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Observatory 20th Anniversary Special Issue



► Observatory 20th Anniversary Special Issue

- 20 years of evidence into practice
- Happy Birthday Observatory
- The role of health systems in the 21st century
- Evolution of health system performance assessment
- EU integration and health policy at the cross-roads
- What's new in health system reforms
- Successes and failures of public health policy
- Universal coverage and evidence-based approaches
- Reframing the health workforce

:: Special Issue ::

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Twenty years of evidence into practice

This special issue of *Eurohealth* marks the 20th anniversary of the European Observatory on Health Systems and Policies. Written by the staff of the Observatory, it offers a range of reflections arising from our experience in assessing health systems, working with policy makers and, ultimately, with striving to address the very complex interface between evidence and policy practice.

Beginning with a lead article highlighting the ten main lessons in knowledge brokering, other contributions in this issue explore the role the international community has played in strengthening health systems; the growing needs and policy uses of assessing health systems performance, as well as the impact that European integration has had on health systems and policies. In addition, it covers some key trends in health system reform, in public health policy, universal health coverage and health workforce policy, all issues that have been central to the Observatory's work over the past twenty years. This issue also includes an outline of some of the key milestones in the development of the Observatory and some messages and wishes received from partners on our anniversary.

While the Observatory was born in 1998, it was conceived at the first European Ministerial Conference on health systems that was organised by WHO in Ljubljana in 1996 as a response to the expressed need of Member States to systematically assess, compare and learn from health system developments and best practices across the European region. Since countries have traditionally adopted different approaches to organise and finance their health systems and deliver health services, Europe is often referred to as a natural laboratory where health system reform in one country could benefit from the experience and experiments in other countries.

From the very outset, however, it became clear that the realisation of rigorous comparative analytical studies – while central – would not

be sufficient if the Observatory was to have a significant and lasting impact on European health policy. The first study, formally attributed to the nascent Observatory, *'European Health Care Reform: analysis of current strategies'*, authored by Saltman and Figueras, highlighted the need to both ensure effective policy transfer across countries and bring evidence into policy decision making. On the former the authors argued *"while learning from other countries about reform experiences is an essential element (...) so is adjusting and adopting reform mechanisms to fit the local situation (...); their application will depend on individual countries' needs and expectations"*. On the second, bridging the gap between evidence and policy implementation turned out to be a rather complex endeavour to put into practice. While at the time there were no proven strategies and mechanisms for doing this, the development of (and innovation in) knowledge brokering has become one of the defining components of the Observatory's work.

Four key ingredients have proven to be essential for the Observatory's success in transferring evidence into policy practice. We often refer to them as the four "T" principles: translation, tailoring, timeliness and trust.

Translating the evidence in a way that appeals to policy makers and in a language they understand, links very closely with the second principle of **Tailoring** the evidence to the specific needs of policy makers. Building on its comprehensive analytical work, the Observatory has invested in developing dissemination

strategies that make these studies more readily accessible for policy makers. Through formats such as policy briefs and policy dialogues, the evidence is summarised and organised around the specific questions that policy makers have and the practical lessons that are drawn from it, taking into account the specific context in which they have to operate. Moreover, the **Timeliness** in transferring the evidence – by identifying the ‘windows of opportunity’ or ‘honeymoons’ for decision making – cannot be understated for ensuring policy relevance and uptake. To account for this factor, the Observatory has developed over the years a wide range of mechanisms for face-to-face engagement formats that adapt to the particular needs of the policy cycle and are put in place at short notice in response to policy needs.

Trust is the fourth, and perhaps, most important principle underlying Observatory knowledge brokering activities. Gaining the trust of both the policy making and academic communities not only relies on the solidity and quality of our work but also arises from the neutral, non-judgmental stance that the Observatory takes, mindful of the political economy complexities or the role of value trade-offs in addressing health system challenges. Whereas a central tenet of the Observatory is the importance of solid evidence for developing sound policies, it also recognises the limitations of evidence in decision making. This is why we tend to promote the idea of *‘evidence-informed – rather than evidence-based – policy’*.

Trust also relates to the composition of the partnership on which the Observatory is built, representing a wide range of international bodies, national governments, health authorities and academic institutions gathered around one main common denominator: to strive for objective, high quality and policy relevant evidence. With a role that is going well beyond that of traditional donors, the Observatory’s Partners take a central role in its governance, leading its strategic directions and actively incorporating its evidence in their respective policy developments.

Both Observatory Partners and staff are very much committed to continuing this work. Judged by its users, knowledge-driven policies in health are more than ever needed and relevant. At the start of the new five year cycle, we have identified a number of areas that will be core to the new strategic work plan. Clearly, there is no lack of topics to explore and health

systems reform never ends. The Observatory is ready for another twenty years of monitoring, analysing, evaluating and sharing evidence.

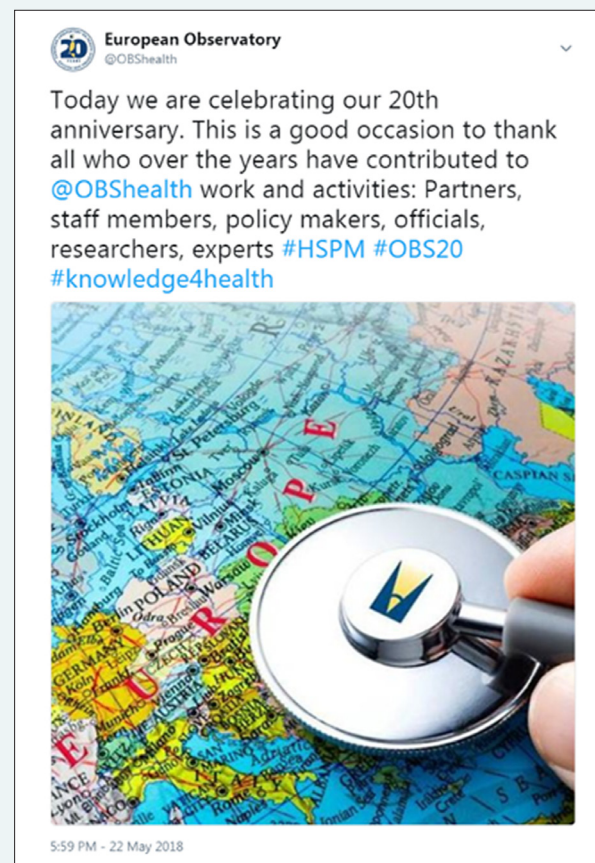


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20 YEARS OF EVIDENCE INTO PRACTICE: REFLECTIONS ON THE OBSERVATORY IN 10 (KEY) LESSONS

By: Suszy Lessof, Josep Figueras, Martin McKee, Elias Mossialos and Reinhard Busse

Summary: The Observatory has spent the last twenty years generating evidence and communicating it to policy makers so that they can take better informed health system decisions.

Ten key lessons are that:

1. Evidence makes a difference
2. The academic approach has huge strengths
3. Academic analysis needs to be ‘mined’ and ‘refined’ to bring out the policy relevance
4. If you don’t communicate findings clearly no one can use them
5. Personally mediated knowledge brokering has the greatest impact
6. Entry points are key
7. Policy makers want to know (and learn from) what others have done
8. Not everyone understands the same thing
9. Partnership works
10. Knowledge brokering is a cycle that turns evidence into ‘evidence for policy’.

Keywords: *Observatory, Knowledge Brokering, Evidence Informed Policy, Policy Learning*

A bridge for knowledge transfer

In 1998 a mix of organisations, all committed to better health systems, founded the Observatory. Its mission was to support evidence informed decision making and to be a ‘bridge’ between policy makers and research. Over the last twenty years it has worked with governments across Europe on a variety of health systems challenges, such as paying for health care; managing the effects of the financial crisis; or ensuring the

right health workforce. The Observatory has contributed to WHO’s thinking on Health-in-all-policies, health and wealth, and governance. It has supported European Commission efforts on issues ranging from responding to patient and professional mobility, comparing countries’ health system performance, to the savings associated with physical exercise and improved diets. Over the years the group of Partners has grown, as have their expectations. They have shaped

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and reshaped the Observatory's work to strengthen the way it monitors countries; to keep its analysis rigorous and relevant; and above all to ensure that knowledge brokering informs everything it does. So what lessons have been learned?

“Evidence allows policy makers to assess if proposals are likely to achieve their stated aims

1. Evidence makes a difference

Health systems are complex. They are the product of long, often contested histories and are embedded in the societies they serve; expressing preferences and possibilities, past and present; providing cure and care, employment and identity. There is rarely a single 'best' way of doing things, but evidence uncovers better and worse ways of dealing with health systems issues in different contexts. In-depth and systematic review of how systems fit together; analysis of the links between money flows and services, incentives and outputs, training and behaviour; and mapping of the consequences of change, all generate insights and understandings that make for better system design.

Evidence allows policy makers to assess if proposals really are likely to achieve their stated aims; to think through unintended impacts; and to nuance and adjust plans. France, for example, has used comparative evidence to avoid introducing performance payments based on an overly narrow set of quality indicators and Switzerland has stepped back from charging citizens for using emergency services inappropriately, by understanding the blocks to accessing primary care. Evidence also helps to make the case for change. Slovenia drew on a raft of examples to show why public health makes sense as an integral part of its primary care and prevention system while

analysis has helped Malta and Austria to present arguments for European action to address market failures and protect small member states purchasing high cost items.

2. The academic approach has huge strengths

Evidence informed policy is only worth pursuing if the evidence is robust. This means working with a set of academic imperatives around consistency, replicability and detail. 'Pure' research may not always apply obviously and directly to policy and it rarely gives instant answers to 'real' questions, but commissioning only overtly policy relevant research would hugely weaken the evidence scene. Work predicated on challenges that are already 'on the radar' does not prompt blue skies thinking or encourage experts to develop new themes. It will tend to mean there is no stream of analysis waiting to be exploited when issues first emerge. There are of course limitations to a purely academic treatment of evidence for policy and many analysts are still interested in methods and results but not the application of their findings. However, the Observatory has been privileged to work with academics who care about policy, are generous in sharing their primary research, and who network and think across disciplinary boundaries. It has learned how important they are and, hopefully, how to support their work, not least with focused terms of reference, with recognition and in dialogue. It has also developed and systematised secondary research strategies to ensure that policy relevance is captured.

3. Academic analysis needs to be 'mined' and 'refined' to bring out the policy relevance

Extracting the policy relevant from the academically rigorous is central to what the Observatory does (see Box 1). It has taken secondary research and meta-analytic models and aligned them to policy needs. It builds on what researchers 'know' and shapes it to tackle the challenges policy makers face. This means that when a policy question presents itself there is a systematic attempt to seek out existing primary research and comparative evidence and to extract the lessons from

Box 1: Research can be shaped to be policy relevant when ...

- A structured approach is used
- Policy makers and academics are involved in framing (and reviewing) the work
- The policy challenge is made explicit
- Existing research is systematically captured (and the organisations involved engaged)
- Proposals define how what is 'known' intersects with the policy issue and are explicit about what needs to be extracted, reshaped or amplified to serve policy makers better
- Detailed terms of reference guide contributors
- Researchers, experts and stakeholders are given a chance to share their thinking with each other so that they can respond to other perspectives
- There is an iterative process of testing, reviewing and revising.

it. The Observatory develops and tests conceptual frameworks with academic experts and policy makers to build in relevance; populates the theoretical skeleton with the work already being done to avoid duplication; and commissions new work to 'fill in the gaps'. This requires a conscious effort to bring disciplines together; to facilitate open discussion across organisations; and to combine perspectives. It also involves constant, deliberate 'worrying' about what findings mean 'in practice' and a willingness to adapt work as the policy-research dynamic throws up the unexpected.

4. If you don't communicate findings clearly no one can use them

There is a difference between communicating analytic findings and working directly with policy makers to understand and apply evidence.

The Observatory is best known for the latter, but making the evidence ‘generally’ available is important. It gives those responsible for drafting, scrutinising and implementing policy, access to expert analysis, even if impact is muted by a ‘generic’ presentation. It also signposts where, if circumstances allow, they might seek further help. Thirdly it means that findings can contribute to the wider debate, not least in the academic health policy community, moving thinking forward.

“Bringing together actual policy makers means that priority setting reflects the realities of key stakeholders”

5. Personally mediated knowledge brokering has the greatest impact

Evidence, and the part it plays in policy formulation, is mediated through a mix of cognitive, environmental and political filters. These vary across Europe with some systems being more ideologically driven, others giving greater weight to technocratic inputs and all dealing with varying degrees of path dependence and resource constraint. There is also huge diversity in the staging of decision making, the types of consultation involved and the role of different levels of government and stakeholders. Presenting evidence, ‘in person’ makes a real difference in all contexts. Explaining the data and analysis directly to decision makers; giving them a chance to interrogate the experts; and creating opportunities for them to talk to each other around an ‘objective’, evidence driven agenda, all increase the uptake and impact of that evidence. This is, in part because of the convening power of a briefing or policy dialogue which brings

the right people together and makes them focus on a single issue at a specific time. It trades too on the fact that when (suitably skilled) experts explain the evidence they can compress complex information into the available ‘attention span’, tackle questions immediately and generally ‘short circuit’ the process of assimilation. It is also about trust. A discussion that is well prepared and, above all, well facilitated creates a safe space that fosters a sense of ownership, advantages the rational, and encourages appropriate reconciliation between competing demands.

6. Entry points are key

Defining the policy making model as rational or politically (policy) driven or path dependent gives insights into how decisions may be reached but real decisions in real time are always based on a complex combination of circumstances. Windows of opportunity open and close depending on the interaction of contextual factors and what is feasible changes. Bringing evidence into the policy cycle effectively – and so that it helps policy makers reach a better informed decision – depends on having access to the right people (i.e. the ones that will influence the decision) at the right moment (i.e. both when they are receptive to evidence inputs and when there is real scope to adjust or improve a policy in the making). Getting a chance to put the evidence ‘on the table’ and to access the right mix of stakeholders is not an easy matter. It can require opportunism – seizing on the slightest opening and reacting quickly; or networks – colleagues, contacts and peers who can lever access; or trust – the decision makers already knowing and valuing the evidence providers. These are often connected. Certainly the academic credibility of experts and the ‘real’ experience of practitioners create trust and once a track record – of providing useful inputs – has been established then trust is reinforced and the next entry point is easier to secure.

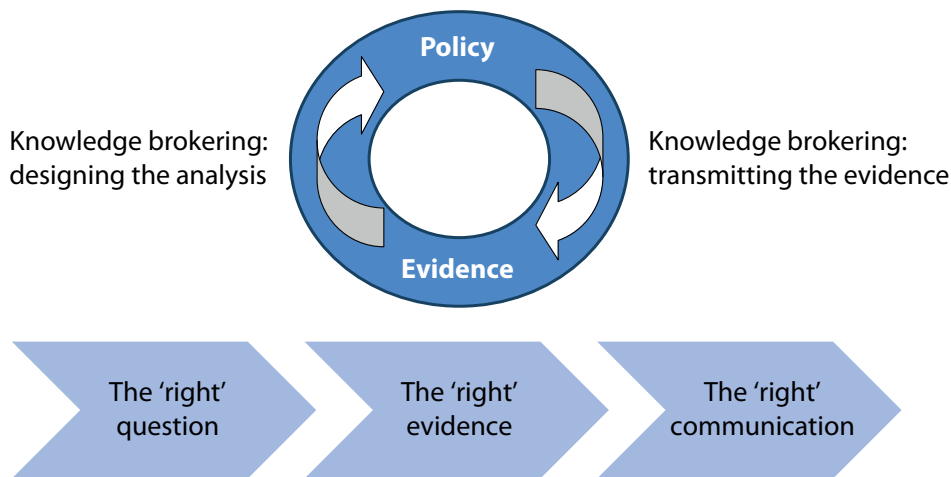
7. Policy makers want to know (and learn from) what others have done

A very clear lesson of the last twenty years is the power of hearing someone else’s experience. Comparative analysis

and evidence highlight the different ways of approaching a policy issue and have been found useful over and over again but there is also value in the anecdotal. Policy makers consistently find it helpful to hear from their peers on the challenges they faced and the practical aspects of implementation. This reflects somewhat on the trust dimension of knowledge brokering. Policy makers have faith in ‘peers’ who like themselves are in the position of seeking to introduce a system change and who are judged on whether reform works in practice and not just on whether a policy ‘stands up’ in theory. They do not distrust sound academic analysis but they are looking for the additional insights that come from having steered a proposal through the political and cultural complexities of agreement. It is also about the reality and the politics of implementation. Context is of course hugely important and no policy makers imagine that another country’s experience, however similar the challenge, gives a blue print for reform in their own specific setting. They do though want to know a model which makes sense actually panned out in a many-layered, non-linear environment.

8. Not everyone understands the same thing

Two decades of knowledge brokering have made clear how easy it is to have conversations at cross purposes. This reflects the complexity of translating policy concepts across a host of European languages, the term ‘policy’ itself is a case in point, with markedly different connotations in different languages. It is also because terms are understood differently and practice has evolved differently. The assumption tends to be that ‘we all mean the same thing’ by a DRGs but it can mask a diverse set of systems and understandings. At the risk of seeming patronising, it is important to define terms carefully. By the same token, it is crucial in assembling the evidence response to a policy question to define what that question actually is. It is surprisingly difficult to define the ‘actual’ question well. A perceived problem around bed numbers may obscure a more profound challenge about how and where to provide social care. If policy makers

Figure 1: The knowledge brokering cycle

Source: Adapted from Ref 7.

knew exactly what the question was they might not need as much help to answer it. The Observatory has learned to work iteratively and carefully with them to reach a clear understanding of where the policy question comes from and what the real evidence need is (and to think through from there who the stakeholders are, what the right expertise is and which country examples will have most resonance).

9. Partnership works

The Observatory itself has always depended on partnership. At the most basic level it was set up by a group of countries, international agencies and universities. Bringing together actual policy makers like the European Commission and countries with international agencies and academic institutions means that priority setting reflects the realities of key stakeholders. But partnership as a key ‘lesson’ extends beyond the structure of the Observatory itself. When evidence generators and policy makers work together collaboratively, and as genuine partners, evidence uptake increases. By the same token policy makers sharing experience openly with each other makes evidence not just more accessible but easier to act on.

10. Knowledge brokering is a cycle that turns evidence into ‘evidence for policy’

The Observatory was set up to be a bridge between the academics ‘with the evidence’ and the policy makers seen to be in need of it. It has learned over the last twenty years that the notion of a bridge is far too static and the idea of one-way traffic is simply wrong. Getting evidence into practice is complex and context dependent and very much a dynamic process. There has to be an active feedback loop shaping research and the way it is communicated and then learning from the interaction with policy makers how to better frame the next round of research (**see Figure 1**). The Observatory uses policy makers to identify priorities and as a key audience to test work and to understand if the messages speak to practitioners. It uses academics to set rigorous standards and deliver work of quality and worth. As the knowledge broker it tries to link both groups and to bridge the gaps between them not as a simple, one or even two directional exercise but as part of an active set of relationships.

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Happy 20th Anniversary @OBSHealth!



Colleagues and friends of the European Observatory express their good wishes and reflect on memorable events.



Paul Belcher

@RCPLondon

Happy 20th anniversary @OBSHealth | Proud to be associated with your 'Eurohealth' journal throughout this time.



Josef Probst

Director-General, Main Association of Austrian Social Security Institutions

Happy Birthday to the young institution with dynamic people and senior knowledge. Thank you for providing objective advice and generating indispensable know-how. Health systems can definitely benefit from the possibility of dialogue and networking between science and policy at European level.



Yves Charpak

@YesWeKnow

Enjoy the anniversary and be prepared for the next 20 years, unknown future in Europe!



Dale Huntington

@Former Director of Asia-Pacific Observatory

High quality, timely analyses produced by well known academics.



Maaïke Droogers

@EUPHA

EUPHA congratulates OBS for the important and very often innovative and creative work that was done in the past 20 years on shedding light on our health systems and the complex dynamics of these systems. Spreading the word about OBS findings contributes to its impact. EUPHA wishes the Observatory another successful 20 years and is looking forward to continuing and intensifying our collaboration.



Jacqueline Bowman

@Third-i

You give the baseline evidence to allow informed policy-making. It would also be nice in the future to include not only a government perspective, but to actively engage users of the health systems and other actors who impact on how policies are implemented in reality.



Natasha Azzopardi M

@EUPHA @uniofmalta

Proud to represent @uniofmalta within @OBSHealth – Happy Birthday! We look forward to the Malta meeting in October 2019. @ValettaCampus @umhealthscience



Lieven De Raedt

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You are an agenda-setter in health policy with innovative and far-sighted studies.



EU_Health

@EU_Health

Happy celebration, to many more to come!



Liisa-Maria Voipio-Pulkki

Director General, Finnish Ministry of Social Affairs and Health

I am so glad and honoured to be a member of this absolutely great team. Congratulations! In Finnish: Lämpimät onnitellut, Observatorio!


Centre for Global Chronic Conditions

@LSHTM_CGCC

Proud to be part of @OBShealth which is celebrating its 20th anniversary!


Walter Ricciardi

@Italian National Institute of Public Health

happy birthday!


Gastein Forum

@GasteinForum

20th anniversary!! 20 years of experience!! 20 years of service!! 20 years shaping the outlook on the future #euhealth policies Congratulations!! Looking forward celebrating with you. #EHFG2018


Rifat Atun

@RifatAtun (Harvard University)

Congratulations to the Observatory family for the outstanding work — a remarkable achievement by a super group of public health leaders. We need the Observatory more than ever in a fast changing Europe.


Hans Kluge

Director of the Division of Health Systems and Public Health, WHO/Europe

The twin-relation between WHO and the Observatory is a winner for countries. You provide us with state of the art evidence, which we can then use to formulate policy recommendations to countries and follow up with technical assistance. Warm congrats for the 20th anniversary!


Francis Arickx

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Congratulations for your 'courage'... Messages are not always simple...


Boris Azais

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Best public health crew in Brussels! You help preventing ideology to get in the way of smart policy making.


Nima Asgari

Director, Asia-Pacific Observatory

As the younger observatory that has been modelled on OBS, I have found the support from OBS fundamental in developing the Asia-Pacific Observatory on Health Systems and Policies.


Stefan Eichwalder

Deputy Head of Unit, Austrian Federal Ministry of Labour, Social Affairs, Health and Consumer Protection

I wish you a very happy birthday.

Thank you for the input and assistance you provide in a timely and reliable way, that contributes in making better (informed) health policy.

Thank you for establishing a trusted platform for discussion and exchange (also among us partners of the Observatory).


Petronille Bogaert

@Sciensano.be

Congrats. You help to make health information easy to use and understandable. Clear recommendable outcomes. Strengthen the use of health information in use with policy makers.

SELECTED HIGHLIGHTS FROM THE FIRST 20 YEARS



1998

- The founding partners sign the agreement creating the “European Observatory on Health Care Systems”

1999

- The official launch of the Observatory takes place in London at the international meeting ‘Evidence into Action’ hosted by the London School of Hygiene and Tropical Medicine
- *Critical challenges for health care reform in Europe* wins the prestigious EHMA Baxter Award
- The first Summer School takes place in Dubrovnik (1999 – 2002)

2000

- Since the launch already 23 country HiT profiles are published.

2001

- The OBS provides evidence support to the Belgian EU Presidency exploring the impact of EU law on health systems.

2002

- OBS becomes the new editing partner for *Eurohealth*
- *Funding health care: options for Europe*, wins the EHMA Baxter Award

2003

- The name changes to the *European Observatory on Health Systems and Policies*; the Secretariat moves from Copenhagen to Brussels
- A range of meetings engaging with senior policy advisors develop into the “Policy Dialogues” program, a particular brand of knowledge transfer

2004

- The study *Health Policy and EU Enlargement* is published to coincide and support the accession of the 10 new Member States of the EU
- The first annual Baltic Policy Dialogue takes place in Lithuania

2005

- Two major new studies are published – *Social health insurance systems in Western Europe* and *Purchasing to improve health systems performance*

2006

- OBS provides health evidence support to the Finnish EU Presidency on Health in All Policies

2007

- A series expert panels on cross-border health care are organised to support the European Commission to develop a new Community framework
- The annual Summer School is restarted, taking place every year on the island of San Servolo, Venice
- A third OBS book, *Mental health policy and practice across Europe*, wins the Baxter Award

2008

- OBS celebrates its 10th anniversary . It receives the World Bank prize for its contribution to knowledge and learning
- With the Health Evidence Network, OBS produces nine policy briefs for the WHO Ministerial Conference on Health Systems for Health and Wealth in Tallinn



Dr Jo Asvall, WHO Regional Director at the official OBS launch (1999)

- OBS supports the Slovenian EU Presidency on its health priority of cancer policies

2009

- OBS leads the EC (FP7) BRIDGE research project to map current knowledge brokering practices for health policy-making in Europe
- OBS supports the Czech and Swedish EU Presidencies with evidence on their health priorities respectively of financial sustainability and antibiotic research
- A new programme of work on health system performance assessment (HSPA) is launched

2010

- The network of National Lead Institutions (NLIs) is founded, later to become the Health Systems and Policy Monitor (HSPM) network
- OBS supports the Belgian EU Presidency with four policy briefs on the health workforce

2011

- The results of the Health Professionals mobility in the EU (PROMeTHEUS) study are presented under the Hungarian EU Presidency
- *Eurohealth* and *EuroObserver* merge to become the OBS's quarterly journal

2012

- OBS staff provide inputs to the EC's Expert Panel on Effective Ways of Investing in Health

2013

- The results of the cross-country review of health system responses to the economic crisis are presented at the WHO High-Level Meeting in Norway
- *The Health Systems and Policies Monitor (HSPM)* and *Health & Financial Crisis Monitor (HFCM)* web platforms are launched

- The open-access Health Reform Monitor series starts in the journal *Health Policy*

2014

- The European Commission invites OBS, along with WHO and OECD, to join the Expert Group on HSPA
- With WHO, OBS provides support to Ireland on its decision making on the financial crisis

2015

- OBS supports the European Commission with implementation of the European Reference Networks (ERNs)
- OBS and WHO conduct a comprehensive review of the Slovenian health system to support national reforms

2016

- With WHO, OBS assesses the performance of the Portuguese health system in the post-crisis recovery period
- OBS leads an international expert panel to pre-review proposed health and social care reforms in Finland

2017

- OBS supports the Maltese EU Presidency with two policy briefs on voluntary cross border collaboration
- OBS collaborates on the TO-REACH consortium for the development of a joint European health systems and services research programme
- OBS and OECD jointly produce the European Commission's *State of Health in the EU country profiles*

2018

- OBS celebrates its 20th Anniversary
- OBS collaborates with WHO/EURO on the High-level meeting on Health Systems for Prosperity and Solidarity – Leaving no-one behind

- OBS provides evidence support to the Austrian EU Presidency on access to medicines

The work begun 20 years ago continues ...

Current OBS Partners

(with date of joining)

WHO/Europe (1998)

World Bank (1998)

Government of Norway (1998)

The London School of Economics and Political Science (1998)

The London School of Hygiene & Tropical Medicine (1998)

Government of Sweden (2002)

Government of Belgium (2003)

Government of Finland (2004)

Veneto Region of Italy (2004)

Government of Slovenia (2006)

Government of Ireland (2009)

European Commission (2009)

French National Union of Health Insurance Funds (UNCAM) (2009)

Government of Austria (2013)

Government of the United Kingdom (2013)

Government of Switzerland (2016)

For a more detailed historical overview on OBS activities and publications, read our brochure: *Celebrating the 20th anniversary of the European Observatory on Health Systems and Policies (2018)* or watch our video *Making sense of the evidence (2018)*.

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THE ROLE OF THE HEALTH SYSTEM IN THE 21ST CENTURY:

THE ROAD FROM LJUBLJANA TO TALLINN

By: Martin McKee, Suszy Lessof and Josep Figueras

Summary: For 20 years the European Observatory has been part of an intensive dialogue about what health systems are for. The goals of health systems have developed from improving health, responding to expectations and financial protection, to promoting economic growth and, ultimately, to social inclusiveness and solidarity. This article describes this evolving thinking, showing how ideas have moved forward at a series of major European conferences.

Keywords: Health Systems, Inclusiveness, Investment, Innovation, European Observatory

What is a health system for?

This is a simple question, but without a simple answer. The most obvious is that it should prevent and treat illness. A person feels ill, they seek help from a health professional, and hopefully they are given a diagnosis, offered treatment, and recover. For most of recorded history that was it. All that changed was that the probability of making an accurate diagnosis or providing effective treatment progressively increased. Yet by the middle of the twentieth century, it became clear that health systems, or at least those that were appropriately designed, could do much more. They could prevent those unfortunate enough to become ill from facing catastrophic expenditure. Modern medicine may have improved the probability of survival from an ever expanding range of conditions but they did so at a cost. And, unlike typical consumer goods, the patient, at least those with a

life-threatening illness, had little choice if they wanted to survive. The problem was that those who had the greatest health needs were typically those least able to pay. Those who were old and poor are most likely to fall ill. Recognising this fundamental problem, the modern health system acts as a means of redistribution. Those who can afford it pay for those that cannot. Often they are the same people, as those who are healthy and in work pay in, in the expectation that the funds will be there when they are old and poor. In this way, health systems took on another role, that of financial protection.

But there is more. Once, there was an expectation that those engaging with those in authority were expected to be deferential. In health care, this meant that “the doctor always knows what is best”. Patients were expected to do what they were told and, if it was thought that they

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needed treatment, they should simply accept it. In most countries those days have long gone and decisions on treatment are reached following discussions between patient and health professional. Health systems gained another goal, to respond to the expectations of their users.

These three goals of a health system were first brought together formally in 2000, in the World Health Report.⁹ Each of the world's health systems was scored on health outcomes, responsiveness, and fairness of financing. For the first two, both overall progress and equity were assessed. The resulting scores were inevitably controversial, not least because of the necessity to estimate a very large number of missing data points. However, the process did stimulate a major research initiative, the Global Burden of Disease programme, which has transformed our understanding of the health of the world's population.⁹ It has highlighted what was previously the hidden burden of non-communicable disease and injuries in low and middle income countries. It has also added to our understanding of the scale of impoverishment attributable to health care where health systems are weak. This evidence also contributed to recognition of the importance of health system strengthening, especially as part of what by then were the growing number of global health system initiatives.⁹ This report changed the way that health systems were viewed. The Observatory had contributed to the text that accompanied scores, in particular using work done for the 1997 Ljubljana conference on health systems,^{9, 10} that was, in effect, the midwife of the Observatory. A particular contribution, that has endured in the discourse on health systems, is the concept of stewardship,⁷ in which governments have a responsibility to anticipate the future and ensure that their health systems remain fit for purpose. The three main goals of a health system are now widely accepted. But it soon became clear that health systems do even more.

Health systems, health, and wealth

The 2008 Tallinn Conference, in which the Observatory played a leading role, presented a new framework for thinking about health systems.⁹ This built on a

rapidly increasing body of research, some undertaken by those working for or with the Observatory.⁹ It presented evidence on how health systems improved health,⁹ but also how better health reduced the need for health care. Economic growth created more money for health care, but health systems, if linked to therapeutic and technological innovation, could promote economic growth. Healthier people are more productive and remain in the labour force longer, thereby contributing to economic growth,¹⁰ while stronger economies enable people to make healthier choices, at least if the resources are shared equitably and governments put in place appropriate regulatory frameworks for harmful products, such as tobacco or junk food. These ideas were incorporated into the 2008 Tallinn Charter, to which the World Health Organization (WHO) Regional Office for Europe Member States committed.¹¹

“health systems need to respond to the expectations of their users”

Unfortunately, a few months after the Charter was endorsed, the world changed. A series of events culminated in the global financial crisis. Governments gave vast sums of money to the large financial institutions, many of which had created the crisis, to protect them against insolvency. To pay for this, many implemented deep cuts to public spending. In some countries, the austerity programmes hit health systems hard. The ideas set out in Tallinn were tested, not by the hoped for programme of investment but by disinvestment. Instead of mutually reinforcing gains in health, health systems, and wealth, some countries went into a vicious downward spiral, with worsening health, weaker health systems, and economic decline.¹² In some, what had been steadily declining mortality began to increase in some areas and at some ages. After what was effectively a lost decade,

some of the worst affected countries began to invest, both in their wider economies and their health systems. Some adopted industrial strategies in which life sciences featured prominently.¹³ However, by now it was clear that health systems had other goals, support for economic growth and, by improving the health of the population, contributing to a more productive workforce. Crucially, the gains from better health came not only to those in the workforce but also to those who might have to leave the workforce to care for sick relatives.

Prosperity and solidarity

Ten years later, health ministers came together again in Tallinn. They were there to take stock of what had happened in the previous decade. But they were also looking ahead, to where health systems were going in the 21st century. At the conference – entitled “Health Systems for Prosperity and Solidarity: Leaving no-one behind” – a new model was proposed, with new goals for the health system. These drew on, but extended what had gone before. Once again, the Observatory played a key role, working with our colleagues in WHO. The model centred on 3 I's: Include, Invest, and Innovate.

The need for inclusion was highlighted by new analyses from WHO's Barcelona Office for Health System Strengthening, showing that even in health systems that, on paper, have achieved universal coverage, many people still face large out-of-pocket payments or even, in some cases, catastrophic expenditure, while other research by those linked to the Observatory, most notably in association with the European Commission, has sought to measure and understand trends and patterns in unmet need for care.¹⁴ All is not well in many countries but health systems can do much to improve things, if they are enabled to by governments by promoting models that include everyone on their territory, including migrants. Fortunately, after some retrenchment during the economic crises, certain countries are bringing vulnerable groups back into the system,¹⁵ but there is still much to do and many problems lie ahead.

The case for investment in health systems was made at the 2008 Tallinn conference and again at another that marked its fifth anniversary. The evidence is now stronger than ever. However, this will not be easy, requiring a mature debate between health and finance ministers. These were presented graphically at the 2018 conference in an imaginative and informative film in which a former state secretary from the Netherlands who has held both positions participated in negotiations with himself.¹⁴

“Health systems are part of the glue that binds society together”

The third imperative is innovation, in medicines, technology, and models of care, including those that take account of the enormous advances in information technology. Looking further ahead there is artificial intelligence. Yet, just because something is new, it does not mean it is something that should be adopted. Too many new medicines offer no benefits over what already exists. Too many seemingly clever ideas, in areas such as telemedicine, fail to live up to their potential. So the challenge facing health systems is how to identify the good ideas and implement them at scale, while avoiding the seduction of the bad ones.

The final message from Tallinn in 2018 was that these three I's must be brought together, for prosperity, as set out ten years earlier, but also for solidarity. Health systems are part of the glue that binds society together. And this means that they are a political statement of our mutual interdependence. As European societies become more diverse, the importance of this role cannot be underestimated.

The Observatory has spent 20 years thinking about health systems. Much of the rest of this special edition of *Eurohealth* is about how they work and, importantly,

how the work that the Observatory has done helps them to do it better. This contribution is different. To go back to the beginning, it asks a simple question. What are health systems for? As it shows, the answer is far from simple. It has evolved over time. And working with others, the Observatory has contributed substantially to the understanding of that evolution.

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EVOLUTION OF HEALTH SYSTEM PERFORMANCE ASSESSMENT:

THE ROLES OF INTERNATIONAL COMPARISONS AND INTERNATIONAL INSTITUTIONS

By: Peter C. Smith, Marina Karanikolos and Jonathan Cylus

Summary: Health system performance assessment (HSPA) has become increasingly important nationally and internationally as a way to evaluate whether and to what degree health systems achieve their goals and to hold decision-makers to account. A core challenge remains how to best integrate HSPA in policy processes and to use the findings to contribute meaningfully to health system improvement and health policy development. In this article we review the evolution of HSPA over the past two decades, discuss some of the conceptual and methodological challenges and consider in particular the roles of international comparisons and international institutions.

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Keywords: *Performance, International Comparisons, Accountability, Health Policy, Measurement*

The evolution of HSPA

Health system performance assessment (HSPA) is becoming a central instrument in the governance of modern health systems.¹ The notion of the health system was first given serious attention nearly 20 years ago in the *World Health Report 2000*² and further developed in the World Health Organization (WHO) report *Everybody's business: strengthening health systems to improve health outcomes*.³ It defined the health system as "... all the activities whose primary purpose is to promote, restore or maintain health." WHO then defined HSPA as "a country-specific process of monitoring, evaluating, communicating

and reviewing the achievement of high-level health system goals based on health system strategies".⁴ The key objectives of HSPA are:

- To set out the goals and priorities for a health system;
- To act as a focus for policymaking and coordinating actions within the health system;
- To measure progress towards achievement of goals;
- To act as a basis for comparison with other health systems;

- To promote transparency and accountability to citizens and other legitimate stakeholders for the way that money has been spent.

HSPA was given a further stimulus in the WHO European Region by the signing of the “Tallinn Charter on Health Systems for Health and Wealth” in 2008. The 53 Ministers of Health from the European region made a commitment “to promote transparency and be accountable for health systems performance to achieve measurable results”. HSPA is seen as an important mechanism for fulfilling that commitment.

What information is included in an HSPA?

As envisaged by WHO, HSPA is primarily a country-specific process for which there is no single accepted template, although there are many generally accepted principles of best practice in developing a specific HSPA.⁵ Some of these include:

- HSPA should focus on the health system as a whole, including health promotion and public health as well as health services;
- Health systems goals should be expressed in terms of outcomes such as improved health and reduced exposure to financial risk, rather than processes such as workforce size or numbers of treatments;
- Wherever feasible, progress should be quantified using reliable metrics and associated analytic techniques;
- HSPA should be a regular process, embedded in all aspects of health policymaking;
- The exact form of HSPA should be a matter of choice for individual systems, although its effectiveness is likely to be maximised by the adoption of metrics and methods that enjoy widespread international use.

Despite differences in how objectives are expressed and measured, there is almost universal agreement that any HSPA should reflect health system goals. These include the improvement in health that can be attributed to the health system as a whole; the health system’s responsiveness

to citizens’ preferences; the financial protection offered by the health system; and the productivity, or value-for-money, of the health system. Furthermore, all HSPA efforts make reference to the issue of fairness, or equity, in how attainment of its goals is distributed across different population groups.

“
to be relevant,
comparisons
require in-depth
knowledge of
health systems

There is less consensus on how to incorporate health system functions into HSPA. These might include: service delivery; workforce; information resources; medical products, vaccines and technologies; financing; and governance. Such functions are the fundamental building blocks of any health system, and how they are deployed can have a major influence on health system outcomes. However, they are often difficult to compare across different types of health system, and a focus on functions can sometimes inhibit progress towards new ways of promoting the ultimate goals of the health system, such as a shift away from treatment towards prevention of disease. It is for this reason that HSPA should focus primarily on outcomes. Assessment of functions may nevertheless be an important diagnostic tool for understanding reasons for progress (or lack of progress) towards health system goals. **Box 1** summarises the key features of HSPA, as envisaged by WHO.⁶

The role of international comparisons in HSPA

HSPA is seen as a national competency due to the need to focus on country-specific goals and maintain relevance within different institutional settings. However, there have been many international efforts to conduct or

Box 1: Key features of HSPA

HSPA is regular, systematic and transparent. Reporting mechanisms are defined beforehand and cover the whole assessment. It is not bound in time by a reform agenda or national health plan end-point, although it might be revised at regular intervals to better reflect emerging priorities and to set appropriate targets.

HSPA is comprehensive and balanced in scope, covers the whole health system and is not limited to specific programmes, objectives or levels of care. The performance of the system as a whole is more than the sum of the performance of each of its constituents.

HSPA is analytical and uses complementary sources of information to assess performance. Performance indicators are supported in their interpretation by policy analysis, complementary information (qualitative assessments) and reference points: trends over time, local, regional or international comparisons or comparisons to standards, targets or benchmarks.

In meeting these criteria, HSPA needs to be transparent and promote the accountability of the health system steward.

Source:⁶

to otherwise support cross-country performance comparisons as an important element of HSPA. These include work by the European Observatory on Health Systems and Policies, as well as the Commonwealth Fund, Organisation for Economic Co-operation and Development (OECD), European Commission, and the Institute of Health Metrics and Evaluation among others.

International comparisons benefit national HSPA efforts in a number of ways, for example by providing the opportunity for cross-country learning in terms of the conducting of HSPA itself, as well as for

indicator benchmarking. However, there remain a number of challenges to take full advantage of the potential offered by international performance comparisons. These include the persistent interest in using international comparisons to rank health systems, the comparability of data and concepts across countries, as well as the difficulties in interpreting cross-country findings.

The problem with rankings

It is not surprising that there is great interest in seeking to rank health systems, especially given that the World Health Report 2000 has largely been the inspiration for much of the appetite for performance assessment and comparison. However, determining that one health system is ‘better’ than another is rarely a clear, evidence-based and transparent process. One of the most controversial examples is the Euro Health Consumer Index (EHCI), which ranks health systems annually based on an arbitrary selection of indicators which are then given arbitrary scores.⁸ For example, amongst its flaws as a comparative health system assessment tool, the EHCI implicitly values shorter waiting times more than it values survival – something that is hard to imagine reflects the preferences of health care consumers.

In reality though, any health system ranking based on a single or composite measure will be unable to fully capture differences in cross-country preferences and other unobserved factors that explain performance. In general, it is hard to advocate the use of composite measures of performance and the associated rankings of health systems, other than as a device to draw attention to the HSPA initiative.

The challenges of comparability

Although much progress has been made, there remain questions over the comparability of apparently similar concepts used by different research institutions. For example, avoidable mortality, one of the key health outcomes indicators in HSPA – has been conceptualised in a number of different ways, which can have obvious effects on the indicator’s comparability as well as important implications for its usefulness

for policy.⁹ While there is general agreement on the definition of amenable deaths, namely those that could be avoided through timely and effective health care, measures of preventable mortality range from those which include just three causes of death (lung cancer, liver disease and road traffic deaths) to others which are more widely defined. In particular, the definition of preventable mortality used by Eurostat⁸ includes the three previously mentioned causes, but also includes deaths from ischaemic heart disease, influenza, diabetes, breast and cervical cancer – conditions that are also included in the measure of amenable mortality. Such differences matter because an important reason for seeking to distinguish between amenable and preventable mortality is to establish broad lines of accountability: identifiable effective interventions and health care providers in the first case; and wider policy measures that stretch beyond the health system, requiring the involvement of other sectors, such as legal measures around road safety or a smoking ban, in the second.⁹ Counting some causes of death as both preventable and amenable provides little concrete information in terms of what is being assessed, who is accountable, and what can be done about it.

Interpreting cross-country findings

To be relevant, comparisons require not only good data quality and conceptual agreement as described above, but also in-depth knowledge of health systems. Identifying the reasons for observed variations is challenging even within a single health system, let alone across countries. For example, the indicator ‘average length of stay for a specific condition’ has little meaning without adjustment for patients’ profile, which is often not available across countries. Moreover, while it may indicate more efficient resource use in the short run, in the long-run discharging patients early may, without appropriate follow-up care, lead to more complications, slower recovery and, ultimately worse outcomes and higher costs.⁹ Therefore, any HSPA requires supporting information on contextual factors in order to offer information on the reasons for the observed outcomes. Work by the European Observatory – including the *Health*

Systems in Transition series – as well as by the OECD in its survey of health system institutional characteristics are beginning to show how this can be achieved.

The role of the international community in strengthening HSPA

Considerable progress has been made in institutionalising HSPA in many countries. Yet while HSPA should be designed at country level to ensure acceptability and relevance, there is also a clear role at European or international level. A good example is the recent collaborative work between the European Observatory on Health Systems and Policies, the OECD, and the European Commission to produce the *State of Health in the EU* profiles, providing policymakers, interest groups, and health practitioners with factual, comparative data and insights into health and health systems in EU countries.¹⁰ Likewise, the European Commission’s Expert Group on HSPA established in 2014 provides a useful forum for Member States and other international stakeholders to discuss good and bad practices, as well as more generally share their experiences.

“primary purposes of HSPA: promoting accountability and supporting policy development

In considering the future of HSPA and how the international community can help to maximise its potential, we consider two of the primary purposes of HSPA: promoting accountability and supporting policy development.

Promoting accountability is important so that citizens, parliamentarians and other stakeholders can check that policymakers, institutions and providers are progressing towards their shared objectives. In

doing so, HSPA also serves to maintain the solidarity that underpins societal willingness to support universal health coverage, since people are able to verify that their health system is delivering on its promises and achieving goals. One of the ways to ensure accountability is through frequent reporting. However, the timeliness of data availability remains variable. For example, international mortality data are published with at least a two-year lag. International organisations, such as the WHO, OECD and the European Commission can help by supporting data harmonisation and streamlined collection processes. This is already the case, for example with the System of National Health Accounts.¹¹ Improving access to administrative data and creating better linkages across providers and registries is of great use in improving timeliness.

Supporting policy development is the other key purpose of conducting an HSPA. Countries like Portugal have explicitly used HSPA to inform their National Health Plan. However, this is not the case everywhere, making it difficult to know the extent to which HSPA feeds into policy development. International organisations like the European Union can play an important role in linking performance assessment to policy. For example, there are ongoing efforts by the Commission to use HSPA data as a screening tool to

identify priorities for improvement and provide policy guidance as part of the European Semester.

Where do we go from here?

HSPA is an important mechanism to ensure effective, accountable health systems. There is a clear role for international comparisons and the international community more broadly in facilitating and supporting national level analysis. International organisations, such as the WHO, the European Commission and OECD can provide not only valuable and much needed information, but also assist in harmonisation of data collection and concepts, assist in highlighting specific issues and common priorities, as well as facilitate knowledge exchange through international expert groups and other forums for sharing experience.

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How to make sense of health system efficiency comparisons?

By: J Cylus, I Papanicolas, PC Smith

Policy Brief 27 (2017): 28 pages

Freely available to download at: http://www.euro.who.int/__data/assets/pdf_file/0005/362912/policy-brief-27-eng.pdf?ua=1

Improving health system efficiency is a compelling policy goal, especially in systems facing serious resource constraints. However, in order to improve efficiency we must know how to properly measure it. This policy brief proposes an analytic framework for understanding and interpreting many of the most common health care efficiency indicators. Key messages are:

- The inexorable growth in health expenditure has led to a widespread demand for efficiency improvements.

- There is no single metric or set of indicators that will give the complete picture of health system efficiency in a country.
- The real causes of any identified inefficiencies need to be carefully identified and analysed to inform good policymaking.



- More nuanced indicators require more standardised and detailed cost accounting data and linked datasets and registries.
- This policy brief gives a useful framework for understanding and interpreting the healthcare efficiency metrics that are widely used.

EU INTEGRATION AND HEALTH POLICY AT THE CROSS-ROADS

By: Willy Palm and Matthias Wismar

Summary: With the European Union trying to find new breath after Brexit and other political crises, the discussion about its role in the field of health may be open to fundamental change. In this context it is good to remind ourselves of how the role of the EU in health matters has grown and matured over the years.

Keywords: European Union, EU Health Policy, Internal Market, Fiscal Governance, Cross-border Cooperation

Twenty years since “Kohll and Decker”

It was more or less around the time that the European Observatory was established in 1998 when two rulings by the European Court of Justice (ECJ) created some quite vigorous political reactions in the health sector. The Kohll and Decker cases, concerning two Luxembourg citizens who were denied reimbursement by their sickness fund for elective health services they had obtained in neighbouring Germany and Belgium, fundamentally dealt with the question of whether European internal market rules also apply to health care. The ECJs decision that statutory health systems indeed also have to respect the principle of free movement of services, came as a surprise to many national health policymakers. They believed that, based on the famous subsidiarity principle, all decisions relating to their health and social protection systems could remain exclusively as a national competence.

Even if today the data on it are still both patchy and diverse, the mobility of patients was always bound to remain a rather small phenomenon, except perhaps for some border regions, holiday destinations and migrant communities.¹ The Court’s

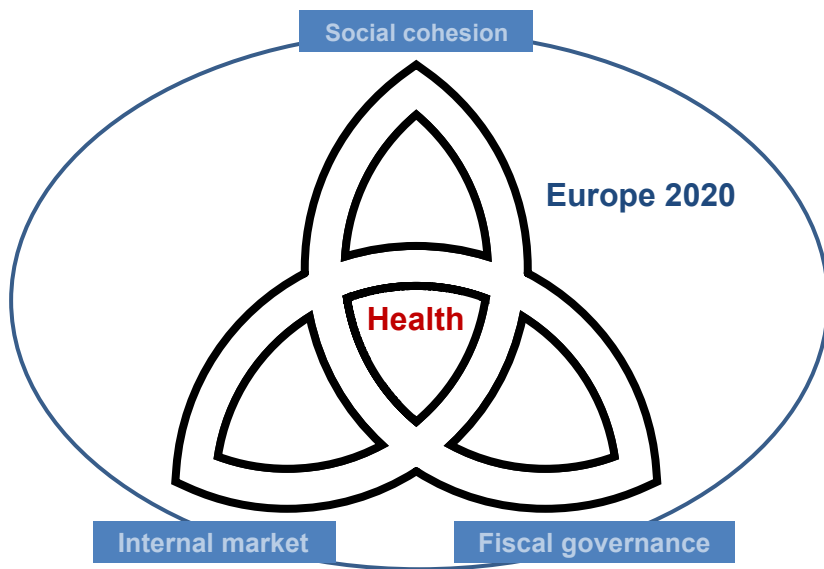
decision, however, that patients would be able to seek health care in another Member State without prior approval from their national payer organisation, was seen in many European capitals as a potential threat to the national welfare state, one of the last standing strongholds of national discretionary power. Member States were concerned that the economic rules of EU integration may supersede and undermine the social construction underpinning national health systems. But at the same time, these rulings also gave an impetus to discussing the actual role of the European Union in health.²

Health as an EU objective

Since the very start of the EU integration process, public health has played a role as one of the three quarantine criteria on the grounds of which free movement of persons, goods or services can be restricted. However, it was only in 1985, with the launch of the first action programme on cancer, that the EU’s health portfolio really started to develop (for an overview of the historical process, also **see Box 1**). After the inclusion of a proper public health article in the Maastricht Treaty, which opened the door for the EU to take action directly aimed at improving

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Figure 1: Health within the EU's agenda for growth and jobs



Source: Authors' own.

health, it took various health crises and subsequent revisions in the Amsterdam and Lisbon treaties, for the EU health mandate to mature.³

Today, the protection and improvement of human health is inscribed as a firm commitment and objective of the EU. Nonetheless, the legal competences attributed to achieving this goal remain essentially limited to supporting, coordinating or supplementing the actions of Member States. Yet, even within this restricted mandate, the EU has managed over time to develop a broad array of activities and measures. They range from combined efforts in health research and the development of guidelines for breast cancer screening to binding rules ensuring the quality and safety of blood products, tissues and organs. Following the adoption in 2007 of an integrated health strategy (“Together for health”) a multi-annual health programme the current version, called “Health for Growth”, directs and funds all EU activities to promote health and protect citizens against cross-border health threats (cf. the establishment of the European Centre for Disease Control and Prevention). It also facilitates access to better and safer health care and increases health systems sustainability. Member States have gradually accepted that the European Commission would set up a framework for strengthening

health systems to become more effective, accessible and resilient. The European Commission’s health-specific Directorate General, which was established in 1999 and coordinates all these activities, has achieved a great deal in making Member States cooperate, coordinate their policies, share experiences, exchange best practice and develop benchmarks. However, in financial terms the Health Programme only represents a fraction of less than 0.1% of the EU’s total budget.

“EU health policy is captured within the trinity dimensions of economic integration, fiscal sustainability and social cohesion”

Health caught within the broader EU agenda

To really understand the interplay between health and EU integration the broader influence from other EU policy areas cannot be ignored. As mentioned, this already became clear through the Kohll and Decker rulings in 1998, but also in the subsequent political debate on the so-called “Bolkestein” Directive on services in the internal market, which required Member States to screen all national regulations to see which measures may unjustifiably hamper free movement of services. The deregulatory effect of such an approach on a tightly regulated area like health care, prompted a lot of criticism and concern that this would undermine health system objectives and eventually led to the exclusion of health services from the Directive’s scope in 2006. Ironically, we currently see similar rules and mechanisms reappearing in a new draft Directive proposing a proportionality test for the adoption of new regulation of professions.⁴

The financial crisis that some ten years ago hit Member States’ economies and fiscal space is another good example of how other EU policies, in this case the mechanism of fiscal governance (introduced to secure the stability of the euro and to coordinate economic policies across the EU) indirectly influence national health policies and systems. The more or less binding policy recommendations on reforming national health systems, coming through the Economic Adjustment Programmes or the European Semester, have only increased the EU’s impact on health.⁵ It shows that EU health policy is captured within the trinity dimensions of economic integration, fiscal sustainability and social cohesion (see Figure 1)⁶, around which the Commission’s European 2020 strategy for growth and jobs is developed. It also provides proof of the “constitutional asymmetry” in the EU, which makes the EU better equipped at integrating markets than promoting social protection.⁷ Indeed, “hard law” regulation stemming from the traditional EU policy domains would easily seem to outweigh the “soft law” instruments on which EU health policy is built (coordination mechanisms, joint actions, projects, grants).

Box 1: Some milestones in the development of EU health policy

- 1965:** First European pharmaceutical legislation following the Thalidomide crisis
- 1971:** Regulation on the coordination of social security systems, including entitlements to cross-border health care
- 1975:** First Doctors' Directive ensuring the mutual recognition of medical diplomas
- 1987:** Launch of the 'Europe against cancer' programme
- 1992:** First public health article in the Maastricht Treaty
- 1993:** Communication on the Framework for Action in the Field of Public Health
- 1995:** European Medicines Evaluation Agency (EMA)
- 1998:** ECJ rulings on Kohll and Decker
- 1999:** DG Health and Consumers (SANCO)
- 2000:** Charter of Fundamental Rights of the EU, including the right to health care (article 35)
- 2002:** European Food Safety Authority (EFSA)
- 2003:** Start of the first EU Health Programme (2003–2007)
- 2004:** European Centre for Disease Prevention and Control (ECDC)
- 2005:** Executive Agency for the Public Health Programme
- 2006:** Council Conclusions on Common values and principles in European Union Health Systems
- 2007:** White Paper "Together for Health"
- 2009:** Communication on "Solidarity in Health: reducing health inequalities in the EU"
- 2011:** Directive on the application of patients' rights in cross-border health care
- 2013:** Social Investment Package for Growth and Cohesion
- 2014:** Communication on effective, accessible and resilient health systems
- 2016:** Start of the first cycle of State of Health in the EU
- 2017:** European Pillar of Social Rights

Sources: Authors

Health focus lost in implementation?

Because EU health policy often has developed in a fragmented and reactive way, but also due to the fact that it is determined by other EU policies, it is sometimes difficult to really see the progress and achievements that have been made.¹⁴ In some cases EU policy in health matters may even seem paradoxical or contradictory, especially when other interests or policy objectives take precedence over health goals and other Commission Directorates take the lead. Over the years health advocates have occasionally criticised the European institutions for their sometimes lukewarm support of the health mandate on issues like the licensing of glyphosate, the

regulation of endocrine disruptors, the positioning of health in international trade agreements, the labelling of food products, alcohol pricing, the imposition of austerity measures affecting health, pharmaceutical regulation and tobacco control measures.

There is also growing concern that under the current political constellation and following Brexit, from the so-called five "Juncker scenarios", which are described in the White Paper on the future of Europe, the option of "doing less more efficiently" would be chosen as the new mantra. As a result health may be removed from the thematic portfolio. In the Commission's proposed new EU budget for the future (Multiannual

Financial Framework 2021–2027), the Health programme is integrated into a new single, comprehensive instrument, together with the European Social Fund, the Youth Employment Initiative, the Fund for European Aid to the Most Deprived and the Employment and Social Innovation programme.

#EU4HEALTH

The possible disappearance of a self-standing health-specific programme and the integration of EU health policy into a broader EU social investment agenda are likely to be interpreted as a step backwards. However, the health focus cannot so easily be abandoned.

First of all, the UK's vote to leave the European Union and the ensuing difficult discussions on finding practical solutions to separate from the existing EU regulatory and policy frameworks, have clearly demonstrated how interconnected EU Member States' health systems and policies have become. Brexit not only affects the position of nearly 150,000 health and social care workers in the UK coming from other EU Member States, or the coverage of health care treatment of EU citizens in the UK and UK citizens living or staying in the EU. It also impacts on any EU-based health regulation more generally, as well as on EU-based funding or cooperation in health research or other fields. Disentangling all that will cost a lot of effort and money, but more importantly, it also risks to negatively impact on public health if it would lead to lowering standards, growing staff shortages, restricting coverage or decreasing health budgets.⁹

“
No policy level
or entity can
claim exclusivity
over health

But also the remaining Member States would have more to lose than to win from withdrawing from a common health agenda. As shown by previous health crises and recent and ongoing initiatives like the European Reference Networks, joint procurement of medical countermeasures, the EUs One Health Action Plan against Anti-Microbial Resistance, as well as collaboration in Health Technology Assessment, many health threats and challenges that countries are facing can only be dealt with effectively through cooperation and solidarity. Some of these areas of cross-border cooperation have now been institutionalised in the Directive on the application of patients' rights in cross-border health care. No policy level or entity can claim exclusivity over health. That is also the true meaning of the

subsidiarity principle: identifying the policy level that is best placed to address specific challenges.

Moreover, as the social dimension is becoming ever more critical for the EU's "survival", its contribution to protecting and improving the health and well-being of its citizens will have to be part of this new narrative. The European institutions all together have just proclaimed the European Pillar of Social Rights, which establishes a set of 20 principles and rights to ensure equal access to the labour market, create fair working conditions and secure social protection and inclusion. This pillar explicitly endorses the right to health and social care. The EU also strongly committed to the UN's 2030 Agenda on sustainable development, which includes the goal of ensuring healthy lives and promoting well-being for all at all ages.

Health in all EU Policies

To deliver on these commitments, the strong links with, and the embedment of health regulation in other EU policies can actually be a value added. The Treaty on the Functioning of the European Union, which states that "a high level physical and mental health protection shall be ensured in the definition and implementation of all Community policies and activities" (Article 168 TFEU), provides a strong mandate for pursuing a Health in All Policies approach.¹⁰ Through various mechanisms, like interservice consultation within the Commission or the involvement of the Public Health Committee in the European Parliament in discussing legislative proposals, health concerns can be brought to the EU table when preparing policies and legislation in fields like agriculture, internal market, environment or education.¹¹ Irrespective of where the locus for health will be in the future configuration of EU institutions, this should be the starting point for an integrated EU health policy, making every EU Commissioner a Health Commissioner.

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20 YEARS OF HEALTH SYSTEM REFORMS IN EUROPE: WHAT'S NEW?

By: Cristina Hernández-Quevedo, Anna Maresso, Sherry Merkur, Wilm Quentin, Erica Richardson, Anne Spranger and Ewout van Ginneken

Summary: Reforming health systems is crucial to keeping them fit for purpose and able to meet the needs of the populations they serve. While reforms 20 years ago were focused mostly on improving efficiency, in many countries they are now concentrated on improving quality, strengthening primary care services and promoting integrated care. Several examples are used to illustrate the shift in focus, including in the areas of payment mechanisms, primary care and hospitals. Looking forward, European countries still have the same goals i.e. to ensure the sustainability, efficiency and quality of their health systems. But they face rising challenges, which include overcoming system fragmentation, addressing multimorbidity and effectively using an ever-growing supply of data.

Keywords: Health Systems, Reform Trends, Quality, Primary Care, Integrated Care

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How has the focus of health system reform changed?

For the last 20 years, the European Observatory on Health Systems and Policies has been providing evidence to support national and international policy making processes by monitoring and analysing health systems across Europe. Several tools have been used for this purpose, including the Health in Transition (HiT) series, analytical studies and policy briefs and, more recently, the Health Systems and Policy Monitor online platform (HSPM)* and the Country Health Profiles (the latter jointly with the OECD).

Owing to the Observatory's varied work across Europe, some observations can be drawn. Overall, there has been a growing recognition of the benefits of adopting a *health system* perspective when tackling reforms. That is, since reforms in one area have implications for other parts of the health system as a whole, policymakers are increasingly aware of the need to formulate plans that go beyond singular policy changes. Furthermore, across Europe there has been a clear shift in the focus of reforms: some changes are in step with national political developments or changing environments (e.g. the financial crisis), while others reflect changing priorities, such as considerations in health care financing or the need to ensure equity

* These resources are freely available from: www.healthobservatory.eu

in tandem with efficiency objectives. This renewed focus on equity can also be linked to international organisations, such as the World Health Organization (WHO), that have long championed the goals of achieving universal health coverage (UHC) and addressing the socio-economic determinants of ill health (**Box 1**; see also the article by Winkelmann et al. in this issue).

Another factor shaping the agenda of health reforms in European Union (EU) countries is the need for Member States to comply with EU legislation. Member States have undertaken reforms in areas such as setting limits on the working hours of doctors and ensuring that the reimbursement of health services are in line with the directive on cross-border care¹ (see also the article by Palm and Wismar, in this issue). In addition, since the onset of the economic crisis some countries, such as Cyprus, Greece, Latvia and Portugal, have pursued quite substantial reforms as part of the conditions specified within Economic Adjustment Programmes tied to financial assistance from international lenders. Such conditions may focus on containing costs and introducing greater efficiencies.² In non-EU countries and particularly Former Soviet Union (FSU) countries, transnational actors, including WHO and the World Bank, or bilateral actors such as USAID, play a major role through assisting countries to devise reform plans and by lending or providing aid.

Moving from improving efficiency to tackling new challenges

Broadly speaking, policies in the late 1990s were focused on improving efficiency, often strengthening competition or using market liberalisation as a tool to increase the effective use of resources. Policymakers faced pressures to achieve better control over expenditure and/or greater productivity and efficiency, while still maintaining universal access to care and improving the distribution of services.³ Changes to payment mechanisms, such as the development of Diagnosis-Related-Group (DRG-) based payment systems, and the increased adoption of Health

Technology Assessment to aid decision-making in reimbursement decisions for pharmaceuticals and other technologies were part of these efforts to improve cost-containment and achieve greater value for money.

Since then, the rising burden of chronic illness, and in particular the rapid increase in the number of people with multiple health problems (multimorbidity), along with the ageing of the population have emerged as tangible health system challenges that need attention. In response, there has been a growing acknowledgement of the importance of prevention and health promotion, having a strong primary care system with integrated services, and improving the quality of services.⁴ Moreover, rising multimorbidity will necessitate a shift from disease focused health systems to patient-centred health systems, but European countries are generally still at the beginning of this transformation. Being able to monitor health systems' performance so that they meet their stipulated goals and priorities has also emerged as an important objective, although much work still needs to be done in designing feasible and appropriate performance metrics (see the article by Smith et al. in this issue).

Health reform trends over time

In this section we provide a broad description of some health reform trends that illustrate the shift in focus.

Payment mechanisms

Over the past 20 years, almost all countries have reformed (and re-reformed) their payment systems for primary care, specialist ambulatory care, and hospital care. In line with overall trends, the main objective in earlier years was to increase efficiency in service provision. Often existing payment mechanisms (e.g. capitation payments) were combined with other elements (e.g. fee-for-service payments) in order to overcome the negative incentives related to more simple forms of provider payment. These reforms have resulted in different – but increasingly quite similar – forms of blended payments systems across countries. In ambulatory care, most countries in Europe now pay

Box 1: Universal Health Coverage

Achieving UHC means that everyone is covered, the type and number of services are appropriate to reflect the population's needs, and people are protected from financial risk through adequate public funding (protecting against high co-payments and other private out-of-pocket spending). Strong political momentum for UHC is endorsed by the 2015 decision of the United Nations General Assembly to adopt health as one of its 17 sustainable development goals (SDGs) and UHC is health target SDG 3.8.⁵ In celebrating its 70th anniversary, WHO has spearheaded several initiatives to achieve UHC including “Health for All” and the “UHC 2030 International Health Partnership”. The latter is a joint initiative by national governments, international organisations and civil society determined to achieve UHC by 2030.

for general practitioner services on the basis of a combination of capitation and fee-for-service. In hospital care, most European countries have refined their payment systems by introducing a variant of DRGs, which is used to determine at least part of the hospital budget. This means that payment depends on the diagnoses of patients treated and on the procedures performed. Nevertheless, global budgets continue to play an important role, for example, as a base payment independent from DRGs or as a limit to the total amount that hospitals can receive on the basis of DRG-based case payments. Furthermore, with the increasing availability of information on quality of care, the focus of payment reform has shifted towards the use of this information in “pay for quality” (P4Q) or “pay for performance” (P4P) initiatives. However, the size of incentives related to quality of care remains limited (e.g. usually 5–15% for primary care, and less than 5% for hospital care).⁶ Too often, countries brand their payment scheme P4P, although in fact it is still focused on production and efficiency increases

instead of quality metrics. Furthermore, given the rather inconclusive evidence about the effectiveness of P4Q⁷ and continuing debates about the reliability of quality information, it remains to be seen whether the growth of P4Q initiatives will continue.

“rising multimorbidity will necessitate a shift from disease focused to patient-centred health systems”

Primary care

While the gatekeeping role of primary care providers is often cited as the main characteristic of a strong primary care system, additional conditions also contribute to the strength of primary care such as the lack of barriers to access, closeness of primary care services to communities, a patient-centred approach, and continuity of care.⁸ Over the last decade, the delivery of primary care has moved increasingly from a system of solo gatekeepers to multidisciplinary health centres. There has also been greater emphasis all over Europe on managing chronic care conditions within the primary care setting. For example, multidisciplinary primary care units are the core element of primary care both in Spain and Portugal, providing better integrated primary care for local populations. Recent reforms in Estonia are aiming to achieve this as well.

Primary care also has a substantial role in managing chronic conditions. In fact, a higher use of health services and related costs due to the increase in multimorbidity are among the key concerns currently faced by policymakers in Europe.⁹ Most of these health care systems have been designed to ‘treat’ acute episodes, rather

than ‘manage’ chronic conditions. They are, therefore, not efficiently organised to respond to the changing needs and preferences of users, in particular, those with multiple chronic conditions. In response, countries have been looking at ways to strengthen the coordination between primary care, secondary care and other-level services for the chronically ill. Among several country examples that include Germany and the United Kingdom, we can add Denmark, which in recent years has launched a national strategy on chronic disease management and developed a generic model for chronic disease management programmes together with the regions and municipalities.

Hospitals

Historically, hospital care has been at the very centre of health service delivery. However hospitals have been faced with many challenges which have changed enormously in recent decades. The factors involved are extremely complex and interlinked but broadly include changes in technology (diagnostics and treatments), changes in patients (who are older, frailer and often more socially isolated), changes in staffing (a move towards specialists and multidisciplinary teams), and changes in the models of care (involving networks and integrated pathways).⁹ Furthermore, hospitals continue to have a concentration of medical and diagnostic expertise, while at the same time striving to provide integrated care for chronic patients, involving transfer to care in the community and the home as well as managing patient expectations. These profound sets of changes have led to many reforms.

Over the past 20 years, hospital reforms in many European countries have focused on reducing the overall number of hospital beds and concentrating highly specialised care. Furthermore, the emergence of patient safety on the policy agenda, which overlaps to some extent with the concept of quality of care, reflects the need for hospitals to put in place appropriate procedures and new organisational structures. The move in hospital funding towards DRG-based payment systems incentivises hospitals to increase efficiency with the consequence of reducing length of stay. The latter

presupposes that patients have somewhere safe and supportive to go to, which requires continuity with other parts of the health and care system.

Long-term care

Over the last 20 years, countries have increasingly developed the public provision of long-term care (LTC) (due to the ageing population, co-morbidities among older people, and the need to provide assistance with daily activities), although the pace of changes has been largely determined by budget constraints. There is a high level of heterogeneity across Europe in the size, organisation and financing of such services, with countries placing different emphasis on the resources dedicated to providing institutional care in nursing homes, formal care within the home and community settings, or providing cash benefits to eligible recipients to purchase the care that they need. An example of a country with a very comprehensive LTC system is the Netherlands, but concerns about its sustainability led to recent reforms which have sought to control spending by keeping people in their homes longer and giving municipalities a stronger role in the coordination of non-residential care. One thing that has not drastically changed over this period is the strong reliance on informal care by family members and other carers, who continue to provide the bulk of care for older people.¹⁰

Quality of care

Most health reforms in Europe over the last two decades have claimed to aim at improving the quality of care, but they have often been vague about what that actually means. There is an emerging consensus that quality of care is the degree to which health services for individuals and populations are effective, safe, and people-centred.¹¹ Efforts to improve quality of care around the turn of the century were still mostly focused on assuring the quality of health system inputs or structures, e.g. by defining standards for buildings, professional training, continuous education and technologies. Since then, efforts have shifted to improving health care processes and outcomes and this remains an open agenda given the difficulty in measuring

Box 2: Strategies for reform: Kyrgyzstan and the Republic of Moldova

The Moldovan National Health Policy (2007–2021) provides a systemic approach to improving the health of the population and outlines the overall priorities for the health system. The importance of cross-party support for health strategies came to the fore during extended periods of political uncertainty in the country such as from April 2009 to March 2012 when political stalemate meant there was no functioning government. This shared political support meant that necessary reforms could still progress.

The first Kyrgyz health programme (*Manas*, 1996–2006) laid the foundations for the rebuilding of the health system following independence from the USSR and extreme economic hardship. The achievements of the first strategy in laying the foundations for a sustainable and equitable health system were consolidated in the second programme (*Manas Taalimi*, 2006–2010). Notably, these plans have had the support of the medical community as well as politicians and donors.

Along with broad stakeholder support, both strategies took a longer-term perspective – beyond a single political cycle – acknowledging that bold reforms to the way health services are financed, organised and provided take time to implement. Both strategies also emphasise how implementation should be monitored and evaluated to ensure they deliver on agreed priorities.

Sources: ¹² ¹³

health outcomes and of attributing change to a particular intervention or provider. In addition, countries have been increasingly interested in collecting patient-reported experience measures (PREMs) as well as patient reported outcome measures (PROMs), as a means to improve health system quality. Nevertheless, as a result of the increasing availability of information—due to the expansion of information and communication technology (ICT) in health systems and health care organisations—there is a continuously growing potential for using this information in order to measure and improve health care processes and outcomes.

What does it take to successfully reform a health system?

There are several factors that can facilitate or limit the successful reform of a health system which can be captured under two main categories: capacity constraints and political will.

Capacity constraints: As mentioned above, sometimes the spur for health system reform has been some form of external economic shock and policies seek to contain health care spending.

However, insufficient resources can limit a system's capacity to reform in times of fiscal constraint. Firstly, lacking policy and managerial capacity to effectively run a reform will blunt implementation efforts. This factor is often overlooked but any reform initiatives should start with an assessment of available policy capacity. Secondly, successful reforms also need to use existing capacity efficiently and if necessary to build capacity in the health system, particularly in the health workforce. If health services need to be provided in a different way, then health workers need the necessary training to implement the required changes. Similarly, health financing reforms are underpinned by capacity building in health care management at the provider level. The successful introduction of active purchasing mechanisms, for example, also relies on good data, so it is necessary to strengthen IT capacity in parallel.

Political will, vision and leadership: The importance of a clear vision and political will to strengthen the health system should not be underestimated.¹⁴ A 'roadmap' with cross-party support and buy-in from a wide range of stakeholders (including health workers) can be a powerful tool

for ensuring that deep, systemic reform stays on track (see Box 2). Without such consensus, there is a risk that a cycle develops with each new government reforming the health system by unpicking the work of those previously in power along ideological lines. Such a treadmill of reform, where changes are announced but with insufficient consensus, can impede successful implementation. Concrete plans for reforms can be hindered by a lack of stakeholder commitment, un-coordinated actions and/or badly designed incentives. Thus, strong leadership and operational planning are needed to keep reforms on track. Subsequently, evaluation of reforms is crucial to building a knowledge base and maintaining support.¹⁵ Evaluations also allow policymakers to learn from reforms that did not work well or had unintended consequences and to address shortcomings with remedial action.

“reform initiatives should start with an assessment of available policy capacity”

Where might reforms be going next?

The emerging patterns of health system reforms point to common challenges facing policymakers across Europe, as well as common difficulties in the implementation of reforms. Looking forward, these challenges include ensuring the sustainability, efficiency and quality of their health systems.

The trends suggest that there will be a continued focus on reforms that aim to guide patients more fluidly through the health system, including enabling primary care systems to manage patients with long term chronic conditions and to better co-ordinate or integrate health services for everyone. This implies that countries need to shift their health systems away from a disease-focused provision of health care

to a patient-centered approach that looks at the patient's (multiple) needs and his or her environment (ie. taking a holistic view) and away from fragmented delivery in several subsystems with separate funding sources (e.g. social care, acute care). Although it is early days, many countries are piloting and exploring population-based integrated care programmes which have the potential to combine the benefits of a patient-centred approach with payment reform, and by doing so, facilitate better cooperation and integration. An ever-growing ambition is to harness the potential of information systems and patient data as enablers of this patient-centred vision and to facilitate the sharing of decision-making between patients, caregivers and doctors. Coupled with more emphasis on prevention and addressing the social-economic determinants of health, policies and new technologies will also aim to identify and target potential health problems further upstream by fostering healthier populations to begin with.

Such developments would reinforce other health system strengthening initiatives that bolster sustainability, such as creating a health workforce that is resilient to future challenges and investing strategically to provide access to health services that are proven, safe and cost-effective. Reforms are also likely to look to innovation to potentially maximise gains and capitalise on experiences elsewhere. This could involve examples of leap-frogging¹⁶ over inferior or less efficient technologies or adopting more innovative delivery structures to accelerate improvements in disease management or health outcomes.

All of this is in keeping with the enduring challenges that have underpinned health system reform trends over the last few decades: to design and implement changes that the health system can afford while at the same time delivering high quality care to the people who need to use its services.

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Reform directions – changing contexts and enduring challenges

Two seminal studies marked the launch of the Observatory in 1998. They basically laid out the groundwork for developing a systematic approach to describing and assessing the development and reform of health systems in Europe.

Both publications – *European health care reform. Analysis of current strategies* (1997) and *Critical challenges for health care reform in Europe* (1998) were the result of the preparatory work for the 1996 WHO Conference in European Health Care Reforms, held in Ljubljana and helped to shape the recommendations made in the Ljubljana Charter, which was approved by the Member States.

We asked one of the editors and co-founders of the Observatory, **Richard Saltman, Professor of Health Policy and Management at the Rollins School of Public Health, Emory University, USA**, whether the context of health system reforms has fundamentally changed over these last twenty years and if the challenges described back then have been met.

Professor Saltman: *Well, from a clinical perspective, many practical dimensions of day-to-day medical care have indeed changed as the international standard of clinical care has evolved, although the rate and degree of change varies across systems. Patient-wise, there has been substantial improvement in patient choice across tax-funded health systems, and, equally as important, a strong shift across Europe in favour of patient control over their clinical care.*

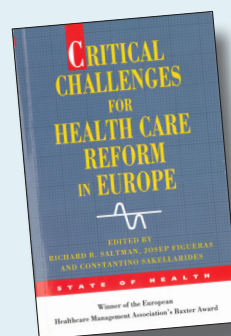
There have been efforts to strengthen primary care, for example in Denmark (extra payment to manage certain chronic elderly patients) and in Sweden (shifting 50% of primary care physicians and visits to a private sector GP model). In Central Europe and Former Soviet Republics primary care has established deeper, mostly private sector, roots. Managing chronically ill elderly has become a central focus, along with finding better ways to collaborate with social sector actors.

Clearly, IT has altered patient pathways for some chronic conditions, although it can sometimes also become a barrier to effective primary care as GPs spend visit time reporting on the keyboard rather than examining the patient. While there has been considerable clinical innovation, there remains much to do, particularly in tax-funded health systems. The rapid developments in genome-based personal medicine will test existing European health systems going forward.

Structurally, a substantial number of country health systems have undergone major organisational reforms, re-arranging formal reporting, managerial and governance relationships. Governance has been both decentralised to institutional level (various types of self-governing hospitals) while centralised more in national political bodies (e.g. Norway, Denmark, Ireland, Netherlands, Germany, also Czech) especially for financing issues. Management has become stronger at hospital level, supported by IT and, at the executive level, often by boards of trustees.

On the financial level, securing sufficient funding still remains the biggest challenge, especially in tax-funded health systems. Since the economic recovery in Europe following the financial crisis has been weak for nearly a decade, even with recent improvement, a next recession may be difficult for nearly all publicly financed health systems.

Lastly, politically, and perhaps underscoring many of these other points, the policy tension between public and private never goes away in European health policy.



GETTING AND KEEPING PEOPLE HEALTHY: REFLECTING ON THE SUCCESSES AND FAILURES OF PUBLIC HEALTH POLICY IN EUROPE

By: Gemma A Williams, Bernd Rechel, David McDaid, Matthias Wismar and Martin McKee

Summary: Public health policies in Europe have achieved much success in the past 20 years, reducing the burden of communicable and non-communicable diseases (NCDs) and thus contributing to rising life expectancy. This article explores some of the successful health promotion and disease prevention policies that have been implemented across the region, focusing specifically on those that aim to combat NCDs. We identify policy gaps and contemplate why some countries have been able to implement effective policies while others have not. We offer concluding remarks on how the public health community can respond to meet new and emerging public health challenges.

Keywords: *Public Health Policies, Non-Communicable Diseases, Tobacco Control, Alcohol Control, Obesity*

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Shifting priorities over the last 20 years

People across Europe are living longer and healthier lives than ever before. Life expectancy and healthy life expectancy have, at least until recently, steadily risen, while rates of communicable diseases and major non-communicable diseases (NCDs) such as cardiovascular diseases and preventable cancers have seen overall declines.¹ Although the exact contribution is difficult to quantify, much of this success is due to implementation of effective public health policies. Once,

the greatest gains were from improving sanitary conditions and tackling infectious diseases. The last 20 years have, however, seen a shift in priorities, with public health becoming increasingly focused on combatting the growing challenge of NCDs, which now account for approximately 77% of the disease burden and 80% of health care costs in Europe.^{1 2}

Public health has a critical role to play in combatting NCDs. Much of the disease burden can be prevented or delayed by reducing exposure to a few

Box 1: Selected European policies and strategies that support comprehensive approaches to health promotion and prevention

The *Vienna Declaration on Public Health* adopted in 2016 reaffirms the region's commitment to the Ottawa Charter, but also embraces new commitments to meet new and emerging threats to public health.¹ These commitments include enhanced use of information systems; greater advocacy for health; monitoring the effects of *Health in All Policies*; and creating a highly qualified public health workforce.

The European *Health 2020* policy framework defines priority areas for action and outlines strategies that rely on joint action across government and society to improve health, reduce health inequalities and ensure the health of future generations.² Priority areas include, but are not limited to, investing in health through a life-course approach and tackling the disease burden of non-communicable and communicable diseases.

The *Health in All Policies* approach was adopted in 2006 with the aim of enhancing collaboration across sectors in recognition that health and health inequalities are determined by many factors outside of the health sector.³ It advocates for impacts on health to be considered in policy making from other sectors. The European Treaties require a high level of health to be assured in all EU policies.

New opportunities for public health and the advancement of the *Health in All Policies* approach are presented by the *European Pillar of Social Rights*, a joint proclamation from the European Parliament, European Council and European Commission. The Pillar provides a framework for improving equal opportunities and access to the labour market, fair working conditions and inclusion by supporting policies and activities that promote 'a high level of employment, the guarantee of adequate social protection, the fight against social exclusion and a high level of education, training and protection of human health'.⁴ The Pillar creates opportunities for multi-sectoral collaboration and actions that are necessary to tackle the social determinants of health (see Box 2).

The *European NCD strategy* promotes a comprehensive and integrated approach to tackling NCDs. It advocates for integrated intersectoral action on risk factors and their underlying determinants, with efforts to refocus health system actions towards improved prevention and control.⁵ The NCD strategy is supported by a number of complementary strategies on individual risk factors in areas including food and nutrition, physical activity, smoking cessation policies and tobacco and alcohol control both at the European and national levels.

major risk factors, namely tobacco, alcohol, unhealthy diets, and sedentary lifestyles, while secondary prevention, such as organised screening for early detection of cancer, also contributes. In the past 20 years, Europe's governments have scaled up their efforts to implement appropriate measures to combat NCDs, with many countries adopting multifaceted responses that cross multiple sectors (see Box 1).

Successes in public health policy

The most successful policies have been those implemented at a population level,

tackling exposure to leading risk factors through action on price, availability, and marketing. Examples of 'best buys' include taxation, initially applied to tobacco and alcohol and now successfully to sugar-sweetened beverages; advertising restrictions on alcohol, tobacco and unhealthy food and drinks; and regulations on availability and accessibility – for example, through minimum ages, smoking bans, bans on trans fats, restrictions on fast food outlets and licensing restrictions on retail monopolies for alcohol sales.⁶

These policies have been accompanied by actions in all countries to reduce more

immediate hazards, such as enforcement of drink driving limits, and measures in some major cities to enhance opportunities for physical activity by investing in cycling and walking infrastructure. More recently, there has been growing recognition of the potential for campaigns that directly target corporations manufacturing these products, exposing the tactics they use to undermine healthy public policies.

“many countries adopting multifaceted responses that cross multiple sectors”

Over the past two decades, these multifaceted policy approaches have contributed to a steady decline in alcohol consumption, smoking prevalence and related harms across the European Union (EU) and to a slight stabilisation in the rate of increase of obesity prevalence in some countries.⁷ As highlighted by research from the European Observatory on Health Systems and Policies on the 'Economic case for prevention', these policies overall have also been shown to be cost-effective and in some cases cost saving.⁸

Public health policies have also played a key role in reducing cancer incidence and mortality by targeting both primary prevention (reducing exposure to risk factors) and secondary prevention through screening for early detection. The majority of countries have implemented population-based screening programmes for breast, cervical and colorectal cancers in the past 20 years, spurred by recommendations from the European Council in 2003 on best practices in early cancer detection.⁹ A recent review of progress found that 25 EU Member States now have population-based breast cancer screening programmes, 22 have population-based cervical cancer

screening programmes, and 23 have or are planning to implement population-based colorectal screening.¹

Public health policy gaps

Despite much progress, many policy gaps remain that are preventing progress in tackling poor health and its determinants. One of the most pressing issues remains the development of effective health and intersectoral policies to tackle health inequalities (see Box 2).

Alcohol

When considering the main risk factors, a discord remains between the strength of alcohol control policies and the scale of alcohol use and related harms. Alcohol consumption and the burden of alcohol-related diseases and mortality remains higher in Europe than in any other region, yet many effective alcohol control strategies have been opposed strongly by the alcohol industry, preventing or limiting their implementation. Affordability is one of the most important drivers of consumption, but minimum alcohol unit prices have only been introduced in Scotland very recently and many countries have failed to adjust taxes for inflation in recent years, increasing the relative affordability of alcohol over time. Additionally, mandatory labelling of alcohol is not required in the EU while a number of countries lack alcohol strategies or national action plans, key components of a comprehensive strategy to reduce alcohol consumption.

Tobacco

Tobacco is one area where there has been considerable success, despite the strenuous efforts of tobacco companies. However, there is still considerable scope to raise prices markedly and not all countries have yet kept up with the leaders who have banned smoking in public places, imposed pictorial health warnings, prohibited point of sales displays and enforced plain packaging. Inevitably, the tobacco industry is fighting back. Recognising the importance of encouraging and maintaining nicotine for its business model, it is now heavily promoting a range of nicotine delivery devices, several targeted particularly at young

Box 2: Tackling health inequalities

Substantial inequalities in health and life expectancy persist across and within EU countries. Health varies by many modifiable factors, including socioeconomic status, employment, and ethnicity, with these factors often clustering. Compared to more affluent individuals, people with a lower socioeconomic status are more likely to have poorer mental and physical health, including a higher prevalence and earlier onset of chronic conditions. They are more likely to smoke, be obese and drink excess alcohol, but less likely to attend routine cancer screening services. This evidence has given rise to the concept of the social determinants of health.

A number of strategies at the European (see Box 1) and national levels have been implemented in the past decade to address health inequalities. These ideally adopt the principles of Health in All Policies, establish health equity as a political priority and take a life-course perspective. However, these policies often fail to tackle the fundamental cause of health inequalities, namely the unequal distribution of resources and power in society, or the transmission of poverty and ill health between generations.

It is important that policies acknowledge that health inequalities have causes beyond the direct influence of health sectors and require intersectoral actions to spur necessary transformations in social and economic development that will improve the health of the most vulnerable to the levels of the most affluent in society.

In the past 20 years, intersectoral actions from different sectors such as sport, transport, finance, agriculture or education and industry representatives, the media, and non-governmental organisations have contributed significantly to improving the efficiency, effectiveness and cost-effectiveness of many public health interventions and to reducing health inequalities. Successful examples include smoking bans in public areas, voluntary reformulation of salt content in food, taxes on alcohol and cigarettes, and expansion of facilities encouraging physical activity. Nevertheless, greater intersectoral collaboration is needed to create healthy environments that make healthy living easier, in particular for those with low socioeconomic status

people. Although these have attracted some support from health professionals, mainly in England, elsewhere there are growing concerns about evidence that they encourage adolescent smoking and reduce rather than help quitting.

Obesity

Existing policies are currently insufficient to stem the alarming rise in obesity prevalence, which has more than doubled since 2000. In terms of best buy policies, less than one-third of EU Member States have introduced taxes on sugar-sweetened beverages, taken action to ban trans fats or introduced mandatory reformulation of salt content in food.² Regulations on the advertising of unhealthy foods and drinks to children are missing in many countries and generally only apply to broadcast media, ignoring social media,

while few countries have introduced mandatory front-of-package labelling to help consumers easily understand the nutritional content of food. Promoting cycling as part of daily commutes represents a cost-effective way to increase physical activity levels among the working-age population, yet outside of some major cities in Western Europe, investment in cycling infrastructure remains low.³

Cancer screening

Further policy efforts are needed to reduce inequalities in access to cancer screening. Population-based screening programmes are absent in Bulgaria, Greece, and Slovakia, while uptake of screening varies markedly, ranging from 6.2% to 83.5% across countries, compared to the EU average of 60.2%. Furthermore,

significant inequalities in uptake remain between social groups, reflecting a need for cancer screening policies to address the barriers preventing people with low socioeconomic status from accessing screening programmes.

“ it is essential that cost-effective public health strategies are implemented and enforced in all countries

Many factors have influenced the success and failure of public health policy

Some countries in Europe have been more successful at adopting effective public health policies than others. Yet, why is this the case? In recent years, there has been increasing recognition that the political and commercial determinants of health present major obstacles to the implementation and effectiveness of public health policies.⁹ In particular, better understanding of the role of manufacturers in opposing healthy public policies has given rise to a new area of study, the ‘commercial or corporate determinants of health’. Powerful corporations can shape the dominant narrative, such as the trade-off between individual rights and government action. They also seek to capture the regulatory process, emphasising largely ineffective voluntary agreements rather than legislation. Politics also matters: a lack of political will to address a public health issue is likely to translate into a lack of action.

Finally, even if a public health issue has been established as a political priority, some countries may lack the necessary resources and infrastructure for the implementation of effective policies.

Routine surveillance of NCDs and related risk factors are not available in some countries, making it difficult to develop country-specific, evidence-based health policies. Many countries also lack an appropriately qualified public health workforce and the governance structures that are necessary to enact and enforce legislation. Importantly, investment in public health remains low throughout the EU, with preventative care generally accounting for an average of only 3% of health budgets,¹⁰ and with some countries experiencing a major reduction in spending following the recent global economic crisis.

The way ahead for public health policy

Public health policies over the last 20 years have contributed substantially to reducing the burden of disease in Europe. However, although good progress in the region has been made overall, a number of proven, cost-effective policies have not been introduced or have only been partially implemented in many countries. These policy gaps are undercutting health improvements and contributing to persistent health inequalities.

Moving forward, it is essential that cost-effective public health strategies are implemented and enforced in all countries. This will help create conditions that make it easier for people to live healthy lifestyles and will lay the foundation for public health to respond to growing and new threats posed by issues such as antimicrobial resistance, climate change and emerging and re-emerging infectious diseases. It is important that the equity effects of any policy are considered to ensure they do not disproportionately disadvantage the least well-off and exacerbate health inequalities.

To improve future public health responses, it is also important that all countries develop a highly motivated and skilled public health workforce that can meet emerging threats, advocate for public health, and build intersectoral partnerships to tackle health inequalities. Enhanced use of health information systems for surveillance of infectious diseases and NCDs, and related risk factors, combined with growing availability of big data – vast

quantities of rapidly collected, complex data – will improve understanding and monitoring of current and emerging health threats and can be used to inform appropriate responses. However, this is threatened by revelations of the misuse of data for commercial and political purposes and there is a need to rebuild public trust.¹¹

To adopt and implement effective public health policies it will be necessary to make better use of intersectoral governance mechanism such as cabinet committees and secretariats, parliamentary committees, interdepartmental committees and units, mega-ministries and mergers, joint budgeting, delegated financing, and public, stakeholder and industry engagement.¹⁰

Meeting future public health challenges can only be achieved by adopting a whole-of-society and whole-of-government approach. The engagement and action of individuals, civil society, researchers, public health professionals, and government and industry stakeholders are fundamental to ensure the successful development, implementation and enforcement of effective public health and intersectoral policies. As recognised by the Vienna Declaration, it is important that these actors are actively encouraged to engage with public health issues and that governments, industry and civil society are held to account for any health-harming actions.

Lastly, responding effectively to future health challenges in Europe will not be possible without renewed focus and investment in public health. Across the region, public health is not prioritised or incentivised, despite evidence that investing in effective prevention strategies can provide a greater return on investment and generally represents better value for money than treatment of disease at later stages. There is thus a strong economic case to be made for greater public health action, and public health professionals must advocate for public health to capture a larger share of health budgets.

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Organization and financing of public health services in Europe: Country reports

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What are “public health services”? Countries across Europe understand what they are, or what they should include, differently. This study describes the experiences of nine countries, detailing the ways they have opted to organize and finance public health services and train and employ their public health workforce. It covers England, France, Germany, Italy, the Netherlands, Slovenia, Sweden, Poland and the Republic of Moldova, and aims to give insights into current practice that will support decision-makers in their efforts to strengthen public health capacities and services.

Each country chapter captures the historical background of public health services and the context in which they operate; sets out the main organizational structures; assesses the sources of public health financing and how it is allocated;

explains the training and employment of the public health workforce; and analyses existing frameworks for quality and performance assessment.

The study reveals a wide range of experience and variation across Europe and clearly illustrates two fundamentally different approaches to public health services: integration with curative health services (as in Slovenia or Sweden) or organization and provision through a separate parallel structure (Republic of Moldova). The case studies explore the context that explain this divergence and its implications.

This study is the result of close collaboration between the European Observatory on Health Systems and Policies and

the WHO Regional Office for Europe, Division of Health Systems and Public Health. It accompanies two other Observatory publications Organization and financing of public health services in Europe and The role of public health organizations in addressing public health problems in Europe: the case of obesity, alcohol and antimicrobial resistance (both forthcoming).



UNIVERSAL HEALTH COVERAGE AND THE ROLE OF EVIDENCE-BASED APPROACHES IN BENEFIT BASKET DECISIONS

By: **Juliane Winkelmann**, **Dimitra Panteli**, **Miriam Blümel** and **Reinhard Busse**

Summary: The extension of universal health coverage along its three dimensions – population coverage, benefit coverage and financial protection – has dominated health policy agendas in recent years. However, decisions on the benefits covered by publicly financed schemes have only recently received increased attention, being supported by evidence-based approaches such as health technology assessment (HTA) to ensure quality and “value for money” of care. Yet, new developments in the area of high-cost speciality medicines have highlighted the limitations of HTA in guiding the optimal allocation of finite resources, posing a challenge to “universality” of coverage and requiring increased efforts towards aligned HTA in Europe.

Keywords: *Universal Health Coverage, Health Basket, Innovations, Pharmaceuticals, Health Technology Assessment*

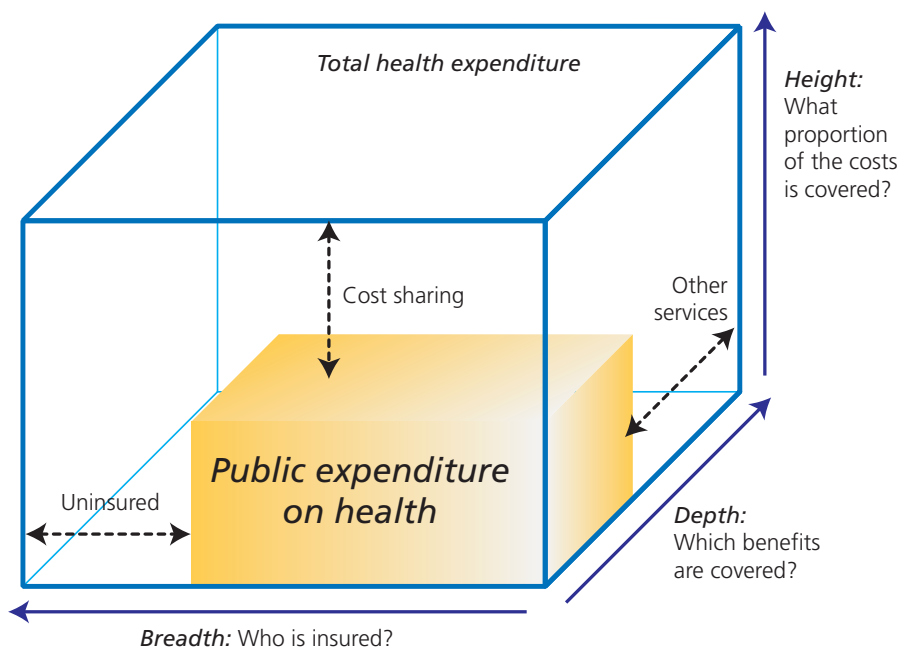
Introduction

All health care systems are confronted with the question of which treatments and pharmaceuticals to pay for publicly as resources for health are limited, thus competing with other sectors within the public budget. Despite health needs and desires, it is not possible for a health system to afford to pay for all available health care benefits for everyone, even under universal coverage aspirations. Therefore, trade-offs arise in coverage decisions when priorities have to be set between different benefits and cost-sharing levels as well as the population groups covered. As a consequence, most countries opt for two-tiered models

of health coverage, encompassing a mandatory public and a voluntary private component.

The rationale behind covering certain benefits while excluding others varies between jurisdictions, reflecting both societal norms and system characteristics. Public benefit “baskets” or packages are usually defined more broadly at the legislative level with a stipulation of the areas of care to be covered. They are then regulated more concretely, centrally or regionally and usually within each area of care, resulting in more or less explicit benefit baskets. Especially in the realm of coverage decisions for health

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Figure 1: The three dimensions of universal health coverageSource: ¹

technologies, evidence-based approaches have been increasingly employed to ensure quality and efficiency of care, or “value for money”, in the composition of the benefit package.

In recent years, benefit baskets in many European countries have been expanded by costly innovations in medicines and devices leading to rising health expenditures. In a context of already constrained health budgets, formal structures to support evidence-based decision-making in a multitude of countries have been established to identify (non-) cost-effective services. At the same time, the fundamental values of universal health coverage (UHC) and solidarity have come under threat; this became evident particularly during the economic crisis when countries had to decide between restricting the number of people covered (most visibly in Greece), the services included the benefit basket (see Box 1) and the extent of the cost to be borne privately for services in the benefit basket.²

Achieving UHC along the ‘coverage cube’

In the last 20 years, UHC has substantially gained importance with governments

demonstrating their commitment to achieving health care for all. Today it is one of the most prominent global health policies, most notably retained in the Sustainable Development Goals (SDGs) in 2015. The UHC concept encompasses three dimensions: coverage for everyone (breadth), type and number of needed health services covered (depth) and the proportion of total health service costs that are publicly funded and not subject to cost sharing (height), also referred to as financial risk protection, and is best reflected in the UHC cube (see Figure 1). The UHC cube was first conceived in mid-2000^{3 4} and was further developed for the framework behind the European Observatory’s Health Systems in Transition reports.⁵ It was most prominently used in the World Health Reports 2008 and 2010^{6 7} and has since become known as the coverage cube. Today, it is used worldwide to illustrate UHC and supports related analyses.

Defining the health benefit basket is still challenging

Despite the importance of the range of benefits covered, the focus in the discussion on UHC to date has been dominated by the two dimensions of

population coverage and financial protection. While both dimensions offer little scope for policy variation if the fundamental values of universality and solidarity are not to be contradicted, the range of services covered by publicly financed schemes constitutes a playing field in health policy for decision-making.⁸

Indeed, there is a lot of variation in the level of explicitness and the approaches countries use to define their priorities and benefit packages. They range from very detailed (positive) lists of all goods and services available through statutory coverage to a vaguely formulated and implicit benefit package with reference to broad categories of services (e.g. primary care, pharmaceuticals).^{4 7 9} For example, UK legislation defines very broad categories of health care services, considering services necessary within ‘reasonable limits’, while leaving providers with the possibility to establish positive lists.^{6 8} At the same time, an institution tasked with identifying necessary, appropriate and cost-effective care, the National Institute for Health and Care Excellence (NICE) provides very clear guidance on whether a new medicine should be made available to NHS patients who meet particular criteria.⁸ Health benefit baskets can also be defined negatively by excluding certain benefits. For example, Italy and Spain use positive and negative lists and have a structured and detailed minimum benefit baskets that can be further adapted by regional health authorities.^{8 9} Israel is probably the only country in the world with one detailed list of all benefits across all sectors covered under the National Health Insurance Act; the list is updated once a year.¹⁰

Over the last two decades, there has been a general trend to make positive lists more explicit, both in tax-funded countries (where benefits were previously left to the discretion of providers) as well as those with Social Health Insurance (where lists used to be merely fee schedules), and to expand the range of services in the benefit baskets.^{8 7} However, the opposite can also be observed, in particular during the economic crisis when services were removed from the benefits package (see Box 1).

Box 1: UHC and the economic crisis

In response to budget pressures during the economic crisis, many countries redefined benefit baskets and some tried to remove non-cost-effective services from coverage. In a study jointly carried out by the European Observatory and the WHO Regional Office for Europe in 2014, 15 European Union countries reported trying to restrict or redefine the publicly financed benefit basket between 2008 and 2013. Of these, only four countries incorporated HTA in decision-making while eleven countries restricted benefits on an ad hoc basis. Disinvestment mostly involved medicines, followed by cash benefits for temporary sickness leave and dental care, but also primary care visits (e.g. a cap was introduced on the number of general practice visits covered in Romania) and preventive services (the Netherlands and Bulgaria).^{11 11 12}

The importance of HTA for coverage decisions has grown

Tools supporting evidence-based decision-making are increasingly incorporated in formal decision-making structures, as mentioned above, especially in the realm of coverage decisions for health technologies (i.e. pharmaceuticals, medical devices, procedures or interventions). The concept of technology assessment as a policy-informing tool to guide decision-making for coverage in health care was first introduced in the United States in 1975. The evaluation model of the Office of Technology Assessment (OTA) included elements of safety, effectiveness and cost, as well as socioeconomic and ethical implications of adopting (new) technologies in health care. It was subsequently adapted by national health technology assessment programmes in a number of European countries.¹³

The exact scope and configuration of HTA are country-specific and heterogeneous. However, HTA is generally applied following marketing authorisation. After selection of the technologies to evaluate

(most commonly following an application for inclusion in the benefit basket by the manufacturer or a request by relevant decision-makers), scientific evidence is collected and evaluated (evidence assessment) and subsequently appraised in context (evidence appraisal).

These formal assessment mechanisms are most frequently in place for pharmaceuticals. In Europe, pharmaceuticals have historically represented one of the largest expenditure items in health care spending with costs predominantly being covered by statutory funds.¹⁴ To bring a new medicine to market, demonstration of safety and clinical “efficacy” are usually sufficient. These are demonstrated within randomised controlled trials, with selected patients (e.g. excluding multimorbid ones) and using placebo as control. It is the role of the subsequent HTA to determine whether – at least in principle – the therapeutic benefit is meaningful to patients compared to alternatives in real world conditions – and therefore whether, to what extent and/or at what price new medicines will be covered publicly. To ensure that they are subsequently used appropriately is mainly the domain of clinical guidelines.¹⁵

Expensive innovations have big implications for coverage decisions

New developments in the output portfolio of the pharmaceutical industry have highlighted the limitations of traditional HTA-based systems in guiding the optimal allocation of finite resources. The market entry of breakthrough therapies with large target populations and steep price tags (such as the pharmaceuticals against Hepatitis C in 2014) served as a wake-up call for policymakers, who were suddenly confronted with unmanageable budget impacts and a lack of suitable management levers. The number of new high-cost specialty medicines and so-called “niche-busters” (aimed at very narrowly defined patient sub-populations) has increased substantially over the last two decades. At the same time, evidence suggests that a substantial majority of these new pharmaceuticals do not provide substantial patient benefit gains compared

to existing alternatives.^{16 17} However, they do require evaluation and investment of HTA-related resources.

New medicines based on novel mechanisms, such as gene and cell therapies, have started entering the market with extremely high price tags (e.g. Novartis’ immunocellular therapy against leukaemia was priced at \$475 000 per infusion for the US market). Viewed against a backdrop of a per capita pharmaceutical expenditure of US\$ PPP 553 (OECD country average in 2015¹⁴), it becomes clear that health systems will be unable to bear such costs in a routine manner as part of the benefit package. A new discussion on the effect of these medicines on the “universality” of coverage in European health systems is warranted. Indeed, the Dutch Presidency of the European Council in 2016 placed the spotlight on the imbalances in the current system of development, pricing and reimbursement of medicines and raised questions about its sustainability for Europe and Europeans.

Looking forward

Decision-makers are increasingly confronted with difficult coverage decisions due to budget constraints and new and costly health technologies. Over the last two decades numerous techniques have been applied to guide the decision-making process and to direct the optimal allocation of finite resources. The desire to maximise the value for money of health services and to ensure the long-term sustainability of access to technologies, have been met by increased use of evidence-based approaches. In this context, the application of HTA has received increased attention in health policy in most European countries and will continue to play an important role, thus requiring enhanced collaboration and knowledge exchange. Indeed, the European Commission has been promoting related research and collaborative activities for more than 15 years, culminating in the establishment of an HTA network in Directive 2011/24/EU. The scientific and technical cooperation of the network has been the responsibility of the EUnet HTA Joint Actions.

A further promising step towards aligned and centralised HTA in the EU was made on 31 January 2018 when the European Commission issued a proposal for regulation building on the experience of EU Member States in the area of HTA and related collaboration and mandating joint assessments of clinical elements (effectiveness and safety) of new medicines and certain new medical devices. Although the proposal has been criticised for various reasons (e.g. manufacturers are not mandated to provide full trial data but are afforded the possibility to comment on assessment drafts and specify which information is not to be made publicly available), more collaboration in the evaluation of new medicines is a welcome concept on the path to ensuring that new technologies with true patient benefit are identified early and evaluated for inclusion in the benefit basket at affordable costs.

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DEVELOPMENTS IN EUROPE'S HEALTH WORKFORCE:

ADDRESSING THE CONUNDRUMS

By: Matthias Wismar, Claudia B Maier, Anna Sagan and Irene A Glinos

Summary: The health workforce makes a key contribution to the performance and sustainability of health systems. There is no adequate care without an adequate health workforce and the models of care are changing profoundly to address changing patient needs. To adapt to these changes the health workforce will need to continue to grow; nurses and other health professions will need to assume new and more sophisticated tasks and roles; and more investment in the health workforce is needed. But at the same time, the recruitment of health workers has limits, we have a looming nursing crisis and realigning investment with sustainability is difficult. To improve health system performance and sustainability it is important to understand and address these conundrums.

Keywords: Health Systems, Health Workforce, Performance, Sustainability, Investment

Expectations and conundrums

The health workforce is one of the main contributors – if not the most important one – to health system performance and sustainability in Europe. Although size and composition of the health workforce may vary widely between countries the challenges it is facing are similar. These challenges pose real conundrums:

- The health workforce is expected to grow further in the future, but the pool of potential health workers is shrinking
- Nurses are expected to assume new tasks and roles, but we don't have enough of them and we are losing too many

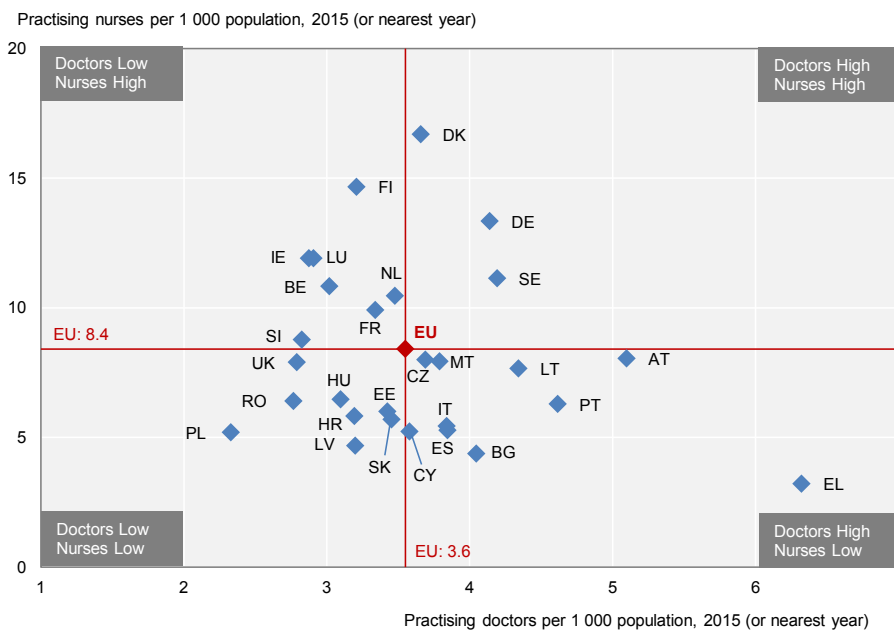
- Investment in the health workforce needs to be made but this may undermine health system sustainability

In this article we address these conundrums by presenting the characteristics of Europe's health workforce and showing why it is important. We will also analyse the three conundrums in more detail, explore what has been done over the last two decades and what more could be done.

What is the European health workforce?

The health workforce is the largest segment of the European labour market. In the European Union (EU) it amounts to 18.6 million workers which is 8.5%

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Figure 1: Doctor and nurse densities in European Union countries

Source: OECD data

of the total workforce.¹ It is bigger than the automotive and hospitality industry workforces, among others.

The health workforce has grown over the last two decades. This growth was more pronounced for medical doctors than for nurses and was stronger in the older EU member states. The financial and economic crisis has affected growth in some countries² but overall the growth pattern has been stable. The health workforce is much more than just doctors, nurses and pharmacists. For example the 2016 Federal Health Reporting for Germany lists 50 distinct health professions (without specialisations) in hospital, long-term care or ambulatory settings.³

The composition of the health workforce varies from country to country. As shown in **Figure 1**, some countries have a high doctor and nurse density, while others are low on both. Other countries are high on doctors and low on nurses and vice-versa.

The health workforce in Europe is diverse despite common legal frameworks. In the European Economic Area (EEA) countries, there are some commonalities in training for the so called regulated

professions under the directive on the recognition of professional qualifications (2005/36/EC). This includes medical doctors, dentists, nurses, midwives and pharmacists. But variations in curricula development and acquired knowledge and skills remain. Moreover, new roles are being continuously created, further adding to these variations. Currently seventeen EU countries have introduced or are in the process of introducing nurses in advanced roles. Finland, Ireland, the Netherlands and the United Kingdom have introduced advanced practice nursing roles with extensive task shifting between doctors and nurses while in thirteen countries the task shifting is more limited. But even within each of the groups there are variations regarding the assigned tasks.⁴ Another example of these variations was the stalled attempt to establish a common European training framework for health care assistants, despite a common core set of learning outcomes identified by researchers, because of different training and regulatory requirements.⁵

The health workforce goes beyond health systems. There are plenty of professions which either have a partial role in health or need to have some health awareness.⁶ This is particularly the case for professions

in long-term care, social care or public health and health promotion; but also social workers, and increasingly fire fighters, police officers, housing officers and volunteers are tasked with health awareness, for example conducting 'safe-and-well' visits, detecting symptoms of neglect, loneliness, depression and diseases.

Why is the health workforce important?

Financing the health workforce requires a lot of money. A study published by the World Health Organization (WHO) has estimated that expenditure on the health workforce as share of total expenditure on health is 73.4% in the WHO European Region.⁷ Even in a high technology environment, like the hospital, it is estimated that two thirds of all expenditure is related to the health workforce.

“nearly 75% of all health expenditure goes on the health workforce”

Producing an adequate health workforce requires planning and forecasting, curricula development, adaptation of training facilities and continuous medical and professional development. This is challenging given the sheer size of the health workforce, the multitude of professions involved and the constantly changing models of care.

In health care delivery, it is absolutely essential that the right number of health workers, with the right skills and qualifications are in the right place. If not, waiting lists will emerge or patients will not have access to services that are in the health care basket. Patients afflicted with chronic diseases will face discontinuity in their treatment. It goes without saying that the health workforce has a critical impact on the quality and safety of services, medical outcomes and patient experience.

Box 1: WHO and the global/European health workforce

In WHO and the United Nation system, the health workforce has increasingly received a lot of analytical and political attention. WHO published in 2006 a landmark report – *World Health Report – Working together for health* – focusing thematically on the health workforce. In 2010 the Member States adopted the *WHO Global Code of Practice on the International Recruitment of Health Personnel* in which member states agreed not to recruit health workers from countries confronted with shortages of health workers. The UN Secretary General established a High-Level Commission which, together with WHO, OECD and ILO, has produced a *Five-Year Action Plan for Health Employment and Inclusive Economic Growth 2017–2021*. In 2017, the WHO Regional Office for Europe published *The toolkit for a sustainable health workforce in the WHO European Region*. The toolbox is framed around four strategic objectives: education and performance, planning and investment, capacity-building, and analysis and monitoring.

The governance of the health workforce is critical for health system reforms. As many countries are constantly striving to improve the performance and sustainability of their health systems, they are planning health system reforms. But the implementation of patient-centred health system reforms, the adaptation of innovations, new patient pathways and models of care will not work without the health workforce. The introduction of new tasks, the redistribution of existing tasks, the increased need for coordination and for more team work (like, for example, in palliative teams, chronic disease teams and mental health care teams) require changes in the health workforce; changes with regard to the numbers, the proportions, the skills and eventually also the professional ethics of health workers. Health workforce changes can trigger so-called ripple effects: changes in the health workforce require changes in regulation and scope of practice, adaptation of payment systems, changes in medical education and changes in governance structures.⁸ This is a challenging task because in most countries responsibilities for those changes sit at different political-administrative levels and are not necessarily within the remit of the ministry of health. They are also often associated with strong vested interests of stakeholders.

Health workforce conundrums

Given the great importance of the health workforce and the challenges it poses

with regard to funding, training, service delivery, outcomes and governance it is crucial to get its future development right. But this is, unfortunately, not straightforward; instead, it poses three conundrums.

“
17 European countries are introducing advanced roles for nursing

Growth and demography

The first conundrum is posed by health workforce growth and demography. The majority of experts predict that the health workforce would need to grow in order to meet future care needs. This is unsurprising since demographic changes and the rise in chronic diseases and multi-morbidities demand more services. There are, however, three emerging questions all linked to demography. First, an accelerated exit of medical doctors from the health workforce is expected. Many European countries that expanded medical training capacities in the 1970s are now facing a wave of retirees. This is calling into question whether the replacement by new

doctors can keep pace. Second, and this concerns all health professions, in the EU the share of children and young people in its population has been decreasing continuously over recent years. The pool from which we can train and recruit future health workers is shrinking, though projections suggest that we will need more. Third, the new generation of health workers is apparently not following the working patterns of its predecessors. The feminisation of the medical profession is advancing. The nursing profession is already almost entirely female: 90% of nurses in the United Kingdom's NHS are women. This requires more opportunities to reconcile family and work. In many countries doctors tend to work fewer hours than previous generations, they tend to work part time and have less appetite for taking on entrepreneurial risks or investing in an office-based setting.

Investment and sustainability

The second conundrum is on looming and current nursing shortages and the expansion of the role that nurses play in health systems. Many countries are trying to strengthen primary health care through the increased employment of nurses. Slovenia, for example, has added half a full-time equivalent nurse to each general practice to focus on prevention and health promotion, a service included in the health care basket but sometimes neglected by medical doctors. Other countries add nurses in order to take on non-medical tasks from medical doctors, for example wound dressing. Germany has recently given nurses and medical assistants additional training to do time-consuming home visits in lieu of medical doctors. As already mentioned seventeen European countries are introducing advanced roles for nurses to unburden medical doctors from standardised medical tasks so that doctors can focus on the more complicated cases. The evidence overwhelmingly shows that nurses conduct simple and standardised medical task as safely and as well as medical doctors.⁹ These developments all seem to make perfect sense if there wasn't a looming nursing crisis. There is some, but limited, evidence that suggests that enabling nurses to work in advanced roles and improve their career opportunities may attract more students into nursing, yet the evidence to date is

Box 2: Health workforce research agenda

- 1) to develop frameworks that align health systems/governance and health workforce policy/planning
- 2) to explore the effects of changing skill mixes and competencies across sectors and occupational groups
- 3) to map how education and health workforce governance can be better integrated
- 4) to analyse the impact of health workforce mobility on health systems
- 5) to optimise the use of international/EU, national and regional health workforce data and monitoring
- 6) to build capacity for policy implementation

primarily from the United States.¹⁰ In the EU, the European Commission had forecast a shortage of 590 000 nurses in 2020.¹¹ This crisis is more evident in social and long-term care, but it also affects health care. It is a particular issue for hospitals with high staff turnover.

Shortages and expansion

The third conundrum is the one on investing in the health workforce to ensure its expansion while at the same time securing the financial sustainability of the health system as a whole. Investment might be a good idea in terms of performance if this improves access, comprehensiveness of care, continuity of care, quality, safety, the patient experience and medical outcomes. But in terms of a health system's financial sustainability it might be a challenge that is difficult to master. How can we ask for more investment if it undermines a health system's capacity to pay for it long-term?

What has been done so far?

In Europe, a lot has been done over the last 20 years to put health workforce

development and policy on an evidence base. European research and policy action on the health workforce has been intensified over the course of EU enlargement in 2004. Further to this, initiated by Belgium and supported by other member states, the European Council adopted Conclusions on the health workforce giving the European Commission a mandate to act in this policy area. The action plan for the EU Health Workforce became part of the EU high level policy on a job-rich recovery. International agencies like WHO have also ensured that health workforce issues remain high on the policy agenda (see Box 1). Against this backdrop, major areas of research and action have evolved:

- *Health workforce forecasting and planning* is a necessity since health systems are undergoing profound changes. It needs to start from the changing needs of patients and health professionals and the evolving models of care.¹² Some countries, such as the Netherlands, are using an integrated, multi-professional workforce planning approach, taking account of skill-mix changes to better project the future health workforce needs.¹³
- *Recruitment and retention* is key to avoid underserved rural and remote and over-crowded urban areas. In addition, an early exit from the health workforce needs to be avoided. There are educational, financial, professional and personal and regulatory instruments which can address the mal-distribution of health workers.¹⁴ There are also policy options for retention in the hospital sector.¹⁵
- *Continuous professional development* is crucial since the knowledge and skills acquired at the end of formal undergraduate and postgraduate professional medical education are insufficient to sustain competence and performance over a career. Physicians, dentists, nurses, midwives and other health professions are expected to effectively engage in lifelong learning strategies. Increased accountability, compulsory engagement, enhanced quality and rigour of programme,

practice-specific and needs-based training plans are among the policy options.¹⁶

- *Public health workforce training and education* lags behind. Large gaps are apparent in both the numbers of professionals trained and the kind of training that exists. There are policy options that help to address a much wider public health workforce than today and to fill deficits with regard to information, prevention, social and regulatory issues.
- *Health professional mobility* is of high importance in the EU, including the EEA. Ireland, Norway, Sweden, Switzerland and the United Kingdom have more than 20% foreign trained doctors in their health workforce.¹⁷ Mobility has been growing with EU enlargements. It has changed directions and magnitude with the economic and financial crisis. The system, while not broken could benefit from some changes to improve the trade-offs between efficiency and equity, between EU labour markets and health systems, between sending and receiving countries and between employers and the health workers.¹⁸ Mobility and cross-border collaboration in the health workforce is essential, especially for smaller countries or in highly specialised care.¹⁹
- *Skill-mix innovations* are essential when improving the performance of health systems. A common strategy is to unburden medical doctors from non-medical or routine medical tasks by assigning advanced practice nurses and other specialised nurses, pharmacists or other professionals with advanced roles. Complex patient pathways also require more coordination skills and more team working skills.²⁰
- To further advance those and other pressing issues the health workforce research community has published a research agenda (see Box 2).²¹

Outlook

There are no easy solutions to these conundrums. But several additional factors may play a role in solving them. Among these, there is the profound change in labour markets that we are expecting in

the near future. Developments in artificial intelligence, self-driving vehicles and robotics are deemed to change the demand for certain professions. This does not need to result in structural unemployment as the health system is likely to absorb more workers. It is, however, more of a mid-term solution as retraining today's lorry drivers and accountants to become nurses and other health professions would pose challenges on all sides.

Second, the investment in the health workforce and particularly in nurses and other health professions may trigger positive recruitment and retention effects as well as positive effects for economic growth. Income levels, career pathways and working conditions that are compatible with family life and conducive to individual work-live-balance choices will matter. These investments may be perfectly in line with improvements in performance. It may also help to build up consumer power in a part of the working population which is at the moment, especially in comparison with the US, not well paid. Above all, it will be essential that we have the economic models, as well as the policies and politics in place to achieve this transition.

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HSPM COUNTRY NEWS

The Observatory's Health Systems and Policy Monitor platform provides systematic descriptions of country health systems and features up-to-date information on ongoing health reforms and policies. See the individual country pages for these news items and more:

<http://www.hspm.org>



Compiled by Sherry Merkur based on 2018 reform logs.

Croatia: Establishment of a national fund for very expensive drugs

In December 2017, the Croatian government decided to establish a special state budget account where private donations can be made to finance very expensive drugs that are not covered by the Croatian Health Insurance Fund. The funds will be spent transparently on strictly defined drugs for the treatment of rare and/or serious diseases. A special commission appointed by the Minister of Health will evaluate, for each individual patient, the medical indications for the use of drugs and will recommend and approve the purchase of drugs.

Czech Republic: Re-establishment of the Patient Council

In October 2017, the Czech Minister of Health appointed 24 members to a re-established Patient Council (Order No. 15/2017). The members were carefully selected so that different types of patients' needs were equally represented. The Council is meant to serve as a mediator between patients' needs and the Ministry of Health and has a four year mandate, which

includes providing comments on changes in legislation and actions. Additionally, the Council can establish working groups to handle specific questions such as those affecting patients with a particular diagnosis.

Denmark: Revised psychiatric care pathways

Psychiatric care pathways were revised, in September 2017, after a few years of monitoring clinical use and patient experiences. The aim of psychiatric care pathways, which were originally implemented by the Danish regions in 2013, was to offer standardised high-quality treatment for patients with similar mental health problems in all psychiatric departments. Twenty pathways have been defined aiming to strengthen the quality of psychiatric care and increase the quality of life and average life expectancy among psychiatric patients. The pathways will be revised further if significant new evidence emerges.

France: New national prevention plan

The new prevention plan covers all population groups. For young children, key objectives include general practitioners prescribing physical activity and information campaigns on endocrine disruptors. For adolescents, measures mainly target risky sexual behaviours and addictions by providing free condoms and easing access to outpatient clinics. For adults, measures include extensive coverage of smoking cessation treatments, better treatment for hepatitis C outside of hospitals, and organised screening for cervical cancer. For disabled and older people, objectives include improving regular follow-ups and dental care in nursing homes. Additional efforts involve educating the general population in first-aid, improved medicines labelling and pharmacists administering vaccines.

Israel: Further expansion of dental care coverage

The Ministry of Health budget (2018-19) will fund the expansion of the health basket to include dental care for older people

aged 65 and over during 2018, and for children up to 18 years old during 2019. This step will conclude reforms concerning dental care for children, which started back in 2010 with the inclusion of dental care for children up to 8 years old in the health basket. Since then, dental care has been gradually expanded for children up to 10 years old (in 2011), 12 years old (2012), 14 years old (2016) and 16 years old (2018). The most costly group for dental care are older people; therefore, the funding for this group will be provided gradually.

Lithuania: Continued expansion of eHealth services

A turning point for eHealth services in Lithuania occurred in 2017 as the use of ePrescriptions and other electronic medical services expanded rapidly. By March 2018, 429 providers had entered into data transfer agreements, and a further 121 had expressed their willingness. Since March 2018, all records of the following must be managed electronically: outpatient visits, hospitalisations, ePrescriptions, birth and death certificates and drivers' health check-ups. Survey data from the Ministry of Health shows that 38% of all health care providers supply data to the central eHealth system (ESPBI IS), issue ePrescriptions and medical certificates, while 46% are still in the preparatory phase.

The Netherlands: New Act on organ donation

Starting in 2020, people who do not actively express their choice in the Organ Donation Registry will be registered as having no objection against organ donation; however, next of kin will have the option to object to donation. All Dutch citizens will receive a letter at the age of 18, in which they are asked to register their choice; also, in 2020 all citizens who are not yet registered will receive this letter. If they fail to respond, they will be registered as having no objection. Despite controversy, the Act was passed by Parliament in September 2016 and the Senate in February 2018, both by a very narrow majority.

Norway: Financing of specialist health care to be revised

In March, the Royal Commission on resource allocation to the Regional Health Authorities (RHAs) was appointed to advise the government on a new model of financing for specialist health care. Currently, the four RHAs are financed by a combination of block grants (based on population size, demographics and cost) and activity-based funding (based on diagnosis related groups). The RHAs are free to decide how to allocate funding to hospitals within their respective regions. In its assessment and proposals, the Commission will take into account the overall responsibility of the RHAs to provide specialist care for their respective populations as well as their obligations regarding research and education of health personnel, but activity-based funding will not be assessed. The findings are expected in November 2019.

Poland: Mobile dental clinics to help improve oral health in children

In 2017, the Minister of Health purchased 16 mobile dental clinics ('dentobuses'), one for each county (voivodeship). Dentobuses have fully equipped treatment rooms, including x-ray machines, and are meant to provide dental care to children in smaller towns, which do not have dental clinics at schools or in the area. The funds to purchase dentobuses came from the state and are part of a special budget dedicated to specific solutions for improving the quality and accessibility of health care services. Dentobuses will be made available free-of-charge to dental care providers contracted by the National Health Fund (NHF). Costs of dental services will be covered by the NHF and maintenance and running costs will be met by the providers.

Portugal: New tax on soft drinks

In February 2017, the government extended the existing tax on alcoholic beverages to all drinks with added sugar or sweeteners. This policy aims to encourage reduced consumption through higher prices; reduce the amount of added sugar in the products; and to use the tax revenue to partially

fund the NHS. Data show a reduction of around 5% in the purchase of these beverages from 2016 to 2017. In 2016, 63% of beverages had more than 80g of sugar per litre, but since reinforcement of the law (2017) the percentage decreased to 38% while the percentage of beverages with 5 to 8g of added sugar increased from 6% to 28%. This suggests a positive impact of this policy in the reduction of the amount of sugar added to soft drinks.

Romania: Implementation of the European Drug Verification System (EDVS)

According to EU legislation, EDVS should be fully operational across the EU from 9 February 2019. In February 2018, implementation of EDVS was officially launched in Romania with the establishment of the Organisation for the Serialisation of Medicines in Romania (OSMR). It is an NGO with the specific task of implementing Directive 2011/62/EU on preventing the entry of falsified medicinal products into the legal supply chain. It will provide a verification platform for Romania, connected to a European hub, through which pharmacies and other stakeholders will be able to verify the authenticity of medicinal products. Producers of medicines will be obliged to place a unique identifier and an anti-tampering device on each pack of medicine to allow their identification and authentication.

Slovenia: Preparation of a new public health strategy based on EPHO

The Slovenian Ministry of Health, together with WHO/Europe and the National Institute of Public Health (NIJZ) have prepared a new public health strategy for Slovenia based on a comprehensive assessment of the ten essential public health operations (EPHOs). After previous unsuccessful attempts to develop a national public health national strategy, the Ministry of Health decided to mobilise and involve a wide range of public health professionals and other stakeholders in assessing public health, including the use of the WHO online tool for the assessment of the EPHOs. The process started in September 2017, with a draft strategy produced in 2018.

Spain: Persistent growth of pharmaceutical care

Total pharmaceutical expenditure in Spain increased 3.1% in 2017 compared to 2016, reaching an overall bill of €21.7 billion. From this total, about half was spent on outpatient prescriptions, 30% on in-hospital medicines and 21% on over-the-counter drugs. Notably, drugs prescribed in outpatient premises experienced a 2.5% increase (from 2016 to 2017), continuing a steady upward trend since 2014. Nonetheless, the amount spent on outpatient prescriptions in 2017 was still below that in 2009 or 2010. In turn, hospital pharmaceutical expenditure increased 3.3%, while over-the-counter spending increased 4.3% in the same period. Average prices for pharmaceuticals rose 1.82% in 2017 compared to 2016, while the number of prescriptions increased by 0.77%.

Sweden: New decision-making process for national concentration of highly specialised care

This new process was adopted into the Healthcare Act in July 2018. The law defines the concept of national highly specialised care as publicly funded health care that needs to be concentrated in one or a small number of delivery units rather than in each health care region in order to maintain quality, patient safety and an effective use of resources. The new process allows for concentration of more services and to an increased number of delivery units with consideration given to whether the care is complex or rare and whether it requires a certain minimum volume, multidisciplinary competence, or large investments.

MY FAVOURITE OBS BOOK OR ACTIVITY



Fred Lafeber

@Ministry of Health, the Netherlands

Congratulations and keep up the good work! My favourite is summer school 2011 on ageing.



Melitta Jakab

@WHO Barcelona Office for Health Systems Strengthening

Happy Bday @OBShealth The European health policy landscape wouldn't be the same without you! My favourite is the Eurohealth issue on leapfrogging health systems responses to noncommunicable diseases.



Dimitrios Florinis

@DGSANTE

Two books that inspired me for my PhD and in my professional life: *"Health Policy and European Union Enlargement"* (2004) and *"Health Systems Governance in Europe: The Role of EU Law and Policy"* (2010). They both present the challenges and opportunities in EU health policy and show that in health there are no borders. Continue the work and inspire future generations of policy makers!



Eduardo Pisani

@UCB Biopharma

Eurohealth has been a great tool to share valuable information across the health community.



Hans Kluge

Director of the Division of Health Systems and Public Health, WHO/Europe

'The 2013 Observatory study: *"Successes and failures of health policy in Europe. Four decades of divergent trends and converging challenges"*, is a landmark publication as it provides a wide-ranging assessment of the performance of healthy public policies, showing us what works to improve health systems and in what circumstances'.



Andre Peralta Santos

@University of Washington

The HiTs are a flagship product, but my favourite activity are the policy dialogues.



Marius Ungureanu

@Cluj School of Public Health, Romania

Happy anniversary, @OBShealth! Great resources, but even greater people! Grateful for all your work, my favourite though is the policy brief on efficiency & equity of #healthworkforce mobility. Keep up the good job!



Luigi Bertinato

@Italian National Institute of Public Health

The Venice summer school: a way to close the gap between scientists and health workers involved in front line activities



Stefan Buttigieg MD

@health20malta

My favourite: Malta HIT 2017 with @natasha_azzmus @nevillecalleja @SherryMerkur



OUR MISSION:

- strengthening health systems
- promoting evidence-based policy making
- bridging the gap between health research and policy making

OUR APPROACH:

- informing policy makers
- sharing international evidence and experience
- building partnerships

OUR FUNCTIONS:

- monitoring country health systems and health policy developments
- analysing trends and health systems performance
- assessing health systems performance
- engaging with policy makers

Health Policy – special issue

- Special issue on the Occasion of the 20th OBS anniversary.
- Collection of cross-country comparative articles (*partly Open Access provided by OBS, partly others*)
- Editorial by Reinhard Busse and Ewout van Ginneken on the Observatory and on comparative Research in Europe
- Table showing 40 cross-country comparisons published in Health Policy since 2014 including topics and countries covered.

