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European Health Forum Gastein 2013

➤ Building resilient and innovative health systems

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- m-Health
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:: Special Issue ::

Volume 19 | Number 3 | 2013



EUROHEALTH

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for researchers, experts and policymakers to express
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Design and Production: Steve Still

ISSN 1356-1030



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Guest Editorial

Last year, the European Health Forum Gastein (EHFG) explored the consequences of the crisis on the health status of the European Union's population. We learned that there were indeed negative consequences and that we will still have to live with the impacts for some years to come. The task facing us now is how to make health systems resilient as well as innovative.



This issue of *Eurohealth* is dedicated to EHFG 2013, with articles specifically focusing on the main theme of building resilient and innovative health systems for Europe and exploring some of the topics addressed in the various conference sessions and workshops. I am very grateful to the *European Observatory* for offering this opportunity, as it not only lets us provide EHFG participants with more background information about this year's topic but it also gives *Eurohealth* readers a taste of what was discussed in Gastein this year.

In response to the current crisis, until now we have seen that European Member States have applied short-term measures to control spending and to improve effectiveness. Waiting times have gone up, wages have been cut, the use of generics has increased and investments have been delayed. However, these measures are coming to an end as they are not sustainable. We now have to think about the middle and long term changes that we want to see in European health systems. We can opt for the usual market-oriented approaches with more co-payments, more privatisation, reduced health baskets and making patients more responsible. But we should remember that already in 2006 there were Council conclusions on common values and principles in European Health Systems listing the overarching values of universality, access to good quality care, equity and solidarity.

The European crisis is not only a financial crisis, it is also about "what Europe do we want?" After the mission to keep peace, build economic cooperation and guarantee the free movement of people, goods and services within the EU, there is now the task of providing "social protection in times of globalisation".

Accordingly, we should judge possible interventions not only in terms of their impact on the market but also question if they comply with our European values. In 2014 there will be European elections and in 2017 we will probably see a new treaty. So now is the time to come up with suggestions for health policy in Europe, which can be discussed in fora like EHFG.

In this issue you will find several articles on how to include innovations in health systems and how they can make systems resilient too. In this respect, we should not limit ourselves to thinking within the "boundaries" of the existing treaty; in times like this, it is legitimate and an obligation to think more broadly. Perhaps some of the suggestions that will come up will sound a little bit like utopia. But we have to remember that in European health policy we have already seen the power that a single person can have when Mr Decker wanted to get the glasses he bought abroad reimbursed at home and the European Court of Justice agreed – starting a new phase of cross-border health care in Europe.

Helmut Brand

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Cite this as: *Eurohealth* 2013; 19(3).



WHAT MAKES HEALTH SYSTEMS RESILIENT AND INNOVATIVE?

VOICES FROM EUROPE

Compiled by: Anna Maresso, Matthias Wismar, Scott Greer and Willy Palm

Summary: This article presents the diversity of ideas on what can help health systems in Europe to be resilient and innovative, coming from a panel of key stakeholders in European health policy, all of whom will be participating at the 2013 European Health Forum Gastein.

Keywords: Health Systems, Europe, Resilience, Innovation, Stakeholder Views

- **#EHFG2013 Plenary session:** Resilient and innovative health systems for Europe
- **#EHFG2013 Forum 4:** Building resilient health care systems

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Note: For this exercise the interviewees were invited to send in written comments on a few questions and their answers were compiled and integrated into the article.

With the impacts of the global economic and financial crisis, as well as austerity, continuing to reverberate in Europe, health system sustainability, more than ever, has become a pressing priority. And as highlighted by this year's chosen theme for the European Health Forum Gastein (EHFG), integral aspects of responding to external shocks are a health system's resilience and its ability to innovate. But how can such aspirations be achieved? Following the EHFG's tradition of bringing together various stakeholders in health, we asked some leading figures in the field (**see Box 1**) for their initial views on these issues as a way to kick off the discussions at this year's Forum.

Why is resilience important?

Generally, the term resilience describes the ability to cope with internal and external shocks. In physics, resilience is the ability of a material or structure to absorb the energy of a shock by deformation and release it again by springing back to its original form. In biology it refers to an ecosystem's capacity to absorb and resist any damage from internal or external

mechanisms and recover quickly. In psychology resilience is the individual's ability to cope with excess levels of stress and adversity, resuming one's previous life after the crisis. Organisations that are resilient manage to adapt to a change of environment. Often, concepts of resilience hold the promise not only of coping but also of strengthening the individual or organisation recovering from the shock. The experience of successfully coping with stress, trauma or change and the effective use of coping mechanisms provides the grounds for even stronger responses in the future.

Amid the financial and economic crisis, it is no wonder that resilience is a very attractive metaphor for health system development in Europe. And it has relevance beyond the current crisis because health systems are constantly confronted with stress, shocks, crises and change of environment: demographic change, rising health care costs, the obesity epidemic and pandemic outbreaks provide just a few examples.

Box 1: The Panel

Zsuzsanna Jakab,
Regional Director,
World Health
Organization Regional
Office for Europe



Tonio Borg,
EU Commissioner
for Health



Helmut Brand,
Jean Monnet Professor
of European Public
Health and Head of
the Department of
International Health,
Maastricht University
(EHFG President)



**Vytenis Povilas
Andruikaitis,**
Minister of Health,
Republic of Lithuania
(holding the EU
Presidency in
July-December 2013)



Monika Kosinska,
Secretary General,
European Public Health
Alliance (EPHA)



The extent to which health systems are exposed to these shocks vary from country to country and so does the ability to cope with them. Some countries have implemented measures to mitigate the effects of the financial and economic crisis whereas other countries have used the crisis as an opportunity to introduce structural health system reform. Therefore, it would be important to better understand what makes some health systems more resilient than others. And this is where the analogy with other disciplines may fall short. Health systems' resilience has little to do with material elasticity, ecological absorption, psychological mechanisms or organisational features. Rather, as highlighted by the World Health Organization (WHO) Regional Director, **Zsuzsanna Jakab**, *"prepared, resilient health systems are primarily the result of good governance"*. In fact, this is one of the ten policy lessons emerging from WHO's ongoing collaborative work with Member States and other stakeholders on how health systems can respond to the impacts of the global financial crisis.*

A strong governance framework for health may include a number of attributes, such as developing strong political and managerial accountability relationships, ensuring transparency, employing suitable forms of participation, guaranteeing sufficient integrity and enhancing policy capacity (**see Table 1**). Quite a few of these features are brought out by our panel when talking about what makes a health system resilient. For example, **Tonio Borg**, EU Commissioner for Health underlines the importance of transparency as part of health reform processes: *"Some health systems managed to successfully increase value-for-money and mitigate effects on patients. These 'resilient' systems maintain an adequate and stable flow of health funds; apply transparency regarding the prices, volume and cost-effectiveness of publicly covered health care; apply sound risk pooling methods to ensure patient equity; explore information systems to pursue a needs-based supply of health care and have a solid health workforce and integrated care practices"*.

Helmut Brand, Jean Monnet Professor of European Public Health at Maastricht University and EHFG President hones in on the importance of participation, stating: *"we will have to help citizens become a 'citoyen' in health, having a high standard of health literacy and by this being able to navigate through the health system,*

making the right decisions". He also emphasises integrity: *"how reforms will be implemented in Europe will differ between the Member States. There is not only a different history in every Member State but differences in trust in the state, self-regulating bodies or the private sector too"*. Within the context of responding to the impacts of the global economic crisis, **Zsuzsanna Jakab** also highlights the key role played by participation and dialogue, particularly between officials in the health and finance sectors, as well as understanding the interests of citizens.

A great deal of consensus among our panellists was centred on the need to enhance policy capacity and efforts to share best practice. **Vytenis Povilas Andruikaitis**, Lithuania's Minister of Health expresses the belief that *"collaboration and sharing best practices, EU support with experts, data and encouraging new initiatives, are a good start to updating national health care systems"*. **Tonio Borg** outlines some of the European Commission's work in this area: *"health is an investment that can boost economic growth by enabling people to remain active longer. Structural reforms and sound innovation can bring efficiency gains and improve health. The Commission works with Member States to identify effective ways of investing in health through studies and expert advice."*

* Member States of the WHO European Region will be invited to endorse the full list of ten policy lessons at the upcoming Regional Committee in September 2013. The 10 lessons stem initially from a 'High Level Meeting on the Impact of the Economic Crisis on Health and Health Systems', held 17–18 April 2013 in Oslo, Norway and have been revised following feedback from Member States. They represent a combination of good practice and concrete guidance.

Table 1: Aspects of good governance for health

Accountability relationships	Strong political and managerial accountability relationships are developed by aligning the interests of different stakeholders. Accountability is a relationship between an actor (such as an agency) and a forum (such as a legislature) in which the actor must inform the other of decisions, must explain decisions, can be mandated, and can be sanctioned.
Transparency	Transparency on evidence, decisions, quality and cost of health services to facilitate many activities, including performance measurement, is vital. Transparency means that institutions inform the public and other actors of upcoming and taken decisions, and of the process and grounds upon which decisions are taken.
Participation	Suitable forms of participation have positive effects ranging from better patient involvement to reform implementation; participation means that affected parties have access to decision-making and power so that they acquire a meaningful stake in the work of the institution.
Integrity	Guaranteeing sufficient integrity means that all stakeholders, citizens and patients can rely on the health system and reforms, that processes are predictable and rule-based.
Policy capacity	Enhancing policy capacity allows decision-makers to adequately plan, implement and monitor health systems reform, which is sufficiently aligned with societal goals and resources.

Source: Matthias Wismar and Scott Greer, EHFG Parallel Forum on Building Resilient Health Care Systems, Bad Hof Gastein, October 2013.

It encourages a more cost-effective provision and use of health services and medicines, a balanced mix of staff skills, a stronger focus on primary health care and disease prevention and better data collection through integrated eHealth tools. The Commission is also developing a health monitoring system in Europe to gather comparable data to improve the knowledge-base on expenditure and outcomes. Particularly important, within the yearly cycle of EU economic policy coordination (European Semester), the Commission coordinates Member States' efforts to implement long-term health system reforms. In 2013 the Commission recommended health system reform in eleven Member States to ensure their cost-effectiveness and sustainability, by strengthening outpatient care and making systems less hospital-centric, reinforcing disease prevention and guaranteeing access to healthcare for all".

Spearheading other pan-European efforts in this area is the WHO. **Zsuzsanna Jakab** highlights that the organisation is involved in "supporting evidence-informed policy development for crisis response: this involves supporting the expansion of expert research networks both within and between countries, such as through facilitating policy dialogues, and providing expert support to specific policy development as the Regional Office

is currently doing in Greece". In the context of monitoring the health impact of economic crisis she adds that "the Regional Office will continue to assist its Member States in improving timely data collection to better inform policy decisions, and to help in developing relevant health system performance indicators, such as those specific to crisis response along Health 2020 targets".

The role of public health in building resilience

Investing in prevention and health promotion measures can have a positive impact by potentially relieving the demands made on the health system by those in ill-health, as well as contributing economically to society through healthy and productive citizens. **Vytenis Povilas Andruikaitis** sums up many of the panel's views: "I could not imagine a resilient health care system without an emphasis on public health. The everyday lives of EU citizens should face as few threats as possible: less exposure to smoke, tobacco, alcohol and bad food, less medicalisation. EU Member States are stressing the importance of prevention but there are still many opportunities to ensure that we can help a healthy person not to get ill rather than simply concentrating on curing people who are already ill". Echoing these sentiments, **Zsuzsanna Jakab**, points

out that another of the WHO's ten policy lessons is that "*adequate funding for public health services must be ensured*" while **Tonio Borg** argues that "*if today we succeed in discouraging young people from smoking, tomorrow's Europe will have fewer smokers, fewer people suffering from lung cancer for example, and lower health care costs*".

Panel members also emphasise the need for a multi-sectoral approach, as enshrined in the Health-in-All-Policies framework. **Monika Kosinska**, Secretary General of the European Health Alliance (EPhA) concisely summarises this objective when she explains that "*we know that from a public health perspective, the adoption of a broad view of health alone is not enough if this occurs in isolation or in opposition with other policies that may have an even greater impact on health. Moreover, austerity measures continue to emphasise the need for policy-makers to design new care delivery models that [among other things] facilitate the transition from treatment to prevention ...*".

Innovation

What is true innovation in the health sector and how can innovation help to strengthen health systems' resilience? **Helmut Brand** reminds us that "*true innovation in [this] sector can be social*

or technological. It influences processes in the health sector in a way that we can deliver better health and health care in an effective and efficient manner and reduce existing inequalities". In a similar vein, **Tonio Borg** defines technical innovation in the health sector as being "all about learning to deliver high quality care to more people in a more efficient and cost-effective manner". This view is shared by **Vytenis Povilas Andruikaitis** who states that "I deeply believe that innovation is an investment and EU Member States have to do their best to ensure that their health care systems are technologically advanced; (...) there are still challenges in making health care systems more efficient, to consume as little resources as possible".

All panel members point to new technologies such as telemedicine, e-health and m-health solutions as having huge potential that can be explored further as aids to delivering better health care. They can help to empower citizens to not only lead potentially healthier lives but also to take a more active role in framing the health care services they utilise. **Tonio Borg** explains that "by being more involved in their own health and health care – for example through tele monitoring – patients can complement professional care. Using e-health solutions can offer patients more freedom in their daily routine and control, enabling them to remain active and in better health longer".

However, **Zsuzsanna Jakab** also stresses the economic considerations that come with innovation: "[there is] the need to look for innovations in the health sector to serve not just patients' interests, but so too towards keeping costs affordable and helping to insulate budgets against future shocks". In addition, she cautions against the blanket applicability of some innovation policies without taking due care of country context, noting that "while there are clear gains to be made in areas such as e-health and m-health, and through more integrated services to provide high quality and efficient care, such advances and innovations tend to be specific to individual country contexts, and any generalisations demand caution".

Taking up the theme of balancing the need for technological innovation with social innovation, **Monika Kosinska**,

advocates that "innovation in the health sector must include social innovation, experimentation of methods, ideas and challenge preconceptions. We need to be brave enough to consider the unthinkable collaborations – bringing together health service delivery, community care, community engagement, even urban farming, art, regeneration, child services and active ageing. We need to foster and support the innovators. Innovation does not happen in large, rigid institutions (whether governmental or industry). Innovation is the craft of the small, the risk-takers, the young, and often is borne of need".

She also echoes the need for concrete strategies to incentivise and help potential innovators: "despite the fact that often the risk is shared by the public sector through government funding of research and often public-private partnerships, our outcomes of research are too often unaffordable, unavailable or simply unsuitable. We have the means to tackle some of these challenges by promoting collaborative research, new innovation models for biomedical research, inducement prizes, patent pools, open source research and public development partnerships". Commenting on European Commission initiatives in this area, **Tonio Borg** also explains that "the Commission helps Member States exploit the full potential of innovation by supporting cooperation for inter-operable e-health systems and effective Health Technology Assessment; we have set up two dedicated networks for this purpose".

Solidarity, collaboration and mutual support

Finally, our panel members were asked about concrete examples aimed at fostering more solidarity and mutual support among Member States in the face of common challenges, particularly with regard to the negative impacts of the economic crisis. A strong theme that emerges in their answers is the need to safeguard solidarity and to join in practical collaborative approaches that not only share evidence but which can also contribute to collective solutions to common problems.

Zsuzsanna Jakab echoes the need for solidarity and equity: "the health gains made across European countries in recent decades are being threatened by the global financial crisis. Further, the crisis is exacerbating the longer-term challenges facing our health systems. We have seen an increase in infectious disease, a growing poor mental health burden (suicide rates in particular have risen, doubling in some countries), and a negative impact on health determinants and risk factors, for example by adversely affecting income, employment, education, nutrition, among others.¹ As noted recently, austerity measures to help stem the crisis appear to have exacerbated the situation.² Since the onset of the crisis, the WHO Regional Office for Europe has been engaged in direct work with our Member States and other stakeholders to help the Region's health systems deal with these impacts. [This work is] built around the regional health framework Health 2020,³ which is rooted firmly in the values of solidarity and equity ...".

Explaining the European Commission's stance, **Tonio Borg** emphasises that: "solidarity in health has always been a guiding principle of EU action on Health. With the economic crisis currently in its sixth year, we need to abide by this principle more than ever. We need to bridge the gaps in health between Member States, between regions and between social groups. For example, the Commission fosters cooperation between Member States and stakeholders on the prevention and management of chronic diseases, as well as on health workforce planning through the EU health programme. The Commission [also] has set up the Innovation Partnership on Active & Healthy Ageing with the target of extending the average healthy life years of an EU citizen by two years by 2020. It has three main objectives: better health for citizens; more sustainable health care systems; and greater competitiveness and growth".

On a final note, **Helmut Brand** reminds us of the European Council's conclusions on common values and principles in European Health Systems, which list the overarching values of universality, access to good quality care, equity and solidarity as the guiding principles for any new

blueprint on Health in Europe. It is his hope that these values will be honoured both within policy debates on the future direction of health system reforms and in their implementation.

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HOW WELL ARE EUROPEAN COUNTRIES PERFORMING IN ADVANCING PUBLIC HEALTH?

By: Martin McKee and Johan Mackenbach

Summary: Governments make choices on what priority to place on promoting health and how to achieve it. We have developed a composite measure of how successful they have been in ten areas of health policy and identified factors that can explain success or failure. We document large differences in how governments respond to the same evidence and find that, although there are many nationally specific factors, overall those countries where the population has moved furthest from the struggle to survive and is able to articulate a vision of where it is going have been most successful, although success is reduced in ethnically divided societies that are less willing to invest in public goods.

Keywords: Health Policy, Government Effectiveness, Public Health, Tobacco, Alcohol

➤ #EHFG2013 **Forum 6:**
Non-Communicable
Diseases. From research
to action

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Acknowledgement: The book on which this paper is based was written and edited by the authors during a residency at the Bellagio Centre hosted by the Rockefeller Foundation.

Introduction

Governments make choices. They choose how much they will raise in taxes, and where they will get it from – in particular whether they will take it disproportionately from the rich or the poor. They also choose how they redistribute tax revenues, between young and old, healthy and ill, individuals and families, and rich and poor. Then they choose where, among competing sectors, they will spend it, whether on capital or

revenue, or on health, education, transport or defence, among other sectors. The choices that they make have consequences, for economic growth, for social cohesion, and above all, for health.

As public health professionals, we are especially interested in the health policy choices that governments make. For us, Europe represents an invaluable natural laboratory. We know that, faced with the same evidence that secondhand smoke

damages health, different governments moved at different speeds to implement bans on smoking in public places. Indeed, some have yet to implement them while, even within countries such as the United Kingdom, the constituent parts have gone forward at different speeds. The same is true for policies in many other areas. Life expectancy in Denmark and Sweden was almost identical in the 1960s. Subsequently, Denmark followed a laissez-faire approach to many of the determinants of health, doing little to curb smoking rates which, among Danish women, rose to some of the highest levels ever seen. Death rates from tobacco and alcohol-related diseases steadily rose, opening up a gap with Sweden of almost four years, for women, by the mid 1990s.³ Subsequent Danish governments have responded to these alarming figures and life expectancy among Danish women is now beginning to catch up with Swedish counterparts, but the gap remains wide.

“
governments
placed different
priorities in
promoting health

But why do some governments place a high priority on the health of the population while others seem not to? To understand this, we undertook a major study in which we identified ten areas of health policy that have contributed to major health gains in recent decades: tobacco; alcohol; food and nutrition; fertility, pregnancy and childbirth; child health; infectious diseases; hypertension detection and treatment; cancer screening; road safety; and air pollution. The full details of the study are published in our European Observatory book *Successes and failures of health policy in Europe: four decades of diverging trends and converging challenges*⁴, with shorter extracts in papers in several journals.⁵⁻⁸

Assessing the evidence

In our study we reviewed the evidence to identify which policies had been effective in improving health. We then looked at the countries of Europe to ascertain the extent to which they have implemented these policies and what they had achieved. We were interested in both measures of process and outcome. In some cases, we could use existing validated measures, such as the Tobacco Control Scale. In others, we had to develop other measures, based on available data and our knowledge of the processes involved. This process yielded 27 indicators. Crucially, while some countries did well or poorly on most or all of these measures, they were not perfectly correlated. In other words, this confirmed that governments did make choices between different priorities even once they had decided to invest, or not to invest, in improving the health of their populations. Our next step was to develop a composite score. The method we used has been described elsewhere⁹ but, in brief, we considered actions in all areas to be equally important and failure in one could be compensated for by success in another.

Our final step was to propose certain hypotheses that might explain why countries had adopted different policies. Using standard statistical methods we could then test whether these provided an explanation or not. We identified six possible hypotheses. The first related to the extent to which a population had been able to move beyond basic survival to look to its future. This is measured in the World Values Survey, on a scale with survival values at one end and self-expression values at the other. We thought that countries in which the population had moved furthest towards the self-expression end of the scale would have adopted more healthy policies. The second hypothesis was that more democratic countries would do more to promote health, on the basis that they could be held accountable for their actions by the population. The third related to party politics. In general, Social Democratic governments have pursued more egalitarian policies than have Conservative governments. Consequently, we hypothesised that greater participation by left-wing parties would be associated with more healthy policies. Our fourth

hypothesis was driven by evidence from the United States, which showed that those states where there was a higher proportion of African Americans had invested significantly less in social welfare. Similar findings have been obtained in our previous work looking at the relationship between ethnic fractionalisation and progress towards the health Millennium Development Goals worldwide.¹⁰ There was considerable evidence that countries that were more divided would invest less in those public goods that will benefit everyone. Our fifth hypothesis was that wealthier countries would find it easier to adopt healthy public policies, and especially those that involved spending money, such as cancer screening and programmes for hypertension control. Finally, we were interested in government effectiveness. Even if a government has the resources to promote health, if it is dysfunctional, it may be unable to do so.

Findings

Our first set of results confirmed what we already knew, that different governments had placed different priorities in promoting health and had adopted different policies to achieve their goals. For example, the United Kingdom, Ireland, Norway and Iceland had put in place some of the strongest measures against tobacco while Austria, Germany, Hungary, Luxembourg lagged well behind. In some countries with weak policies, such as Germany and Hungary, the powerful role played by the tobacco industry is well recognised, including recruitment of prominent scientists.¹¹ Of course, even the best performers could do more. Only Ireland and Scotland have so far committed to following the lead of Australia and New Zealand in requiring cigarettes to be sold in plain packs; the failure to proceed with a proposal to do so in England has been widely linked to the appointment by the Prime Minister of an adviser with strong links to the tobacco industry¹², although this has been denied by the government.

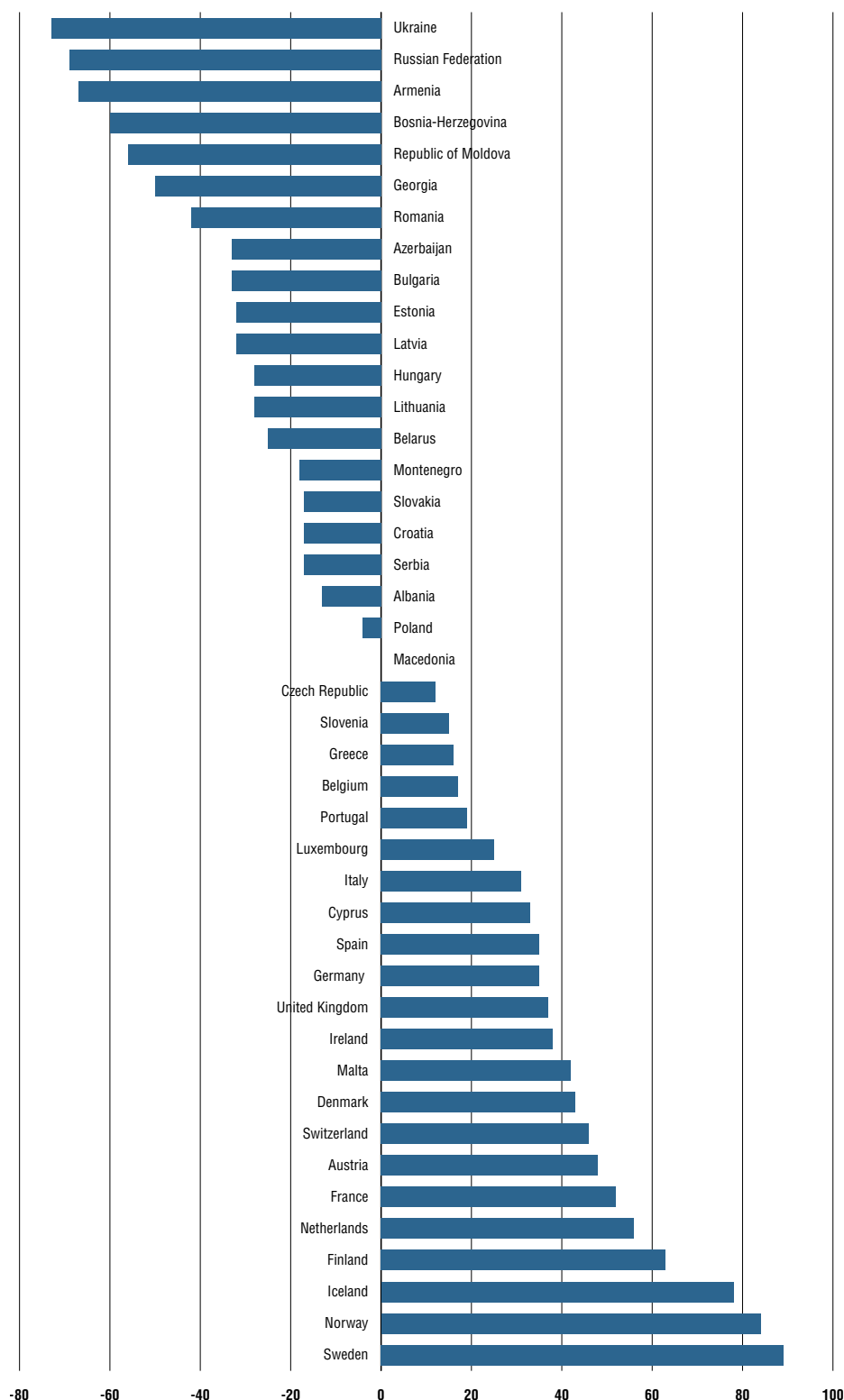
In other examples, neonatal death rates from congenital anomalies, an indicator of the outcome of reproductive health policies, are especially high in Ireland and Malta, countries where deeply held religious views have blocked adoption of

progressive policies in this area. Deaths from road traffic injuries are especially high in central and eastern Europe, where enforcement of road safety legislation is weak (in some cases reflecting widespread corruption among police)² and correlate closely with the proportion of drivers not wearing seat belts. Based on our data, for the first time, we were able to compile a comprehensive overview of how all countries performed on this wide range of indicators of public health performance.

In our subsequent analysis we looked both at those factors explaining performance in each area and those explaining performance overall. We distinguished between those factors that indicated the will to act, such as political persuasion and self-expression, and those indicating the means to do so, such as wealth and government effectiveness. Both are important. Thus, the collective will to achieve high levels of immunisation could be deflected by scares about the safety of vaccines, as happened with measles, mumps and rubella in the United Kingdom. The means to implement actions may be impaired by the collapse of health systems, as happened in the western Balkans during the wars of the 1990s.

Looking more generally, there were some areas where the means to adopt effective policies dominated. Performance in a number of areas was clearly associated with greater availability of resources. People living in wealthier countries eat more fruit and vegetables but also more fat, reflecting both higher disposable income and increased penetration of fast food corporations. Wealthier countries also experience lower teenage pregnancy rates, lower postneonatal mortality rates, and higher rates of influenza immunisation, reflecting their better resourced health systems. Their lower number of deaths on the roads, among both vehicle occupants and pedestrians, reflects higher budgets for road maintenance, but government effectiveness also played a part, with greater enforcement of safety legislation. In some cases, however, differences seem to reflect more closely the will to act. This was especially apparent on the range of tobacco-related indicators, which were most closely correlated with levels of self-expression values in the population,

Figure 1: Summary of health policy performance scores



Source: Reference 2.

suggesting that those countries most likely to adopt healthy public policies were those where the population was most confident

about the future. The same was the case for several measures of performance on alcohol policy.

While these macro-level factors had considerable explanatory power, there were a number of outliers, often reflecting particular national characteristics, some of which already have been mentioned. Malta and the United Kingdom both perform worse than expected on teenage pregnancies, with religious constraints on education about contraception important in the former while in the latter, well recognised failings in adolescent health, affecting alcohol, tobacco, and illicit drugs alongside sexual health are important factors. In contrast, although the United Kingdom scores relatively highly on levels of self-expression, it performs even better on tobacco control than would be expected on this measure. The Nordic countries also perform much better than expected on alcohol policies, possibly representing a reaction to the major alcohol-related problems they faced in the early part of the twentieth century and which gave rise to influential temperance movements. In contrast, Austria, Denmark and Germany perform somewhat worse than predicted, suggesting that political willingness to act may be lagging behind the public will to do so.

“Performance is associated with availability of greater resources

So which countries performed best and worst overall? In our study, the highest scores were in the Nordic countries, with the remaining western European countries trailing behind. The worst performing countries were in the former Soviet Union, with the countries of the western Balkans and central Europe in intermediate positions (see Figure 1). But what factors explained these rankings?

Taken in isolation, national wealth was clearly important. However, in combination, it was the country's level

of self-expression that emerged as being most closely associated with performance. Importantly, after adjustment for self-expression, ethnic fractionalisation came in second. As predicted, more divided societies, such as Belgium, Switzerland, and Latvia, were less likely to adopt public health policies. Another finding was that in general, the contemporary political complexion of the government was not significantly associated with performance, but the cumulative post-war years of government by left-leaning parties was associated with better performance¹⁰, reflecting the accumulation of many individual decisions by politicians with a more egalitarian ideology.

Conclusion

These findings should form the basis for a wide-ranging conversation about the responses to threats to public health in Europe. We were able to show that, should all countries adopt those policies in place in Sweden, the best performing country, then almost two million deaths could have been averted in 2009, 750,000 from reductions in cardiovascular deaths alone. This shows clearly that we know what must be done. The problem is that too many governments, for a myriad of reasons, have failed to demonstrate the will to act or to achieve the means to do so. As we noted at the outset, improving public health involves making political choices. Armed with the evidence we have assembled, Europe's citizens now have the opportunity to hold their political representatives accountable for the health policy decisions they make.

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US PERFORMANCE IN ADVANCING PUBLIC HEALTH: A VIEW FROM ACROSS THE ATLANTIC

By: Tsung-Mei Cheng

Summary: Reflecting on the article by McKee and Mackenbach, this article offers some observations on health inequalities and health policy in the United States. Although the US is one of the wealthiest nations in the world and spends the most on health care in terms of both the percentage of Gross Domestic Product (GDP) going to health care and per person health care spending, it is also a less healthy country in many ways compared to most other rich industrialised countries. A combination of high income inequality, a sharp ideological divide among the populace and a weak, ideologically-split and interest-group dominated government with a dysfunctional political campaign financing system results in poorer performance in the health sector than would be expected.

Keywords: *Income Inequality, Health Disparities, Health Reform, Governance, United States*

In their joint article *How well are European countries performing in advancing public health?* (see this issue) Martin McKee and Johan Mackenbach implicitly treat certain governmental policies or activities as inputs into the production of the health of national populations. They develop performance scores mainly for the production process of health, rather than on the end-product, namely, population health. Their theory is that, just as process measures for the quality of health care are predictive of health outcomes, the governmental health policy processes they examine are predictive of population health outcomes.

The authors find “large differences in how governments respond to the same evidence.” They conclude that “although

there are many nationally-specific factors, overall those countries where the population has moved furthest from the struggle to survive and is able to articulate a vision of where it is going have been most successful, although success is reduced in ethnically divided societies that are less willing to invest in public goods.” They also hypothesise that, other things being equal, success is less likely in countries with weak governments that are unable to translate into action proposed policies known to be conducive to good health.

These observations resonate in this American author. The US ranks among the wealthiest nations in the world. Expressed in purchasing-power-parity dollars (PPP\$), US per-capita income in 2012 was \$49,965.

► #EHFG2013 **Forum 6:**
Non-Communicable
diseases. From research
to action

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The comparable figure for countries in the European Union (EU) was \$33,014 and for the richest 22 European countries, \$39,538. On average, per capita GDP in the richest 22 European countries comes to 79% of the per capita GDP in the US. Yet, as the Institute of Medicine of the U.S. National Academy of Sciences concludes in its January 2013 report:

*“The United States is among the wealthiest nations in the world, but it is far from the healthiest. For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This health disadvantage prevails even though the US spends far more per person on health care than any other nation”.*¹

Perhaps not coincidentally, if one agrees with the thesis put forth by Michael Marmot that a sense of loss or lack of control over one's own destiny is harmful to one's health, the US today, despite being the country that spends the most on health care (17.9% of GDP in 2011, with per capita health spending at US\$8,680²), it is also a less healthy country compared to most other rich industrialised countries. According to a recent *New York Times* article³ the US today ranks No. 1 in adult diabetes and No. 2 in deaths from coronary heart and lung diseases; and although more Japanese smoke and the French and Germans drink more than Americans, they enjoy a higher life expectancy. What is more, life expectancy among non-white Americans lagged 3.8 years behind that for white Americans (black American males lag a full five years behind white American males) in 2010.⁴

Using McKee's and Mackenbach's set of hypotheses, one might explain this relatively poor performance by at least two of the factors they identify, namely, (1) a weak, ineffective system of governance dominated by interest groups, and (2) ethnic fractionalisation.

I would add a third factor which one might call “economic fractionalisation,” which manifests itself in ever greater income inequality in the US, as measured by the widely-used Gini-coefficient. The higher the numerical value of that metric, the more unequal is the distribution of income

in a country. The US Gini coefficient currently is 0.45, compared to the average of only 0.282 for 22 of Europe's richest countries.⁵ In a well-known paper by Atkinson, Pickety and Saez, the authors show that in 2007, households in the top 10th percentile of the nation's income distribution captured 50% of total national income in the US. Households in the top 1% of that distribution captured 58% of all income growth over the period 1976–2007 and 65% over the period 2002–2007 (see Figure 1).⁶ According to the same *New York Times* article cited above, today 20% of America's children live below the poverty line, a 35% increase over the past decade and UNICEF recently ranked the United States 26th in childhood wellbeing out of 29 developed countries.⁷ If current trends continue, then the upper-income strata in the US, which also dominate the system of governance, may not be able to empathise with poor Americans, hence my term “economic fractionalisation.”

Inflation-adjusted median income in the US has fallen from about \$56,000 in 2000 to \$51,500 in May 2013.⁸ To put that number in perspective, according to the benefit consulting firm Milliman, total health spending for a typical American family of four, including insurance premiums paid on the job and out-of-pocket spending on health care, amounts to US\$22,000 in 2013.⁹ Small wonder that the high per-capita cost of US health care has priced millions of Americans out of the kind of health care to which the rest of the country and better-off European countries have long been accustomed. Currently, some 50 million Americans do not have any health insurance at any point in time. As a result of the Affordable Care Act passed in 2010 that number is expected to decline to about 20 to 30 million or so by 2019, but at the time of writing it is far from certain that this goal will be reached.

While earlier studies on the relationship between income inequality and population health did not find a correlation between the two, later studies did find a negative correlation. A 2006 study, by Richard Wilkerson and Kate Pickett, identified 169 analyses in 155 papers on the association between income distribution and population health and showed that 70% of the surveyed literature

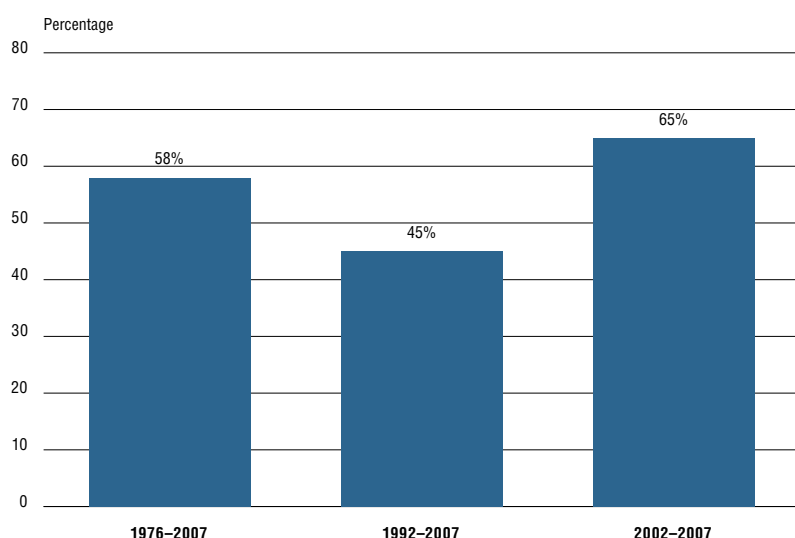
suggests a negative correlation between higher income inequality and population health.¹⁰ Moreover, a 2011 study, by Roberet Torre and Mikko Myrskylä of the Max Plank Institute for Demographic Research in Germany found income inequality, measured by Gini coefficients, to be strongly associated with male and female mortality up to age 15, and that for women the association disappears at older ages, but for men the association persists up to age 50.¹¹

“20% of America's children live below the poverty line”

In the short term I am not optimistic about the prospects for success of the American government in advancing public health in the American population. There is no political consensus on health policy in America today. The country seems divided along a wide ideological spectrum from extreme individualism to willingness to undertake collective action in the form of a single-payer system. The successive failure of the US to implement health reform demonstrates that division. In this regard, the Affordable Care Act of 2010 is no exception (See also the article by Rice et al in this issue). It is not really a fundamental reform of the existing, chaotic and expensive US health system. Even so, there are many ideologues in the US who want to kill this modest reform.

Aside from an ideologically divided population, the founding fathers of the US deliberately designed its government to be weak and dominated by private interest groups. Therefore, even if there were a consensus for collective action among the general population, powerful moneyed interest groups holding sway over government could easily thwart these aspirations, as often they have. One further dimension on which McKee and Mackenbach do not dwell, but which strikes me as crucial, is the high cost

Figure 1: Fraction of total US income growth captured by households in the top 1% of the nation's income distribution



Source: Reference 6.

of political campaigns and the uniquely American manner in which they are financed, which differs greatly from political campaigns in Europe. As the distinguished American commentator Fareed Zakaria noted in a recent column, the total cost of the 2010 national elections in Britain was US\$86 million, compared to an estimated US\$6.3 billion cost of the 2012 US elections, a 75-fold difference.¹² The bulk of that money is supplied by trade associations with narrow interests, or by millionaires and billionaires with similarly narrow economic or ideological interests. When we speak in the US of “representative government,” it is anybody’s guess exactly whom a particular member of Congress represents. A good guess is that it is a handful of special interests to whom the member is financially beholden. Thus, to impose a tax on products that are harmful to human health – sugar, fat, etc. – is always a fierce and often futile political struggle.

These factors combined – high income inequality, a sharp ideological divide among the populace and a weak, ideologically split and interests-group dominated government – lead to the paradox that the US spends more money on health care per capita than any other country, yet has a performance in health that is not a source of national pride.

Only limited lessons can be extracted for one country from the performance in health care of other countries, because so much of that performance is shaped by historical, cultural and institutional factors that cannot easily be transferred among countries. European nations, however, can anticipate a further widening of their income distribution and can think ahead how, in the face of that inexorable development, they can maintain or achieve high-performance health policies and systems.

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“There is no political consensus on health policy”

MENTAL HEALTH: A KEY CHALLENGE FOR EUROPE IN THE 21ST CENTURY

By: David McDaid

Summary: The impacts of poor mental health are well documented. Increased awareness of these human and economic costs has not gone unnoticed but the challenge of translating policy plans and goals into actions across Europe remains. Innovative actions to promote and protect mental health need to go beyond health care systems. They can harness resources, goodwill and mutual interests of other sectors. One key area for greater collaboration is in the workplace. Europe's workforce will need protection to help it retain its competitive advantage in terms of knowledge and skills. It will need to respond to changing dynamics in the global economy. Good mental health will be vital if Europe is to compete effectively with the rest of the world. This means tackling issues such as stress, depression and alcohol harm in the workplace.

Keywords: *Mental Health, Workplace Health, Occupational Health, Depression, Alcohol*

Introduction

The impacts of poor mental health are well documented. Globally, major depressive disorders are the second leading cause of years lived with disability.¹ They affect about 150 million people, including 33.4 million people in the World Health Organization (WHO) European region. The costs are substantial; costs for depression alone in 30 European countries were estimated to be €92 billion in 2010, with costs for all anxiety disorders accounting for a further €74 billion.² The majority of these costs are due to lost productivity from work and other economic activity.

Increased awareness of these human and economic costs has not gone unnoticed in many policy-making circles. It is now nearly a decade since the WHO's *Mental Health Declaration for Europe* in 2005 acknowledged the need for more attention to be paid to mental health and psychological wellbeing. The European Commission subsequently published its *Pact for Mental Health and Wellbeing* in 2008, which in turn has been followed up by the recent launch of a *Joint Action on Mental Health and Wellbeing* in 2013. There have been further significant developments in mental health policy in some European Union (EU) Member States, including a welcome increased interest in the benefits of prevention and actions to promote mental wellbeing.

► #EHFG2013 **Forum 1:**
Mental health. The motor for
a healthy economy

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In the workplace the *European Strategy on Health and Safety at Work 2007–2012* encouraged Member States to incorporate specific initiatives aimed at preventing mental health problems and more effectively promoting mental health into their national strategies, in combination with Community initiatives on the subject. Two autonomous framework agreements were also signed and implemented by the EU social partners: the 2004 Framework Agreement on work-related stress and the 2007 Framework Agreement on harassment and violence at work.

Notwithstanding these positive developments, the translation of policy to practice has proceeded at an uneven pace. Moreover, the economic landscape has changed dramatically since most of these policy initiatives were conceived. The European economy is only now beginning to emerge from its deepest recession in decades; a crisis that has dramatically affected the working and living conditions of many people in the EU. In June 2013, 26.4 million people were still unemployed, with the impacts on young people being most pronounced in those countries hardest hit by the crisis.

We know economic shocks have immediate impacts on mental health and psychological wellbeing, including potentially increased risks of suicidal behaviour and inter-personal violence.⁵ Unemployment is one major risk factor for mental health, but it is not just about those excluded from work; those fortunate enough to be in work still may have a greater fear of reduced hours or job loss in both the public and private sectors. These changing economic circumstances merit further attention on protecting and promoting mental health, including at the workplace. Innovation in mental health systems at a time of austerity and financial crisis is therefore critical. The current economic crisis in Europe presents an opportunity to carefully consider the structure of services to support mental health in Europe.

This topic is also one of the main themes for discussion at this year's European Health Forum Gastein, a gathering which for many years has provided an opportunity for leading policy makers, professionals and thinkers to debate key

directions in health policy in Europe. This forum will aim to analyse the value of targeted measures and the different components of integrated policy approaches to mental health. Participants will be invited to analyse how to integrate mental health promotion and management of mental health problems into broader health and employment policies in order to effectively tackle both current and future social and economic challenges. For instance, can health work with different sectors more easily to achieve mental health related goals? What more can be done to work with employers to protect mental health at work? How cost-effective are preventive strategies? What role can the EU play in this process?

Protecting mental health at work

Work makes a contribution to our wellbeing. We simply cannot leave our mental health and wellbeing at the door of the workplace. Employment in a good working environment is beneficial to physical and mental wellbeing. Moreover, for people who have experienced poor mental health, maintaining or returning to employment can also be a vital element in the recovery process, helping to build self esteem, confidence and social inclusion. However, overall satisfaction with working conditions has declined over five European Working Conditions Surveys since 1991.⁶ Less than 20% were 'very satisfied' with their working conditions in 2010; in 1991 this rate was closer to 30%.

While some levels of stress and high demands at work can be good for health, a poor workplace environment can have an adverse impact on health and lead to excess levels of psychological distress, which in turn can lead to the development of poor mental and physical health. Vulnerabilities to psychosocial stress, burnout and mental health problems are becoming more challenging as the nature of work continues to change, moving away from traditional occupations towards service sector jobs with high levels of demand and work intensity. The boundaries between home life and work are also becoming blurred, especially in the service sector.

New working practices, such as increased use of temporary and short-term

employment contracts, perhaps intended to help adapt economies to the challenges of competing in a global marketplace, may increase feelings of job insecurity; for instance, where there is a possibility of outsourcing tasks to external locations. This fear is also an important risk factor for psychosocial stress and mental health problems. Restructuring can also increase job demands and workload which increases the chances of burnout and depressive disorders.⁷

Even very minor levels of depression are associated with productivity losses.⁸ Where there is a loss of highly skilled workers due to depression, additional recruitment and training costs may be incurred by employers. Businesses also have to contend with 'presenteeism': poor performance at work due to excess stress and mental health problems. The Impact of Depression in the Workplace in Europe Audit (IDEA) surveyed more than 7,000 people in seven European countries in 2012. It highlighted that common symptoms of depression such as poor concentration, indecisiveness and forgetfulness have significant adverse impacts on work functioning thus contributing to presenteeism. Yet awareness that these factors are symptoms of depression is poor and managers responding to the survey reported a lack of support to help them to assist their employees.⁹ Presenteeism is difficult to measure, but its impact may be as much as five times greater than the costs of absenteeism alone.¹⁰ Presenteeism is also a strong predictor of future poor mental and physical health,¹¹ which itself may imply additional costs when employers are responsible for paying the health care costs of their employees.

Another reason for investing in measures to protect and promote wellbeing is due to the spillover impacts of poor mental wellbeing to other workers: there can be a detrimental impact on those working in teams. Sickness absence may lead to an increased workload on remaining team members, with consequences for work-related stress. There will also be adverse impacts on workers' families.

There are also reputational and legal consequences of having an unhealthy workplace. If a business is perceived to

have high levels of absenteeism due to stress and depression it may potentially have an adverse impact on its standing. This might be seen, rightly or wrongly, by both the general public and potential future recruits, as a signal of the low priority that a company places on having a healthy workforce. Potentially, it might lose customers and procurement contracts. Within the workforce there can be a detrimental impact on morale and staff loyalty. Poor mental health and excess work-related stress can also increase the risk of accidents due to human error; this in turn could lead to litigation and compensation claims in some circumstances.

Investing in mental health at work

Better mental health at work therefore has benefits both for business and for health systems. The workplace can provide a healthy culture and environment that is psychologically supportive to the workforce, helping to foster and maintain wellbeing. It is not just about avoiding mental health problems. Not only are improved levels of psychological and physical wellbeing associated with better workplace performance, but they can also help improve the level of staff retention, improve employee-employer dialogue, encourage greater levels of creativity and innovation that are vital to dynamic businesses, and enhance the reputation of the workplace.¹⁰

From a public health perspective the workplace is an important location for mental health promotion and the early identification and management of depression and other mental health problems. This public health approach means that action in the workplace should be about much more than simply focusing on the prevention of mental health problems and poor wellbeing that may be linked to a poor work environment; it is also about those non work-related problems that may become visible and sometimes exacerbated within some working environments. About one third of all the costs of depression and anxiety disorders fall on health care systems; actions at the workplace to address these issues can reduce the need for health care interventions, strengthening the economic arguments for action. In addition, health

care systems are themselves major employers whose performance can be improved through better staff mental health.

Alcohol, mental health and work

Alcohol and its impact on the workplace is another important issue. One review of the impact of alcohol on the workplace and on productivity found “little doubt that alcohol and heavy drinking can negatively impact on the workplace and the productivity of the European Union as a whole”.¹¹ One report estimates that 29% (€45 billion) of the total societal costs of alcohol in the EU in 2010 were due to absenteeism and unemployment alone.¹²

Increased levels of alcohol consumption have been associated with greater rates of sickness absence¹³ and early retirement.¹⁴ In general, individuals with alcohol problems are vulnerable at work as alcohol addiction is not well protected under workplace discrimination laws. This also means the individuals are reluctant to disclose any alcohol problems that they might have. There is also some limited evidence supporting an association between greater levels of work-related stress and heavy rates of alcohol consumption. While alcohol consumption may be a reaction to stressful working conditions, alcohol may also increase inefficiencies, leading to greater rates of work-related stress.¹⁵

One of the benefits of effective policies to reduce the harms of alcohol, such as the use of taxation and restrictions on advertising and sales to reduce access and limit consumption, may be a reduction in productivity losses associated with depression and stress-related sickness absence and poor performance at work. While the EU alcohol strategy recognises the workplace as a key setting, few measures have been implemented directly in the workplace. Moreover, there are still only a few studies that have evaluated their impact.¹⁶ Nonetheless, one review concluded from the limited literature that “brief interventions, interventions contained within health and life-style checks, psychosocial skills training and peer referral may all have the potential to produce beneficial, although rather small,

results.”¹⁷ There are also probable benefits to business and the wider economy, but they still need to be analysed.

Conclusion

Despite all the evidence on risks to mental health and psychological wellbeing, services for mental health can be an easy target for cost cutting measures during times of austerity. Cuts to mental health budgets may be seen as a lesser evil compared to cuts in budgets for physical health problems where illness and premature death are very visible. Mental health may be emerging from the shadows but it is still not as visible in the public consciousness; yet mental health impacts are felt early during a time of economic shock and can be long lasting. They also increase risks to physical health.

Budgets are inevitably tight and tough choices have to be made. This makes it even more important that innovative actions to promote and protect mental health go beyond health care systems. They need to harness the resources, goodwill and mutual interests of other sectors. One key area for greater collaboration is in the workplace. Europe's workforce will need protection to help it retain its competitive advantage in terms of knowledge and skills. It will need to respond to changing dynamics in the global economy. Good mental health will be vital if it is to compete effectively with the rest of the world. This means tackling issues such as stress, depression and alcohol harm in the workplace.

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► #EHFG2013 Forum 3: Free-Trade Zone EU-US

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THE EU-US FREE-TRADE ZONE: CHARADE, RACKET OR ROCKET?

By: **Angela Brand, Denis Horgan** and **Ralf Sudbrak**

Summary: The trade agreement between the EU and the US represents potentially the world's biggest free-trade zone. This has enormous implications and opportunities for health. Agreeing standards with the US will give the EU a good chance to set global standards. Thus, the free-trade zone negotiations between the EU and the US are an historic opportunity to address legacy issues such as differences about biotechnology and other safety standards. One of the largest challenges is the independence of the national regulatory authorities. The US Food and Drug Administration (FDA) is a prime example: can American authorities accept European certifications and vice versa?

Keywords: EU-US Free-Trade Zone, Trade Services, TTIP, Health Systems

Introduction

The negotiations of the Free Trade Agreement (FTA) between the European Union (EU) and the US have become a recent hot topic for discussion. Will it be a charade, a racket or a rocket, launching benefits for both sides?

The EU and the US economies together represent about half of the world's Gross Domestic Product (GDP) (47%) and contribute to almost a third of the global trade flow.¹ Thus, the potential benefits of the agreement are huge: the US is the EU's largest trading partner and each day goods and services of almost €2 billion are traded bilaterally. According to estimates, a free trade deal between both parties would bring annual gains of a 0.5% increase in GDP for the EU, with an equivalent 0.4%

for the US by 2027.² Although the two economic areas are highly integrated, there is still significant potential for further economic cooperation.

Looking back, despite being the founding fathers of the global trading system, the EU and US have had a fractured trading history underlined by recurring trade wars such as the Boeing/Airbus dispute at the World Trade Organisation (WTO) or the USA's scanning obligations for shipping containers. However, the two longest running WTO dispute cases, beef hormones and the 'banana wars', have just recently come to an end and demonstrate the willingness and possibility of solving EU-US commercial tensions. In addition, with the collapse of the Doha (trade) negotiations among WTO members,

and against the background of the rise of the BRICS countries (Brazil, Russia, India, China and South Africa), there have been increasing calls on both sides of the Atlantic to overcome previous disputes and move towards the start of trade negotiations. For example, in October 2012, the European Parliament voted through its own initiative report on trade and economic relations with the US (Moreira Report), endorsing a swift move towards negotiations.⁵

In November 2011, a High-Level Working Group on Jobs and Growth led by the EU Commissioner for Trade, Karel de Gucht and his American counterpart Ron Kirk, was established to identify policies and measures to increase EU-US trade and investment.

The High-Level Group concluded in early 2013 that the best way to deepen trade ties was through a comprehensive trade and investment agreement, known as the Transatlantic Trade and Investment Partnership (TTIP). This way forward, which if successfully completed would create the world's biggest free-trade zone, was formally endorsed by the EU and the US in February 2013. In a speech, José Manuel Barroso, the European Commission's president, points to three reasons why the bilateral deal would be good: the shared need for growth, the difficulty of securing a global deal, and higher food prices which have reduced anxieties in the agricultural sector.⁶ Shortly afterwards, on June 14, Member States gave the European Commission the green light to start trade and investment talks with the US, triggering a 90-day period of discussion. An agreement by November 2014 remains the target, but realistically the negotiations may stretch into 2015.

The trade picture

While these negotiations are an historic opportunity to address legacy issues, what about the independence of national regulatory authorities? Karel de Gucht called it a "living agreement" to be finished by the end of 2014. The Treaty of Rome in 1957 was ground breaking in promoting the idea of an "ever closer union". Is that compatible with TTIP?

While politics can move the sands quickly, and there are still many hurdles that may block the negotiations, there is great hope that cooperation will reduce unnecessary regulation on both sides of the Atlantic. However, health care is not an arena where the free market works perfectly. Can the FDA and other American authorities accept European certificates without question and vice versa?

The trade picture for the EU shows a significant relationship with the US (see Box 1). The additional benefits from the agreement will come from standard setting. TTIP will cover various sectors and disciplines not already covered by multilateral trade rules such as investment, raw materials and state owned enterprises. The expectation is that, if the world's two largest economies can agree common standards, the common approach could contribute to the development of trade rules at the WTO and in other bilateral free trade agreements.

Potential benefits and challenges

Based on an initiative from the Swedish Ministry of Foreign Affairs, the National Board of Trade has conducted a simulation of a potential free trade agreement.⁷ The report, from 2012, points out that the average import tariff between the EU and the US is low. Thus, it is especially non-tariff barriers (NTBs) that can impede transatlantic trade. These barriers exist in most sectors, mainly due to differences in regulatory systems and standards. Although these rules are in place for good reasons in areas such as consumer health protection and environmental policy, they can create unnecessary barriers to trade. Reducing these barriers by harmonisation, simplification and mutual recognition, can lead to gains for both economic areas while retaining the primary objectives of the rules.

A general conclusion from this simulation is that the US appears to gain the most, since a larger share of the total US trade is directed towards the EU rather than in the other direction, so that an increase in bilateral trade with the EU can be expected to have larger relative effects on the US than on the EU economy. Furthermore, in the simulation consumers and businesses

Box 1: EU trade profile

- Total US investment in the EU is three times higher than in all of Asia.
- EU investment in the US is around eight times the amount of EU investment in India and China together.
- EU and US investments are the real drivers of the transatlantic relationship, contributing to growth and jobs on both sides of the Atlantic. It is estimated that a third of the trade across the Atlantic actually consists of intra-company transfers.
- The transatlantic relationship also defines the shape of the global economy as a whole. Either the EU or the US is the largest trade and investment partner for almost all other countries in the global economy.
- The EU and the US economies account together for almost half of global GDP and nearly a third of all world trade.

Source: Reference 6.

are assumed to distinguish between foreign and domestic goods and services. When US companies obtain increased market access to EU countries, EU companies that export to other EU markets will experience increased competition and lose some of their previous preferential status to the benefit of US companies. In contrast, US companies will not lose their advantages on the US market to the same extent because domestic companies have an advantage over foreign companies. Furthermore, in terms of reach, services contribute more than goods to the value of production in the EU and the US. However, the economies still trade more in goods; services represent less than a quarter of their total trade.

There are also benefits to be gained by specific Member States. The opening up of the US public procurement market is a key area for Finland in these negotiations, since Finland is mostly interested in professional, information community technology, maintenance, and engineering

services.¹ Currently, only 32% of the US procurement market is open to EU business under WTO commitments. The TTIP agreement will generate huge trade, employment and welfare gains both in the EU and in the US. In theory, the elimination of tariffs and barriers, including the opening up of public procurement and services markets, would decrease the costs of doing business and lead to a more efficient allocation of resources. Furthermore, it would increase pressure to innovate, open new markets for companies and diversify their imports, which would, in turn, yield positive employment effects. Moreover, increased competition would lower consumer prices and increase households' choice over goods.

Results of a recent study by the German Institute for Economic Research, commissioned by the Bertelsmann Foundation and released one day before the visit of US President Barack Obama to Berlin in June 2013, show that if it is possible to largely eliminate not only tariffs but also non-tariff trade barriers, real GDP per capita would significantly increase and new jobs could be created.² The social welfare gains in this free trade zone of over 800 million inhabitants would stand in contrast with real income and employment losses in the rest of the world.

Views and opinions

It is true to say that the proposed free-trade zone has strong critics and supporters. Nobel Laureate Joseph E. Stiglitz, Professor at Columbia University and a former chief economist at the World Bank, is known for his critical views on globalisation. In July 2013 he stated that the EU-US free-trade area will not establish a true free-trade system but rather 'a managed trade regime' serving the special interests of Western trade policy.³ Furthermore, he warns, that no trade agreement should put commercial interests before national interests or values like the right to a healthy life and the protection of the environment, which are non-negotiable by nature. He calls for good regulation in order to push economic prosperity at the global level. His position is based on two recent US cases. In the first on delays in access to generic drugs,

the EU has already reacted and taken action against one European company. In the second case, the US Supreme Court struck down the patenting of human genes, stating that these genes are a "product of nature" and thus cannot be claimed to be a human invention. Stiglitz fears that the FTA negotiations will focus mainly on the NTBs, including regulatory barriers, resulting in levelling common standards downward rather than upward, as well as decreasing social wellbeing. He has also referred to the undemocratic and non-transparent process of the negotiations as 'the free-trade charade'.

Dean Baker, US macroeconomist and co-founder of the Centre for Economic and Policy Research, has an even stronger opinion. He describes the EU-US free trade pact as 'the free-trade racket', securing regulatory gains for major corporate interests such as increased patent and copyright protection. He is convinced, that 'this is yet another case where the US government is working for a tiny elite against the interests of the bulk of the population', and thus is in fact nothing less than political corruption.⁴

Javier Solana, former EU High Representative for Foreign and Security Policy, Secretary-General of NATO, and Foreign Minister of Spain, is currently President of the ESADE Center for Global Economy. In contrast to critics, Solana argues that the transatlantic agreement is the right, timely and perhaps only way to assert Europe's place in the world in the future.⁵ His view is based on his understanding of Europe and the US as well as the global context. For example, by 2030, only Germany (among all European countries) will be among the world's seven largest economies, and by 2050, the US might be the only representative of the West in the top seven. Thus, European states are just too small to compete alone in the world of the twenty-first century. Moreover, when confronted with the planet's limited resources, and with 'a world marked by interdependence and constant change, Europe will find that unity is strength'. Indeed, Solana argues that unless Europeans work toward integration, they may find themselves surpassed by emerging countries in terms of technological developments, job

creation, production costs, talent, and creativity. In addition, he highlights that the TTIP will boost growth in the EU and the US alike, which suggests that the TTIP could have an effect comparable to that of the single market for Europe.⁶

“TTI will form the largest free trade zone in the world

Conclusions – charade, racket or ... rocket?

The discussions about these negotiations have really hit a nerve and the spirit of the day! To stimulate an open discussion about the implications of the transatlantic free-trade zone for health systems in Europe and beyond, three points might serve as a blueprint for the negotiations in the upcoming months and provide some food for further thought.

First, TTIP will form the largest free trade zone in the world. Thus, this negotiation will set the standard, not only for future bilateral trade and investment between the EU and US, but also for the development of global rules. Furthermore, at a time when many are seeking salvation in nationalism, the EU-US free-trade zone will be a powerful symbol of cooperation in overcoming global challenges. If we together share a world view based on democracy, transparency, human rights and the rule of law, we share an engagement and ambition to cooperate across borders, to think and act multilaterally, and to look for global solutions to global problems.

Second, the economies still trade more with goods than with services, representing less than a quarter of their total trade. In the area of health care, including not only personalised health care but also the complementary area of health protection, it will become impossible to separate between products (goods) and processes (services). For example, already the use of medicines has moved

towards “theranostics” (a combination of diagnostics and treatments for individual patients). There will also be a greater use of medical devices and “just in time treatment” based on device monitoring, in space and real time, of highly dynamic individual health information. Thus, regarding health care issues, the negotiations need to focus much more on services than on goods. At the same time, it is questionable whether regulation is the way ahead. Instead, defining values, frameworks, corridors and best practices may be the end solution.

Third, the idea behind free trade is that it is free, not predominantly regulated by top-down governmental agreements, but also by social movements, ethical values and bottom-up principles. Karel de Gucht called the free trade agreement a “living agreement”. That would imply understanding the agreement as a flexible framework, allowing learning from mistakes and leaving space for future known and unknown global developments. Against that background, any over-regulation in health care would just be a worst case scenario. It is as simple as that.

In a nutshell, Europe should know where it belongs. The EU-US free-trade zone is neither a charade nor a racket. Following the argumentation of Javier Solana, it

certainly is a rocket that will not only strengthen transatlantic political bonds but also effectively refute the frequent lament that America has lost interest in Europe. It is a rocket whose engines work by action and reaction. It is a vehicle to speed up the rethinking of our European values, setting the standard for our global rules and the framework for our global actions and reactions. We can only advance that global view if we are consistent in applying it, even in times of crisis, and especially in times of crisis.

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New HiT on the USA

By: T Rice, P Rosenau, L.Y Unruh, and A.J Barnes

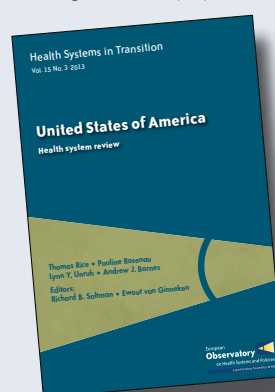
Copenhagen: World Health Organization 2013 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Number of pages: 431, ISSN 1817-6127 Vol. 15 No. 3

This analysis of the United States health system reviews the developments in organization and governance, health financing, health-care provision, health reforms and health system performance. The US health system has both considerable strengths and notable weaknesses. It has a large and well-trained health workforce, a wide range of high-quality medical specialists as well as secondary and tertiary institutions, a robust health sector research program and, for selected services, among the best medical outcomes in the world. But it also suffers from incomplete coverage of its

citizenry, health expenditure levels per person far exceeding all other countries, poor measures on many objective and subjective measures of quality and outcomes, an unequal distribution of resources and outcomes across the country and among different population groups, and lagging efforts to introduce health information technology.

It is difficult to determine the extent to which deficiencies are health-system related, though it seems that at least some of the problems are a result of poor access to care. Because of the adoption of the Affordable Care Act in 2010, the United States is facing a period of enormous potential change. Improving coverage is a central aim.



HEALTH AT YOUR FINGERTIPS

By: Terje Peetso

Summary: There are more than 97,000 mobile apps available related to health and fitness, mostly helping users track specific health parameters, as well as providing basic information and guidance. Health care professionals should seriously consider the possible impact of these apps and see this new channel of communication as a promising tool in the area of preventive medicine. However, in its report of May 2012, the eHealth Task Force stressed that although tens of thousands of health and wellbeing apps are already available on the market, there are no quality criteria for these applications or standards for data management and for provision of information to consumers. To enhance legal clarity, the European Commission is now considering the legal, policy and knowledge management framework for health and wellbeing apps.

Keywords: mHealth, Health and Wellbeing Apps, Preventive Medicine, European Union

Introduction

Mobile health (mHealth) is considered to be a subset of eHealth and can be defined as “*medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices*”. mHealth offers the promise of giving patients easier access to their health information, increasing efficiencies across the continuum of care, and enabling more accurate diagnosis and treatment. Furthermore, it allows the collection of a great deal of medical and also physiological, lifestyle and daily activity data.

Currently, there are more than 97,000 mobile apps available related to health and fitness, mostly helping users track specific health parameters as well as providing basic information and guidance. The mobile health app marketplace is expected to grow significantly over the

next few years. According to a recent market research report, the mobile health market will be a mass market within five years, with a reach of more than 3.4 billion smartphones and tablets with access to mobile apps. The report demonstrates that consumers are increasingly using health and wellbeing apps, with the top ten mobile health apps generating up to four million free and 300,000 paid downloads per day.¹ By 2017, it is expected that 50% of mobile users will have downloaded mobile health apps. Experts believe that mobile health apps could change the way health care is practised and also could influence people’s behaviour. Potentially, the emphasis could shift from people having to manage multiple chronic diseases in their later stages to receiving their doctor’s advice on healthy lifestyles, performing regular medical check-ups and treating diseases discovered in the early stages of their development.

► #EHFG2013 **Forum 5:**
m-Health. Health at your
fingertips

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Disclaimer: The views expressed in the article are the sole responsibility of the author and in no way represent the view of the European Commission and its services.

Different apps

Among the apps available, it is important to draw a distinction between apps targeted towards health care professionals and apps targeted towards citizens. The first group includes apps which support doctors' everyday work by facilitating research of medical information and supporting remote consultations with experts. A study by QuantiaMD in June 2011 revealed that the top professional activities undertaken by US physicians when using mobile devices are looking up drug and treatment reference material, learning about new treatments and research, and diagnosing and choosing treatments for patients.¹ In addition, these apps can help support the prevention of disease or establish a diagnosis or treatment outside of health care settings.

However, serious concerns have been raised about the safety of medical apps if targeted towards patients for the purposes of diagnosis and monitoring, particularly if such apps have been marketed without prior authorisation by competent authorities. For example, Ferrero and colleagues have demonstrated the need to regulate medical apps by analysing the sensitivity of an app detecting melanoma.² In a survey of 93 cases, the app classified 88.2% (82/93) of the melanomas as medium-risk lesions and 1.2% (1/93) were reported to be low-risk lesions. In addition, the app was frequently "unable to analyse" lesions despite repeated attempts. The analysis showed that the potential for harm from delays in medical treatment is substantial because patients are advised to simply keep track of lesions analysed as "medium" and "low" risk.

In addition to the apps described above, there is a huge market (with equally good potential) for 'health and wellbeing apps' – apps that do not diagnose or monitor a disease but which help to maintain good health. Health care professionals, particularly public health specialists, should seriously consider the possible impact of these apps and see this new channel of communication as a promising tool in the area of preventive medicine, i.e. as an excellent opportunity to convey health messages to wide groups of people and, in particular, to reach those groups in society who may be difficult

to reach to or who do not respond to standard health education methods such as lectures, information leaflets or articles in newspapers.

Patient empowerment

The role of these apps cannot be underestimated from the perspective of patient empowerment—a process to help people take the initiative, solve problems and make decisions concerning their own health. New approaches, such as using games or collecting the results of physical exercise and then comparing them with earlier results or with other people's results using social networks, is a good opportunity to potentially improve the level of health education, encourage healthy lifestyles, and as a result, improve overall public health outcomes. This approach would also help to design messages that are tailored for special population groups and which are able to take gender, age and cultural differences into account. The World Health Organization (WHO) has already demonstrated good results with using mobile apps for tobacco control in some of its programmes such as mSmoke-free, mCessation, and mAwareness.^{3,4}

Safety and legal clarity

In its report of May 2012, the European Commission's eHealth Task Force⁵ stressed that although tens of thousands of health and wellbeing apps are already available on the market, there are no quality criteria for these applications or standards for data management and consumer information. One of the challenges will be to establish knowledge management systems to analyse and compile the data collected by apps on an individual's health and activities so that such information could be integrated with that person's electronic health record – to be utilised by the person him or herself, health professionals and/or public health monitoring authorities with the appropriate privacy safeguards.

Following the eHealth Task Force Report, the European Commission recognised in its *eHealth Action Plan 2012–2020*⁶ the wide variety of actual and potential functions of health apps, the rapid pace of

innovation in this field, and the potential benefits and risks to public health. The Action Plan underlines the importance of tackling clarity on legal and other issues around mobile health and wellbeing applications.

“mobile health apps could change the way health care is practiced”

Moreover, it is essential to clarify the regulatory framework applicable to mHealth as it is considered the biggest barrier impeding mHealth deployment in Europe, according to a WHO survey on mobile health.⁷ To enhance legal clarity, the European Commission is now considering the legal, policy and knowledge management framework for health and wellbeing apps. The US Food and Drug Administration has started a similar process with the Federal Communications Commission addressing the relevant legal framework.

Conclusion

In her speech at the informal ministerial conference in Dublin during eHealth Week in May 2013, the European Commission's Vice-President Neelie Kroes said: “apps prevent citizens from becoming patients”. With this aspiration in mind, it is paramount that we use the opportunities accorded by health and wellbeing apps in the most efficient way while not forgetting about consumer safety and the protection of privacy.

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By: Daniela Negri, Louise Boyle and Edwin Maarseveen

Summary: During the 2013 European Health Forum Gastein (EHFG) conference, the Young Forum Gastein will bring together young European health researchers and policymakers for the seventh time. Last year they were also active in several external policy initiatives, like the EC Digital Futures project, and in promoting policy projects, like the Human Brain project aimed at changing tomorrow's medicine. For this article, Young Forum Gasteiners interview MEP Amalia Sartori about the European Union's new research and innovation programme, as well as colleagues from the European Commission's Directorate General for Communications Networks, Content and Technology about a number of innovative projects already underway that will affect the health landscape over the next ten years.

Keywords: *Young Forum Gastein, European Union, Innovation, Digital Futures, Human Brain Project.*

Introducing Young Forum Gastein (YFG)

Supporting new ideas and creative thinking, bringing together young researchers and policymakers and facilitating networking opportunities with high-level European stakeholders to further work and careers: these are the key ideas behind the Young Forum Gastein (YFG) Scholarship.

The year 2013 marks the seventh anniversary of the project, with over 370 people now comprising the alumni network. Over the years the initiative has grown in the number of sponsored participants, the number of participating countries, and the sponsors themselves, with the World Health Organization Regional Office for Europe joining the European Commission (EC), the main sponsor of the programme, which supports

approximately 70 scholarships every year. In addition to their participation in a tailored programme at the annual European Health Forum Gastein, Young Forum Gasteiners have increasingly been asked to lend their expertise to European health initiatives outside the EHFG conference week that require a fresh, innovative approach.

Over the last year, Young Forum Gasteiners contributed to a range of projects such as the European Innovation Partnership on Active and Healthy Ageing, an area which the EC has identified as presenting considerable potential for innovation. The aim is for Europe to lead the way in developing ideas that lead to increases in the average healthy lifespan by two years by 2020. The knowledge and enthusiasm of the Young Forum Gasteiners will be invaluable to advance this work.

► #EHFG2013 Young Forum Gastein

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Acknowledgement: With thanks to the 2013 *Young Forum Gastein Taskforce* for providing comments on a draft of this article.

With the support of International Forum Gastein President, Professor Helmut Brand, the YFG Network is anxious to further broaden its participation outside of the EHFG conference week.

“innovation can radically alter the course of medical service provision

Another such initiative enlisting the ideas of the YFG network is the European Commission's Digital Futures project. Digital Futures is a horizon-scoping project launched by the Directorate General for Communications Networks, Content and Technology (DG CONNECT) to co-create long-term ICT visions (within the timeframe 2040–50) and provide fresh ideas for policies that can inspire the future strategic choices of the EC and DG CONNECT. Twenty-two Young Forum Gasteiners participated in an initial workshop in Brussels in Spring 2012, where they discussed ideas about what life would be like in 2050 and the health policy challenges and opportunities that these future scenarios could create. The discourse about the Digital Future in 2050 is continuing, both offline during a second Young Forum Gastein workshop hosted by DG CONNECT in Brussels in September 2013, and online as part of the Futurium, the online platform of the digital services project. The YFG scholars will pitch their most promising ideas during the 2013 EHFG Dragon's Den session. All successful ideas will be drafted into recommendations for the Futurium output document to be completed in 2014, which will subsequently be presented to the new European Commissioner for Communications Networks, Content & Technology.

What does the future hold?

Investing in innovation and research can radically alter the course of medical service provision. Within this context, the European Union has announced a series of initiatives that aim to promote medical advances and improve the quality of health care delivery in Europe. The Young Forum Gasteiners were keen to find out more about these initiatives, and were therefore granted the opportunity to interview MEP Amalia Sartori about the European Union's new research and innovation programme (see below), and discuss with colleagues from DG CONNECT a number of innovative projects already underway that will affect the health landscape over the next ten years.

Horizon 2020

The YFG spoke to MEP Amalia Sartori, Chairwoman of the Committee on Industry, Research and Energy (ITRE), the lead Committee for Horizon 2020, about the new programme for research and innovation, which aims to create new growth and jobs in Europe. She gave the YFG a brief perspective of how today's research and innovation efforts will change the medical innovations of tomorrow.

How will Horizon 2020 ensure the sustainable implementation of biological and medical science research in order to make progress towards a knowledge-based society that can face the societal challenges in Europe?

“I am very glad that we have reached an agreement with the European Council and the European Commission on the need to provide a more streamlined, efficient research and innovation programme that has the potential to drive economic growth in Europe and create new jobs. Pursuing excellence in science and industrial leadership as well as providing solutions for societal challenges can generate significant breakthroughs and innovations that will also advance medical knowledge and ultimately improve the quality of care across Europe”.

What are the aims of Horizon 2020?

“This programme aims to enable researchers to find new solutions to meet the major societal challenges, including the health of the ageing population, as well as facilitating access to cutting-edge technology platforms for academia”.

Why is this so important for Europe?

“It is our responsibility to retain world-leading scientists within the European Research Area and generate opportunities to maximise the competitiveness of Europe's knowledge-based industry. Only in this way can we create a positive environment to progress medicine and achieve the targets set by the Europe 2020 Strategy”.

Information Technology and health

Research and innovation have been recognised as key aspects of two other important initiatives promoted by the European Commission: the Human Brain Project and the *eHealth Action Plan 2012–2020*. Both have the potential to lead to significant progress in health care. In January 2013, the European Union announced that the Human Brain Project would receive €1 billion of funding in order to advance medicine and shed light on how the brain works. The ultimate objective is to develop personalised treatment of neurological and related diseases. The initiative brings together researchers from at least 15 EU Member States that will collaborate for the next ten years. To better understand how the project will impact the health care sector over the next decade, we interviewed colleagues from DG CONNECT.

Can you give us a brief overview of the Human Brain Project?

“The Human Brain Project is developing a combination of several IT platforms, to aggregate neuroscience knowledge and medical data from brain diseases, to develop models at and across the various functioning levels of the brain and to run these models on high performance mega computers or specialised hardware mimicking the neurons circuitry for faster evolution analysis”.

How will this be translated into better diagnostics and outcomes for patients with neurological diseases?

“Massive aggregation of data will allow the identification of unique brain disease signatures and probably a better classification of these neurological or mental disorders. First targets are the neurodegenerative diseases like Alzheimers. The simulation will allow the identification of potential new drug targets against such diseases, opening better development opportunities for the pharmaceutical industry. It will also offer carers the possibility to personalise treatment to the patient’s exact condition. Regarding other brain functions, a so-called neuro-robotics platform will allow progress in further understanding the brain by making the developed models interact with virtual or real environments”.

We understand there are significant project impacts outside the health sector too?

“In terms of non-health related impacts, it is expected that simplified versions of the cognitive models of the brain will permit the realisation of better robotic control and possibly new algorithms for complex problem solving, while neuron-like electronics will be much less power-consuming and more resilient to faults. Finally specific requirements in the very high-performance computing required to run the most comprehensive modelling of the brain will further develop this IT field, in particular for very large computer memory management and big data interactive visualisation”.

Will the project impact on the curricula of the future generation of researchers?

“The project will strengthen the potential impact of these translational results of combining neuroscience and neuro-informatics by developing a large training programme for existing and future scientists, health care providers, and IT specialists. It will also put in place an important activity concerned with analysing the ethical and societal implications that these research results might bring, via discussions with

stakeholders and ethics specialists, including philosophers, and via dialogue with the public”.

“core
roles played by
IT to break new
boundaries
in health

“The Human Brain Project is one example of the core roles played by IT to break new boundaries in health. The increasing potential of eHealth (using digital tools and services to improve health) has been highlighted by the development of the European Commission’s *eHealth Action Plan (eHAP) 2012–2020*. This plan provides a roadmap to empower patients and health care workers to connect devices and technologies and paves the way for the personalised medicine of the future”.

Can you tell us a little more about the eHealth Action Plan?

“The eHAP aims to improve the quality of life of European citizens; provide equal access to high quality and sustainable health care systems for all European citizens; and enhance the competitiveness of EU industry in the area of eHealth. Its operational objectives include supporting research, development and innovation in eHealth and promoting international cooperation”.

How will the implementation of the action plan support research, development and innovation?

“The eHAP calls for more emphasis to be put on international cooperation to promote benchmarking and evaluation projects in order to provide evidence to support deployment of eHealth solutions and to support new innovative solutions such as the Virtual Physiological Human, Personal Health Systems and ICT for Public Health”.

We understand that this international collaboration includes countries outside Europe too?

“Absolutely. Examples of international collaboration include the EU–US eHealth/Health IT Memorandum of Understanding (MoU) and its Roadmap and Stakeholder Call-to-Action which are facilitating transatlantic collaboration, initially on interoperability for Electronic Health Records and IT skills for the health care workforce. It is foreseen that cooperative action plans for additional areas, such as research and innovation for health care systems, will be included in the activities of the MoU Roadmap”.

What plans are there for eHealth in Horizon 2020?

“Likely topics for eHealth-related research in *Horizon 2020* include the improvement of health information, data exploitation and the provision of an evidence base for health policies and regulation. It is anticipated that this will also have a strong emphasis on international collaboration”.

Conclusion

The future of health is in all of our hands. The Young Forum Gasteiners therefore look forward to further discussions on the future of health at this year’s EHFG and to participating even more actively and visibly than in previous years in debates about how we can best ensure that our future health systems are adaptable, responsive and open to innovative ideas and new approaches.

INVESTING IN HEALTH: A EUROPEAN COMMISSION PERSPECTIVE

By: Paola Testori Coggi and Bartosz Hackbart

Summary: On 20 February 2013, the European Commission adopted a policy paper that urges Member States to consider the importance of investing in health to achieve the Europe 2020 objectives of smart, sustainable growth and a job-rich recovery. This policy paper complements the EU Health Strategy and reaffirms that health is a value in itself as well as a precondition for economic prosperity. It calls on Member States, with support from EU funds, to invest in sustainable health systems, in people's health, and in reducing health inequalities. Investing in health, the paper argues, is decisive for economic growth.

Keywords: Public Policy, Public Health, Health Systems, Sustainability, European Union

Introduction

The European Union (EU) faces mounting health challenges related to an ageing population, a rise in chronic diseases, growing citizens' expectations for more and better health services, and technological progress.¹ These challenges, along with the increasing share of public expenditure devoted to financing health care, have compelled countries to consider reforming their health systems. Moreover, the financial and economic crisis has put an additional strain on public finances and has led several EU Member States to reduce their budgets. For the first time in decades health expenditure has dropped.² This has increased the urgency to rethink how health systems could face present and future challenges with increasingly limited resources.

At European level, this reflection progressively entered discussions on

coordination of economic policies and identification of macroeconomic reforms. The European Semester became increasingly concerned with reforms in the health care sector.³ The European Commission (hereafter referred to as the "Commission") recognised the contribution of the health care sector to overcoming the current crisis and delivering high levels of employment, productivity and social cohesion, thus contributing towards achieving the European growth strategy (Europe 2020) targets. The Annual Growth Survey (AGS), a macroeconomic reform agenda, recommended reforming health systems.⁴ More generally, the Commission advocated *Investing in Health*⁵ to reaffirm that health was a value in itself as well as a precondition for economic prosperity. It called on Member States, with support from EU funds, to invest in sustainable health systems, in people's health and

► #EHFG2013 Forum 2:

Investing in health. From health to wealth

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in reducing health inequalities, given Member States' responsibility for the organisation and delivery of health care.

“ reforming health systems to ensure their sustainability

Investing in sustainable health systems

Representing close to 15% of total government expenditure and growing faster than gross domestic product (GDP) for decades, health spending growth came to a halt in 2010 as many Member States started consolidating public budgets. However, the slowdown hides wide variation between EU countries, with steady increases in countries such as Sweden and drastic contractions as seen in Greece.² Overall, projections still forecast an increase by one-third in expenditure on health and long-term care by 2060.³ Present budget constraints require improving the value and effectiveness of health spending and reconciling fiscal consolidation targets with the continued provision of sufficient levels of public services.

Improving efficiency

The Commission works with Member States to identify effective ways of investing in health in a Reflection Process that should draw conclusions by the end of 2013, and supports this reflection with specific studies as well as expert advice. For instance, in a joint report with Member States, the Commission identified a number of reforms that could improve the sustainability of health systems: for example, by encouraging more cost-effective provision and use of health services and medicines, a balanced mix of staff skills, improved primary health care services, better health promotion and disease prevention, and improved data collection.⁴

The 2013 AGS recommended reforming health systems to ensure their cost-effectiveness and sustainability. It assessed health system performance against the dual aims of providing access to high-quality health care and using public resources more efficiently. It paved the way for eleven *Country-Specific Recommendations*⁵ on health that put the emphasis on cost-effectiveness, strengthening outpatient care and making systems less hospital-centric, reinforcing disease prevention activities, and guaranteeing access to health care for specific population groups.

Sound innovation

Decisions on health investments require a solid assessment of the efficiency and effectiveness of spending. This is especially true for new technologies, which may help achieve more cost-efficiency in the long-run, but at a high initial cost. Such solutions should be thoroughly assessed. This is why the Commission helps Member States exploit the full potential of innovation by supporting cooperation on Health Technology Assessment (to pool expertise and prevent duplication of work), and on e-Health, to increase productivity and support health systems reform.

The Commission is working towards a sustainable health monitoring system in Europe that uses European Core Health Indicators (ECHI) to ensure that data are comparable in order to improve the evidence and knowledge-base on health expenditure and health outcomes. In addition, it is contributing to the development of a sound methodology for health system performance assessment as well as assessing the cost-effectiveness of health systems through Life Table Analysis.⁶

Investing in people's health

Improving the health status of the population and enabling people to remain active and in better health for longer can boost economic growth and create a cycle in which improvements in health and prosperity are mutually reinforcing.

Despite a steady rise in life expectancy, healthy life years (HLY) in the EU are

only 62.2 for women and 61 for men on average. This means that Europeans live almost 20 years, on average, with restrictions on their quality of life and productivity. Almost a quarter (23.5%) of people who are currently employed suffer from chronic conditions and restrictions to their daily activities. This has significant human and economic implications as ill-health leads to absenteeism (estimated as 3% to 6% of working time), premature labour market exit (up to 10% of people leave their job mainly for health reasons) or mortality. Depression, musculoskeletal diseases and unhealthy lifestyle factors (e.g. obesity and physical inactivity), are additional factors associated with reduced on-the-job productivity.

Patient empowerment may help in facing this challenge by complementing professional acute care and enabling people to remain active and in better health longer, and therefore reducing health care costs. However, increasing people's employability and enabling them to stay longer in the workforce will require tackling the problem of chronic diseases and addressing the main risk factors that determine population health.

Promoting good health

Devoting resources to prevention, screening, treatment and care can reduce or delay the human and economic burdens of chronic diseases. However, currently only about 3% of health expenditure is allocated to these types of activities. The importance given to health promotion and disease prevention activities, particularly through the health-in-all-policies approach, should therefore be reassessed. There is a wide array of measures that authorities could use, such as information campaigns, excise taxes, labelling, food product reformulation, health education and financial incentives for consumers, patients and providers.

Health sector workforce

Efficient health systems require an appropriate investment in the health workforce. The health and social work sector created close to 1.5 million new jobs in the EU between 2008 and 2012 and accounts for about 10% of the total workforce. Increasing health care needs, coupled with the ageing of health care

professionals, is projected to result in 8 million job vacancies by 2020.¹⁰ However, increases in employment in this sector should be balanced against public spending constraints, which points to the need to exploit efficiency gains and better productivity to meet future needs.

The Commission complements Member States' action by developing knowledge (on health investments' effects on employability and patient empowerment practices) and facilitating cooperation between Member States (in the areas of health promotion and disease prevention, as well as health workforce planning). It also works with Member States in a Reflection Process aimed at identifying options to optimise the response to the challenges of chronic diseases.

Finally, it develops cooperation with key stakeholders in initiatives such as the European Innovation Partnership (EIP) on Active and Healthy Ageing or the EU platform for action on diet, physical activity and health. For instance, members of the Platform (the food industry, public health advocates, non-government organisations, advertisers and the medical profession) already have taken more than 300 voluntary commitments in areas such as advertising restrictions, labelling or awareness raising campaigns. These commitments are regularly monitored and evaluated in a transparent, participative and accountable manner.*

Investing in reducing health inequalities

Health outcomes vary considerably within and between countries, with a maximum gap in life expectancy at birth of 11.6 years for males and 7.9 years for females. People with lower income and less education die younger and their health is worse. Disability levels, in terms of reported restrictions on daily activities, are more than twice as high in the lowest income quintile as in the highest income quintile.¹¹ Even larger health inequalities exist for some vulnerable groups such as ethnic minorities (in particular Roma) and migrants. Reasons for these differences include barriers in access to health care as well as poorer diets, housing, living and

working conditions, and higher levels of health-damaging behaviours. The impact of the current crisis on these factors threatens to increase health inequalities further. These health inequalities represent not only a waste of human potential, but also a potential economic loss estimated at between 1.5% and 9.5% of GDP.¹²

A genuine multisectoral approach is required to break the vicious spiral of poor health contributing to, and resulting from, poverty and exclusion. This approach should focus on achieving greater gains in less advantaged groups by addressing the underlying risk factors in health behaviours, and ensuring adequate incomes and living and working conditions. It should ensure the effectiveness of social protection systems in countering the effects of the crisis. Moreover, it should promote social inclusion and prevent poverty, including by providing access to affordable, high-quality health services for all. Data on the effects of social transfers on poverty suggest that health care plays a significant role in reducing the at-risk-of-poverty rate.¹³ Cost-containment measures such as increases in co-payments should be carefully assessed as they may result in reducing vulnerable populations' access to health care and aggravating their economic hardship.

The Commission will continue to support measures to address health inequalities within and between Member States by increasing available knowledge and evidence, facilitating the exchange of best practice and improving the understanding of the effects of health investments on social exclusion and poverty reduction.¹⁴

Conclusion

The Commission encourages Member States to continue to invest in health and the sustainability of health systems so that they can respond to current and future challenges. This policy requires reforms and targeted investments for achieving greater cost-efficiency. What is advocated is smarter spending – not necessarily more spending. This will help reconcile public finances consolidation with the continued delivery of public policy goals, such as universal access to high quality health care, prevention of chronic diseases,

and the commitment to reducing health inequalities. Taken together, these three factors make a crucial contribution to prosperity and social inclusion.

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Note: The ICARE4EU project (2013–2016) aims to support the European Innovation Partnership on Active and Healthy Ageing (<http://ec.europa.eu/active-healthy-ageing>) and is co-funded by the Health Programme 2008–2013 of the European Union (<http://ec.europa.eu/health/programme/policy/2008-2013/>). More information on the project and its partners can be found at: www.icare4eu.org Email: icare4eu@nivel.nl



ICARE4EU: IMPROVING CARE FOR PEOPLE WITH MULTIPLE CHRONIC CONDITIONS IN EUROPE

By: Mieke Rijken, Verena Struckmann, Mariana Dyakova, Maria Gabriella Melchiorre, Sari Rissanen and Ewout van Ginneken, on behalf of the ICARE4EU partners

Summary: Currently, an estimated 50 million people in the European Union live with multiple chronic diseases, which deeply impacts on their quality of life. Innovation in chronic illness care is urgently called for. First, most current care delivery models are disease-specific and therefore are not adapted to the needs of the growing number of people with multi-morbidity. Second, chronic illness care places a high burden on financial and human resources. The ICARE4EU project, a major new European initiative co-funded by the Health Programme of the European Union, wants to improve care for people living with multiple chronic conditions by identifying, analysing and disseminating innovative patient-centred multidisciplinary care programmes to address multi-morbidity.

Keywords: Multiple Chronic Conditions, Multi-morbidity, Integrated Care Strategies, Innovation, ICARE4EU

Introduction

As in previous years, the 2013 Gastein Forum has put non-communicable diseases (NCDs), or chronic diseases*, high on its agenda and for good reason. Chronic

diseases are the leading cause of mortality and morbidity in Europe.¹ Therefore, it is not surprising that several European countries are now developing disease management programmes to improve care for patients living with chronic diseases. Yet, such programmes have not adequately addressed the problem of multi-morbidity²

* Some definitions may not equate NCDs with chronic diseases.

even though in the European population alone, an estimated 50 million people live with multiple chronic diseases.^{[4][5]} In this article we will discuss the challenges facing health systems and provide some examples of promising innovative care models for patients with multiple chronic conditions. Lastly, we will introduce an important new initiative co-funded by the European Union's Health Programme 2008–2013, called ICARE4EU, which will help improve, analyse and disseminate innovative patient-centred multidisciplinary care programmes for chronic comorbidity.

Innovative solutions required

The challenges facing health systems are many. Not only will the number of chronically ill people increase, their needs for care will also increase and become more complex because of ageing and multi-morbidity. Until now, multi-morbidity and its sub-concepts – like comorbidity – are ambiguously defined. Yet its significance in care and service systems has been acknowledged widely. European health and social systems will need to manage the very complex and substantial burden arising from continuous multidisciplinary care. Yet, also from a patient perspective, improvements in the organisation and quality of care, for instance, as well as their own involvement in the care process are important. Therefore, innovations for chronic illness care are urgently needed for two key reasons.

First, most current care delivery models are disease-specific or structured around acute episodes; therefore, they are not adapted to the needs of the growing number of people with multiple health problems. For people with multi-morbidity, single-disease programmes incorporate the threat of too narrow a focus on their health and social problems (the focus is on the disease that the programme has been designed for), lack evidence regarding treatment and subsequently lack decision support (clinical practice guidelines may contradict each other and do not sufficiently address aspects of multi-morbidity). There may also be a greater chance of inadequate coordination of care and the possible interference of self-care

(even if advised by a doctor) for a single disease with the care of multiple co-existing diseases.^{[6][7]}

“single disease programmes are too narrowly focused

Second, chronic illness care puts a high burden on financial and human resources. Increasing health care expenditures and shortages, as well as disparities in the supply of health professionals raise concerns about health system sustainability in many countries. About 70–80% of health care costs are spent on chronic diseases, which corresponds to €700 billion in the European Union.^[8] Innovation is necessary to provide good quality care with limited resources. Patient-centred multidisciplinary care, integrating health and social care, using new technologies to support self-management, improving collaboration with family caregivers, and fluid care processes all have the potential to meet the complex needs of people with multiple chronic conditions, while making more efficient use of resources. Such integrated care models respond to the nature of multi-morbidity, as they prioritise and integrate treatment and support across the whole range of care and services. New models and integrated care programmes for people with multiple chronic conditions are now being developed, implemented and evaluated. **Box 1** contains two examples.

However, De Bruin and colleagues^[9] recently published a systematic literature review of so-called comprehensive care programmes for people with multiple chronic conditions. Their search identified few European programmes: of the 28 programmes described, only four were implemented in European countries (Italy, Netherlands, Norway and the UK). The lack of European programmes identified may be due to the restriction of searching for only English language

papers. In addition, recent initiatives may not have been described in scientific literature yet.

It is more likely, however, that many such programmes remain unidentified since a current and comprehensive overview of European integrated care programmes addressing multi-morbidity is not available. The provision of such an overview, including an analysis of their characteristics is essential and would allow swift adoption of good practices. Moreover, regular updates need to be ensured as they create an important step to enhance the quality and sustainability of multi-morbidity care for chronic multi-morbidities in Europe.

“70–80% of health care costs are spent on chronic diseases

ICARE4EU: A major new European initiative

Against this background, the management of multi-morbidity is increasingly considered to be an important issue by policy-makers and researchers. The ICARE4EU project wants to improve care for people living with multiple chronic conditions in various ways and on several levels.

First, data from 30 European countries will be compiled to provide an insight into the ‘state of the art’ of integrated care for people with multi-morbidity and the strengths and weaknesses of care programmes, their inputs, processes and outcomes. Information about the availability and variation in the dissemination of integrated care programmes in (parts of) European countries will help policy-makers and stakeholders to plan, decide and advocate integrated care for people with multiple chronic conditions.

Second, the project will identify best practices from four perspectives: patient-centred; management practice and professional competencies; use of e-health technology for older people; and financing systems. In-depth analysis will provide information on their features, success in terms of outcomes, costs and sustainability, as well as management and implementation strategies. Best practices are particularly valuable for policy-makers, care managers and other stakeholders as exemplars for a wider implementation of effective and successful management of multi-morbidity in Europe.

Third, the project will develop a template that can be used (at the least in a simplified version) for future systematic monitoring of developments in multi-morbidity chronic illness care. To ensure sustainability, the aim is to create a link with the Health Systems and Policies Monitor of the European Observatory on Health Systems and Policies (www.hspm.org/mainpage.aspx). Furthermore, by collaborating and building an effective platform for experts from different European countries, ICARE4EU will facilitate the exchange of knowledge and experiences throughout Europe. This will allow better understanding, improved design, wider applicability and more effective implementation of care programmes addressing multi-morbidity around Europe.

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Box 1: Examples of innovative integrated care programmes for patients with chronic multi-morbidity in Spain and The Netherlands

Andalusia, Spain

In the Spanish region of Andalusia, a programme called Polypatology was set up, specifically designed for people with multi-morbidity. The programme started with the development of criteria for 'polypathology' in order to define the target group. According to these criteria, patients are defined as having multi-morbidity when they have chronic diseases that belong to two or more (of eight) disease categories. In addition, the patient with multi-morbidity is defined by a special clinical susceptibility and frailty which entails a frequent demand for care at different levels that is difficult to plan and coordinate. This is a result of exacerbations and the appearance of subsequent conditions that set the patient along a path of progressive physical and emotional decline, with a gradual loss of autonomy and functional capacity. Subsequently, the Andalusian Ministry of Health has designed an organisational process to manage the care of such patients in collaboration with internal medicine specialists, family physicians and nurses. The aim of the programme is to improve continuity of care and thus focuses on professional roles, workflows and best clinical practices, supported by an integrated information system.^{10, 2}

West-Friesland, The Netherlands

In the West-Friesland region of The Netherlands a programme called CasCo has been developed for type II diabetes patients with comorbid conditions, to improve the delivery of integrated care. The Guided Care (GC) Model was used to design a case management care programme customised to the Dutch primary care setting. Case management is a model to counteract fragmented care for comorbid patients. Practice nurses receive training in case management and act as case managers. The programme aims to coordinate all care involved for patients enrolled in different single-disease management programmes who have to adhere to various treatment protocols. It draws on evidence-based optimal care to systematically manage all existing conditions in a patient, and is tailored to the individual patient's preferences. The programme is currently being evaluated by comparing its added value to a single diabetes management programme in a randomised controlled trial.¹¹ Similar approaches based on GC principles were piloted with multi-morbidity patients (not necessarily with type II diabetes) in 2011 and 2012 in local primary care practices in other regions of The Netherlands.¹²

MEASURING AND IMPROVING THE SOCIETAL IMPACT OF HEALTH CARE RESEARCH

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Note: This article has been written as the first product of an international working group on improving the societal impact of health care research. Final results of the working group will be available at the end of 2013 and disseminated through the channels of its members.

Summary: Health care research is increasingly being evaluated in terms of its contribution to new market products and services, among other factors, in the European Union's new Framework Programme for Research and Innovation, *Horizon 2020*. However, discoveries in health care research often are not marketable products but innovations intended for the public domain. Therefore, funders and the research community need to review the applicability of impact frameworks for evaluating these types of research. Of key importance is the development of societal impact indicators for *ex-ante* evaluations of research programmes and projects. Such assessments should also take the specificities of European versus national level research into account.

Keywords: Societal Impact, Health Care Research, Europe, Evaluation, Horizon 2020

The need for societal impact

In light of the many health care challenges that countries face, there is growing recognition that high quality health care research can help decision-makers by providing scientific evidence to inform policies and practices.^[1] With governments and health care systems becoming more and more focused on effectiveness and efficiency, it is a logical development that the same also applies to research production. Health care research needs to be accountable and show that investments produce value for money.

How to determine this value and for whom, is a topic of debate. There is growing awareness that the impact of research should not only be determined in

scientific terms. Especially when funded through public sources it is also important that research findings are actually used by end users, such as policy makers, managers, patient organisations or the public at large. A major concern is that national and European health research funding bodies increasingly interpret this societal impact in terms of economic impact, e.g. in terms of cost reductions in the delivery of health services or the employment benefits resulting from healthier workforces.^[2] This shifting focus is well exemplified by the ambition of the European Commission's new programme for research and innovation, *Horizon 2020*, which should contribute to boosting competitiveness, creating jobs and supporting growth.^[3]

This is a narrow interpretation of the health and wealth agenda, focused on tackling societal challenges by helping to bridge the gap between research and the market, thus getting Europe out of the economic crisis. Emphasis is largely placed on the importance of patents, products or spin-off companies. While this focus on exploitable intellectual properties may be suitable for certain domains within biomedical research, it is far less appropriate for what we describe as health care research (see Box 1).

Box 1: Our domain of health care research

We use the term health care research to describe the overlapping areas of health services and systems research, health policy research as well as public health research, all of which contrast with biomedical and clinical research. Typical elements of health care research are its broad domain, studying a variety of factors at health system level, the level of organisations and that of patients and professionals.

Its objective rarely is to develop innovations that can be marketed through patents or products. Instead, the application and societal value of health care research lies far more in supporting policy decisions, both at governmental and organisational level – for example, to improve the quality and safety of health care, the financial sustainability and productivity of health systems, innovations in health care organisation and delivery or the effectiveness and efficiency with which health care interventions are used. As a consequence, the value of health care research cannot be defined that easily in terms of commercial products and their effects on e.g. employment and tax revenues, but rather in terms of the diverse impacts, including at the economic, organisational and societal levels, that contribute in the longer term to a healthier and more productive workforce.

From a market-based to a society-based approach

When deciding how to establish the societal impact that better fits health care research, it becomes clear that there is a wide variety of impact assessment methodologies available.^{[1][2]} Probably the most common methodology, among others used by funding bodies in the UK, Canada, Netherlands and Ireland, is the payback framework.^[3] Other frameworks have also been developed, sometimes specifically as alternatives to the payback framework. Box 2 provides a summary of various ways in which societal impact has been determined. In all models, some elements are incorporated that are less relevant for health care research.

The overview in Box 2 illustrates that no single framework can be applied integrally in all cases. Instead, it is recommended to carefully select relevant dimensions and indicators, possibly from various models. Which ones to choose – and how to weight them – depends, in part, on the circumstances within a specific country or research field. Below, we will discuss a number of issues to take into consideration when determining the right impact dimensions and indicators for health care research at national and European level, also in light of the launch of *Horizon 2020*.

1. The distinction between ex-post and ex-ante evaluation.

Typically, impact evaluation is conducted after research has been completed and actual impacts can be determined. However, for decisions about the allocation of funding the ex-ante assessment of potential impact is especially important. It requires suitable indicators of future success. Their specification for European health care research needs further development. For example, what are the relevant dimensions of potential impact for a particular area of research and are reviewers aware of this? It involves factors that are known to facilitate impact based on the literature on knowledge utilisation, such as the early involvement of policy makers during the research process, the embedding of a research project in existing networks,^[4] or the existence of well-constructed dissemination plans.^[5]

“the application of health care research lies in supporting policy decisions

2. National level versus international impacts

The impact assessment of European-level research differs in a number of ways from that of national research. For one, direct, instrumental use of research for implementation is far less likely to occur at European level as health policy is still more within the realm of Member States. Stakeholders at European level are also less visible than at the level of one single country. Thus, research at European level may have more unobserved effects; e.g. it is difficult to assess whether one or more of 28 Ministries of Health used certain research findings. Impacts depend on the national context – e.g., on how health care is organised. It requires a good understanding of health care systems and their key stakeholders to assess impacts in more than one country.

3. Time span of ex-post evaluations

Typically, assessment methods differ between cross-sectional or short term evaluations versus longer term evaluations. The former are less costly and more practical, but the latter are sometimes seen as preferable. Particularly for individual or population health, it may take up to twenty years before impacts can be determined.^[6] This raises the question as to whether such time paths really apply for health care research. After longer durations it becomes increasingly difficult to attribute impacts to a specific study or research programme, as other societal or policy factors may have intervened. As such, the optimal duration depends on a multitude of factors, including the research domain, type of study, funder's objectives, and the particularities of a country's health care system.

Box 2: Overview of societal impact dimensions in a selection of impact frameworks

Framework	Societal benefits*
Payback (See Reference 3)	<ul style="list-style-type: none"> • Benefits from informing policy and product development: <ol style="list-style-type: none"> a. Improved information bases for political and executive decisions b. Other political benefits from undertaking research <c. Development of pharmaceutical products and therapeutic techniques> • Health and health sector benefits <ol style="list-style-type: none"> a. Improved health b. Cost reduction in delivery of existing services c. Qualitative improvements in the process of delivery d. Improved equity in service delivery • Broader economic benefits <ol style="list-style-type: none"> <a. Wider economic benefits from commercial exploitation of innovations arising from R&D> b. Economic benefits from a healthy workforce and reduction in working days lost
Research impact (See Reference 10)	<ul style="list-style-type: none"> • Policy impacts (e.g. nature of policy influence, policy networks, political capital) • Services impact: (e.g. type of services, evidence-based practice, quality of care, cost-containment and cost-effectiveness) • Societal impact (e.g. knowledge, attitudes and behaviour, health literacy, equity and human rights, social capital and empowerment, sustainable development outcomes)
European Commission (Seventh Framework Programme)	<ul style="list-style-type: none"> • Description of main dissemination activities and exploitation of results • Synergies with science education (involving students or creating science material) • Engagement with civil society and policy makers (e.g. NGOs, government, patient groups) and production of outputs which could be used by policy makers • Use of dissemination mechanisms to reach the general public in appropriate languages • Use and dissemination of the following indicators: <ol style="list-style-type: none"> a. Articles in (preferably open-access) peer reviewed journals <b. The amount of new patent applications> <c. The amount of Intellectual Property Rights> <d. The amount of spin-off companies created or planned> • The employment consequences of the project
Research utilisation ladder (See Reference 11)	<ul style="list-style-type: none"> • Transmission (of research results to practitioners and policy makers) • Cognition (reading and understanding) • Reference (quoting of research results in reports, studies, actions) • Effort (to adopt research results) • Influence (on choices and decisions) • Application (giving rise to applications and extensions)

Source: Authors.

Note: * The items in angle brackets <> indicate that they are less relevant for health care research.

4. Methodological considerations

A number of quantitative and qualitative techniques are available to measure impact, each with their own complexities.⁹ More quantitative measures run the risk

of oversimplifying matters ('counting beans'), while qualitative – narrative – approaches demand a lot of effort and may tend to focus on success stories which are hard to generalise ('cherry picking'). It is preferable to combine several methods in

order to improve the quality of the impact assessment. This applies especially to health care research, which – given its broad scope – cannot rely on only one or a few simple indicators of societal impact.

Moving forward

There is growing awareness among health care researchers and funders that assessing societal impact is a key priority for all those involved in producing or funding health care research, especially in times of scarcity. Which impact assessment tool to use is highly dependent on the exact purposes: is the assessment intended for monitoring research performance of health care research or for biomedical research? And is it intended for evaluation of research within one national setting or at European level? The latter is becoming more and more important, not only because of the research opportunities of *Horizon 2020*, but also due to the synchronisation between national initiatives, among others through Joint Actions or Joint Programming Initiatives.¹ It is also important to realise that impact assessment has certain limitations and pitfalls to be avoided. To facilitate the optimal use of impact assessments for our area of research, we think the following issues should be addressed.

- A. Both funders and the research community need to agree upon suitable indicators to assess impact afterwards and predict impact beforehand. What information should be incorporated in the impact section of a research proposal, e.g. for *Horizon 2020*?
- B. With the wide availability of existing impact frameworks it may not be necessary to develop another version, but rather find clever ways to combine elements from different frameworks to best fit the particularities of a certain research topic.
- C. The optimal time span of an impact assessment should be decided on in advance, together with a prioritisation of impact indicators which can realistically be achieved in that time period.
- D. We need a refinement of an impact framework that fits the particularities of different countries across Europe and that involves stakeholders in all European regions. Special emphasis should be given to countries in Eastern and Southern Europe, where capacities are lower.

E. The development of one single impact factor, as in the case of bibliometric analyses, is not desirable since societal impact consists of different dimensions. Still, it is worth striving for a means to compress impact into a shortlist of key impact indicators.

F. Impact assessment should not become a goal in itself, but should be used as a tool for impact improvement. For this, continuing dialogue at conferences and smaller-scale meetings is required.

G. The active involvement of end users, robust dissemination plans with appropriate resources and mid-term reviews should be mandatory for all projects.*

H. Public health (care) research should be supported more strongly within the EU and nationally, and must continue to be free of commercial conflicts.*

To achieve these goals, a continuous dialogue is needed, both within the offices of research funders and research teams, but most importantly in joint dialogues. An end report on societal impact by this group of authors aims to contribute to such a dialogue and will be available by the end of 2013.

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GOVERNED COORDINATION IN THE **AUSTRIAN HEALTH SYSTEM:** A REMEDY FOR FRAGMENTATION?

By: Maria M. Hofmarcher, Wilm Quentin and Ewout van Ginneken

Summary: The Austrian health system provides universal coverage for a wide range of benefits and high quality care. People enjoy direct access to all providers and their satisfaction is well above the EU average. However, the system is costly, which is mainly related to insufficient coordination within and across care sectors. Health reform in 2005 created the Federal Health Agency and Regional Health Platforms. Since then, cross-stakeholder coordination has intensified with the aim of promoting ambulatory care activity and improving performance. Nevertheless, more tangible measures are needed to remedy the system's structural fragmentation.

Keywords: Health Care Reform, Financing, Fragmentation, Care coordination, Austria

Introduction

The Austrian health system guarantees its population of 8.4 million access to a wide range of benefits and high quality care. Life expectancy at birth (80.4 years in 2010) and satisfaction with the system are above the European Union (EU) average¹ while healthy life expectancy lags behind.² Free choice of providers and unrestricted access to all levels of the health care system, including hospitals, is a key feature of the system and is highly valued by the population. This comes at a cost: Austria spent almost 11% of its Gross Domestic Product (GDP) on health in 2010, considerably more than the EU average, although less than countries such as The Netherlands, France and Germany.³ While cost-sharing is relatively high compared to other countries, equal access to care is ensured by many exemptions

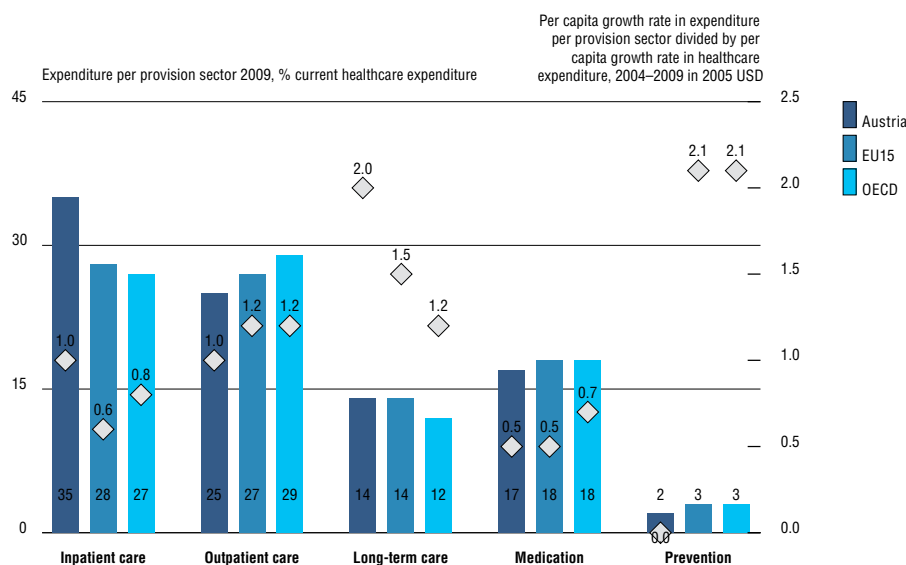
(e.g. a prescription fee cap) and only 2% of the population report that they have difficulty accessing services.⁴

The health system has been shaped by three important institutional characteristics: (1) The constitutional make-up of the state with shared health care competencies between the federal level and the regional level (*Länder*); (2) a high degree of delegation of responsibility to self-governing bodies; and (3) a mixed model of financing, where the state and social health insurance contribute almost equal shares.

The financing model combines capped proportional insurance contributions of usually 7.65% of people's gross income, shared equally between employers and employees with progressive taxation, which safeguards vertical equity. Further, it fosters economic competitiveness as

► **#EHFG2013 Launch:** The new Austrian Health System Review

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Figure 1: Current expenditure per care sector* (%) and elasticity of spending

Note: * Most important care sectors; thus they do not add up to 100 %. Data were not available for Italy, Ireland, Greece, the Netherlands, the United Kingdom, Turkey, Switzerland and Israel.

Source: Authors' graph using OECD data.⁴

the burden of health financing on labour costs is spread across public pools. However, the mixed scheme coupled with divided responsibilities between the federal government, the *Länder*, and sickness funds impedes the development of efficient and better coordinated care within and across sectors and has been one of the key challenges of the Austrian health care system since the introduction of the General Social Security Act in 1956. Although the Federal Audit Office has repeatedly recommended aligning key actors' responsibilities in the Constitution, health reforms since the mid-1990s have always aimed to achieve their goals within the current administrative framework.

Administrative fragmentation

Figure 1 shows that the hospital sector (inpatient care) in Austria absorbs a share of total health expenditure (35%) that is above the EU-15 and OECD averages, reflecting an above average acute care beds density. In contrast, spending on outpatient care (including hospital outpatient departments) and prevention are below the EU-15 averages. In addition, expenditure imbalances seem stable over time. Several counteracting incentives

lead to insufficient coordination between inpatient and outpatient care as well as between acute and long-term care.

First, *Länder* have to ensure that there is sufficient hospital infrastructure. They mostly own and regulate these facilities. The financing of hospitals is shared between the federal government, the *Länder*, municipalities and the nineteen social health insurance funds. The latter contribute with a fixed budget, at about 35% of their revenues. The federal government allocates resources for hospital care to the *Länder* on the basis of political bargaining. However, *Länder* and their populations tend to resist downscaling or closure of hospitals. Moreover, public hospitals have quotas for beds to take on privately insured patients, which then supplements their revenues but restricts their ability to downsize capacity.

Second, selective contracting by the sickness funds restricts the number of practicing primary and specialist care doctors who are largely remunerated on a fee-for-service basis. While this is likely to contain "supplier-induced demand" in this sector, utilisation is pushed into the well-endowed hospital sector, at no extra cost to the sickness fund, as their budgets for hospital care are capped. While this

has helped to secure technical efficiency in hospitals on the basis of Diagnosis Related Group (DRG) financing, allocative efficiency is impeded as sickness funds lack incentives to invest in ambulatory care capacity.

Third, in care sectors outside hospitals, payment methods, service volumes and staffing levels are diverse across *Länder*. Moreover, staffing and volume in most *Länder* are not coordinated with regional hospital plans, although hospitals provide an important share of ambulatory care. In addition, health insurers cover 80% of the regular fees to non-contracted ambulatory care physicians, which erodes the effectiveness of planning.

Finally, while the system ensures direct access to all providers, it is often difficult for patients to find the most appropriate care for their particular needs in this maze of options. This is increasingly true for chronically ill patients who often also need long-term care. Thus, a lack of coordination and planning of patient flows between inpatient and ambulatory care or ambulatory care and long-term care, including preventive measures, is prevalent throughout the system.

Governed coordination

Health reforms since 2005 intensified efforts to overcome the negative impact of fragmentation.⁵ They have focused on (a) improving governance of and planning in the health system through the introduction of cross-stakeholder institutions and (b) strengthening ambulatory care provision, which spans from introducing incentives for disease management programmes, widened possibilities for group practices, e-health applications and recently through defined targets to promote day care (**see Table 1**).

Improved governance and planning

Since 2005 the Federal Health Agency (BGA) has united all relevant actors in the health sector within its Federal Health Commission, comprising representatives of the federal government, the *Länder* and local municipalities, the Federation of Social Insurance Institutions, the Austrian Chamber of Physicians, the Austrian

Table 1: Health reform measures for improved coordination in the Austrian health system

Year	Measures	Aims
2005	Art. 15a agreement 2005–2008	Introduction of “collective overall responsibility” of (federal and state) governments, together with social insurance institutions, for the entire health care sector.
	Creation of the Federal Health Agency	Strengthened decision-making structures at the federal level and improved coordination of all relevant stakeholders for planning, quality management and the development of e-health.
	Creation of Regional Health Platforms and Regional Health Funds	Strategic development of health care at regional level through stakeholder cooperation.
	Introduction of “Reform Pools” at regional level receiving 1 to 2% of total public health expenditures	Provide dedicated financing for the increased use of outpatient treatment when new care models replace inpatient treatment.
	Healthcare Telematics Act	Creation of the Working Group on Electronic Health Files (ARGE ELGA) for the development of electronic health files and the electronic health card (e-card).
2006	First Austrian Structural Plan for Health (ÖSG 2006) and development of Regional Health Plans (RSG)	Improved planning by defining activity levels (instead of inpatient beds and equipment) and by including all health care sectors in planning.
2007	Structured disease management programme for diabetes	Improved coordination and integration across sectors for diabetic patients.
2008	Article 15a agreement* 2008–2013 and new ÖSG 2008	Improved planning of activities in ambulatory and rehabilitation care.
2010	Amendments to the Healthcare Telematics Act	Creation of a limited liability company (ELGA-GmbH) for the development of electronic health files (ELGA) and e-medication.
	Introduction of the Children’s Health Strategy	Strengthen “Health in All Policies” approach to improve the health of children and young people.
	Federal Act to Strengthen Public Outpatient Healthcare Provision (Ärzte GmbHs)	Increased outpatient care capacity and improved coordination through the establishment of multidisciplinary group practices (Ärzte-GmbHs).
2012	Adoption of National Framework Health Goals	Improved strategic planning in the health sector.
2013	Article 15a agreement*: Governance by objectives	Cooperative contracts at the federal and state levels detail measures and targets in four areas to foster care delivery at the “best point of service”. Financial targets on the basis of a global budget. National health goals become guiding principles.

Source: Authors compilation based on Ref 5.

Federal Pharmacy Board, patients’ representatives, and many more. The BGA develops the Austrian Structural Plan for Health (ÖSG), defines quality guidelines

and supervises the development of e-health technologies. In addition, the BGA distributes federal resources to Regional Health Funds (LGF) and may link the

disbursement of funds to compliance with federal requirements for inpatient care, in particular concerning inter-regional cooperation.

In addition, the LGFs’ tasks mirror the agenda of the Federal Health Agency. Each LGF receives funding from the federal government and sickness funds. By now many *Länder* have also pooled their own resources into these funds. To ensure cross-sectoral planning, relevant actors at the regional level are represented in the LGF’s Regional Health Platforms. The first result of inter-sectoral and interregional planning was the Austrian Structural Plan for Health for 2006, which replaced the preceding hospital and medical equipment plans and extended planning to the entire health care sector. Per-hospital capacity planning was converted to provider activity plans for 32 regions and four zones, and quality assurance criteria were established. The 2006 Plan defined the framework, while detailed planning now is carried out by the Regional Health Platforms, developing Regional Structural Health Plans (RSG). Subsequent Plans (in 2008 and 2010) have focused on extending planning to the outpatient and rehabilitation sector. In addition, for certain specialist areas, such as cancer treatment, planning is supra-regional and makes recommendations on combining complex specialist areas of service provision in reference centres.

Strengthening ambulatory care

A new instrument (“Reform pool”) was created in 2005 to stimulate greater patient flow between sectors. These virtual pools contain 1 or 2% of all public spending in a given year. Reform pool funds should ensure that both *Länder* and health insurers can benefit from cost savings resulting from changing delivery patterns. Regional Health Platforms can provide funding for three different kinds of projects: (1) projects that better coordinate care for chronic patients, (2) projects that shift service provision to the ambulatory care sector, and (3) pilot projects that attempt to introduce cross-sectoral financing models. While only about 16% of mandated resources were used in 2009 for about 36 initiatives,⁵ this

instrument fostered innovation and led to a disease management programme for diabetes (*Therapie Aktiv Diabetes*), which has now been rolled out in most *Länder* and since 2009 has been accompanied by federal guidelines on diabetes care. Evaluations of the programme found improvements in adherence to treatment guidelines (more regular eye and foot examinations) as well as reduced body mass index and cholesterol levels,⁹ and a reduced number of hospital admissions for programme participants.⁹ So far, enrolment rates in the programme have been moderate, at about 7% of diabetics in 2011. Moreover, the participation of physicians is low, at 8% of all contracted physicians, even though additional lump-sum fees are paid. However, the plan is that by 2015 the majority of diabetes patients will be enrolled in the programme.

“reforms
have focused on
supply-side
measures

A second initiative, group practices (*Ärzte GmbH*), was introduced in 2011 and aims to better balance utilisation of inpatient and outpatient care through multidisciplinary care outside hospitals. A collective contract for such group practices was recently signed in Vienna. However, and in stark contrast to what was issued in the corresponding legislation, this collective contract only permits group practices with doctors exhibiting a similar specialty profile, e.g. only general surgery, internal medicine, etc. While market authorisation for doctors with a valid contract is rather simple it has many barriers for “outsiders”, raising some doubts about whether ambulatory care capacity will increase and ultimately help balance demand across sectors.⁹

Third, progress has been made in implementing electronic health records (ELGA) after the administration of provider access and billing was successfully digitised via e-cards in 2005. Aiming to improve coordinated patient safety, the first application of ELGA is

e-medication, with a planned roll-out in 2013. In 2011 e-medication was piloted in three *Länder*. Patients in selected districts in Vienna, Upper Austria and Tyrol could register medications in an electronic database when prescribed by physicians or bought over the counter. In an evaluation, not only did the majority of participating physicians and pharmacists report the system to be an improvement for patient safety but patients did too.¹⁰ However, resistance by physicians to the introduction of e-medication continues to be strong even after presentation of the evaluation results. Some questions regarding data protection also remain unresolved.

Finally, health reform in 2013 also aims to right-size supply to ensure safe care in adequate settings through new regulatory instruments (*Zielsteuerungsverträge*). The framework for these contracts between *Länder* and regional sickness funds has been devised by the federal level and, in principal, imposes sanctions for non-compliance to global fiscal rules. Guided by national health goals introduced in 2012 and supported by a global budget cap which links public expenditure growth to GDP growth, the balancing of regional care provision will be managed by “key performance indicators” which currently are being developed.

The need for further reform

In contrast to other countries, including Germany, Switzerland and USA, Austrian health reforms have focused on supply-side measures which deal mainly with inter-sectoral planning and health system coordination to mitigate the impact of fragmentation, an intrinsic feature of the country’s constitutional make-up. However, the Austrian approach to better health system governance always faces administrative barriers, reflecting structural weaknesses in the system and a lack of accountability across jurisdictions.

First, even though enhanced coordination has been combined with greater decentralisation aimed at making regional stakeholders more accountable in reaching system goals, this has hardly been achieved as central government’s ability to impose sanctions has been largely missing.

Instead standardised reporting in various performance dimensions has been required but remains in its infancy.

Second, while increased coordination is useful, it is not enough: counteracting incentives related to fragmented financing continues to undermine attempts to restructure service provision. Regional Health Platforms have brought all actors to the table but the *Länder* continue to have a veto on issues concerning the inpatient sector, while health insurers can block decisions concerning ambulatory care. A more stringent governance model would require giving the federal government more responsibility for the hospital sector and to strengthen central governance at the level of the sickness funds.

Third, past reforms have had only a limited impact on better-balanced care provision. Renewed efforts in the context of the 2013 health reform are under way but more needs to be done. This would involve (a) greater central pooling on the basis of resilient growth in the funding from central government level and performance-oriented disbursements of this funding to lower government levels, (b) federal guidelines for pooling of expenditure at the regional level for the whole range of ambulatory care provision, including hospital outpatient care, and (c) governance and allocation of these funds on the basis of regional capacity plans as determined by the ÖSG framework plan and performance-oriented payment schemes in both inpatient and ambulatory care.

Finally, while the health reform in 2013 develops some of these options (e.g. strengthened federal plans), further advancement to expand coordination, particularly for chronic care patients, is needed. This would involve encouraging the *Länder* to phase-in social expenditure, including expenditure on long-term care, into their widened “ambulatory care” pool, also supported by the federal level through rules which are developed jointly by the health and social sectors. It would also require a reduction in the number of sickness funds, in order to make regional funds, together with the *Länder*, effective purchasers of high quality and coordinated care for their populations.

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New HiT on Austria

By: MM Hofmarcher and W Quentin

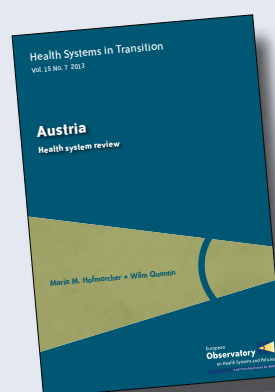
Copenhagen: World Health Organization 2013 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Publication: ISSN 1817-6127 Vol. 15 No. 7

The Austrian health system provides universal coverage for a wide range of benefits and high quality care. People enjoy direct access to all providers and their satisfaction is well above the EU average. However, the system is costly, with total health spending in 2010 at approximately 11% of GDP, greater than the EU15 average of 10.6%.

The history and structure of the Austrian health care system has been shaped by both the federal structure of the state and a tradition of delegating responsibilities to self-governing stakeholders. While decentralised planning and governance allows for adjustments to cater to local norms and preferences, this also leads to the fragmentation of responsibilities and often to insufficient coordination within and across care sectors. For this reason, efforts have been made for several years (particularly following the 2005 healthcare reform) to achieve

more joint planning, governance and financing of the health care system at the federal and regional level. The intensification of cross-stakeholder coordination aims to promote ambulatory care activity and improve performance. In particular, the inpatient care sector is particularly dominant while proportionately less funding than in other countries is available for ambulatory care, including hospital outpatient departments and for preventive medicine



At the same time, there are stark regional differences in utilisation, both in curative services (hospital beds and specialist physicians) and preventative services such as preventive health check-ups, outpatient rehabilitation, psychosocial and psychotherapeutic care and nursing. There are clear social inequalities in the use of medical services, such as preventive

health check-ups, immunisation or dentistry. Income-related inequality in health has increased since 2005, although it is still relatively low compared to other countries.

THE UNITED STATES HEALTH SYSTEM: TRANSITION TOWARDS UNIVERSAL COVERAGE

By: Thomas Rice, Pauline Rosenau, Lynn Y. Unruh, Andrew J. Barnes, Richard B. Saltman and Ewout van Ginneken

Summary: The United States health system is facing major challenges. Some resemble those in Europe, most notably, procuring sustainable financing. Some, however, are unique to the US – for example, seeking coverage for 50 million uninsured individuals. Currently, the United States is engaged in the most significant health reform since its introduction of Medicare in the 1960s, with the goal of providing insurance coverage for the vast majority of Americans. As a result, it is facing a period of enormous potential change. This short article provides a review of the US health system's ongoing reforms, and concludes with an outlook for the future.

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Workshop 6: Transatlantic lessons: What can the US and Europe learn from each other?

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Keywords: Health Insurance, Health System, Health Reforms, United States

Introduction

One factor that sets the United States apart from its European counterparts is more limited government regulation. The country has a federal system with substantial authority delegated to the 50 states. Historically, there has been a strong reluctance towards engaging in central planning or control either at federal or state level. The US health care system has developed largely through the private sector although federal spending is substantial for those subgroups covered by government. Spending per capita is more than 50% higher than the second-highest country, Norway. From an international perspective a varied picture of population health persists. Very good quality and outcome indicators for some diseases (e.g., certain cancers) alternate with poor ones (e.g., asthma). The country has low smoking rates but the most obese population in the world.¹

Multiple systems

The US health care system can be thought of as multiple systems that only sometimes operate in collaboration. The Federal government funds and manages Medicare, an insurance programme that provides coverage for seniors and some of the disabled. It also partly funds Medicaid, a programme that provides health coverage for some of the poor and near poor. States fund and manage many public health functions, regulate and pay part of the cost of Medicaid, and set the rules for those health insurance policies that are not covered by self-insured employer plans. Public or private entities may regulate quality, access and costs and there is relatively little coordinated system-level planning in comparison to other countries. The private sector led the development of the health insurance system in the early 1930s until the arrival of Medicare and Medicaid in the mid-1960s, which now

accounts for about half of health spending. Both public and private payers purchase health care services from providers subject to regulations imposed by federal, state and local governments as well as by private regulatory organisations.

Fragmented insurance schemes

Public sources constitute 48% of total health care expenditures, private third-party payers fund 40%, with the remaining 12% being paid by individuals out-of-pocket.¹ Even though the proportion of public and private spending on health care is roughly comparable, only a minority (30%) of the United States' population is covered by the public financing system because these programmes (mostly Medicare and Medicaid) cover more vulnerable and costlier individuals. The majority of Americans (54%) receive their coverage from private health insurance, predominantly through their employer. These take the form of Preferred Provider Organisations (PPOs), which contract with a network of providers, making it possible to seek care outside the network, albeit at a higher out-of-pocket price; and Health Maintenance Organisations (HMOs), which provide health care services on a prepaid basis through a network of providers. In 2012, among insured employees, 56% were in PPOs and only 25% in HMOs or similar plans.²

“One in six Americans is uninsured

One in six Americans (approximately 17% of the population) is uninsured. Even among those with coverage, high out-of-pocket (OOP) costs can be a barrier to receiving timely care and medications. One estimate is that medical costs are responsible for over 60% of personal bankruptcies in the country.³ OOP payments per capita are ranked near the top of other high income countries.⁴

Hospital bed trends and medical technology

Since the 1970s there has been an increase in ambulatory facilities, such as physician and dentist offices and ambulatory surgical centres, and a decrease in institutional settings such as hospitals and nursing homes. The proportion of hospital beds has fallen and is among the lowest among high-income countries; yet average occupancy rates remain low, primarily due to a dramatic decrease in inpatient length-of-stay. The United States uses relatively more medical technologies such as MRIs and CT scanners than in comparable countries, but the average age of its physical infrastructure, such as hospital buildings, is slightly increasing.

Health care professionals

Employment of physicians, chiropractors, nurses, physician assistants and all types of therapists has increased since 1990. Particularly high increases in the employment of physician assistants and therapists over the last three decades (and moderate increases in nurses) may indicate increasing reliance on these professionals for primary health care. On the other hand, employment of dentists, optometrists and pharmacists has decreased slightly in this period. Relative to comparable countries, the United States is around the median in physician supply but has more concentration among specialists.⁵ Its nurse supply is also high. Licensing and certification of health professionals is carried out at state level and there is reciprocal recognition of licenses between most states, but not all.

Patients' access to providers and care

Insured individuals tend to enter the health care system through a primary care provider, although with some kinds of insurance (e.g. PPO) individuals may go directly to a specialist. Uninsured individuals often do not have a regular primary care provider, but instead tend to visit community health centres (which provide primary care for low-income, uninsured and minority populations) and hospital emergency rooms for their health care, which hinders continuity of care. Due to OOP costs they may be reluctant

or unable to seek out specialty, surgical, or inpatient care unless they need emergency care. Emergency departments in hospitals that receive payment from Medicare (which is nearly all hospitals in the US) are required by law to provide care to anyone needing emergency treatment until they are stable. Retail clinics (in pharmacies or large stores) are also emerging as places to go for treatment of minor medical conditions.

The number of acute inpatient (hospital) discharges, as well as length-of-stay, has fallen over the past decades, with more acute-care services, such as surgery, being performed on an outpatient basis. For example, in 2010 more than three-quarters of all surgeries were provided in an outpatient setting.⁶ Mental health services have also shifted predominantly from inpatient to outpatient settings, accompanied by substantially increased use of pharmaceuticals and a reduction in the provision of psychotherapy and mental health counselling. The utilisation of post-acute-care services such as rehabilitation, intermittent home care, and sub-acute care has increased over the past decades due to the financial need for hospitals to discharge patients not requiring acute care. Pharmaceuticals are expensive in the United States compared to other industrialised countries, and their use has been growing. With the exception of Medicaid and health coverage for veterans, there is little regulation of drug prices.

Public health is decentralised, with the main locus of power at the state level. The actual public health structures at state level vary significantly; in some states, public health functions are further decentralised (eg. to county level). At the federal level, the United States Public Health Service brings together eight federal public health agencies (including the Centers for Disease Control and Prevention, the Food and Drug Administration, and the National Institutes of Health). Federal, state and local public health services have been underfunded, and tend to be driven by immediate concerns; for example, as concerns rose over terrorist attacks in the United States, much of the public health funding and services switched to terrorism preparedness, leaving holes in other areas of public health.⁷

Vulnerable populations

Vulnerable populations in the United States include racial and ethnic minorities, those with low income, the uninsured, the disabled, the homeless, women, children, people with HIV/AIDS, the mentally ill, older people, and those living in rural areas. Low income and racial and ethnic minorities are more likely to be uninsured. The health of racial and ethnic minorities is generally poorer than that of the white population; the health of low-income individuals is worse than that of individuals with higher incomes; and the health of those without insurance is poorer than that of the general population. There are environmental, employment and social factors contributing to these disparities but lack of access to health care and differences in the quality of care are also contributors. Federal, state, and private agencies have programmes for reducing disparities in health and health care for these populations. Populations that have special access to health services include Native Americans and Alaska Natives, military personnel, veterans, and those who are institutionalised, such as prisoners.

Health processes and outcomes

The US health system has both considerable strengths and notable weaknesses. It has a large and well-trained health workforce, a wide range of high-quality medical specialists as well as secondary and tertiary institutions and a robust health sector research programme. For selected services, medical outcomes are among the best in the world. But it also suffers from incomplete coverage of its citizenry, health expenditure levels per person far exceeding all other countries, poor measures on many objective and subjective measures of quality and outcomes, an unequal distribution of resources and outcomes across the country and among different population groups, and lagging efforts to introduce health information technology.⁵ Because a myriad of cultural, socioeconomic, environmental and genetic factors affect health status, it is difficult to determine the extent to which deficiencies are health-system related, though it seems that at least some of the problems with the

United States' performance with respect to health outcomes are a result of poor access to care.

Changes on the way

The adoption of the Patient Protection and Affordable Care Act (ACA) of 2010 – most of which goes into effect in January 2014 – was highly controversial and its content reflects the general American preference for minimal government intervention. Improving coverage is a central aim, with the ACA introducing a requirement for nearly all individuals to have some form of health insurance. Improved coverage is envisaged through both the public and private sectors: subsidies are provided for the uninsured to purchase private insurance, and, in some states, more low-income people will obtain coverage through expanded eligibility for Medicaid. The ACA also addresses under-insurance, providing greater protection for insured persons from their insurance being too limited in scope, inadequate in coverage or being cancelled once they became ill. Moreover, those with a history of illness cannot be charged more than others, although differences are allowed by age, smoking status, and geographic location. There are also increased funds for primary care to improve access. Public health is strengthened through increased funding and regulatory requirements. An example is that chain restaurants and vending machines must display calories for food products.

Improving quality and controlling expenditures are also addressed through a range of measures. These are broadly a combination of incentives for efficiency and better-quality care plus penalties linked to inefficient care (e.g. for hospital readmissions), rather than any major restructuring of the health system as such. However, the ACA also contains measures pulling in the other direction. Examples include a ban on US residents from buying and importing medication from other countries where it is cheaper, and preventing the use of cost-benefit analysis for health care practice or reimbursement in the Medicare programme. The overall quality and financial impact of the ACA is disputed and difficult to predict.

Variable implementation of reform

Implementation has been on-going in stages since the ACA was signed in March 2010, with most aspects of the law scheduled to be fully operational by 2014; however, political, economic, and social variables could change both the substance and the timetable. For example, a ruling of the US Supreme Court⁶ has already made the participation of individual states in the expansion of Medicaid effectively optional, with some states planning to opt out. Many states have decided not to implement a state “exchange” for the purchase of insurance in the private market, relying instead on the federal government’s exchange. In 2014, seventeen states were organising their own exchanges, seven were partnering with the federal government, and the remainder relied solely on the federal exchange. States may revisit this aspect of participation in future years.

“The impact of the ACA is difficult to predict

Future outlook

For the future, since the birth rate in the United States is higher than that of most high-income countries, the budgetary pressure from demographic ageing on social service programmes will be less acute than in most other high-income countries. Nevertheless, given high costs and mixed performance, major concerns about the macro-level efficiency of the health system remain.

There is general agreement among those on the left and the right of the political spectrum that reforms are necessary to control spending. There is less agreement on whether there is a quality problem, nor much agreement on the need to provide coverage for the uninsured. In spite of these disagreements, and because of the adoption of the Affordable Care Act in 2010, the United States is facing a period of enormous potential change.

Whether the ACA will indeed be effective in addressing the challenges identified above can only be determined over time.

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PURSuing HEALTH CARE EFFICIENCY IN LITHUANIA

By: Marina Karanikolos, Liubove Murauskiene and Ewout van Ginneken

Summary: Since the early 2000s changes in the health system in Lithuania have focused mainly on gaining efficiency in service provision. This includes developing primary care, expanding ambulatory and day care services, and restructuring outpatient and inpatient services. The most progress has been achieved in primary care and day care services, while overreliance on inpatient care still remains. At the same time, the strain put on providers by cuts in service funding, as a result of the financial crisis, has created concerns over financial viability and quality of services in the longer term. The next step is to put in place effective instruments, incentives and measurable goals that nurture change, build transparency and accountability, and gain the trust of health professionals and patients.

Keywords: Health Care Reforms, Primary Care, Hospital Services Restructuring, Lithuania

Introduction

In the late 1990s, the Lithuanian health care system became a mixed system funded primarily through mandatory health insurance contributions, the state budget and out-of-pocket payments. Since the early 2000s changes in the health care system have focused mainly on gaining efficiency in service provision, i.e. developing primary care, expanding ambulatory and day care services, and restructuring outpatient and inpatient services. At the same time, broader changes to fiscal policy were implemented aimed at ensuring stable health system financing. These changes have proven crucial in recent years, when the Lithuanian health system mostly made headlines because

of the deep financial crisis it faced. It is easy to see why, as Lithuania's Gross Domestic Product (GDP) dropped by a startling 15% in 2009 and unemployment increased from 5.8% in 2008 to 17.8% in 2010.¹ This led to dramatic reductions in statutory health insurance revenue, which in turn necessitated drastic cuts in public spending.

However, the ensuing austerity package was less harsh than in some neighbouring countries and mostly included cuts to pharmaceutical expenditure, service provision costs, salaries of medical professionals, and sick leave benefits. Meanwhile less resource-intensive care was prioritised, but in contrast to some other countries heavily affected by

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the crisis, the existing broad benefits package was left intact and no changes were made to user charges. This was possible because the National Health Insurance Fund's (NHIF) budget was partially protected despite the falling revenues from the working population by a gradually increasing and countercyclical state contribution, aimed at covering economically inactive and unemployed people.²

“successful development of primary care requires a change in patient perceptions

Now that the Lithuanian economic outlook is improving—although concerns remain about the future impact of some of these cuts – it may be time to start focusing again on some of the country's structural reform efforts, particularly the restructuring of primary care and hospital care, with the ultimate aim of achieving greater efficiency. Although such reforms have been a top priority in many countries in the former Soviet Union, as well as in central and eastern European countries, results have been mixed. The Lithuanian case may hold important lessons.

Pursuing efficiency

Restructuring inpatient care has been pursued in Lithuania since 2001, with technical support provided under a World Bank loan. Implemented over the following ten years, goals included restructuring within the health sector by reducing inpatient services, accelerating the expansion of outpatient services and improving the efficiency of facilities.³ These plans mirror those in other Baltic countries.⁴ Although many of the reform processes took place in parallel, three distinct stages can be identified.

In 2002 the Parliament approved the initial phase of the health care restructuring plan. The first stage (2003–2005) focused on expanding ambulatory services and primary care, introducing alternatives to inpatient services (e.g. day care and day surgery), optimising inpatient care and developing long-term and nursing services. This stage involved a substantial decrease in inpatient hospital beds (by about 5,000 in general and specialised hospitals), average length of stay (by 2.2 days) and hospital admission rates (from 22.4 to 20.9 per 100 population).⁵ At the same time, the provision of outpatient services increased by 6%, inpatient care volume decreased by 8%, nursing care increased by 15% and 600 day care facilities were established.⁶

The second stage (2006–2008) focused on further developing family medicine. The development of private general practice services had already been supported since the late 1990s by regulation (e.g. by applying the same payment rules for private and public providers for value added tax) and investments (e.g. refurbishing about 40 private general practices under the 1999 Programme of Community Aid to the Countries of Central and Eastern Europe (PHARE) project and another 137 practices between 2006 and 2009 with EU structural funds).⁷ A comprehensive primary care planning, financing and management model was scheduled for implementation in the early 2000s, together with training programmes for general practitioners (GPs), introducing gate-keeping and developing infrastructure. These plans were only partly fulfilled because only a third of the necessary funds needed for their implementation were made available.⁸

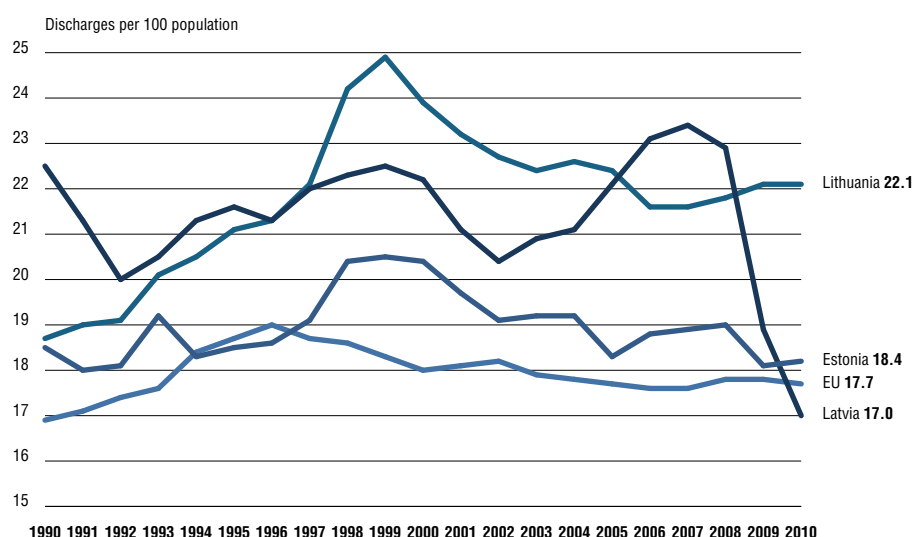
Although gate-keeping was introduced in 2002 and a shift from capitation alone to a mixed system with fee-for-service was achieved, the necessary infrastructure upgrade lagged behind. However, funding from international sources partly offset the shortage of state funding, mostly for capital investment. A World Bank report suggested that efforts to strengthen primary care in Lithuania should be accelerated through expanding the range of health services and incentives to treat patients.⁹ This would be achieved through

the provision of equipment and increasing capacity and/or competences to provide more comprehensive services. As a result, GPs may now carry out certain laboratory tests and prescribe pharmaceuticals that hitherto only could be prescribed by specialists. The competences and number of nursing staff working with a GP have also been expanded. Nonetheless, successful development of primary care requires a change in patient perceptions and attitudes, as many only visit GPs to obtain a referral to a specialist.¹⁰

Other areas of change included restructuring of inpatient services and developing day care and day surgery. Transferring resources from specialist hospitals to general hospitals and the outpatient sector resulted in a reduction in the total number of hospital beds and a conversion of facilities for other uses. This stage was marked by a slight increase in the overall number of inpatient beds (about 1%) and a 2% increase in hospital admissions due to the expansion of nursing, long-term and palliative care in hospitals, while the number of acute hospital beds decreased by a further 2%.¹¹

These achievements can be contrasted with the targets set for service restructuring during the second phase. These targets included a 3–5% decrease in inpatient services; a 10% increase in day care; treatment of common diseases in facilities close to the patient's home; and concentration of modern technologies in tertiary-level hospitals. In 2010, Lithuania's National Audit Office reviewed inpatient care provided between 2006 and 2009 against these targets and concluded that the major goal of reducing the number of inpatient admissions to 18 per 100 population was not achieved in either the first or second stage of restructuring (see Figure 1). The review also noted an apparent lack of consistency regarding the targets and criteria setting.¹²

Another major objective was to increase service delivery in day care. Between 2006 and 2009, the total number of day care procedures rose from 27,791 to 86,440. Despite this rapid increase, day surgery still accounted for just 8% of hospital

Figure 1: Inpatient care discharges in Lithuania and selected countries, 1990–2010

Source: WHO European Region Health For All database, updated January 2013.

Note: For the purposes of this discussion, hospital admissions and discharges data are interchangeable.

service provision in 2010, while hospital inpatient services represented 45% of total hospital services.¹⁴

The third stage (2009–2012) of the health care restructuring plan aimed to optimise the network of health care institutions by further reducing oversized hospital infrastructure and better adapting it to the needs of the population. Since the restructuring programme began in 2003, 42 mergers have been carried out; 11 surgical and 23 obstetrics departments have closed, and ambulance service restructuring is underway.¹⁵ In addition, there are now fewer legal entities providing services, mainly as the result of the merger of smaller and single-profile institutions with larger so-called ‘multi-profile’ hospitals.

The targets set for the third stage included a minimum 5% increase in outpatient care delivery and an 8% increase in day care in order to facilitate a decrease in the hospitalisation rate to 18 admissions per 100 population. Between 2009 and 2010, the NHIF reported a 2.5% increase in provision of outpatient services, a 15% increase in day care, a 9% increase in day surgery and a 6% increase in short-term admissions, while inpatient services volume decreased by 2%. Other targets (quality, safety and accessibility of care as well as increased financing) have

not been defined in a measurable way. However, at the end of 2012 the Ministry of Health adopted a set of criteria aiming to improve the quality of services and performance evaluation in inpatient care.

The whole restructuring process has taken longer than expected and not all planned elements have been fulfilled. A lack of clarity in legislation caused a high degree of uncertainty in the system and significant space for power-driven decisions, as some authorities owning health care institutions (state, municipalities or other sector ministries) resisted closures and mergers. Changes have been achieved mostly indirectly through general regulation (e.g. adoption of extensive requirements for care provision) and by applying different financing tools.¹⁶

Future service delivery

The vision for future health services provision envisages the concentration of advanced medical services at the tertiary care level (mostly in university hospitals), of specialist services in regional level hospitals and of general medical services in district or community hospitals. Furthermore, reforms will remain focused on the continued development of outpatient specialist care and day care, which is known to be a long-term process

in many countries, not least because of the change in attitude it requires from patients. However, concerns have been raised over the actual implementation of the reforms on inpatient care planning (e.g. shortcomings in nationwide needs assessment); the application of service closure criteria (such as requirements for a minimum annual surgery volume of 600 cases and 300 infant deliveries per annum, plus a maximum 50 kilometre distance to a hospital providing inpatient surgery) and the possible impact of hospital service restructuring on access to care.¹⁷

The financial crisis has highlighted the importance of ensuring clarity and accountability in financing mechanisms, as some providers (particularly rural and nursing hospitals) now barely receive enough funding to avoid bankruptcy. These financial pressures underline the urgent need for both continuous investment and innovative primary and ambulatory care services and reforms, particularly if the level of access and quality of health services is to be maintained.

Conclusions

While service provision in Lithuania has made substantial progress since the late 1990s, service restructuring in the 2000s has yet to prove its success in terms of efficiency gains. The reforms have sought to provide alternatives to inpatient care by shifting care delivery from specialist and inpatient care into primary and outpatient settings, day care, day surgery and short-term hospitalisations. Most progress has been achieved in primary care and day care services where a broader range of services is now offered and competences have been expanded. Overreliance on the inpatient sector still exists, however, reflected in the high number of acute care hospital beds and the inpatient admissions rate. This relates to the lack of measurable goals, consistency in definitions and clarity in patient pathways.

Hospital network restructuring was incomplete and hampered by different levels of public ownership and a powerful provider lobby. At the same time, the strain put on providers by the cuts in

funding to services has raised concerns about their financial viability and the quality of service provision. The next step in Lithuania's pursuit of efficiency and sustainability in the health system should be to put in place effective instruments, incentives and measurable goals that nurture change, build transparency and accountability and gain the trust of health professionals and patients.

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New HiT on Lithuania

Edited by: L Murauskiene, R Janonienė, M Veniute, E van Ginneken and M Karanikolos

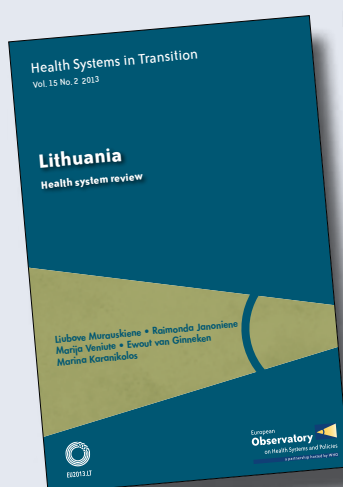
Copenhagen: World Health Organization 2013 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Number of pages: 150

ISSN: 1817-6127 Vol. 15 No. 2

Available online at: http://www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf

Coinciding with Lithuania's Presidency of the Council of the European Union from 1st July 2013, the publication of this new



Health Systems in Transition review on the country's health system highlights past reforms and current challenges.

The Lithuanian health system is a mixed system, predominantly funded from the National Health Insurance Fund through a compulsory health insurance scheme, supplemented by substantial state contributions on behalf of the economically

inactive population, amounting to about half of its budget. Public financing of the health sector has gradually increased since 2004 to 5.2% of GDP in 2010.

Lithuania was one of the countries that was hit hardest by the economic crisis in 2008, with a fall in GDP of 15% in 2009 and a significant increase in unemployment and government debt. Given this context, Lithuania may provide interesting lessons on possible policy measures in times of crisis. In addition to implementing public spending cuts, Lithuania used the crisis as a lever to reduce pharmaceutical prices and applied counter-cyclical contribution policies (ensuring coverage for the economically inactive population) to weather the storm. Yet the future impact of these cuts on health status and on the health system's performance remains to be seen.

Population surveys indicate a varying degree of overall satisfaction with the health system, from comparatively low (European Commission's *Eurobarometer*) to relatively high (national surveys). Increasing waiting times reported in population surveys point to organizational barriers. There is little evidence on equity of access to health care by socioeconomic group. While family doctors formally serve as gatekeepers, there is an option to access a specialist doctor directly for a fee. This, in turn, may have an impact on equity of access to specialist care.

Out-of-pocket payments remain high (in particular for pharmaceuticals) and could threaten access to health care for vulnerable groups. A number of other challenges remain. The primary care system needs strengthening so that more patients are treated at this level instead of being referred to a specialist. In addition, transparency and accountability need to be increased in resource allocation, including financing of capital investment and in the payer-provider relationship. Finally, population health, albeit improving, remains a concern, and major progress can be achieved by reducing the burden of amenable and preventable mortality.

NEW PUBLICATIONS

European Union Public Health Policy: regional and global trends

Edited by: S Greer and P Kurzer

Abingdon, Oxon: Routledge, 2013

Number of pages: 264

ISBNs: 0415516641, 9780415516648

Ranging from influence over world trade laws affecting health to population health issues such as obesity to the use of comparative data to affect policy, the EU's public health policies are increasingly important, visible, expensive and effective. They also provide an invaluable case study for those who want to understand the growth and impact of the EU as well as how states can affect their populations' lives and health.

European Union Public Health Policy capitalises on extensive new research, providing an introduction to the topic and indicating new intellectual directions surrounding the topic. An introductory section and extended conclusion explore the meaning of public health, the relationship of EU public health policy to health care policy, and the place of public health in the study of European integration and Europeanisation.

Drawing together an international and multidisciplinary selection of experts, this volume is an important contribution for all those interested in public health policy, EU health policy and EU governance.

Contents:

Chapter 1. Introduction: What is European Union Public Health Policy?; Chapter 2. European Union Health Care Policy; Chapter 3. European Union Health Information Infrastructure and Policy; Chapter 4. The Politics of European Public Health Data; Chapter 5. European Regulation and Harmonisation of Clinical Practice Guidelines; Chapter 6. The European Regulation of Medicines; Chapter 7. The EU as a Global Health Actor: Myth or Reality?; Chapter 8. Trade in Services and the Public's Health: A 'Fortress Europe' for Health?; Chapter 9. Intellectual Property Enforcement in the European Union; Chapter 10. Catch Me If You Can: Communicable Disease Control; Chapter 11. Non-communicable Diseases: The EU Declares War on 'Fat'; Chapter 12. Alcohol Policy in the European Union; Chapter 13. Tobacco Control: The End of Europe's Love Affair with Smoking?; Chapter 14. Conclusion.



Clinical guidelines for chronic conditions in the European Union

Edited by: Helena Legido-Quigley, Dimitra Panteli, Josip Car, Martin McKee and Reinhard Busse

Observatory Study Series

Number of pages: xxviii + 229 pages ISBN: 978 92 890 0021 5

Available online at: http://www.euro.who.int/__data/assets/pdf_file/0009/195876/Clinical-Guidelines-for-Chronic-Conditions-in-the-European-Union.pdf

Chronic non-communicable diseases make up a large part of the burden of disease and make a huge call on health systems' resources.

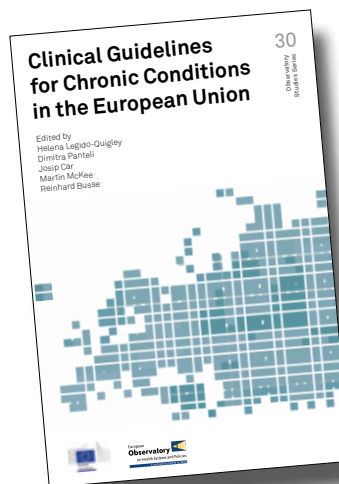
Clinical guidelines are one of the ways European countries have tried to respond and to ensure a long-term perspective in managing them and addressing their determinants. This book explores those guidelines and whether they actually affect processes of care and patients' health outcomes. It analyses: the regulatory basis, the actors involved and processes used in developing clinical guidelines across Europe; innovative methods

for cost-effective prevention of common risk factors, developing coordinated patient-centred care and stimulating integrated research; the strategies used to disseminate and implement clinical guidelines in various contexts; and the effectiveness of their utilisation.

This study reviews for the first time the various national practices relating to clinical guidelines in 29 European countries. The level of sophistication, quality and transparency of guideline development varies substantially across the region; nevertheless, there are clear examples that, if shared, can assure and improve quality of care across Europe.

Contents:

PART 1: Overview, conceptual framework and methods; PART 2: Mapping clinical guidelines in Europe; PART 3: Case studies on clinical guidelines for the prevention and treatment of type 2 diabetes mellitus; PART 4: Are guidelines in Europe well developed? Are they well implemented? Do they have any impact? A systematic review of the literature; PART 5: Conclusions, policy recommendations and areas for further study; PART 6: European country profiles on clinical guidelines.



NEWS

International

Priorities for health during the Lithuanian EU Council Presidency

In a presentation given during the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) in Luxembourg on 21 June, Lithuanian Minister of Health, Vytenis Povilas Andriukaitis, highlighted the priorities for health under the Lithuanian EU Council Presidency. These include the revision of the Tobacco Products Directive, concentration on sustainable health systems, continuity of Ireland's efforts to reach a general approach on clinical trials on medicinal products for human use and mediating the discussions on the regulations on medical devices, as well as on in-vitro diagnostic medical devices. The minister also congratulated members of EPSCO on the Council's common approach on the Tobacco Products Directive calling for further cooperation in effort to update and complete the current Directive. The EPSCO Council also took note of the progress reports presented by the Irish Presidency on the proposals of the European Parliament and the EU Council regulations on medical devices and on in vitro diagnostic medical devices, as well as a progress report on the regulation on Clinical trials.

A subsequent informal EPSCO Council in Vilnius on 8–9 July, included discussions on the prevention of youth smoking, mental health and ageing, as well as looking at the long-term sustainability of health systems and shaping of EU health policy after 2013.

European Parliament vote on EU Decision on serious cross-border threats to health

Communicable diseases and health threats caused by chemical or biological agents, or environmental events do not respect borders. The Commission's assessment of past public health crises, such as the pandemic (H1N1) in 2009/2010 or the e.coli crisis in 2011 revealed shortcomings in

the health security framework currently in place. The gaps identified were notably in risk assessment, preparedness and response planning and crisis management. To date threats to public health arising from chemical or environmental hazards had been treated on an informal basis, whereas EU legislation to control communicable diseases has been in place since 1998.

On 3 July 2013, the European Parliament adopted the Commission proposal for a Decision on serious cross-border threats to health. The Decision extends the existing framework of communicable diseases to cover preparedness planning, risk assessment, risk management and risk communication aspects of all serious cross-border threats to health caused by communicable diseases, antimicrobial resistance and healthcare-associated infections, other harmful biological agents, as well as chemical and environmental events.

Welcoming the vote, Tonio Borg, EU Commissioner for Health, called it 'a major milestone for health security in Europe' adding that 'people in Europe will be better protected from a wide range of health threats through strengthened preparedness planning and coordination at EU level for serious cross border threats caused by communicable diseases, chemical, biological and environmental events.' Commissioner Borg also observed that 'one of the key achievements of the Decision is that it establishes the legal basis for the coordination of voluntary joint procurement of vaccines and medicines at EU level. We will start with the procurement of pandemic vaccines: the Member States who participate in this process will be able to provide their citizens with vaccines under better conditions than in the past.' He also noted that 'for the first time, the EU can recognise a situation of public health emergency in order to accelerate the provision of any necessary vaccines or medicines, under EU pharmaceutical legislation.'

The proposal also foresees that the European Commission recognises a public health "emergency situation" independently from the World Health Organization (WHO). This will allow the European Union to use existing pharmaceutical legislation to quickly authorise medicinal products and therefore make vaccines immediately

available on the market in the absence of such a decision by the WHO. In order to enter into force, the draft Decision still needs to be approved by the Council.

More information at: http://europa.eu/rapid/press-release_MEMO-13-645_en.htm

Progress report on medicines for children

On June 24 the European Commission published a progress report on medicines for children covering the five years since the Paediatric Regulation [(EC) 1901/2006] came into force. This regulation had three key objectives: 1) to ensure high-quality research into the development of medicines for children; 2) to ensure, over time, that the majority of medicines used by children are specifically authorised for such use with appropriate forms and formulations; and 3) to ensure the availability of high-quality information about medicines used by children.

This preliminary snapshot points to improvements in the paediatric medicines landscape: better and safer research, more medicines for children on the EU market and more information for parents and health professionals. Although it will take at least another five years for the full impact of the legislation to be understood, due to the long development cycles for medicines, the EU commitment to better medicines for children is clear.

Tonio Borg, European Commissioner for Health and Consumer Policy said that "the Paediatric Regulation was adopted to address a very serious gap in health care. Despite the fact that children make up over 20% of the population, many of the medicines prescribed to them were not specifically studied and authorised for use in children. I am pleased to see that in five years, progress has been made on research and the safety of children's medicines, and I hope that this marks the beginning of a much needed paradigm shift."

Before the Paediatric Regulation entered into force, many pharmaceutical companies considered the adult population as their main market. Research into the potential use of an adult medicine in children was often side-lined or not considered at all. The new report shows that the situation is

changing. Pharmaceutical companies now prepare paediatric investigation plans (PIPs) when developing a new product. By 2012 the European Medicines Agency (EMA) had agreed 600 PIPs. Moreover, 33 of the 600 approved PIPs had been completed by the end of 2012, and it is expected that many more of them will be completed in the next five years. Since the Regulation came into force, 31 out of 152 new medicines have been authorised for paediatric use and many more authorisations are expected in the coming years.

There is also more information on medicines used in children. To address the lack of adequate information on the use of medicines in children, the Paediatric Regulation requires that companies submit their data on the safety and efficacy of products authorised for use by children to the competent authorities. Since 2008, more than 18 000 studies on roughly 2,200 medicinal products have been submitted to the competent authorities. The analysis of those studies resulted in assessment reports on 140 active substances for medicines authorised nationally. For centrally approved medicines the number is 55.

Whilst the report shows considerable improvements in the developments of medicines for children, the European Commission have stated that they will continue to monitor the implementation of the Paediatric Regulation, thereby also addressing any weaknesses or deficits that are identified.

More information on medicines for children at: http://ec.europa.eu/health/human-use/paediatric-medicines/index_en.htm

Commission launches initiative to promote physical activity in Europe

On 28 August the European Commission adopted an initiative on health-enhancing physical activity. This is the first ever proposal for a Council Recommendation on sport. The initiative follows a call from the European Council in 2012 inviting the Commission to present a proposal for a Council Recommendation promoting a cross-sectoral approach to health-enhancing physical activity based on the 2008 EU Physical Activity Guidelines.

The promotion of health-enhancing physical activity depends on Member States. Many public authorities have stepped up their efforts in this field. Likewise, the EU has addressed the issue through policies and financial support in the fields of sport and health and by using the relevant EU level structures for policy coordination, in particular the Expert Group on Sport, Health and Participation, set up under the EU Work Plan for Sport, and the High-Level Group on Nutrition and Physical Activity, set up in the framework of the Strategy for Europe on Nutrition, Overweight and Obesity related health issues (2007–2013).

However, despite these efforts the rates of physical inactivity in the EU remain alarmingly high, with two thirds of Europeans never or seldom exercising or playing sport. Sport and physical activity help people to stay physically and mentally fit by combating excessive weight and obesity and preventing related health conditions.

The new initiative builds on these on-going efforts. It invites Member States to develop a national strategy and a corresponding action plan for promoting health-enhancing physical activity across sectors, reflecting the EU Physical Activity Guidelines and to monitor physical activity levels and the implementation of policies. The Commission is invited to assist Member States in their efforts to effectively promote health-enhancing physical activity by providing support for the establishment of the monitoring framework and to regularly report on progress in implementing the Recommendation.

Androulla Vassiliou, the European Commissioner responsible for sport said “much more can be done through our policies to encourage people to get out of their chairs. This initiative is an important milestone in the Commission’s efforts to promote health-enhancing physical activity in the EU. We propose to Member States to take measures across all those policy sectors that can enable citizens’ to be or to become physically active. One key element of our proposal is to help Member States to trace developments and identify trends regarding their national efforts to promote sport and physical activity. By acting together with the Member States we will

reduce the significant costs arising from by the lack of physical activity in Europe”.

The Council will start discussing the proposed recommendation in September and could possibly adopt it in 2013. EU support for the implementation of the measures is proposed to come from Erasmus+, due to start in 2014.

More information at: http://ec.europa.eu/sport/news/201308-comm-initiative-hepa_en.htm

Major reforms needed to improve the quality of care for older people, says new report

According to a new OECD report, “A good life in old age?”, sponsored by the European Commission, the fastest-growing age group are people over 80 whose numbers will almost triple by 2060, rising from 4.6% of the population to 12% in 2050 in the European Union. It is estimated that up to half of this population will need help to cope with their daily activities. The report notes that families and public authorities are struggling to deliver and pay for high-quality care to older people with reduced physical and mental abilities.

The report was presented at a conference on “Preventing abuse and neglect of older persons in Europe” which marked the World Elder Abuse Awareness Day celebrated globally on 15 June. The event was organised by the European Commission and the United Nation’s Office of the High Commissioner on Human Rights.

Most countries have legislation to prevent abuse, including encouraging public disclosure of specific cases, complaint mechanisms and an ombudsman to deal with concerns. However, the report shows that very few countries systematically measure whether long-term care is safe, effective, and meets the needs of care recipients. To meet future demand for higher-quality care and choice by the person receiving care, the report argues, governments should ensure that the necessary information on long-term care quality is available to the public. England, Finland, Germany, Ireland and some other countries do this now, allowing users to compare the quality of different care providers.

The report is available at: <http://www.oecd.org/health/health-systems/good-life-in-old-age.htm>

ECDC survey: health care-associated infections still a major public health problem

Although some health care-associated infections can be treated easily, others may more seriously affect a patient's health, increasing the length of hospital stays and hospital costs and causing considerable distress.

The European Centre for Disease Prevention and Control (ECDC) has therefore conducted the first Europe-wide point prevalence survey on health care-associated infections and antimicrobial use. Conducted in more than 1,000 hospitals in 30 European countries, the survey provides the most comprehensive database on health care-associated infections and antimicrobial use in European acute care hospitals to date.

The survey was a count of the number of patients with either a health care-associated infection or an antimicrobial agent for a one day period as a proportion of the total number of patients who are hospitalised at that particular time. It estimated that on any given day, about one in 18 or 80,000 patients in European hospitals have at least one health care-associated infection.

The report and the database include data on the most commonly reported health care-associated infections and involved microorganisms, how often and for which indications antimicrobial drugs are being used and indicators on infection control structures and processes in European hospitals. The prevalence of health care-associated infections is the highest among patients admitted to intensive care units (ICUs). The most common types of infection are respiratory tract infections, surgical site infections, urinary tract infections and bloodstream infections. At least one in three patients receives at least one antimicrobial agent on any given day in European hospitals.

Based on the survey results the ECDC has made recommendations that should be further developed and implemented across Europe. Increasing the skills for surveillance

of health care-associated infections and antimicrobial use, and raising awareness of health care-associated infections among thousands of health care workers across Europe were the main contributions of the point prevalence survey.

The data are published as a report and also available online as an interactive database.

More information is available at: <http://www.ecdc.europa.eu/en/activities/surveillance/HAI/>

Post-emergency situations offer opportunity to transform mental health services

On World Humanitarian Day, 19 August, the WHO launched a report on improving mental health services for the long term in the aftermath of emergencies. The report *"Building back better. Sustainable mental health care after emergencies"* notes that despite their tragic nature and adverse effects on mental health, emergencies also provide an opportunity to transform mental health care and thereby improve the lives of many people.

The report provides guidance for strengthening mental health systems after emergencies and examples from around the world. In the WHO European Region, the report follows the changes in mental health services in the United Nations Administered Province of Kosovo (in accordance with Security Council resolution 1244 (1999)). Following violence and conflict in the 1990s, a mental health task force was formed, and a mental health strategic plan developed. This plan emphasised strengthening community-based mental health services, where previously the system had been hospital-focused. Today, each of the Province's seven regions offers a range of community-based mental health services and, despite ongoing challenges, reform is progressing.

The report is available at: http://www.who.int/mental_health/emergencies/building_back_better/en/index.html

World Health Report 2013: research vital to universal health coverage

15 August saw the publication of the World Health Report 2013: research for universal

health coverage. The report includes case studies on specific areas of health research that have contributed to the understanding of what needs to be addressed to achieve and maintain universal health coverage.

One of the case studies highlighted in the report reviews research in five European countries to forecast changes in public health expenditure due to ageing populations. The main finding of this research reveals that contrary to common assumption, projected increases in health expenditure associated with ageing are modest. Other factors, notably technological developments, have a greater effect on total health care costs. Furthermore, an important predictor of high health care expenditure is not age itself but proximity to death, with the cost of health care becoming substantial in the last year of life.

Key messages of the report include:

- 1) Universal health coverage, with full access to high-quality services for health promotion, prevention, treatment, rehabilitation, palliation and financial risk protection, cannot be achieved without evidence from research. Research has the power to address a wide range of questions about how we can reach universal coverage, providing answers to improve human health, well-being and development.
- 2) All nations should be producers of research as well as consumers. The creativity and skills of researchers should be used to strengthen investigations not only in academic centres but also in public health programmes, close to the supply of and demand for health services.
- 3) Research for universal health coverage requires national and international backing. To make the best use of limited resources, systems are needed to develop national research agendas, to raise funds, to strengthen research capacity, and to make appropriate and effective use of research findings.

The report is available at: <http://www.who.int/whr/2013/report/en/index.html>

Country news

Ireland: Protection of Life During Pregnancy Act becomes law

Abortions under limited circumstances will be allowed in the Republic of Ireland under a new law. The law will allow terminations to be carried out where there is a threat to the life of the mother. They will also be allowed where there is medical consensus that the expectant mother will take her own life over her pregnancy. The new law does not include those women seeking terminations because of rape or incest. Irish President Michael D Higgins signed the bill into law on 30 July. This means it does not have to be forwarded to the Supreme Court to determine whether it is constitutional.

The introduction of the legislation follows the case of an Indian woman, Savita Halappanavar, who died in hospital in Galway from septicaemia a week after she was refused an abortion. Her death drew attention to the lack of clarity about the legal position. The inquest into her death heard that she could not get a termination at the time because her life was not in danger but, by the time her life was at risk, an abortion would have been too late to save her.

According to the Department of Health and Children about 4,000 Irish women travelled to hospitals and clinics in England, Scotland and Wales in 2012 to terminate their pregnancies, including 124 women under the age of 18. It remains to be seen how the law will work in practice, given that some medical professionals with deeply held religious convictions have stated that they will refuse to perform these procedures.

The new Act is available at: <http://www.irishstatutebook.ie/pdf/2013/en.act.2013.0035.pdf>

Reforms to primary care in Denmark

Writing in the European Observatory's *Health Systems and Policy Monitor* platform, Alan Krasnik reports that on 27 June the Danish Parliament approved a new law to reform general practitioner (GP) care.

General practice in Denmark is predominantly provided by private physicians who are financed by the five regional administrations in line with an agreement with the general practitioners association (PLO). In recent years these regions have argued for a more direct influence on the planning, general quality and funding of these services.

Under the new law the Minister of Health is empowered to define new regulations regarding the right to free care by patients at their GP, as well as the rules for individual choice of GP, which will also include the possibility of choosing GPs working outside the general agreement with PLO.

A new committee for practice planning will be established in each. Furthermore, a patient participation committee will be established in each Region, in order to promote involvement of patients in health policy decisions.

To ensure a more equitable distribution of general practice, the regions will be entitled to sell or use a newly established license to practice. The license can be transferred to other private or public players (outsourcing) and a GP can own more license numbers (maximum six). The regions will also be able to establish temporary public clinics in cases when a GP or other potential providers are not willing to establish a certain practice in a geographical area without sufficient coverage of GPs according to general standards.

Individual GPs are also obliged to follow national guidelines and standards, as well as the regional practice planning regulations, and to deliver information about their activities to the regions. GPs also have to publish information about their practice which is relevant as a basis for patient decisions on choice of GP.

The present agreement will be in place until 1st September 2014. As Krasnik notes, the legislation has the potential for major changes regarding the composition of providers of primary care, the collaboration between municipal services, hospitals and general practice and the processes aimed at ensuring equal service provision in the different parts of Denmark regarding access and quality.

Health Systems and Policy Monitor is available at: <http://www.hspm.org/>

Luxembourg: national surveillance system for accidents and injuries

Injuries and accidents are one of the major causes of death, hospitalisation and disability in Luxembourg. With an average of 279 fatalities each year, injuries and accidents are the fourth leading cause of death in the population and the leading cause of death in children, adolescents and young adults. According to European statistics, for each injury death, a further 28 people were hospitalised, 140 received outpatient hospital care and another 75 medical treatment elsewhere. Every year in Luxembourg, about 55,000 people are injured at work, on the road, in a sporting activity, at home or during leisure time.

With this in mind, 'Traces' a national injury and accident surveillance monitoring system has been set up by the Ministry of Health in collaboration with the CRP-Santé/Centre for Health Studies and five emergency hospitals in the country. This system will collect information on the number and nature of accidents (per year), the known location and circumstances of accidents, severity and consequences and affected populations. This information will be used to measure the individual impact, social and economic accidents and injuries and help develop a prevention program for the Luxembourg context. Using the system it can already be seen that in the last four months of 2012, approximately 20,000 cases of trauma were listed in the emergency departments of hospitals in the country. Of these 97.1% were due to accidents, 3.6% were the result of violence and 0.9% were cases of self-inflicted injuries.

More information at: <http://www.sante.public.lu/fr/rester-bonne-sante/010-accidents-blessures/index.html>

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