The institutionalisation of Health Technology Assessment in Slovenia

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In the transition process Slovenia focused on systems for delivering health care. Health technology assessment (HTA) was only conducted at a rudimentary level. Today Slovenia has to contend with similar issues facing its health care system to those being experienced in long standing member states of the European Union. The development of medical and pharmaceutical technologies, better education and a growing influence of mass-media continue to increase public demand for new medical diagnostics, rehabilitation techniques and therapies.

All of this requires financial means, which are limited. Hence, a critical continuous assessment of the introduction of new methods of medical treatment is urgently required. To date, most HTAs have been driven largely by the pharmaceutical industry, who have commissioned the assessments from private providers. Currently there is no independent body to assess the findings of such work and to evaluate it against internationally accepted standards.

**The current decision making process**
The process of introducing new health technologies into the health system is performed in several ways, namely through the Health Council, Medicines Council and a Commission for the Classification of Medicines at the Slovenian Health Insurance Institute. We now describe in turn the role of each of these bodies.

The Health Council is the highest coordinating and principal advisory body to the Ministry of Health, which ultimately determines which programmes will be financed from public resources (either compulsory health insurance or from the national budget). To aid in these decisions, the Health Council examines the scope and content of different options for health programmes in terms of their feasibility, affordability and the balanced development of all disciplines. Any decision to introduce new technologies into the health system must comply with the principles of evidence-based medicine, cost-effectiveness and a fair selection in those patients who will benefit.

The second tier in introducing and/or reimbursing new technologies into the system is via the Health Insurance Institute. Its special interdisciplinary Commission is responsible for the classification of prescription medicines, which are covered through obligatory health insurance, on positive and intermediate reimbursement lists. In addition to the classification of medicines, the functions of the Commission include monitoring the status of market authorisations, prices and the status of repayment for medicines, the use of medicines and any adverse effects and their pharmacoconomics.

The Medicines Council was established as a new advisory body to the Ministry of Health in 2009. Its main task is to unify the decision making process for (new) medicines. It coordinates the work of various institutions operating in the field of pharmacotherapy or treatment with pharmaceuticals and cooperates with the Commission at the Health Insurance Institute.

**A Slovene Network for HTA (MreHTAS)**
The transition to a formalised and systematic HTA programme requires a high level of support and commitment from government institutions and a motivated team that will take up the preparation of a plan for HTA in the country. International studies have demonstrated that the establishment of a national HTA agency is a time-consuming process that requires the participation of all stakeholders; this may not always be the best approach. This is particularly the case in countries with limited human resources, where a structured network for HTA that connects and integrates existing national institutions may meet with more success. Such networks typically coordinate and manage a Board, Council or Committee for HTA.

Slovenia is such a country with very limited human resource capacity for conducting HTA studies; thus the establishment of a Network for HTA in Slovenia (MreHTAS) may be a plausible way forward. MreHTAS will consist of representatives of the different disciplines involved in HTA. Its main tasks, in addition to the preparation and review of national studies, will be to review and adapt the results of international studies to the Slovenian context. This adaptation will be conducted in accordance with Slovenian HTA guidelines, which include the European Network for HTA (EUnetHTA) adaptation toolkit. MreHTAS will be coordinated by the HTA Council. The functions of the HTA Council will include the coordination and identification of potential members of MreHTAS, the selection of contractors to undertake HTA studies, updating HTA guidelines and collaboration at an international level.

This latter function will be of great significance, given that Slovenia is probably too small to have the capacity to set up its own independent HTA programme. Collaboration and coordination with other countries within EUnetHTA is the best way forward. Thus far the institutionalisation of HTA in the country is a promising approach. It can contribute to a transparent decision-making process within the health care system, providing a
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The Belgian population generally enjoys good health and high life expectancy, with good access to health services of high quality. The health system is based on progressive solidarity-based finance in combination with mainly private health care delivery. Patients benefit from a high degree of choice and relatively unbridled access to health services. Nearly the whole population is covered under a very broad benefit package.

Private and public health spending reached 10.2% of GDP in 2007 – among the highest in Europe. Although a yearly growth norm for the statutory health insurance budget of 4.5% has been applied since 2004, patients pay a high share out-of-pocket, either through official co-payments or diverse supplements. To prevent patients from foregoing essential care due to these high out-of-pocket costs, existing protection mechanisms have been extended to new categories of beneficiaries and co-payments. In addition, special measures were taken for chronically ill patients, and supplementary fees charged to hospital patients were prohibited for some categories of patients. The economic downturn and resulting soaring budget deficit may put pressure on the 4.5% growth norm.

In addition to addressing these financial challenges, reforms also aim to further improve overall quality and efficiency of the health system. Quality of care and patient safety is increasingly monitored through the establishment of information systems, with providers stimulated through feedback and peer review mechanisms. Financial incentives are also used to tackle significant differences in clinical practice (including prescription patterns). Other important issues include strengthening primary care, as well as better integration of different levels of care. The use of the general medical file held by the general practitioner (GP) is consolidated as a way to strengthen the position of the GP. Through the creation of patient pathways and the establishment of care programmes and networks, a more structured and coordinated health care delivery system is being put in place.

The need for a coordinated approach also extends to prevention and population-based interventions, as well as long-term care. This inevitably requires coordination between different levels of policy-making, as health policy in Belgium is a combined responsibility of the state, regions and communities. To facilitate cooperation inter-ministerial conferences are held regularly, and result in protocol agreements on specific policy areas (for example, long-term and geriatric care, vaccination programmes, and cancer screening). A good example of this broad integrative approach is the Cancer Plan 2008–2010, which combines actions on prevention and screening, care, treatment and support for patients, with research, technological innovation and assessment.

Despite a traditionally abundant supply of health care providers, Belgium increasingly suffers from a shortage of health care professionals. The quota for medical graduates accepted for further training has been increased for 2015–2018. Financial incentives were also introduced to set up new GP practices and in 2008 the government adopted a plan to increase the attractiveness of the nursing profession by: reducing work load; strengthening qualifications; improving salaries; and providing better social recognition.