



Autumn 2003
Volume 5, Number 3

Contents

Regionalization
and drugs cost-
sharing in the
Italian NHS 1

International
Forum on
Common Access
to Healthcare 5

Iceland's
healthcare reform
agenda 6

Observatory's
workshop on
Mental Health
Policy in Europe 7

Health in Austria: 8
An international
comparison

If you would like more
information about the
Observatory please contact:
European Observatory on Health
Care Systems,
WHO Regional Office for Europe,
8 Scherfigsvej,
DK-2100 Copenhagen Ø
Denmark.

Tel: +45 39 17 13 41

Fax: +45 39 17 18 70

E-mail: observatory@who.dk

www.observatory.dk

Regionalization and drugs cost-sharing in the Italian NHS

Claudio Jommi and Giovanni Fattore

In the 1990s, the Italian National Health Service (NHS) underwent a series of reforms introducing managerialism, quasi markets, and regionalization. Under managerialism, public health-care organizations have been given greater discretion over their own affairs, but are also kept accountable to meet higher performance standards. The Italian quasi-market requires that money "follows the patient". Regionalization, finally, implies that Italy's 21 regional governments have been given the opportunity to introduce different organizational and funding models to achieve an acceptable combination of equity, efficiency, freedom of choice, and cost containment. As a result, both managerialism and quasi markets have been formulated and implemented by regions with very significant differences.¹

A new constitutional law, passed in 2001, is promoting further power shifting from the central government to the regions, as it assigns greater powers to the regions on health, policing and educational matters. Moreover, part of the present ruling coalition at national level is advocating that even more powers be devolved to the regions and is pressing for more regional fiscal autonomy.

Since 2001 regions have become accountable for any health care deficit they incur. To cover deficits regions can: (i) raise local taxes (however, to a limited extent); (ii) introduce cost-sharing on drugs (abolished by the central government in 2001); and (iii) allow hospitals to dispense drugs to outpatients.

Regions have made different choices on which of these measures to introduce, according to the magnitude of their deficit and their policy priorities (Table 1, overleaf).

Furthermore, since 2002 public expenditure on community drugs has been capped: the cap was fixed at 13% of public health care expenditure. Regions were mostly well-above this target; only a few northern and central regions have come in under or close to the ceiling. Consequently, the regions advocated the decentralization of drugs policy and, once decentralization occurred, they implemented a variety of different cost-containment measures.

The shift of power from the central government to the regions has important implications within the Italian context. The process of decentralization is proceeding at a different pace in different regions depending on their willingness and their capacity to exert effective power at regional level. Northern and central (more affluent) regions appear to be more dynamic and effective in this respect. On the other hand, many southern regions appear to be weak and unprepared to adequately design and implement regional pharmaceutical policies. It is apparent that such a situation, together with different regional cost-sharing models, has increased regions' and health care organizations' accountability and cost-sensitivity on the one hand whilst, on the other, pose the risk of generating inter-regional inequities and weakening national standards of access to health services.

The European Observatory on Health Care Systems is a partnership between:
The World Health Organization Regional Office for Europe, The Government of Greece, The Government of Norway,
The Government of Spain, The European Investment Bank, The Open Society Institute, The World Bank,
The London School of Economics and Political Science, and The London School of Hygiene and Tropical Medicine.

Cost-sharing on drugs

In Italy user charges on drugs have been widely used since the inception of the NHS in 1978. Up until 1994, cost-sharing regulation was a constant feature of any cost-containment intervention in health care. Legislation has been erratic, but the various rules shared certain characteristics. Products covered by the NHS were generally grouped into three

classes: class A, consisting of a few life-saving products with no cost-sharing; an intermediate class B (including most reimbursable drugs on the positive list) that incurred a fixed charge per item prescribed and an additional 15–30% of its price as a co-payment; and, finally, a group (class C) including drugs for minor diseases with similar arrangements as for class B but with a higher price-percentage (40% or 50%) co-payment.

In 1993 the cost-sharing rules were significantly strengthened. Under unprecedented pressure to contain health care expenditure, the central government increased the fixed charge (to approximately €2) and co-payments (to 30% and 50% of the price for class B and C, respectively). It also substantially decreased public coverage for high-income individuals and limited the number of exempted scripts that each citizen could have each year. The measure was harshly criticised for being very inequitable and was implemented for only one year.

A new policy, which assigned a more limited role to user charges, was launched in 1994.^{2,3} The old positive list was abolished and drugs were regrouped into three co-payment classes: class A for essential and chronic-disease drugs (including most reimbursable drugs); class B for drugs not included in class A but which met primary therapeutic requirements; and class C for all other drugs. According to the new rules, class C drugs were not covered by the NHS, class B products were subject to a 50% co-payment and for class A drugs patients had to pay a flat per-prescription charge of €1.57 (one product) or €3.14 (two or more products). These new rules reflected an 'all or nothing' approach to NHS coverage in that the number of products covered by the NHS was significantly reduced; and most of the products that were covered were included in class A, making class B (with a 50% co-payment) a somewhat residual category.

In 2001 the 'all or nothing approach' was enhanced further; the incumbent central (centre-left) government revoked the policy on drugs co-payments just a few months before the general election. In 2002, many regions, pressurised by health care expenditure increases, and now held fully accountable for their past deficits, took advantage of newly devolved powers to re-introduce their own user charge systems in an uncoordinated way. These systems were mostly modelled on the 1994–2000 formula (a low flat-rate charge per prescription on almost all reimbursable drugs and very

Table 1 REGIONAL RESPONSES TO HEALTH CARE BUDGET DEFICITS, 2002

| Region | Population (1000s) | Per capita deficit (Euro) | Local taxes | Cost-sharing* | Direct dispensing** |
|---------------|--------------------|---------------------------|-------------|---------------|---------------------|
| NORTH | | | | | |
| Piemonte | 4,289.7 | -28.2 | Yes | Apr | m |
| Valle d'Aosta | 121.1 | 0.0 | No | - | w |
| Lombardia | 9,154.8 | -62.3 | Yes | - | m |
| Bolzano | 468.0 | 0.0 | No | Jul | n |
| Trento | 481.0 | 0.0 | No | - | m |
| Veneto | 4,560.0 | -76.8 | Yes | Apr | m |
| Friuli VG | 1,188.6 | 0.0 | No | - | m |
| Liguria | 1,613.6 | -51.6 | No | Apr | m |
| Emilia R | 4,022.7 | -57.0 | No | - | w |
| CENTRE | | | | | |
| Toscana | 3,551.2 | -41.1 | No | - | w |
| Umbria | 842.7 | -61.3 | No | - | w |
| Marche | 1,474.5 | -65.2 | Yes | - | m |
| Lazio | 5,320.8 | -149.5 | No | Feb | n |
| SOUTH | | | | | |
| Abruzzo | 1,283.4 | -121.9 | No | Aug-Nov | m |
| Molise | 326.7 | -39.5 | No | Aug | n |
| Campania | 5,790.6 | -88.7 | No | - | m |
| Puglia | 4,089.1 | 4.1 | Yes | Aug | n |
| Basilicata | 603.7 | 5.9 | No | - | n |
| Calabria | 2,039.7 | -77.3 | No | Feb | n |
| Sicilia | 5,074.3 | -86.7 | Yes | Jul | n |
| Sardegna | 1,647.1 | -80.5 | No | Aug | n |
| ITALY | 57,943.4 | -66.2 | | | - |

* month that cost-sharing was introduced

** w = widely employed; m = moderately employed; n = not employed

Source: Osservatorio Farmaci (2003)⁶

strict exemption criteria). In addition, regions were allowed to delist some drugs listed by the central government. In 2003 regional delisting was abolished, but regions are still empowered to impose cost-sharing on patients for reimbursable drugs.

Interestingly, the employment of cost-sharing seems to be strongly associated

with the type of political coalition governing at regional level and with the development of other cost-containment measures in each region. Most of the regions ruled by centre-right coalitions have introduced cost-sharing, while only one out of the nine regions ruled by centre-left coalitions has done so. In all likelihood, centre-left regional governments may feel uncomfortable

with re-introducing a policy that was abolished by the same coalition at national level, while centre-right regional coalitions feel more comfortable with reintroducing moderate levels of co-payments as these have been a common feature of pharmaceutical policy since the inception of the Italian NHS. Whatever the reason, however, the link between the political composition of regional governments and their user charges policy is a marked one. Moreover, regions, which in the past had implemented several cost-containment programmes, have been less willing to impose cost-sharing on drugs on patients; where regional authorities have developed adequate public expenditure competencies through more sophisticated policy measures, cost-sharing has been relegated to a marginal role or dispensed with altogether. In contrast, where government capacity is less mature, the use of cost-sharing might be the only reasonable measure with which to tackle the escalation of pharmaceutical expenditure.

Cross regional-variability

Regional cost sharing policies noticeably affected pharmaceutical expenditure in 2002 (Table 2). Where cost-sharing was introduced (for example, Piemonte and Liguria), per capita public pharmaceutical expenditure showed the lowest growth rate. However, cost-sharing also produced an important shift from public to private coverage; this shift, together with a very limited number of exemptions, could raise equity problems. In other regions, where cost-sharing has not been introduced, both the public and private expenditure growth rates were very low: this trend is partly due to the implementation of other cost-containment measures. A third group of regions (e.g., Lombardia and Basilicata) did not introduce either cost-sharing or other policies in 2002 (Lombardia has since introduced cost-sharing in 2003). Consequently, both public and private expenditure increased in these regions.

Interestingly, drugs expenditure and public coverage showed a high level of

Table 2 PER CAPITA PHARMACEUTICAL EXPENDITURE IN 2002*

| REGION | TOTAL | | PUBLIC | | | | PRIVATE | | |
|---------------|-------|---------------------------|--------|------------|---------------------------|--|---------|------------|---------------------------|
| | Euro | Growth rate (%) 2002/2001 | Euro | % on total | Growth rate (%) 2002/2001 | % on total health care spending (2002) | Euro | % on total | Growth rate (%) 2002/2001 |
| NORTH | | | | | | | | | |
| Piemonte | 295.2 | 0.6 | 177.4 | 60.1 | -5.1 | 13.1 | 117.8 | 39.9 | 10.6 |
| Valle d'Aosta | 286.5 | 3.6 | 178.4 | 62.3 | 1.9 | 11.4 | 108.1 | 37.7 | 6.4 |
| Lombardia | 303.5 | 6.3 | 189.9 | 62.6 | 6.3 | 13.8 | 113.7 | 37.4 | 6.3 |
| Bolzano | 245.2 | 3.5 | 153.8 | 62.7 | 4.3 | 7.8 | 91.3 | 37.3 | 2.0 |
| Trento | 258.5 | 2.0 | 153.7 | 59.4 | 3.0 | 11.2 | 104.8 | 40.6 | 0.6 |
| Veneto | 274.5 | 2.0 | 171.2 | 62.3 | -0.9 | 12.4 | 103.4 | 37.7 | 7.0 |
| Friuli VG | 286.2 | 2.5 | 186.5 | 65.1 | 5.4 | 13.0 | 99.8 | 34.9 | -2.6 |
| Liguria | 375.4 | 1.9 | 222.2 | 59.2 | -5.5 | 15.0 | 153.2 | 40.8 | 14.8 |
| Emilia R | 319.8 | 3.9 | 194.1 | 60.7 | 5.4 | 13.3 | 125.7 | 39.3 | 1.6 |
| CENTRE | | | | | | | | | |
| Toscana | 310.3 | 0.6 | 191.3 | 61.7 | 0.7 | 13.6 | 119.0 | 38.3 | 0.4 |
| Umbria | 293.7 | 0.3 | 197.5 | 67.3 | 1.0 | 14.0 | 96.2 | 32.7 | -1.1 |
| Marche | 304.5 | 2.4 | 208.9 | 68.6 | 4.9 | 15.4 | 95.6 | 31.4 | -2.6 |
| Lazio | 339.8 | 1.5 | 234.4 | 69.0 | 0.3 | 16.9 | 105.4 | 31.0 | 4.2 |
| SOUTH | | | | | | | | | |
| Abruzzo | 316.4 | 1.3 | 223.5 | 70.6 | 2.2 | 15.9 | 92.9 | 29.4 | -0.7 |
| Molise | 276.5 | 6.0 | 213.0 | 77.0 | 7.3 | 16.4 | 63.5 | 23.0 | 2.0 |
| Campania | 285.1 | 0.3 | 211.1 | 74.0 | -2.8 | 16.6 | 74.1 | 26.0 | 10.4 |
| Puglia | 284.8 | 3.4 | 204.0 | 71.6 | -1.2 | 16.8 | 80.8 | 28.4 | 17.0 |
| Basilicata | 272.4 | 8.4 | 212.6 | 78.0 | 7.5 | 18.0 | 59.9 | 22.0 | 11.8 |
| Calabria | 296.1 | 4.8 | 216.0 | 73.0 | 0.1 | 17.5 | 80.1 | 27.0 | 19.9 |
| Sicilia | 324.8 | 2.8 | 234.7 | 72.3 | 0.6 | 18.3 | 90.1 | 27.7 | 9.0 |
| Sardegna | 293.7 | 3.2 | 198.7 | 67.7 | 0.1 | 15.3 | 95.0 | 32.3 | 10.2 |
| ITALY | 303.7 | 2.4 | 202.1 | 66.5 | 0.8 | 14.9 | 101.7 | 33.5 | 5.7 |

*Drugs administered in hospital-settings and directly dispensed by public bodies are not included.

Source: Osservatorio Farmaci (2003)⁶

cross-regional variability, even before the introduction of cost-sharing (and different cost-sharing policies emphasised this variability). Differences among regions stem from a number of factors.

In affluent regions patients are more willing to pay out-of-pocket. In northern and central regions patients are accustomed to buying over-the-counter drugs for minor diseases and paying out-of-pocket for less expensive drugs, even if they are reimbursable. In these regions, per capita expenditure is higher than the Italian average, but public coverage is noticeably lower than in southern regions.

There are also important discrepancies in the population age structure: in the central and northern regions the number of elderly people is higher than in southern regions. Regionalization is also emphasising differences among regions as far as the general organization of health care services is concerned.

In southern regions patients contact GPs and request a prescription for medicines more frequently; if possible, patients in the south seek to avoid hospitalization, except in cases of urgency, and migration to northern hospitals for elective, highly-specialized hospitalization is common.

In the northern and central regions drug dispensing by public institutions is more common than southern regions either because of more intensive use of hospital care, or because innovative community services (like home care, hospital at home, hospices, country hospitals, etc.), are more developed than in the south.

Overall public expenditure is also strongly affected by policy capacity and effective cost-containment measures taken by regional governments. Among these measures, it is worth mentioning:

Measures affecting GPs (for example, reporting on prescribing behaviour; public information and advice; controls over the prescription of drugs subject to central compulsory guidelines; local guidelines and protocols; planning and control systems formalised in local agreements with GPs' unions; and actions aimed at diffusing the prescription of generics);

Measures affecting specialists (for example, public information and advice, even if less developed than programmes for primary care; and local regulation of access to hospitals by pharmaceutical companies' representatives);

Measures affecting patients (for example, public campaigns on rational consumption of pharmaceuticals); and

Drugs dispensing by public organizations ('direct dispensing'). Regional governments are entitled to extend direct dispensing (this is normally permitted for only a few drugs, usually prescribed by specialists), in order to cover past deficits on health care spending; hospitals are entitled to provide discharged patients with the first therapeutic cycle; public organizations are entitled to dispense medicines to patients under long-term care, rehabilitation residential and semi-residential services and home-care. Interestingly, pharmaceutical companies are obliged to apply a 50% minimum discount on the pre-VAT final price, if a drug is directly dispensed (and the price is not subject to negotiation⁴).

A recent study⁵ has examined cross-regional variability in public pharmaceutical expenditure. The study shows that regional and local cost-containment measures had an important impact on cross regional variability, together with the population age-structure (the relationship with public per capita expenditure was positive), the socio-economic conditions of the relevant population (a negative relationship) and GP density (a negative relationship). Thus, it can be argued that: (i) on the one hand, regional cost-sharing contributed to reducing public expenditure; and (ii) on the other hand, public expenditure could be reduced through the implementation of other policies that could avoid an important shift from public coverage to out-of-pocket expenditure.

In short, regionalization has decentralized decisions and has raised regional and local authorities' accountability.

However, this process is raising some concerns. All regions have more or less introduced specific measures and the country as a whole already shows large variations (for example, in terms of co-payments and public procurement practices). Variations reflect different regional arrangements for structuring health care organizations, different political attitudes, different regional institutional and policy capacities and, last but not least, different socio-economic conditions affecting the relevant populations. Different political attitudes, heterogeneous policy formulation and implementation skills, as well as significant socio-economic differences, may greatly impair equitable access to drugs across the country.

REFERENCES

1. Jommi C, Cantù E, Anessi Pessina E. New funding arrangements in the Italian National Health Service. *International Journal of Health Planning and Management* 2001;6:347-68.
2. Fattore G, Jommi C. The new pharmaceutical policy in Italy. *Health Policy* 1998;46:21-41.
3. Jommi C. *Pharmaceutical Policy and Organisation of the Regulatory Authorities in the Main EU Countries*. Milano: Egea, 2001.
4. Jommi C. Italy: past reforms and future prospects. *Eurohealth* 2001;2:11-13.
5. Jommi C, Gerzeli S, Villa S. Politiche regionali e variabilità della spesa farmaceutica convenzionata [Regional policies and variations in national health system pharmaceutical expenditure], *Economia Pubblica* (forthcoming).
6. Osservatorio Farmaci, CERGAS [Pharmaceutical Observatory, Centre for Research on Health Care Management], Bocconi University. *Report 11 - Report annuale per il 2003* [2003 - Annual report], April 2003.

Claudio Jommi is adjunct professor and director of the Pharmaceutical Observatory at Bocconi University, Milan. Giovanni Fattore is associate professor at University of Naples (Parthenope) and adjunct professor at Bocconi University, Milan.

International Forum on Common Access to Healthcare

The International Forum on Common Access to Healthcare – an initiative involving the ministers of health of Chile, Germany, Greece, New Zealand, Slovenia, Sweden and the United Kingdom – held its second meeting on 23rd May 2003 in London to discuss issues of quality, citizen participation and new forms of public ownership, and choice. The Forum also looked at ways that different health systems can learn more effectively from each other. We publish here the Programme Statement issued by the Forum.

Programme statement

In Stockholm this January, we heard compelling evidence for the equity and the efficiency of healthcare funding based on social solidarity. This served to reinforce our political commitment to the way we have chosen to fund healthcare.

Healthcare should be provided according to need, not ability to pay. It should be available on an equitable basis and funded in a way that pools risk and embodies social solidarity.

We also identified two major challenges:

- How to make this case more effectively;
- How to reform our broadly equitable systems so that they are more responsive to patients and their choices.

Both of these challenges emerge from a perception that health services are struggling to keep up with the demands of a modern, more flexible world. Some of these perceptions are well-founded, others less so. Where they are founded in reality we must respond with reforms that match the needs and the expectations of our populations. Where they are based on myth and distortion, we must make the political case for our funding systems and the shared values on which they are based.

A political defence based on our values and thoroughgoing reform of the delivery of healthcare must be combined: they are not enough on their own. Reform without values would be directionless, affirmation of values without real reform would be of no benefit to patients and the public.

We met again in London in May 2003. Our discussions have been centred around four main themes:

Quality of care

More must be done to ensure that the quality agenda is fully integrated into healthcare systems and healthcare practice. It is important to closely follow the process of quality improvement and establish measures monitoring and assessing quality development as well as performance into the health sector.

Engaging citizens

Health services are a public good, and should be provided in a way that embodies social solidarity. This does not preclude active engagement with the private sector – consistent with the unique ways which countries have decided to fund the delivery of health services to their populations. Patients want high quality and the most effective services provided on the basis of need not ability to pay, and this must be the overriding objective of any partnership between the public and private sectors. Public ownership cannot simply be equated with state control of assets – it must be a tangible reality not an abstract concept. Government and healthcare institutions must strive continually to ensure that the public – patients and citizens – are able to influence their health system and explore ways of best involvement in design, provision and evaluation of health care services.

Responding to patients and their choices/preferences

Patients cannot understand why, when they are able to make choices in so many other areas of their lives, they are not

able to exercise a similar level of choice over healthcare decisions that could have enormous personal consequences. There are some who will argue this is because equitably funded systems are natural inhibitors of choice. We believe this to be wrong. We have already seen how preferences or choice can be extended within our systems, and we will do more to place patients and their choices at the centre of the care process.

Learn more effectively and cooperate more closely

Our tasks are made easier by the fact that we can come together to share experience and affirm our commitment to shared values. The arguments for equitable funding will be heard more clearly when they are made by more than one Government.

The modernization of our health services includes at its core the idea that new and better ways of delivering healthcare can be found. The Forum is living proof of that principle, and adds to a fruitful tradition of sharing best and effective practice and ideas for reform.

International cooperation and dialogue also helps us to make the case in our own countries for the need for greater diversity of provision. The fact that we share values does not preclude us from having different methods for delivering healthcare, and different ways of handling the mix between public and private or voluntary provision. These differences are historical – our systems have developed in different ways. We are shaped but not bound by this history, and are committed to looking afresh at our own systems in the light of others.

We will meet again in Wellington, New Zealand on 28–30 January 2004, to discuss '*Securing Common Access: Primary Health Care*'. Primary health care is the gateway to most health services. It is the health service people use most often. In many countries, it bridges the public-private chasm. In many countries there are innovative developments occurring in this area which will lead to better access and choice for patients, and better ways to manage health care needs equitably and affordably.

Iceland's health care reform agenda

Marikay McCabe and Vaida Bankauskaite

Only a century ago Iceland was one of the poorest countries in Europe, with a large proportion of the population living near subsistence level. In the second half of the twentieth century, however, Iceland had one of the highest economic growth rates among OECD countries and between 1945 and 2001 the average increase in Gross Domestic Product (GDP) was 4% and the annual per capita increase was 2.7%. In recent years, economic growth has averaged 4.8% and the GDP per capita remains one of the highest in Europe. This relative national wealth combined with the government's commitment to the principle that every citizen is entitled to an acceptable minimum standard of living has resulted in the Icelandic people enjoying one of the highest levels of health care in the industrialized world.

Although a small island country in the North Atlantic with a population of 290,000, Iceland's economy and social services are comparable to other Nordic countries. The Icelandic health care system can be described as universal, comprehensive and primarily financed by general taxation. In effect, Iceland has a national health service administered centrally by the Ministry of Health and Social Security Institute and spends a high percentage of its national budget on health care.

In 2000 total health care expenditure as a proportion of GDP was 8.9%, which is above the EU average. The Health Services Act that came into force on 1 January 1974 accorded all citizens access to the best health services at all times for the protection of their mental, physical and social health. This comprehensive legislation institutionalized various reform efforts undertaken in previous

decades. As a result of these measures, during the twentieth century all major health indicators improved dramatically and currently are among the best in the world. For example, female life expectancy has increased from 61.2 years in 1930 to 82.2 years in 2001. During the same period, life expectancy for men increased from 56.2 to 78.1 years, which is the highest in the world. Perinatal mortality during 1996–2000 was 5.7 deaths per 1,000 births and infant mortality was as low as 3.5 deaths per 1,000 live births, which is among the lowest in the world. At the end of the twentieth century maternal mortality was virtually non-existent.

Recently, the Icelandic health care system has undergone significant reforms in the management of primary health care, hospitals and other areas of the health sector.

As defined by the 1974 Health Services Act, primary health care refers to preventive health care measures, as well as all types of medical care offered to non-hospitalized healthy and sick people. Currently, there are approximately 90 health care centres that provide primary care and where possible, function in association with a hospital, as a unit thereof. A 1998 study by the University of Iceland¹ showed that despite a dispersed population and rugged, mountainous geography, 95% of people lived less than 20 km from the nearest health care centre should they require access to primary care. Primary care, previously provided by primary practitioners working independently, is now available in well-equipped health care centres with specially educated general practitioners (GPs) and nurses. Under the most recent reforms, GPs do

not formally act as gatekeepers to hospital and specialists' services. Instead, a non-obligatory referral system is in place, whereby financial rewards are given to both patients (lower co-payments) and specialists (higher fees) for using health centre GPs as the first point of contact.

Existing dissatisfaction among GPs regarding their terms of payment in comparison with their colleagues in specialized private practice was also addressed. At the end of 2002, GPs were offered the choice between two payment schemes: either a fully salaried scheme or a combination of partial salary and fee-for-service. At the same time, GPs received a salary increase of about 16–20%. Both the Ministry of Health and the GPs seem satisfied with the agreement and a renewed interest in general practice has resulted from these steps and other recent changes.

One of the most important measures in recent years has been the merger of hospitals in the capital, Reykjavik, in order to increase efficiency. The benefits of the merger and the subsequent creation of Landspítali-University Hospital in 2000 have exceeded expectations. The number of administrative posts has been reduced by nearly 70 and the number of on-call doctors and overtime pay have also been reduced. The number of medical procedures has increased, while waiting lists and the average length of hospital stay have been shortened, and the overall operational costs of the hospital have decreased. In 2002 another lingering problem produced by the 1974 health services legislation, the complex administration system, was addressed. The middle management level was phased out as other institutions assumed these responsibilities and directors of health care centres were given more authority.

Furthermore, in response to criticism about the lack of cost reduction incentives in individual departments, Diagnosis Related Groups, a system classifying in-patient cases according to resource use, has been adopted as a pilot programme in Landspítali-University Hospital's gynaecology department. The

experiment is considered to have been successful, as productivity increased by more than 7% with no significant change in the budget. Preparations for the implementation of this system are underway in the surgical, medical and paediatric departments with the goal that the Ministry of Health will become an informed buyer of this hospital's comprehensive services as early as 2005.

In January 2003 a similar attempt to streamline the allocation of funds to nursing homes marked the adoption of the Resident Assessment Instrument (RAI) as the primary tool for determining nursing home budgets. In April 2003 the Public Health Institute was established to coordinate the work of several councils and committees, suggest new initiatives and act as an adviser to the Minister of Health on the issues of prevention and health promotion and the ongoing improvement of primary health care.

The Icelandic health care system faces further challenges, related to cost

containment and the improvement of ambulatory care and the relationship between general practice and specialist care. In one sense these problems have their origins in the Health Services Act itself. One of its goals was to give people and their representatives a greater say in the operation and control of local health services; yet the same Act also created the large central administration that has limited local influence on shaping health care provision. However, the idea of decentralization is difficult to realize in a country with a small and sparse population. In addition to a tension between centralizing and decentralizing tendencies within the structure of health service provision, another persistent issue that will continue to face Iceland is the need to reconcile the demands for increased efficiency (that have been achieved through centralization) with

patients' rights to choice, a principle underlying the reformed health system.

Nevertheless, the aims of the health care system in Iceland, to provide universal access to health care services and to maintain the highest possible quality of health care, remain at the centre of the policy agenda. The monitoring of patient satisfaction with health care services and taking into account providers' and patients' concerns in decision-making, are two of the strategies that have been emphasised recently in the direction of health care reform.

REFERENCES

1. Vilhjalmsón R, et al. *Aðgangur að heilbrigðisþjónustu*. [Access to health services]. Reykjavík Directorate of Health, Iceland, 2001.

This article is based on the Health Care in Transition Profile on Iceland, written by Matthias Halldórsson, Deputy Medical Director of Health in Iceland and edited by Vaida Bankauskaite, European Observatory on Health Care Systems, forthcoming 2003

Observatory Workshop on Mental Health Policy in Europe

The Observatory is currently working on a new study, *Mental Health Policy and Practice across Europe: the future direction of mental health care*, edited by Martin Knapp, David McDaid, Elias Mossialos and Graham Thornicroft. Part of the European Observatory series published by Open University Press, the book will map the current state of mental health service provision across Europe, taking account of the differing historical contexts influencing the development of services and the ways in which they are delivered.

It will also identify current and future

epidemiological trends in the prevalence and incidence of mental health disorders, and in particular examine trends in the capacity and development of human resources for mental health care. A holistic approach to mental health care will be adopted, looking not only at mental health care services, but also at the influence of environmental factors such as housing, poverty, employment and social justice on mental health.

There will also be a review of human rights legislation, including the examination of rights to treatment, variations in laws relating to compulsory

detention and compulsory treatment, and legal and financial obligations and benefits available both to individuals with mental health disorders and their caregivers.

As part of the study process, an author's workshop was held in Oslo on 12–13 September 2003, bringing together many of book's lead authors and other experts in the field. Over two days, each chapter was discussed extensively within a lively and diverse forum.

The book is due to be published in the autumn of 2004.

The Observatory would like to extend its special thanks to the Norwegian Directorate of Health and Social Affairs for its generous sponsorship of the workshop.



World Health
Organization
Regional Office
for Europe



Government
of Greece



Government
of Norway



Government
of Spain



European
Investment
Bank



Open Society
Institute



World Bank



London School
of Economics
and Political
Science



London School
of Hygiene &
Tropical
Medicine

Health in Austria: An international comparison

A recent publication by the City of Vienna's Health Reporting Unit places key health indicators related to life expectancy and mortality in Austria, at both regional and national level, in an international context. This report is timely as there is still relatively little information that allows benchmarking of patterns of health in the regions of Europe.

The report highlights the striking rise in Austrian life expectancy over the last 20 years, of almost 7 years in men and 5.6 years in women, thus catapulting Austria from below average life expectancy in the 1980s to a country that now ranks among the top 10 within Europe.

Austria's performance has improved in terms of both quality and length of life. With a healthy life expectancy (HALE) at birth of 69 years in men and 73 years in women, Austria again ranks highly within the European Union, at rank 6 for men and rank 3 for women, and even higher among older people with healthy life expectancy at age 60 (men: 3rd with 15.7 years, women: 2nd with 18.5 years).

Despite decreases in the most frequent causes of death over the last two decades, over half of all deaths are still due to cardiovascular diseases, especially heart disease, followed by cancer, which is now responsible for one in four deaths. Compared to other western European countries, cardiovascular mortality in Austria is relatively high for both women

(age-standardised death rate of 268.6 per 100,000) and men (415.3), while the cancer rate is near the European average (women 132.3; men 226.5). The improvements in life expectancy, driven largely by falling death rates from cardiovascular diseases and cancer, particularly over the last decade, can be attributed largely to factors such as improvements in socioeconomic conditions and advances in medical care. Thus, in the 1980s, deaths considered amenable to medical care were substantially higher than, for example, in west Germany. However, by the end of the 1990s, levels had fallen below those of west Germany.

The readable and concise report, in the form of a 40 page illustrated brochure with numerous charts and maps, is published in four languages (English, German, French and Italian) and can be ordered or downloaded at:

www.wien.at/who/berichte/index.htm
(Broschüren/brochures).

Other publications from the City of Vienna's Health Reporting Unit include a recently published brochure on Health in Vienna (available in English and German), which provides an overview of the most important aspects of the public health care system of Vienna, and various other reports on the health status of the Viennese population (see website). The reports also include overall summaries in English at the beginning of the report as well as summaries in English at the beginning of each chapter.

The Editorial Team welcomes submissions from individuals for publication in future issues.

Editor

Anna Maresso

Editorial Team

Josep Figueras
Elke Jakubowski
Jeff Lazarus
Martin McKee
Elias Mossialos
Richard Saltman

To join the mailing list, please contact

Anna Maresso

Observatory – London Hub

Tel: +44 20 7955 6288

Fax: +44 20 7955 6803

Email: a.maresso@lse.ac.uk

Euro Observer is published quarterly by the European Observatory on Health Care Systems, with major funding provided by a grant from Merck & Co., Inc., Whitehouse Station, New Jersey, USA.

The views expressed in *Euro Observer* are those of the authors alone and not necessarily those of the European Observatory on Health Care Systems or its participating organizations.

© European Observatory on Health Care Systems 2003. No part of this document may be copied, reproduced, stored in a retrieval system or transmitted in any form without the express written consent of the European Observatory on Health Care Systems.

For ordering details on any of the Observatory publications mentioned in this issue, please contact the European Observatory on Health Care Systems, WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen Ø, Denmark.

Telephone: +45 39 17 13 41,

Fax: +45 39 17 18 70

E-mail: observatory@who.dk

Website: www.observatory.dk

Design and production by

Westminster European
westminster.european@btinternet.com