is to create a system of primary medical care more closely oriented to the needs of the patients: multidisciplinary, well-coordinated, and accessible 24 hours a day.

Against this background, the 11 projects under the general title Interprofessional Education for Collaborative Patient-Centred Practice are investigating ways in which health professionals can be prepared for the healthcare system of the future. Over a period of five years, Can\$13 million (9 million euros) is available for this work.

Each of the coordinated research projects at various universities in Canada has its own focal point, such as changes in the professional culture or interdisciplinary care of specific patient groups (e.g., the chronically ill, mentally ill children and geriatric patients).

The projects have their origins in the recommendations of a number of commissions, such as the Romanow Commission, the Kirby Standing Committee on Social Affairs, Science and Technology, and the Health Council of Canada, which repeatedly called for the further development of primary care and patterns of education.

The program, developed by the national Ministry of Health in 2004 in consultation with the provincial governments and various professional associations, met with general support. Ideally, the project concepts should find their way into university courses and continuous-training curricula for all health professions so that health personnel will be prepared for well-operating collaborative practices. However, it will first be necessary to assess the long-term benefits of interprofessional training measures and examine the consequences for the quality of health care.

Improved
quality of care?

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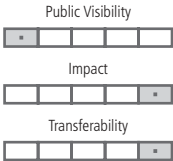
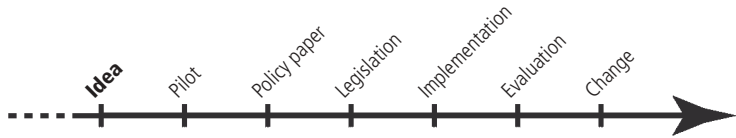
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Israel: Community training for specialists



Together with the Medical Council, the Israeli Ministry of Health put forward a position paper in 2005 recommending that parts of the specialist training for physicians be moved from the hospital sector to the community health centers.

In ophthalmology, dermatology and ENT, medical procedures are increasingly carried out on an outpatient basis. However, in contrast to other sectors such as general medicine, psychiatry, pediatrics and gynecology, specialist training in Israel, as in other countries, is still conducted exclusively in hospitals.

Practical specialist training

By rotating in the community health centers, future residents will acquire qualifications more relevant to their daily professional work. For example, they will have the opportunity to gather experience with diseases that rarely involve a hospital stay.

Medical faculties and hospitals opposed

The idea was not welcomed in the academic hospitals, since residents make up a significant proportion of the physicians on duty in the wards and hospitals. Therefore, hospitals expect to receive some compensation for the loss of their services, which in the future would have to be carried out by extra, more highly paid physicians. The alternative would be a marked increase in work loads, with the possible consequence of a decline in the quality of care.

For the medical faculties, the changes in the training curricula would mean that they would be responsible for less teaching, and their budget therefore would be reduced. They are also worried that the quality of specialist training for physicians would decline if the academic level were not maintained in the outpatient sector.

Ambivalence in the community health centers

Many community health centers see the chance to establish themselves as academic training institutions for specialists. However, they are also afraid that they may not have sufficient personnel, time and financial resources. On the basis of data from

other countries, they expect that their costs would rise by 24 percent to 36 percent.

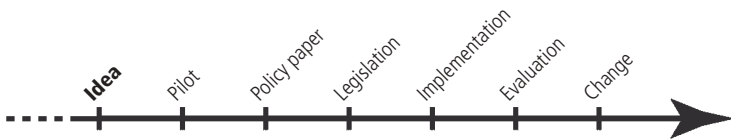
It is the task of the Medical Council to introduce the new requirements in the specialist training curricula and to reach the necessary agreements with the training institutions (i.e., the academic hospitals and health-insurance funds that run the community health centers). A successful agreement will require the resolution of two key points: how the further training of residents will be financed, and the extent to which funds will be switched from the hospitals to the community health centers.

Funding still unclear

Sources and further reading:

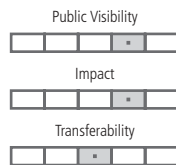
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Slovenia: Independent specialists



The Slovenian Ministry of Health and the Medical Council are working on a strategy aimed at providing more flexible services by specialist physicians.

In Slovenia, specialists are employees of a hospital, whether they work in hospital wards or outpatient departments. A law prohibits physicians from working in more than one place. The government plans to gradually abolish this exclusive employment relationship between specialists and hospitals. The specialists will be allowed to enter into contracts with more than one institution.



Concept of "free" specialists

The ministry also intends to relax the strictly implemented limitations on working hours, which allow overtime only on standby duty and at night.

The objective of the strategy is to adapt the services of the specialists more to the needs of the patients and the hospitals. In particular in surgical disciplines, the government hopes that efficient, highly motivated physicians will be encouraged to make their services available to several institutions. The proposal is attractive for the specialists because it offers greater independence and a higher income. On the other hand, consumer associations and patient representatives have expressed worries about the quality of medical services if the specialists are mobile.

**Liberalization
in focus**

The “free” specialists are one facet of the reform strategy the government is implementing with the aim of liberalizing the Slovenian health services and opening it to market mechanisms. The idea came from the Slovenian Medical Council, whose 2000 strategy paper included the goal of greater independence for the specialist physicians. Encouraged by experiences in the Netherlands and Canada, the Ministry of Health adopted the proposal.

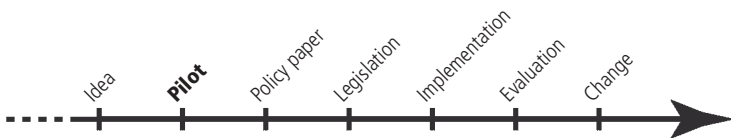
**Disadvantages
for other
professionals?**

Opposition is expected from the Ministry of Labor and the Association of Public Providers. They are skeptical about giving specialist physicians legal privileges regarding their working situation and working hours, and they are worried that the example will be copied in other sectors, with expensive consequences. However, given the consensus already reached between the Medical Council and the Ministry of Health (the key parties involved), it seems probable that the new strategy for medical specialists in Slovenia will be implemented.

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England and Wales: General practitioners and health trainers for disadvantaged areas

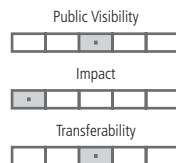


With the goal of reducing geographical and social inequalities, the British government is planning to increase the number of general practitioners in disadvantaged regions and to establish what they call health trainers.

Initially, the reform will be implemented in the form of pilot projects. New medical centers and practices will be set up by six Primary Care Trusts (PCTs), additional GPs and nursing personnel will be employed, and opening hours will be extended. The PCTs, of which there are 302 in England, have been responsible at the local level since 2002 for the control and funding of the health care provided within the National Health Service (NHS). In a second stage, it is planned to extend the project to include 15 additional PCTs.

The task of the health trainers, who initially will work in 12 regions, is to promote a healthy lifestyle in the population. For example, the community workers make information available about smoking-cessation services, accompany people to screening appointments, and help people who have difficulty in reading and speaking English. In 2007, the program is to be extended throughout England and Wales.

In recent years, the Labor government has been returning increasingly to its basic principles, which include improving the position of disadvantaged groups. The latest pilot projects are among a number of initiatives introduced by the Ministry of Health to redress health inequalities. The main aim by 2010 is to reduce by at least 10 percent the gap in infant mortality between routine and manual occupational groups and the population as a whole, and also to reduce by at least 10 percent the gap in life expectancy between the worst fifth of local authority areas and the population as a whole.



Pilot projects in disadvantaged areas

Health trainers

**Objective:
Reducing health inequalities**

Nanny state?

The government can count on support for its latest reform projects from the PCTs and the medical profession, because they are very much in agreement with increasing the numbers of health professionals working in areas in which doctors are lacking. The public health community, including health scientists, sociologists, physicians and some politicians, welcome in particular the idea of health trainers and hope there will be more room for health promotion and prevention. The media, on the other hand, accuse the government of wanting to introduce a nanny state, and the majority of the public rejects the intervention in their lifestyle. It remains to be seen, therefore, whether the latest initiatives will succeed in changing health behavior and the provision of care.

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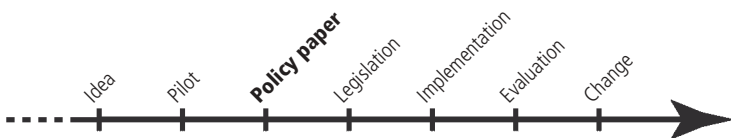
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Singapore: Upgrading family medicine

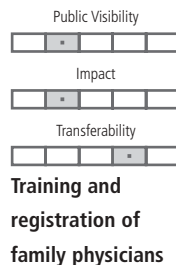


Singapore hopes to improve training standards in primary health care by introducing a register of family physicians who have completed certified training courses in general medicine.

In contrast to other countries, Singapore so far has not had any obligatory postgraduate training program for general practitioners. After five years at medical school and five years of rotation through hospital departments and polyclinics, physicians can set up as family physicians without additional formal qualifications or examinations. The register of family physicians planned for 2007 will include only physicians who have completed a two-year supplementary course in general medicine. In addition, the Ministry of Health has announced that newly founded medical centers must employ at least one registered general practitioner who works full time.

The initiative of the Ministry of Health is a direct response to the demands of the Advisory Committee for Transforming Primary Care, which in 2005 called for improvements in the training of family physicians. General practitioners lacked knowledge and experience in the care of patients with chronic conditions, and their high work loads kept them from spending enough time with these patients. As a rule, they would transfer patients at an early stage to several specialists, who in Singapore are based in hospitals. The consequence was high costs and highly fragmented care.

It is hoped that the training and registration of family physicians will make it possible to provide better and more cost-effective medical care for patients with chronic conditions, with greater emphasis on prevention. The population of Singapore, now at 4 million, is aging faster than any other nation in Asia. Half of the people over 65 living in the city-state suffer from



Improving care for patients with chronic conditions

Singapore is aging faster than the rest of Asia

**General medicine
undervalued**

hypertension, a quarter from diabetes mellitus and another quarter from hypercholesterolemia. The growing number of older patients with chronic diseases is steadily pushing up health expenditures, which are currently 3.8 percent of gross domestic product. The factor of aging alone is expected to double this figure by 2030.

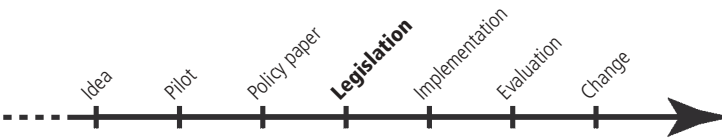
The College of Family Physicians Singapore has long been calling for training standards and the recognition of family medicine as a specialty alongside internal medicine or surgery. They are disappointed that the registration of family physicians and participation in the training program will be voluntary. They are demanding that in the future, all young doctors who are considering working as family physicians first have to complete a two-year training course. Much persuasion will be needed because many physicians feel that they have had enough education after the long years spent at the university and working in hospitals, and they are worried that the additional training would only add further unnecessary stress to their already heavy work load.

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Newsflash

California: Safe Cosmetics Act

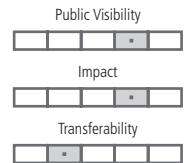


In October 2005, California became the first state in the United States to enact a law intended to provide protection against harmful substances in cosmetic products (California Safe Cosmetics Act 2005). If called on to do so by the California Department of Health Services (DHS), cosmetics manufacturers must disclose any contents that can damage people's health. The federal Occupational Safety and Health Administration is also entitled to examine the range of products used by beauty salons.

If it identifies dangerous substances among the contents, the DHS must file a report to the attorney general and the federal Food and Drug Administration. However, the act does not empower the Californian DHS to ban products containing harmful substances.

The DHS estimates that a third of all cosmetics contain carcinogenic substances. Some products are suspected of leading to birth defects. The legislation in California was partly inspired by a directive of the European Union from 2003 that bans phthalates in consumer products. These plasticizers are widely used as a base material in cosmetics.

The proposed legislation led to considerable protests from the chemical and pharmaceutical industries. In advertising



Transparency for the contents of cosmetics

Many products with health risks

Resistance from the pharmaceuticals and chemicals industries

campaigns costing up to \$600,000, the companies and industrial associations argued that the law threatened the existence of cosmetics studios and beauty salons.

No ban on the sales of dangerous products

Critics of the political decision makers say that they have given in to the companies. According to breast-cancer associations and the Health Committee of the California Senate, the law lacks punch. It can uncover dangerous substances in cosmetics products. But because it is not possible to impose a distribution ban, the consumers and the employees in the beauty industry will continue to be exposed to the harmful substances. It remains unclear whether the goal of protecting the population against impairments to their health will be achieved.

A model for nationwide legislation?

In the view of experts, the act can play a pioneering role in legislation across the United States and has at least withstood some of the powerful lobbying pressure of the drugs and chemicals sector. In the future, the California Safe Cosmetics Act 2005 could serve as a model for other states and for the United States as a whole.

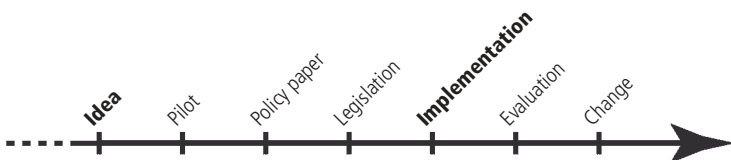
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South Korea: Extending the benefit basket

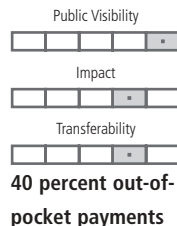


In September 2005, the South Korean Ministry of Health began to extend the benefit basket of the national health insurance to include new drugs and expensive medical treatments.

In South Korea, patients pay an average of 40 percent of the costs of treatment themselves (out-of-pocket payments). Many expensive special treatments are excluded from the public benefit basket, with the result that certain groups of patients have to pay an even higher proportion of the costs for diagnosis and treatment privately. Out-of-pocket payments for cancer patients, for example, are about 50 percent. The high costs are due in particular to new drugs, medical procedures and technologies that are not yet included in the basket of benefits. Health experts say that the government is holding back from including them in the public coverage and is reacting too slowly to new medical developments.

In contrast, the trend among South Korea's physicians is to adopt and implement new technologies very quickly and to charge privately for them. One reason for this is that services not included in the public benefit basket, for example new drugs, can be charged at market prices. But all too frequently, privately financed medical treatment can drive patients and their families into poverty.

According to Ministry of Health planners, the benefit coverage is to be augmented in the next two years to include various highly specialized services. The goal is that in 2008 the average out-of-pocket payment will be just 30 percent. As a first step, in September 2005 coverage was added for new pharmaceutical products and procedures from the fields of oncology, heart surgery and neurosurgery. Future additions to the benefit basket will also concentrate on special medical treatments. The goal is to reduce financial burdens, in particular for patients undergoing expensive forms of therapy.



Poverty through illness, despite health insurance

Inclusion of highly specialized, expensive benefits

Inequality of benefits will persist

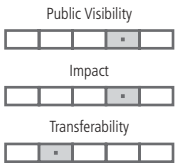
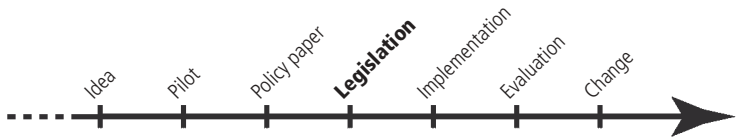
The responses of both the national health insurance and the patient groups have been very positive. They note, however, that the budget for health insurance so far has provided only the basic provisions to the population and that it will not be adequate to cover additional benefits.

So far, only patients in the three sectors previously mentioned have benefited from the new regulations. In the future, according to experts, the government will have to endeavor to achieve greater equality for all expensive medical services. They also point out that the decisions on the inclusion of services in the benefit basket so far have not reflected the findings of cost-benefit studies.

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Finland: Reform package for pharmaceuticals



In January 2006, the Finnish president ratified a comprehensive reform package for pharmaceuticals. The key points of the new legislation are price reductions for drugs, promotion of nicotine-replacement therapies, implementation of European Directive 2004/27/EC amending regulations on drugs for human use, and requirements for the generics market.

Cost containment for pharmaceuticals

The goal of the government is to achieve a lasting reduction in expenditures for pharmaceutical products. The law aims to eliminate nonessential products from the benefit basket. In addition, the reimbursement rates in the first two of the three categories of pharmaceutical products in Finland will also be lowered. In return,

the supplementary prescription charge of between five and 10 euros currently paid by patients will be eliminated.

In future, patients will be refunded only 42 percent of the price of so-called basic medicines. Patients currently receive back 50 percent of costs exceeding the prescription charge. In the second, “lower special reimbursement” category, the refund will be reduced from 75 percent to 72 percent. This covers a group of pharmaceutical products for ten chronic diseases such as asthma, arterial hypertension and heart failure. In the future, costs for medications in the third, “higher special reimbursement” category will still be covered 100 percent. These are for the treatment of serious diseases such as diabetes or cancer. The new law also requires a 5 percent reduction in wholesale prices.

A particularly controversial topic is the proposed unrestricted sale of nicotine replacement therapies over the counter. With this amendment, the government intends to make it easier for people to stop smoking. But pharmacists are worried that they will lose their monopoly in this highly profitable sector, and that in future they will find themselves having to compete with retail outlets for other products that only pharmacists currently may sell. Compounding their worries is the fact that the fixed wholesale prices introduced by the new law eliminate the option of negotiating individual discounts for bulk orders.

In the course of harmonizing European legislation, the Finnish reform ensures that the marketing authorization holders of an original product obtain at least eight years of data exclusivity in Finland and 10 years of market exclusivity (8+2 rule). The 10-year period may be extended to a maximum of 11 years if, during the first eight years, the marketing authorization holder has obtained an authorization for one or more new therapeutic indications bringing significant clinical benefit in comparison with the existing therapies.

The former data exclusivity in Finland was six years (and 10 years for so-called high-technology products). The new rules significantly prolong the period before a generic applicant may refer to the pharmacological, clinical and toxicological studies submitted by the holder of the original marketing authorization to the regulatory authorities.

**Nicotine-
replacement
therapies available
over the counter**

**Data exclusivity
under EU
legislation**

**Concessions
to the
pharmaceutical
companies**

In the past, the Finnish process patent that protects the manufacturing method of pharmaceutical products simplified the substitution of generics for original drugs. Before the reform, it had been possible to put these original products on the list of interchangeable drugs even if they still were subject to patent protection.

Under pressure from the researching drug companies, the government has gone against its original intentions and limited the substitution of generics for original products (see issue 4, “Restricting generic substitution”). The holder of the marketing authorization can request that its original product be excluded from the list of interchangeable drugs if it is protected by a Finnish process patent applied for before January 1995. Alternatively, generics can be substituted for an original product only if it has lost its product patent or supplementary protection certificate in Finland or in at least five other EU member states. Patient organizations have criticized this decision because the regulation benefits only the drug companies, not patients or the public-health system.

**Financial savings
questionable**

Scientists question whether the reform will actually keep costs down. Pharmaceutical products will become less expensive, but the savings could be wiped out by the inability to use certain high-volume generics. They also point out that it is necessary to restructure the categorization of the drugs in the benefit basket. There have been no fundamental changes to the class allocations since the 1960s. According to the researchers, changes here offer an opportunity to achieve lasting reductions in the costs for pharmaceutical products in Finland.

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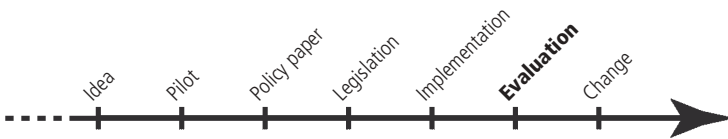
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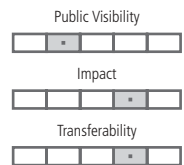
England and Wales: Progress toward reducing waiting times



The British government wants to reduce waiting times for hospital treatment under the National Health Service (NHS) to a maximum of six months by the end of 2006. Following this, further reductions are planned. By the end of 2009, all patients should be receiving treatment within three months; and for 2023, waiting times should not exceed two weeks.

Since it came to power in 1997, the Labor government has worked to reduce waiting lists and waiting times for hospital treatment. By 2001, there were 100,000 fewer people on the waiting lists than in December 1997 (1.26 million).

The reduction in the waiting lists was achieved primarily by increasing the health budget. The total public expenditure on health rose from 6.8 percent of the gross domestic product in 1997 to 7.7 percent in 2002. The declared aim of the British



Shorter waiting lists and waiting times

government is to continue to increase expenditure until the NHS budget equals the national average in the European Union. This was 9.05 percent of GDP for the old EU member states in 2002.

**Budget expansion
instead of
increased
efficiency**

Many British scientists view the past increase in expenditure and the growth in the range of services provided by the NHS positively because the capacity of the public services was far from adequate to meet the demand for health care. However, they underline that the success in recent years should not be interpreted as the result of increased efficiency. Some researchers also take a critical view of further budget expansions to reduce waiting times because of the growing overall shortage of resources and the effects of unforeseen opportunity costs.

**Waiting times as
public indicator**

The British media use the topic of waiting lists as a key criterion for assessing the performance of the health system because it is something that people can easily understand. It is expected that the government will continue to attempt to present a positive image of the health system to the general public through the reduction in waiting times.

Because they are worried about a slowdown in the rate of progress in reducing waiting times, despite the budget increases, the government is making plans to use the available funds more efficiently. They want to create more choice for patients and in this way increase competition. Patients will be able to select between four or five hospitals offered by their general practitioner in order to give them more say about when and where they are treated (see issue 3, “Choice and responsiveness in the English National Health Service”).

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