



# EUROHEALTH

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## ➤ Enhancing the sustainability of long-term care

- Preventing social isolation and loneliness
- Improving outcomes of people with long-term care needs
- Policy measures to support unpaid care
- Long-term care and migrant care work
- Patient engagement in Alzheimer's Disease
- Switching health insurer in the Netherlands
- Implementing Advanced Practice Nurses in Swiss primary care
- Centralising health care administration in Finland
- New primary care policy in the Russian Federation

## EUROHEALTH

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**2** EDITORS' COMMENT

## Eurohealth Observer

**3** **PREVENTING SOCIAL ISOLATION AND LONELINESS** AMONG OLDER PEOPLE – Joanna Marczak, Raphael Wittenberg, Lorraine Frisina Doetter, Georgia Casanova, Stella Golinowska, Montserrat Guillen and Heinz Rothgang**6** **IMPROVING OUTCOMES FOR PEOPLE WITH LONG-TERM CARE NEEDS** THROUGH PERSONALISATION – Lorraine Frisina Doetter, Francesco Barbabella, Montserrat Guillen, Blanche Le Bihan, Joanna Marczak, Ricardo Rodrigues, Heinz Rothgang, Miguel Santolino, Alis Sopadzhiyan, Agnieszka Sowa-Kofta and Raphael Wittenberg**10** **POLICY MEASURES ADOPTED TO SUPPORT UNPAID CARE** ACROSS EUROPE – Blanche Le Bihan, Giovanni Lamura, Joanna Marczak, Jose-Luis Fernandez, Lennarth Johansson and Agnieszka Sowa-Kofta**15** **LONG-TERM CARE AND MIGRANT CARE WORK: ADDRESSING WORKFORCE SHORTAGES WHILE RAISING QUESTIONS FOR EUROPEAN COUNTRIES** – Agnieszka Sowa-Kofta, Ricardo Rodrigues, Giovanni Lamura, Alis Sopadzhiyan, Raphael Wittenberg, Gudrun Bauer, Lorraine Frisina Doetter, Stefania Ilinca, Joanna Marczak, Andrea Piersinaru and Heinz Rothgang

## Eurohealth International

**19** **PATIENT ENGAGEMENT STRATEGIES TO MOVE TOWARDS EARLIER DIAGNOSIS OF ALZHEIMER'S DISEASE** – Mercè Boada, Annette Dumas, Laura Campo, Bengt Winblad and David Krivec

## Eurohealth Systems and Policies

**22** **SWITCHING HEALTH INSURER IN THE NETHERLANDS: PRICE COMPETITION BUT LACKING COMPETITION ON QUALITY** – Judith De Jong and Anne EM Brabers**25** **IMPLEMENTING ADVANCED PRACTICE NURSES IN SWISS PRIMARY CARE** – Beat Sottas, Renata Josi, Stefan Gysin and Stefan Essig**29** **CENTRALISING HEALTH CARE ADMINISTRATION IN FINLAND – AN INEVITABLE PATH?** – Liina-Kaisa Tynkkynen, Ilmo Keskimäki, Eeva Reissell, Meri Koivusalo, Vesa Syrjä, Lauri Vuorenkoski, Bernd Rechel and Marina Karanikolos**34** **NEW PRIMARY CARE POLICY IN THE RUSSIAN FEDERATION** – Erica Richardson and Igor Sheiman

## Eurohealth Monitor

**38** **NEW PUBLICATIONS****39** **HSPM COUNTRY NEWS**

Long-term care in Europe is struggling to keep up with rising demand from an ageing population that brings with it an associated increase in complex disabilities and chronic conditions such as dementia. With demand expected to continue growing in the future, policymakers have become increasingly interested in finding innovative solutions to ensure the sustainability of long-term care. Many of these solutions involve efforts to prevent or delay formal long-term care dependency by older people, either by improving health and wellbeing or by securing the supply of informal carers.

In the opening article of this issue's **Observer** section, Marczak et al., explore the impact of a wide range of interventions that have been implemented to help tackle social isolation and loneliness amongst older people, two issues of growing concern that have been linked to poorer health and wellbeing. Personalisation, or person-centred, approaches to improving outcomes for people with long-term care needs are assessed in the following article by Frisina Doetter and colleagues. The authors suggest that mixed findings on the effectiveness of personalisation places the onus on policymakers to develop additional solutions, which are likely to involve digital health. In the remaining two articles, the spotlight is turned on policies and strategies to ensure that the future supply of care workers can meet demand. Le Bihan and colleagues start by mapping the different types of policy measures that have been implemented across Europe to support informal carers to provide care for as long as they wish to do so, highlighting the many challenges in balancing the needs of carers with those of dependent people. In the final article of the section, Sowa-Kofta and co-authors explore the migrant long-term care workforce, showing that while transnational care migration is growing in importance, social policies specifically regulating this type of service provision are rarely adopted.

The **International** section presents an article looking at Alzheimer's disease which is the most common form of dementia. Boada et al. discuss the reasons for late or under-diagnosis of Alzheimer's disease and stress how early diagnosis is a crucial step in accessing care and support. They go on to look at innovative ways to address this challenge.

Four countries are covered in the articles in the Eurohealth **Systems and Policies** section. First, we go to the Netherlands where De Jong and Brabers tell us about switching health insurer. They discuss the rate of switchers over time and the reasons for doing so. Heading south to Switzerland, Sottas and colleagues consider how a lack of GPs has led to the implementation of the role of advanced practice nurses in primary care. They present some pilot projects which are underway and assess the benefits and challenges which have been observed thus far. Next, we turn to Finland where discussions about centralisation in the organisation of health systems have been enduring. Tynkkynen et al. detail the slow process of centralisation that has taken place since the early 2000s, including a reduction in the number of municipalities. Lastly, going east, Richardson and Sheiman enlighten us about a new national project to strengthen primary care in the Russian Federation.

We wish all our readers a happy holiday season and healthy new year!

*Sherry Merkur, Editor*  
*Gemma Williams, Editor*

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# PREVENTING SOCIAL ISOLATION AND LONELINESS AMONG OLDER PEOPLE

By: Joanna Marczak, Raphael Wittenberg, Lorraine Frisina Doetter, Georgia Casanova, Stella Golinowska, Montserrat Guillen and Heinz Rothgang

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**Summary:** Social isolation and loneliness among older people are linked to lower quality of life, cognitive function, wellbeing and independence, and contribute to increased use of health and social care services. As populations age, implementing policies to identify, prevent and reduce social isolation and loneliness has therefore emerged as a major concern for health and social care policy makers. Across Europe, action is being taken to address social isolation and loneliness. While the evidence on the effectiveness of measures is variable, examples show that much can be done to promote social integration and improve the quality of life of older people.

**Keywords:** Older People, Social Isolation, Loneliness, Social Care Prevention

#### Introduction

Social isolation and loneliness can occur at almost any age, but while they are an emergent problem among younger people, they still predominantly affect individuals at older ages. It has been estimated, for example, that almost half of individuals aged over 60 are at risk of experiencing social isolation, while one-third will experience some degree of loneliness.<sup>1</sup> Social isolation and loneliness among older people have been linked to lower quality of life, cognitive impairment, reduced well-being and loss of independence. Longitudinal evidence has shown that the oldest old who experience cumulative exposure to social isolation and loneliness are at greatest risk of experiencing negative consequences for physical health and well-being.<sup>2</sup>

The significant negative physical and mental health consequences of social isolation and loneliness contribute to increased use of health and social care services and bring substantial costs for health systems. Implementing policy actions to identify, prevent and reduce social isolation and loneliness has therefore emerged as a major concern for health and social care policymakers, in particular as populations age. Action is being taken across Europe to address social isolation and loneliness. While the evidence on the effectiveness of measures is variable, examples show that much can be done to promote social integration and improve companionship and emotional support to older people. In this article we synthesise findings from a rapid literature review to assess the effectiveness of some of these interventions.

### Box 1: Definitions

**Social isolation** relates to lack of contact with family, friends or other people. The extent of social isolation can therefore be assessed from data about the frequency and duration of such contacts.

**Loneliness** is an emotional feeling, which may or may not be accompanied by social isolation and can only be assessed by asking people whether they feel lonely.

The number of older people has been rising and will continue to rise across Europe. This is due partly to the baby boom cohorts reaching old age but also to increased life expectancy. It is important for the quality of life of older people and their families that the period in which they experience social isolation, loneliness and disability reduces rather than rises as life expectancy increases.

It is important to recognise that while measures to reduce social isolation and loneliness are often implemented together, these concepts are not the same (see Box 1).

### Types of interventions to prevent and reduce social isolation and loneliness

Interventions aiming to reduce social isolation can be broadly classified into one-to-one interventions; group interventions; neighbourhood and community interventions; and technology focused interventions. More specifically, they may include at the individual level ‘befriending’ and at the collective, group level a range of services from lunch clubs to schemes that help people widen their social circles or promote health and well-being. Wider community programmes promote participation in various activities (e.g. sport facilities, libraries) as well as joining and using outreach and volunteer programmes.

A thematic analysis identified that these types of interventions could be classified into six categories based on their purpose, their mechanisms of action

and their intended outcomes.<sup>8</sup> They were: social facilitation interventions, psychological therapies, health and social care provision, animal interventions, befriending interventions, and leisure/skill development.

### Evidence on effectiveness of interventions to reduce social isolation and loneliness

#### One-to-one interventions

There is some evidence that one-to-one interventions can improve psychological and physical well-being. For example, a study on home visiting in a retirement home in the USA over a two-month period illustrated an increase in social activity, amount of time spent in active pursuits and number of activities planned among participants.<sup>9</sup> A study among older people in Ireland who received a volunteer visit for 10 weeks compared to usual treatment demonstrated a decrease in loneliness.<sup>5</sup> Another example, from Canada, involving volunteer visitor programmes in the community showed increased social integration at six weeks, but no effect on perceptions of intimacy, nurturance and guidance.<sup>4</sup> However, another Canadian study involving volunteer weekly home visits showed no effect on social and leisure activities, or satisfaction with social relationships at either three or six months.<sup>6</sup> In the Netherlands, computer and internet training sessions delivered by an instructor over a two week period to community dwelling older people with no previous internet experience and computer use over a 12-month period reported no effect on loneliness or social network size at either 4 or 12 months compared with a control group.<sup>4</sup>

#### Group based interventions

Evidence has also shown that group-based interventions to prevent social isolation and loneliness are often effective. For example, in Finland delivery of socially stimulating group activities including ‘art and inspiring activities’, ‘group exercise and discussion’ and ‘therapeutic writing and group therapy’ reduced isolation and loneliness in older people, improved well-being and cognitive function and also lowered health care costs of participants.<sup>8</sup> In another example, a 14-week community

singing group initiative in the United Kingdom was found to reduce depression and anxiety and increase mental health related quality of life, with the intervention marginally more cost-effective than usual activities.<sup>7</sup> A study of a Friendship Enrichment Programme in the Netherlands, which involved 12 weekly group lessons in self-esteem, relational competence, phases in friendship formation and social skills, also resulted in a significant reduction in loneliness within a year after the programme, with a combination of developing new friendships and improving existing friendships reducing loneliness.<sup>8</sup>

“ Social isolation and loneliness contribute to increased use of health and social care services

Nevertheless, other interventions were less successful in reducing social isolation and loneliness. For instance, a hen-keeping project in England where volunteers were trained to establish hen-houses and support other older people to maintain them, did not result in any long-term change in reported loneliness, depression and anxiety, although it did overall increase quality of life of participants.<sup>9</sup> Similarly, a psychological group rehabilitation in Finland, where facilitated groups met once a week for three months with the aim to empower participants and promote friendships did not improve loneliness or social networks between groups, although a significantly larger proportion of group participants found new friends during the follow-up year.<sup>10</sup>

#### Technology focused interventions

Emerging evidence also shows that technology-focused interventions can successfully contribute to reducing social isolation and loneliness in older people.

For instance, use of a video network in the Netherlands which allowed users to contact a nurse 24/7 and to interact with carers, friends and family contributed to a significant reduction in loneliness in older users.<sup>11</sup> Similarly, a decrease in loneliness was reported by users who participated in a national pilot study in the United Kingdom of telephone befriending support projects, where volunteers provided emotional support for older people.<sup>12</sup> In Finland and Slovenia, provision of computer sessions teaching basic information technology (IT) skills and training on Skype and internet use also led to a significant reduction in loneliness overall especially for those using email, although there was no reported change in loneliness among those using Skype.<sup>13</sup>

### Policy implications / implications for the future

Research indicates that loneliness and social isolation increase the likelihood of people experiencing adverse health outcomes and are linked to various conditions such as high blood pressure, heart disease, obesity, depression, cognitive decline, Alzheimer's disease, sensory and mobility impairments. A wide range of interventions has been developed to tackle social isolation and loneliness amongst older people. Although numerous interventions reviewed here reported some success in reducing social isolation and loneliness, there was a significant heterogeneity between interventions. For example, evidence indicates that group level interventions may be more beneficial than one-to-one interventions, and interventions that include social activity and support were more likely to be effective. It should be noted however that the effectiveness of interventions may depend on their specific content, the specific groups of older people to whom they are offered and the specific context in which they are offered.

The methodological quality of evaluations may also be contributing to the variability of their findings. Assessing effectiveness and cost-effectiveness of preventative interventions can be challenging for several reasons. These include the use of various interventions simultaneously, the long time periods required to assess

outcomes and the difficulty of obtaining data to assess what would have happened in the absence of the preventative interventions.

Further research is needed to enhance our understanding of how interventions can mediate social isolation and loneliness and to provide more robust evidence on effectiveness. There is also a need to investigate which groups of older people are most prone to suffer from social isolation and loneliness and would benefit most from interventions. Future studies need to address some of the challenges involved in evaluating preventative interventions to ensure that they are sufficiently robust to inform policy and practice reliably.

Governments should consider including in their strategies for preventing disability and promoting health and wellbeing policy initiatives to reduce social isolation and loneliness in old age. Agencies responsible for commissioning services for older people should consider supporting a range of measures to prevent or reduce social isolation and loneliness. Further studies should be undertaken to improve the evidence on effective ways to combat social isolation and loneliness. Policy strategies and priorities for commissioning preventative measures should take account of the developing evidence.

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# IMPROVING OUTCOMES FOR PEOPLE WITH LONG-TERM CARE NEEDS THROUGH PERSONALISATION

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**Summary:** Population ageing and an associated increase in chronic conditions such as dementia have seen demand for long-term care (LTC) rise, with this trend expected to continue. At the same time, the supply of informal carers is expected to decline, leading to greater reliance on formal provision of LTC. These challenges have prompted strong interest from policymakers in implementing innovative solutions to increase LTC sustainability. One such innovation is delivery of personalisation approaches such as personal budgets, direct cash payments and vouchers. This article explores evidence on effectiveness of personalisation and provides examples of good practice from Europe.

**Keywords:** Long-term Care, Personalisation, Direct Payments, Cost-effectiveness

## Introduction

Population ageing and the associated increase in the prevalence of complex multimorbidity and chronic and degenerative conditions such as dementia, has seen the demand for long-term care (LTC) services rise, with this trend expected to accelerate in the future. While future trends in disability are difficult to gauge, demographic changes coupled with a decrease in the number of informal caregivers (due to, among other things, greater participation in the formal workforce by women and shrinking family size) will necessitate a growing reliance on the formal care sector. This has prompted strong interest from policymakers in implementing innovative approaches to improve the productivity of

LTC services that aim to support activities of daily living (ADLs). One approach that has received great attention and has been widely implemented across Europe is referred to as personalisation of care, which particularly emphasises the role of self-management and greater involvement on the part of care recipients.

Also known in many countries as person-centred care, personalisation is premised on the notion that if users (and/or a family members) receive services tailored to their actual needs and preferences, they will achieve better outcomes than in traditional, standardised services which do not consider and incorporate the perspectives of users.<sup>1</sup> Personalisation allows service users to pursue maximisation of those outcomes



which they personally value and to choose the types of care which they believe can best promote those outcomes and personal satisfaction. Care is therefore centred on the needs and preferences of the user and is argued to be more cost-effective through optimisation of available resources and increased benefits for both patients and care organisations. Strategies to realise personalisation or person-centred care include a reorganisation of care pathways and availability of more service options, as well as needs-related cash measures such as cash-for-care programmes, care vouchers and personalised budgets, which all aim to enable greater autonomy of choice by users. In what follows, we highlight two prominent examples of personalisation measures in Europe, before turning to the larger body of evidence concerning the effectiveness and cost-effectiveness of person-centred care. We conclude by reflecting on implications for policymaking.

### Examples of promising developments in personalisation from across Europe

#### *Moving cash payments into the residential care setting in England*

Local authorities in England have offered cash payments, known as ‘direct payments’, as an alternative to a package of care services since the 1990s. These payments have been available for community-based care but not for residential care (other than for short stays). In 2013, the UK government set out to test how direct payments would work for people in residential care in 18 local authority ‘trailblazers’. More specifically, it commissioned an independent evaluation to understand how direct payments were being offered and used in residential care, whether they were making a difference to residents and their families, and how well they were working for councils and care homes.<sup>2</sup>

The take-up of direct payments in residential care was much lower than expected, with only 40 in use at the end of the programme.<sup>2</sup> The small number of residents with direct payments were generally satisfied with them and welcomed the opportunity to access additional or different services, and some family members said that they felt

empowered by the sense of control direct payments gave them over their relative’s care and support. Those declining the offer of a direct payment were mostly happy with their current care or did not want the burden of managing finances.

“Care is therefore centred on the needs and preferences of the user

The findings also indicated that there remained substantial barriers to implementing direct payments, including concerns of providers about loss of income, a lack of clarity about the demand for direct payments among residents of care homes, and a lack of clarity about how the demand for choice of service provider intended to be facilitated by a direct payment could be met by the current supply of services available to publicly-funded care home residents.<sup>2</sup>

#### *Shared housing arrangements in Germany to increase personalisation of the care setting*

Although the longstanding reliance (since 1994) on cash benefits to pay for informal care is certainly the predominant form of personalisation to be found in Germany, more recent developments in the LTC system point to a new emphasis on personalisation made possible through novel care settings. One such setting which has gained attention in recent years is shared housing arrangements or residential groups (*ambulant betreute Wohngemeinschaften*). Generally, a limited number of people in need of care, often people with dementia (if necessary, with the support of their relatives), rent private rooms while they share a common space, domestic support, and access to nursing care. The concept aims to provide a small-scale, home-like care facility with ample leeway for individual choice of activities that differ from the daily routines of traditional nursing homes. In line with the aims of person-centred care, the

concept particularly supports residents in maintaining independence and autonomy. Further, shared housing arrangements seek to integrate care with support from relatives, friends, neighbours, voluntary workers or the community, alongside the purchase of professional services.

First developed in the late 1980s, the concept has since gained in acceptance by public authorities and the social insurance system. Generally speaking, reforms since 2008 have gradually improved the environment in which shared housing models flourish. The government has increased financing for care provided in an outpatient setting in several steps. There is now the possibility to commonly claim services through the LTC insurance. In 2013, a monthly lump-sum of €200 per resident to finance the coordination involved with residential groups was introduced.

With incentives, the number of residential groups has increased from about 143 in 2003 to an estimated 3,121 in 2015.<sup>3</sup> This is, however, a rather cautious estimate since there is no general obligation to report the groups. To date, limited evidence about the quality of care provided within these small-scale, home-like settings is available. Most evaluation studies refer to residential groups for LTC-patients with dementia located in Berlin. Comparing residential groups with care units in nursing homes shows no significant advantage in quality of life, but may have positive effects for nutrition of residents in shared housing compared to nursing home.<sup>4,5</sup> Further, a qualitative survey suggests superior working conditions and job satisfaction by caregivers.<sup>6</sup> Residential groups for patients with dementia do not, however, appear to present cost advantages over nursing homes.<sup>7</sup>

### Evidence on the effectiveness of personalisation

While personalisation has been a driving force behind many recent reforms introduced in LTC systems in Europe, evidence based on its benefits and especially cost-effectiveness is often contradictory and marred by methodological limitations. Nevertheless,

some evidence on effectiveness of personalisation is available, with the strongest findings pointing to an increased level of satisfaction with care by users due to a better matching of care characteristics and individual preferences, particularly where consumer-directed home care and cash for care schemes are concerned.<sup>8</sup>

Among the possible explanations for this is the better matching of the characteristics of caregiving to the preferences of users that personalisation entails (i.e. better allocative efficiency). This is made possible through the possibility of purchasing different types of care, choosing specific people to provide the care, defining tasks or asking carers to carry out tasks that formal services providers would otherwise refuse to do.<sup>9 10</sup>

Evidence on whether personalisation can improve clinical or health outcomes such as ADLs, instrumental ADLs (IADLs), psychological wellbeing or quality of life is more mixed. A number of studies report a higher sense of control and independence and feelings of confidence associated with the use of cash-for-care or similar consumer-directed schemes.<sup>10</sup> These benefits however, seem to be highly dependent on the target group of personalisation. For example, evaluations of the individual budget pilot scheme (forerunner to the personal budgets currently in place in England) found that frail older people reported lower psychological wellbeing than other groups of people with disability.<sup>11 12</sup> One important aspect to consider is that, at least in the English case, the value of the personal budgets provided to older people is often low, which could limit the scope for achieving improved outcomes.

Two often-voiced concerns regarding personalisation in LTC are the risk of financial abuse, particularly in schemes that allow for the payment of relatives, or adverse care outcomes as a result of poor choices by users. Regarding the former, the risk of greater neglect or financial abuse seems to be relatively low, although this is contradicted by more recent research from England.<sup>9 13</sup> One may also speculate as to the role played by under-reporting or non-reporting of abuses among the older people themselves, particularly where family caregiving

is involved. As for increased harm or worsening of health outcomes that could directly be attributed to poor choices, there is no consistent sign of this.<sup>14</sup>

### Evidence on the cost-effectiveness of personalisation

One argument commonly made in support of personalisation is that it can contribute to reducing the use of more expensive types of care, particularly institutional care. In Germany and the Netherlands, for instance, where reliance on cash benefits is high, the cash alternative to in-kind benefits has been shown to provide lower amounts for the same level of assessed needs (about 50% lower in Germany and 25% lower in the case of the Dutch personal budget relative to in-kind benefits, whether received within the home or at an institution). Despite this, the cost-effectiveness of personalisation has not yet been established.

“take a societal view to evaluating the success of a measure

One of the possible reasons is that personalisation has often entailed higher use of services, or increased take-up of benefits by people previously unable to access care services.<sup>15</sup> In Germany, where cash benefits represent tax-free household transfers that may be used entirely at the beneficiaries' discretion, the take-up of cash benefits is especially prominent, making up nearly 60% of all benefits (as of 2015, 45.7% receive cash-only benefits and an additional 14% receive a combination of cash and in-kind services).<sup>16</sup> As cash benefits are not strictly tied to care in Germany, the quality and/or effectiveness of services provided by informal carers incentivised by this scheme is not monitored, further contributing to the lack of data on outcomes related to personalisation. The shortage of evidence available (beyond

the situation in Germany) can also be partially attributed to the methodological shortcomings of most of the evaluations carried out, which include failure to account for all costs of establishing and running the schemes or to account for the full societal costs (e.g. informal care provision leading to lower female labour force participation).<sup>17</sup>

### Making sense of the evidence on personalisation: implications for policy

Available evidence suggests that personalisation has the potential to be well regarded by users, as well as to positively impact the outcomes of at least some dimensions of quality of life of users. Overall, however, evidence on the use of personalisation points to mixed and limited results. This is especially the case where questions of (cost-)effectiveness are concerned, which brings to light the crucial need for better data that allows us to draw robust, generalisable and comparative conclusions. We may also wish to revise our interest in cost-effectiveness as an outcome, given difficulties over its definition and measurement. Instead, new domains of outcomes could be preferred and policy objectives that take a societal view to evaluating the success of a measure could be prioritised. Furthermore, equity considerations or distributional effects need to be ascertained in future evaluations to better understand the societal benefits of personalisation.

The reality of mixed findings on the impact of personalisation should be taken into account when making informed policy choices. This necessitates trade-offs and imperfect solutions. Of the various imperfect solutions in existence, personalisation schemes tend to respond to care recipients' need for greater autonomy and choice of services in the face of declining physical or mental autonomy. However, personalisation also implies a greater reliance on informal carers, which may not be possible in the future. This places the onus on policymakers to fill this gap with other solutions, which are likely to involve digital health solutions as the next best imperfect policy solution. The question then is, to what extent should

investment in technological innovations take the place of greater financing for professional personnel – a question beyond the scope of this article, but which is crucial for moving forward.

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## Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies (2019)

By: R Busse, N Klazinga, D Panteli, W Quentin

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Quality improvement initiatives take many forms, from the creation of standards for health professionals, health technologies and health facilities, to audit and feedback, and from fostering a patient safety culture to public reporting

and paying for quality. For policy makers who struggle to decide which initiatives to prioritise for investment, understanding the potential of different quality strategies in their unique settings is key.

This volume, developed by the Observatory together with the OECD, provides an overall conceptual framework for understanding and applying strategies aimed at

improving quality of care.

Crucially, it summarises available evidence on different quality strategies and provides recommendations for their implementation. This book is intended to help policy makers to understand concepts of quality and to support them to evaluate single strategies and combinations of strategies.



# POLICY MEASURES ADOPTED TO SUPPORT UNPAID CARE ACROSS EUROPE

By: **Blanche Le Bihan**, **Giovanni Lamura**, **Joanna Marczak**, **Jose-Luis Fernandez**, **Lennarth Johansson**  
and **Agnieszka Sowa-Kofta**

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**Summary:** Providing informal care can have significant negative effects for carers in terms of reducing psychological and physical health outcomes, constraining social participation and limiting ability to remain in formal employment. Developing policies to support informal carers is therefore an important policy objective to enable carers to continue caring for as long as they wish to do so and to ensure that the future availability of unpaid care is sufficient to meet demand. There are different types of policy measures addressed directly to carers that have been implemented across Europe to support provision of informal care.

**Keywords:** *Informal Care, Unpaid Carers, Long-term Care, Cross-country Mapping*

## Introduction

Global increases in life expectancy and population ageing translate to increasing numbers of people in need of long-term care (LTC). This poses challenges for the sustainability of formal LTC systems and has led to a growing policy interest in carers who provide support on an unpaid basis to disabled, ill or older people. Developing policies to support informal carers to enable them to continue caring for as long as they wish to do so is an important policy objective to ensure that the future availability of unpaid care is sufficient to meet demand. This is especially important in light of demographic and social trends such as increases in the physical distance between family members, greater female labour force participation, growing divorce rates

and a reduction in the number of children that will likely contribute to future gaps in informal care supply.

For those who provide unpaid care, particularly at higher intensities, there is substantial evidence of negative effects on psychological and physical health and carers may thus need support to maintain their own health and well-being.<sup>1</sup> In addition, caring responsibilities may constrain social participation and necessitate withdrawal from the workforce, leading to financial losses.<sup>2 3</sup> Policy measures to support informal care must therefore be multifaceted to meet different aims. Support must be provided to assist carers in undertaking their caring role; to improve carers' health and well-being; to assist carers in combining work with care; and to provide compensation for

**Table 1:** Core typologies of policies and measures directly addressing unpaid carers

| Type of measures             | Definition / Aims  | Measures   |
|------------------------------|--|--|
| <b>Compensation measures</b> | Means to reward carers' time financially or via social security rights     | <ul style="list-style-type: none"> <li>• Carers' allowance</li> <li>• Insurance right</li> <li>• Tax relief</li> <li>• Elder care benefit (if usable by the carer)</li> </ul>  |
| <b>Supportive measures</b>   | Help to enable carers to carry out their caring activities                 | <ul style="list-style-type: none"> <li>• Information (on the different services, allowances, support solutions available to meet the needs of an older person)</li> <li>• Counselling (on decision to make and services to use)</li> <li>• Training (competencies needed to care for an older person in terms of nutrition, transfers, mobility and activities of daily living)</li> <li>• Support groups (carers organisation, carers' group subsidised by public authorities)</li> <li>• Formalised assessment of carer's needs (existence of specific assessment procedures for informal carers, psychological support and counselling by professionals)</li> <li>• Formalised definition of informal carer</li> <li>• Respite (measures which facilitate in-home or day care or institutional short time respite, i.e. existence of this type of service and/or of financial support to pay for these services)</li> </ul> |
| <b>Conciliation measures</b> | Interventions to facilitate carers who have a job to combine work and care | <ul style="list-style-type: none"> <li>• Care leave: short/long; paid/unpaid</li> <li>• Legal possibility of working flexibility</li> </ul>  |

Source: This typology draws on different research works, including sources <sup>4</sup> and <sup>5</sup>.

income (including pension) loss incurred as a result of their caring activities.<sup>4 5</sup> An important question is therefore how best to address informal carers' complex needs, especially within the financial and organisational constraints faced by LTC systems. In this article we map the type of policy measures to support informal care in place in 12 case study countries (Austria, Bulgaria, Czech Republic, England, Finland, France, Germany, Italy, Latvia, Poland, Spain and Sweden) in Europe.

### The implementation of unpaid care policies across European countries

The forms of direct support provided to informal carers across Europe can be classified into three main types: compensation measures; supportive measures; and reconciliation measures (see Table 1).

The mapping of the various policy measures (services and allowances) directly addressed to informal carers in the 12 investigated countries is based on the evidence gathered by means of country reports produced by national experts, referring to national legislation in 2018.

### Compensation measures

"Compensation measures" include all interventions aiming at directly rewarding unpaid carers for their informal activity, by granting them financial or economic rights. These include carers' allowances, insurance or pension benefits for carers as well as tax reliefs whose beneficiary is the carer his-/herself. It should nevertheless be noted that in many countries, measures addressing older care recipients are often used to compensate their carers.

As shown in Table 2, according to the current legislation, in the majority of countries, no cash benefits are provided directly to the carer. When this occurs, it more often has a symbolic value, given that the amount provided is generally low. Exceptions are represented by England, Finland and Sweden. However, while in the former two countries these benefits take the form of cash compensations for the care provided, in Sweden it is represented by an employment contract between the carer and the municipality (so that the latter becomes the employer of the carer – eligible only if no older than 65 – who receives salary and social protection like the staff of formal care services).

What is available in almost all countries is the possibility for the carer to be indirectly compensated via the cash benefits granted to the care recipient, who can use them to reward the carer for the informal assistance provided by him/her. However, it should be noted that the benefits granted by current legislations are relatively low or moderate, with the exceptions being the more generous Austrian and German cash-for-care schemes. Other forms of compensation are used less frequently, such as insurance/pension rights or tax relief for expenses incurred for the care of dependent family members, that carers can claim directly as the main beneficiary.

### Supportive measures

Supportive measures correspond to interventions directly addressed to carers and aimed at helping them in performing their assistive role. They include a wide range of possible interventions, i.e. information, counselling, training, support groups, formalised assessment of carers' needs, formalised recognition of carers, respite solutions, which are present in the countries studied (see Table 3).

According to the availability of the different forms of supportive measures, a continuum can be identified, from countries where these types of measures is largely absent (Bulgaria, Poland and Latvia) to countries where the variety of possible supportive measures have been introduced (France or Finland) (see Table 4 overleaf).

**Table 2:** Direct or indirect compensation measures available to unpaid carers, by country

| Type of compensation measures  | Austria | Bulgaria | Czech Republic | England | Finland | France | Germany | Italy | Latvia | Poland | Spain          | Sweden |
|--|---------|----------|----------------|---------|---------|--------|---------|-------|--------|--------|----------------|--------|
| <i>Direct compensation</i>   |         |          |                |         |         |        |         |       |        |        |                |        |
| Carer's allowance  |         | +        |                | ++      | +++     |        |         | +°    |        | +      |                | +++*   |
| Insurance/pension rights   | X       |          |                | X       | X       | X      | X       | X     |        | X      | X <sup>^</sup> |        |
| Tax reliefs for carers   | X       |          |                | X       |         | X      | X       | X     |        |        |                |        |
| <i>Indirect compensation</i>   |         |          |                |         |         |        |         |       |        |        |                |        |
| Benefits to care recipients used to compensate carers for their informal support | +++     | +        | +              | ++      | ++      | +      | +++     | ++    |        | +      | ++             | +      |

Note:

+ low level / ++ medium level / +++ high level

°: legislated, but not yet implemented

\*: takes the form of a contractual employment of the carer to provide assistance to the care recipient

^: acquired by carers through contributions paid on a voluntary basis

**Table 3:** Supportive measures available to unpaid carers, by country

| Type of supportive measures            | Austria | Bulgaria | Czech Republic | England | Finland | France | Germany | Italy | Latvia | Poland | Spain | Sweden |
|--|---------|----------|----------------|---------|---------|--------|---------|-------|--------|--------|-------|--------|
| Information/counselling                | X       | X        | X              | X       | X       | X      | X       | *     |        |        | X     | X      |
| Medical check ups                      |         |          |                | X       | X       |        |         |       |        |        |       |        |
| Training                               | X       |          | X              | X       | X       | X      | X       | *     |        |        | X     | X      |
| Support groups                         | X       |          | X              | X       | X       | X      | X       | X     |        |        |       | X      |
| Formal recognition of carers           | X       |          | X              | X       | X       | X      | X       | X     |        |        | X     | X      |
| Formalised assessment of carers' needs | X       |          |                | X       | X       | X      | X       |       |        |        |       |        |
| Respite                                | X       | X        | X              | X       | X       | X      | X       | X     |        |        | X     | X      |

Note: \*: Only in some regions.

An additional potentially useful distinction can be made between measures related to the legal or formal recognition of the role of unpaid carers, and interventions intended to practically support carers in their caring activities, thus enabling the

development of the competencies needed. In 8 out of the 12 countries studied, there has been an official recognition of the role of carers. This is shown for instance in Finland by the 2016 reform of the law on informal care support, in Germany

with the 2015 Care Leave Act, in France with the 2015 Act on adapting society to an ageing population, and in Austria with the introduction of a care leave in 2014. In Sweden, the 2009 Social Services Act has been reviewed in 2014, confirming the

**Table 4:** Countries by level of availability of supportive measures for unpaid carers

| Level of availability             | Countries  |
|-----------------------------------|--|
| Measures are largely absent       | Bulgaria, Latvia, Poland                           |
| Some measures exist               | Czech Republic, Italy, Spain                       |
| Wide range of supportive measures | Austria, England, Finland, France, Germany, Sweden |

leave (although the level of payment and conditions for taking up these measures vary across countries).

A first possible criterion to classify countries in this regard refers to the level of availability of different conciliation measures is shown in **Table 6**. According to this criterion, a distinction can be

**Table 5:** Availability of conciliation measures for unpaid carers, by country

| Type of conciliation measures | Austria | Bulgaria | Czech Republic | England | Finland | France | Germany | Italy | Latvia | Poland | Spain | Sweden |
|-------------------------------|---------|----------|----------------|---------|---------|--------|---------|-------|--------|--------|-------|--------|
| Long unpaid care leave        |         | X        |                |         |         | X      | X       | X     |        |        |       |        |
| Short unpaid care leave       |         |          |                | X       | X       | X      |         |       |        |        |       |        |
| Long paid care leave          | X       |          | X              |         |         |        |         | X     |        |        |       | X      |
| Short paid care leave         | X       | X        |                |         |         | (*)    | X       | X     |        | X      |       |        |
| Working flexibility           | X       |          | X              | X       | X       | X      | X       |       |        |        |       | X      |

Note: \*: Possibility to receive a small financial compensation for a maximum of three weeks. The creation of a paid care leave was voted in October 2019 and will be implemented in October 2020 (financial compensation of €43/day, with three months leave possible).

**Table 6:** Countries by level of availability of conciliation measures for unpaid carers

| Level of availability | Countries   |
|-----------------------|---|
| Absent                | Latvia, Poland, Spain                                 |
| Two types             | Bulgaria, France, Sweden, Czech Rep, England, Finland |
| Variety of measures   | Austria, Germany, Italy                               |

obligation for social services to support informal carers, while in Italy different legislative proposals have underlined the recognition and support of family carers in 2016, leading in December 2017 to the adoption of a yearly fund of €20 million to support carers for the 2018–20 period.

It should be noted, however, that while this process of a growing recognition through legislation of the role of unpaid carers can be considered as a common trend in Europe, no commonly agreed definition of informal carers exists across countries.

### Conciliation measures

Different types of interventions can be identified as supporting carers to participate in the labour market (see **Table 5**). These interventions aim at giving carers more time to combine their different care and work responsibilities, and to provide the necessary flexibility to provide support to older parents without giving up jobs. Providing time to both professional and caring activities is therefore the key objective of these measures. The most frequently available are the possibility to work flexibly and to benefit from a longer period of paid

made between: countries in which these measures are absent; countries where two types of conciliation measure exist; and countries where a variety of conciliation measures exist. Except for Latvia, Poland and Spain, all countries have introduced explicit reconciliation measures. Despite the many differences between the LTC policy in Germany and Italy, both countries have developed a variety of reconciliation measures. This evolution is recent in Germany, whereas it has existed since the 1990s in Italy. The Finnish case should be more precisely clarified, since the main existing “care leave” options correspond actually to “carer” breaks” for the so called “compensated informal carers”, i.e. those who have a contract with the municipalities to take care of their older relatives. A leave of absence from work to care for a sick relative was also introduced in Finland in 2011, but it is unpaid and marginal.<sup>7</sup>

**Table 7:** Countries by duration of the care leaves available to unpaid carers

| Duration                | Paid  | Unpaid                   |
|-------------------------|---|--------------------------|
| Short (days off)        | Austria, Bulgaria, Germany, Italy, France, Poland | Finland                  |
| Long (3 months or more) | Austria, Sweden, Czech. Rep., Italy               | France, Germany, England |

A second result concerns the characteristics of the leave available (see Table 7). Though there is a common orientation to facilitate reconciliation in these countries, the contents of the measures developed are different for two reasons. First, because the existing care leave options, which are all limited in time, can either be long, i.e. lasting three or more months (in 7 out of the 9 countries) or short (in 5 out of the 9 countries). In most countries, long care leaves often concerns end of life care. Short leave aims instead at giving carers the possibility to claim time off work to deal with care-related emergencies or difficulties, and to facilitate the organisation of care activities.

a growing recognition through legislation of the role of unpaid carers

Secondly, the financial benefit related to the care leave can vary greatly. In some countries, beneficiaries continue to receive a full salary, up to a rather high income level (e.g. €41.000 per year in Italy, or full compensation of salary for short care leave in Austria), in others they receive more limited financial compensation (from 80% in Sweden, to 55–60% in Germany, or the Czech Republic), while in some countries the care leave is fully unpaid (Finland, France and England). In France, financial compensation exists for one of the two possible short care leave forms existing –

which concerns the end of life of the older person – but only to a very limited extent (i.e. €50 per day for a maximum of three weeks). However, this changed in October 2019 with the vote for paid care leave (three months leave possible in a career) for informal carers who work and care for a disabled or older relative.

Finally, flexible working is offered in 7 out of the 12 countries studied. However, considering measures specific to care for older people (we will not analyse here the general legal right to flexible working hours, which exists for example in England and Italy), working flexibility is mainly possible through the use of care leaves which permits the possibility of working part time.

### Conclusion

Countries across Europe have begun to implement a number of policies to support informal carers. There remains, however, a lack of evidence on what kinds of support may be most effective in meeting different goals such as improving health and well-being of carers and supporting carers to participate in the labour market.<sup>8</sup> Therefore, a number of key questions remain in terms of informal care policy. For example, is it more effective to directly support carers or to support dependent people? And if carers are supported, which measures are the most beneficial for improving quality of life outcomes of the carers and the cared for: financial or non-financial? Tensions at the policy level also relate to properly balancing the LTC objectives of achieving the best outcomes for dependent people, while at the same time supporting their carers.

The reality of mixed findings and limited evidence necessitates trade-offs and imperfect solutions when translating research evidence into policy measures.

Knowledge of local care systems and the needs of different population groups is vital to design measures to support a wide range of carers. Still, it is also important to remember that generic services for people with care needs may be critical to carers' health and well-being.<sup>9, 10</sup> For example, if people with care needs receive good quality and prompt health care services both they and their carers may benefit. This places the onus on policymakers to proactively combine support specifically designed to support carers with other solutions which are likely to improve support for the people they care for.

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# LONG-TERM CARE AND MIGRANT CARE WORK: ADDRESSING WORKFORCE SHORTAGES WHILE RAISING QUESTIONS FOR EUROPEAN COUNTRIES

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**Summary:** Long-term care (LTC) is highly labour intensive and will likely remain so in the future. Meeting growing demand for LTC from an ageing population will therefore depend on the ability to recruit and retain sufficient numbers of carers, whether in formal settings or within homes. Many European countries have responded to this challenge by employing a considerable number of carers from other countries, whether from Europe or beyond. This raises a number of important issues for policy and practice for both source and host countries, but social policies specifically regulating this type of service provision are rarely adopted.

**Keywords:** *Migrants, Carers, Workforce, Home Care, Long-term Care*

## Introduction

Long-term care (LTC) is highly labour intensive by its very nature and will likely remain so, even with advances in the use of assistive technologies. Meeting growing demand for LTC from an ageing population will therefore depend on the ability to recruit and retain sufficient numbers of carers, whether in formal care

settings or within families. This presents a substantial challenge for many countries, given that jobs in the formal LTC sector are generally low paid and have a low social status, even though they require a high level of responsibility. Moreover, provision of informal care by family members of friends may become ever more

challenging given competing employment responsibilities, family obligations and changing family structures.

To address the challenge of insufficient care staff and inability to provide care within the family, many European countries employ a considerable number of carers from other countries, whether from Europe or beyond. Freedom of movement for labour between European Union (EU) countries opens doors for employing non-professional carers in households, often providing full-time care to older dependent people, resulting in increasing numbers of migrant carers. Care chains are observed, with workers migrating from central and Eastern Europe to Western Europe, but also globally from poorer to richer countries. Migrant carers can be considered in three groups: professionally qualified staff working in formal care agencies; carers employed by formal care providers; and carers employed by individual households. In some countries, carers employed by private providers and families may be unqualified while in others some level of qualification is required.

“social policies specifically regulating this type of service provision are rarely adopted

The increase of migrant carers' population raises a number of important issues for policy and practice. For destination countries, applying employment policies for migrant carers, assuring quality of care and enforcing adequate immigration regulations for carers from outside the EU are important challenges. For source countries, policy dilemmas are related to how to ensure that sufficient carers remain to care for their own older and disabled citizens requiring LTC. In these countries,

the evolution of the number of available professionals, particularly with respect to nurses (e.g. Bulgaria), has been negative since the 1990s, with emigration and care drain as the main factors reducing the local health and care workforce.

### The size of the migrant care workforce

The number of migrant care workers in Europe can only be easily assessed in Austria, as a result of the mandatory introduction of registries in 2007. In 2017, registry data show the overall number of migrant carers employed by households was approximately 70,000, which means that approximately 5% of beneficiaries of the care allowance were cared for by migrant carers.<sup>1</sup> In other countries only estimates are available. In Germany these range between 100,000 to 200,000 carers, mostly from Poland.<sup>2</sup> In Italy the official number in 2017 was 393,000 carers;<sup>3</sup> however, this figure does not include those providing household chores only (i.e. excluding personal care), who officially number 471,000, nor the large number of those working on an undeclared basis, which is estimated to reach 1.2 million.<sup>4</sup> In Poland, it has been estimated that every fifth migrant worker is a household worker, which would give a total number of about 100,000 migrant household workers,<sup>5</sup> including care workers, coming mainly from Ukraine.

### Common trends in care migration in Europe

Migration related to care is a different phenomenon from migration in other sectors of the economy. It is strongly gender biased, with middle-aged females employed much more frequently than men. Most care migration is financially motivated due to poor wages, poor working conditions or inability to find a job in a home country. Sometimes it is an additional job, for instance through a contract with a temporary work employment agency, performed in turns with spells of employment in the source country.

In many countries, by being a household task, care by migrants remains undeclared work or even when declared, it is prone to

being underreported due to high labour costs, long administrative procedures of migrant labour recognition or procedures related to visa regulations. Although it is rarely considered as a part of the LTC system, it is an important element of it and affects the system's sustainability.

### Migrant care work in different long-term care systems

The participation of migrant care workers as domestic helpers is linked to the welfare system and particularly LTC services provision: the types of services available, types of benefits, their generosity and targeting. In countries with developed formal LTC systems and low or strictly targeted cash benefits, migrant carers are employed primarily in the formal care sector (e.g. England, France). In countries with more generous and unconditional cash benefits granted to older people with care needs (e.g. Germany, Italy) migrant care workers are frequently employed by private households.<sup>6,7</sup> Services provided by migrants complement available care services, lessening the pressure on informal carers (e.g. in Austria and Germany) and in countries with underdeveloped LTC they provide services which are otherwise unavailable, as the existing services are insufficient or target restricted population groups (e.g. in Poland).

Austria is the only country to designate some benefits specifically for employing migrant care workers, who are required to have certification to help assure service quality. In other countries (Germany, Italy), generous cash benefits create the potential for employing migrant carers, while falling short of formalising this care arrangement. In Italy benefits vary greatly between regions: in some they are very generous and not necessarily related to objectively assessed care needs, but allow for the employment of household help or a carer. Another incentive to employ a migrant care worker is created by tax relief on payments for this form of work in a household (Italy, Austria).

On the other hand, in England, while there are migrant care workers employed by households, their number is relatively small and not reflected in any official

statistics. There is no tradition of employing migrant care workers, nor does the LTC system support this option, as cash benefits are relatively highly regulated and less generous.

### Recent policy developments in migrant care work

Migrant care work is a socially accepted segment of care, yet social policies specifically regulating this type of service provision are rarely adopted, with Austria and Italy being the only exceptions.

“There are risks of human trafficking and abuse

In Austria, subsidies to partially cover the cost of 24-hour care by registered migrant care workers have been introduced in 2007. Since the introduction of legal regulations in 2007, migrant care work has become an alternative to costly institutionalised services. Quality assurance measures have been introduced via certification requirements, training of care staff and quality monitoring. Introduction of the regulations allowed for monitoring the number and the flows (in and out of the country) of migrant carers. In fact, a market for services developed with brokering companies matching care recipients with care providers, although most regulated carers still operate as self-employed workers.

In Italy, the main policy objective (until 2012) with respect to migrant carers was to monitor the number of workers. This was done either *ex post* by checking and registering migrant care workers or by setting yearly quotas for them. However, this policy was abandoned in 2012 as a result of the migration crisis. Quality of care or working conditions are not subject to any regulations and monitoring at the national level.

Other receiving countries have not introduced similar policy measures.

Migrant care workers operate based on labour market regulations and the rule of free movement of workers between EU countries, which means either self-employment or working based on a contract with a brokering agency. In several countries, migrants can be legally employed by households (Germany, Italy and Poland). Sometimes, however, the work takes place in a ‘grey zone’ of the economy. The lack of regulation increases the risk of abuse of the carers and may affect the quality of services.

In source countries, migration related to care is also rarely a subject of policy debate. One exception to the lack of debate or regulation can be seen in Romania, where a regulation protecting Romanian citizens working abroad was enacted in 2017, although it is difficult to see how well or with what results it can be implemented. The policy debate related to migration in source countries, when it exists, concentrates on the brain drain threat for medical professions, particularly among physicians and nurses, where numbers are low and the profile is ageing.

### Equity issues in migrant care services

Important equity issues arise with respect to the affordability of care and regulation of the market for migrant care services. Evidence points to inequity in the use of migrant carers across economic strata, with only wealthier families typically able to afford to employ a migrant care worker. In countries like Austria, Germany and Italy, where benefits (either specific subsidies for employing a migrant care worker or subsidies not specifically tied to this purpose) are available, care workers tend to be employed by people living in larger houses, with separate rooms for carers (particularly in the case of round-the-clock care). In Poland, where available cash benefits are low and insufficient to cover the costs of migrant carers’ employment, services are obtained by older people and families with higher incomes, mostly living in large cities where family networks are more fragile.

On the supply side, inequities are related to the labour market structures within the country and the LTC sector as well as cross-border differentiations of

employment and services regulations. In Austria, Germany and Italy, migrant care workers are typically employed in private household care, while native employees work in the formal care sector. There are inequities related to migrant workers’ access to social security and labour protection, (particularly if the work is undertaken as temporary employment) and to wages and working conditions, as well as a risk of abuse.

Migrant care workers employed by households have limited access to social security and limited chances to improve their qualifications. Recent changes to family benefits in Austria have made child benefit amounts dependent on the place where the child is actually residing (although contributions are not similarly adjusted), in practice reducing payments for children of eastern European migrants (including EU citizens), unless they are also living in Austria. As many migrant carers legally employed in Austria rely on these benefits to supplement their wages, these changes are likely to further increase inequalities. Their work is rarely supervised and it is difficult for them to complain or seek redress in cases of mistreatment. In England, employment in care services is more equitable, with migrant care workers employed more frequently in the same positions as UK nationals, although wage differentiation can still be observed.

Another area of inequality is related to the cross-border activity and the role of employment agencies. There is still little comprehensive information on the mechanisms of the cross-border market for care services. Many migrant care workers are temporary workers: either self-employed or employed by a placement agency, typically a small one. Their work, although undertaken abroad, is registered as a domestic task in the source country and falls under domestic labour regulations concerning social security and the minimum wage; thus their situation is significantly different from the situation of other employees in the country they work in. In the case of temporary employment, their work falls under civil law rather than labour code regulations. As a result, the cross-border employment care sector is characterised by high level of uncertainty

and legal flexibility.<sup>1</sup> Research shows that even regularisation of the care services market – as in Austria – does not prevent problems with the quality of market services and employment.<sup>2 3</sup>

### Challenges and opportunities related to migrant care work

Migrant care work can be perceived as an opportunity to overcome gaps in the LTC system as it lessens pressure on formal LTC to provide services to all dependent people. Supporting home-based care and reducing institutionalisation for people with dementia and high levels of incapacities and care needs is cost-effective (at the macro level), although the question of quality of care might arise. In the case of countries with low provision of LTC, migrant care supplements the insufficient supply of services in the public system. For the family, employing a migrant carer, although costly, is likely to lessen the psychological pressure on informal carers and might support their labour market reintegration. It is sometimes described as a ‘win-win’ situation: the family gains support, and the carer improves his or her financial standing, and has the opportunity to gain qualifications and experience.

Challenges related to migrant care work arise from the lack of integration with other LTC services and the lack of incentives to improve the system of LTC provision as long as care needs are being met by privately purchased migrant care services. In Italy, for example, migrant care provision is encouraged by generous cash benefits. Quality standards for care provided by migrants are in most cases not defined and difficult to monitor. There are risks of human trafficking and abuse although these should decrease with stricter controls of the operations of brokering agencies and monitoring of services. There are also challenges for the health and LTC systems of source countries (e.g. Poland, Slovakia and Ukraine). The outflow of migrant workers, which includes many medical professionals, brings more pressure to underdeveloped health and LTC system that already suffer from low numbers of medical professional due to poor wages and poor working conditions. These

pressures are expected to increase, with these countries expected to be among the most aged populations in the coming decades.

### Conclusion

While transnational care migration has grown in importance over the last decade with increasing number of migrant carers, there have been few policy changes with regards to domestic care work and available statistics generally fail to recognise the area. Issues, particularly those related to push and pull factors arising from the design of the LTC system in European countries, need to be addressed by policy measures. Inequities related to labour market structures, especially from a transnational perspective are another area where policy intervention may be helpful. Migrant carers need to be recognized in order to facilitate professional integration of care workers, improve quality of care and professionalize care work. In source countries, more attention should be given to policies preventing brain drain and improving formal LTC systems.

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# PATIENT ENGAGEMENT STRATEGIES TO MOVE TOWARDS **EARLIER** **DIAGNOSIS OF ALZHEIMER'S** **DISEASE**

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**Summary:** Alzheimer's disease (AD) is an incurable disease that steals memories, identities, livelihoods and lives. We now know more about the pathophysiology of the disease and the scope of various preventative mechanisms; we also know that early intervention and treatment in AD can be both beneficial and cost-effective. Despite the importance of a timely diagnosis, many patients are not diagnosed at all. A cultural shift towards making the diagnosis of AD at a very early stage needs to be encouraged. The early recognition of AD is the first step towards providing patients with optimal opportunities for intervention.

**Keywords:** *Alzheimer's Disease, Diagnosis, Patient Engagement, Clinical Trials*

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## Alzheimer's disease remains a challenging disease

Alzheimer's disease (AD) is the most common form of dementia (60%–80% of the cases). In 2018, it was estimated that 7% of the population over 60 years were affected by dementia in the European Union (EU). With age being a risk factor, this figure is expected to grow to 8% in 2040 due to the ageing of the population.<sup>1</sup> Other risk factors include genetics, general unhealthy lifestyles and vascular, metabolic, and nutritional risk factors.

The financial impact of unhealthy ageing is projected to be a significant challenge to the sustainability of health care services in almost all EU Member States.<sup>2,3</sup> Dementia is one of the major causes of disability

and dependency among older people worldwide and consequently creates substantial costs for health and long-term care sectors and the wider economy. Moreover, it has an enormous physical, psychological, social and economic impact on carers, family and society at large. Understandably, AD is a critical public health concern in Europe.<sup>4</sup>

Patients with mild cognitive impairment (prodromal AD) or early stage AD remain outside clinical settings and most patients are not diagnosed in a timely manner, or not diagnosed at all.<sup>5</sup> Despite progress in identifying people with dementia, the diagnostic process is still poor and diagnosis rates are very low: more than half of the population in OECD (Organisation for Economic Co-operation

and Development) countries still do not receive a diagnosis<sup>14</sup> and, if they do, it is at a late stage, when the symptoms are too severe to intervene.

Early AD diagnosis is a crucial step in accessing care and support for a person with dementia. With a proper diagnosis, patients and carers can have timely access to education, training and support programmes. Being aware of these different support opportunities can drive the decision to seek a diagnosis.

Unfortunately, there still is no treatment to cure dementia or to alter its progressive course. The numerous failures in clinical trials on AD drugs, and the need for modifying treatment to delay/cure the disease, call for further and significant research efforts in drug development.

The way ahead is to offer sustainable solutions for AD patients, their carers and health care systems to help people live better with AD, which relies on implementing better processes to support early diagnosis.

### The underlying causes of late or under-diagnosis

There is evidence that early intervention and treatment of AD is beneficial for patients and their families, as well as cost effective for health care systems.<sup>15</sup> However, there is still a significant proportion of undiagnosed or late diagnosis cases in Europe due to several factors:

*A lack of awareness and understanding of the disease*, results in stigmatisation and barriers to diagnosis and care.<sup>16</sup>

According to an Alzheimer's Disease International (ADI) 2019 report: one in four people think nothing can be done to prevent dementia and just under 40% of the general population think that there are adequate community services for people living with dementia and for their carers.<sup>17</sup>

*Primary care is the entry point for people concerned about memory problems.*

However, medical school training on dementia is inadequate, and the number of general practitioners (GPs) has decreased in the EU in recent years. Primary care physicians are sometimes ill-prepared

to take on the role of diagnosis, do not have the sufficient time slot needed to make a proper diagnosis of dementia, and lack motivation to develop their skills to fulfil the task. In OECD countries, GPs accurately identify dementia in only 50–75% of cases.<sup>18</sup> This is also supported by the ADI 2019 World Report which states that 62% of health care providers worldwide assume that dementia is part of the natural ageing process. The report also reveals that around 40% of the general population are under the impression that doctors and nurses ignore people with dementia and 36% of all respondents say that they would seek help on the internet instead.

*Insufficient referral and care pathways between primary and secondary health care settings in relation to both diagnosis and management of AD.* Having access to a diagnosis and support is complex and varies across EU Member States. It is vital to monitor patients along the care process, and to provide them with appropriate facilities, services and tools. The monitoring process, which uses data from primary care physicians and professionals in other health settings, is still not standardised across Europe.

“having access to a diagnosis and support is complex”

A number of national EU dementia strategies focus on referral systems that require improvement, both in relation to diagnosis and management of the condition. Nevertheless, some examples of more efficient coordinated care in dementia strategies in EU Member States exist. Italy, for example, makes reference to a multidisciplinary team approach covering both diagnosis and coordination of interventions for dementia. The French strategy prioritises access to shared assessments and guarantees access to personalised care.<sup>19</sup> In Spain, the system uses a shared medical history

system, where a multidisciplinary team covers both diagnosis and coordination, with interventions involving the patients' relatives.

### Looking at innovative ways to address the diagnosis gap in AD

In this challenging policy context, while research into AD causes and treatments remains a major priority in Europe, it is crucial to also identify approaches to help overcome the obstacles to more efficient, early and appropriate diagnosis. One example of such research can be found in the EU funded MOPEAD (Models Of Patient Engagement for AD, <https://www.mopead.eu>) project, which is designed to assess different Patient Engagement models across Europe, to identify efficient approaches of earlier identification of mild AD dementia and prodromal AD patients.

MOPEAD is an Innovative Medicines Initiative (IMI) multi-regional project performed in Germany, the Netherlands, Slovenia, Spain and Sweden. It was established to test four different strategies for efficient identification of early stage AD and mild AD in the general population. MOPEAD tested two pro-active strategies whereby citizens voluntarily perform a cognitive test: 1) Citizen Science – an online pre-screening tool; 2) Open House – pre-screening tests performed in a memory clinic without a physician's referral. MOPEAD also studied two passive strategies for patients at risk, in which their cognition was tested in two settings: 1) Primary Care setting – patients were identified and tested by the primary care physician; 2) Tertiary Care setting – the identification and tests were performed by endocrinologists specialised in treating Type-2 Diabetes, a risk factor for AD. The persons considered of being at risk were then offered a full diagnostic assessment in a memory clinic that they were free to accept or refuse.

MOPEAD assessed key tools, mechanisms and processes for community engagement, patient identification and evaluated resource utilisation. The project aims to ultimately provide value to patients, their carers and to health care systems. MOPEAD's findings will be used to raise

awareness about prevention, the value of early diagnosis, engagement in clinical trials and social research.

“patient engagement can be a cornerstone in early diagnosis of AD

Preliminary findings show that the two proactive strategies delivered better results in terms of citizens' willingness to be tested. In contrast, patients offered tested using passive strategies were more reluctant to participate and accept a full diagnosis. Results also show important gaps such as: lack of time and education in primary and tertiary care settings, lack of clinical practice consistency across countries (diagnostic tests and methodologies vary), lack of knowledge about risk factors in AD and possible life-style preventive changes. MOPEAD's full results and recommendations will be available in December 2019.

### The role of patients in early diagnosis of AD is critical

Engaging citizens to be tested for dementia early is key. MOPEAD has shown that patient engagement can be a cornerstone in early diagnosis of AD. The role of AD patients in speaking openly about early diagnosis has proven to be pivotal in raising awareness and breaking the stigma. For example, the members of Alzheimer Europe European Working Group of People with Dementia are given a platform to share the priorities and views of people with dementia. Some members have also contributed to research on topics such as outcome measures and participated in peer-review research. In the United Kingdom (UK), the Alzheimer's Society has pioneered patient and public involvement in dementia. The UK Dementia Friendly Communities and Dementia Friends initiative have propelled patients to the forefront of an inclusive and compassionate environment, thereby helping tackle the stigma linked to AD.

### Taking stock of EU research and policy recommendations

There is a political will to combat AD and other forms of dementia: dementia has been recognised as a European, national and international health and societal challenge. At EU level, two European Joint Actions have investigated and confirmed the importance of improving the diagnosis of AD: ALCOVE (Alzheimer's COoperative Valuation in Europe) (2011–13) and 'Act On Dementia' (2016–19).

The 2009 European Commission Communication, *European Initiative on Alzheimer's disease and other dementias*, recommended early action to diagnose the disease. Under its 'Health, demographic change and wellbeing' priority, Horizon 2020, the current EU research programme, funds projects that address unmet medical needs such as dementia. In the next programme, Horizon Europe, the 'Global challenges and European industrial competitiveness' pillar includes a health cluster. Dementia is an area where Horizon Europe could make a significant impact on society and policymaking and, as such, be considered as one of Horizon Europe's future missions.

At national level, several countries have committed to improve dementia care systems by establishing national dementia plans. At international level, the World Health Organization has declared dementia control a global health priority.<sup>10</sup>

The European Alzheimer's community, including people living with the disease, their carers, researchers and policymakers, must build upon this momentum to promote early intervention. Early intervention would give people the opportunity to have more time to take serious decisions that would affect their present and future lifestyle. Without a proper diagnosis, family members and carers do not have access to training and support programmes available to help them cope with the disease. There are great expectations that the new European Commission and the new European Parliament will take stock of the past recommendations and new initiatives to improve the diagnosis of AD.

In this context, MOPEAD serves as an innovative strategy to make the “hidden” population with cognitive impairment visible and to encourage health care systems to implement diagnostic and support strategies that will respond to the challenge. An AD diagnosis without a supportive environment minimises the value of early diagnosis.

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# SWITCHING HEALTH INSURER IN THE NETHERLANDS: PRICE COMPETITION BUT LACKING COMPETITION ON QUALITY

By: Judith De Jong and Anne EM Brabers

**Summary:** Consumer mobility plays an important role in the Dutch health insurance system. The assumption is that insured individuals choose an insurer and insurance plan that best fits their needs and preferences, and that all those insured have the same opportunity to switch. The idea is that insured individuals who are not satisfied because of premiums or the quality of provided care, will switch. In 2011–19 the percentage of switchers was stable at around 9%. The premium is the most important switching reason (price competition), while quality hardly plays any role.

**Keywords:** Health Insurance, Reform, Switching Behaviour, Premium, The Netherlands

## Background

The health insurance system in the Netherlands is based on managed competition. This system was introduced on 1 January 2006 with a new health insurance law (see [12](#) for a more detailed description). In this system, consumer mobility plays an important role; insured individuals are free to switch insurer and insurance plan every year during a fixed enrolment period. The assumption is that the insured choose an insurer and insurance plan that best fits their needs and preferences, and that all insured, irrespective of their characteristics, have the same opportunity to switch. In order for the system to work as intended, the idea is that insured individuals who

are not satisfied with their insurer or insurance plan, because of, for example premiums or quality of provided care, will choose a different insurer or insurance plan. Insurers would thus be incentivised to offer plans that meet the needs and preferences of beneficiaries, and a good balance between price and quality of care. To make it possible for all insured to switch insurer, it is mandated that insurers must accept everyone for the basic package, which is compulsory for everyone who lives or pays employment taxes in the Netherlands.

The percentage of insured switching health insurer was relatively high in the first year: one fifth of the population switched in 2006. In the years 2007–09,

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the percentage of switchers was stable at around 5%.<sup>5</sup> In 2011, the premium increased more than in previous years. In that year the percentage of switchers increased to 8%. This suggests that the premium was an important incentive for switching, which was confirmed by the reasons given by the insured for switching. Brabers, Reitsma-van Rooijen and De Jong concluded that there was price competition in the system, but that competition on quality seemed absent.<sup>6</sup>

A key question now is whether more time was needed for competition on quality to get off the ground. The objective of this article is therefore to analyse whether the system works as intended, many years after its introduction. The idea is that it might take time for a system to work as intended. The main question is whether competition on the basis of quality of care has now increased relative to price competition. Our focus is on switching health insurer during the enrolment periods 2011–19. What is the percentage of insured switching health insurer? What are their characteristics, and their reasons for switching, is it mostly premiums or are quality aspects also taken into account?

The data used in this article are derived from regular surveys of participants of the Dutch Health Care Consumer Panel, which is run by the Netherlands Institute for Health Services Research (Nivel).<sup>7</sup> As several countries have introduced market elements in their health care system aiming at both quality improvements and cost containment, the study results are of international relevance.

### **The percentage of switchers is stable at around 9%, with young people most likely to switch**

Compared to 2007–09, the percentage of switchers in the years 2011–19 is higher (5% versus 9% respectively).<sup>8</sup> For all years it was found that young people (18–39 years old) were more likely to switch, with switching rates of between 11%–22%.<sup>9</sup> Insured in the age group of 40–64 years showed switching percentages between 5% and 10%. The oldest age group (65 years of age and older) showed the lowest percentages of switchers, between 2% and 4%.<sup>10</sup> One explanation among others for the finding that switching rates are

consistently higher among younger people might be that young people have relatively good health compared to older age groups.

Comparing insurance plans is easier for insured individuals with relatively good health status, because they will probably only base their choice on price. For people who are more frequent users of health care, the content of the insurance plan is more important, and therefore comparing insurance plans might be more difficult. Our data shows that people 65 years and older indicate price less often as a reason for switching than people of lower age. Furthermore, at the age of 18 young adults have to choose their own insurance plan, because they can no longer be insured for free on one of their parents' policies, which could result in higher switching rates among the 18–39 age group.

Premiums are still the most important reason to switch health insurer

### **What are the reasons for switching or not switching?**

For the system to work as intended, it is important to understand why people switch insurer. The surveys asked people about their reasons for switching or their reasons for staying with their current health insurer.

#### ***The premium is the most important reason to switch***

In all years, the premium is the most important reason to switch insurer. However, the percentage of insured mentioning the reason 'not satisfied with the amount of the total premium' for switching changes over time: it was about half (52%) in 2011 and only about a quarter (23%) in 2015. This high percentage in 2011 could be explained by a relatively high increase in premium for 2011 (10%),

compared to the years before and after (see Figure 1). Differences in premium between the cheapest and most expensive basic insurance in 2011 were €276 per year (see Figure 1). In 2015, the premium increased by 5%, and differences between the cheapest and the most expensive basic insurance were approximately €377 per year. The increase in the difference in premiums was mainly caused by a low increase in premium for the cheapest policies (with selective contracting).<sup>11</sup>

#### ***Quality plays a limited role in switching, expectations related to health care use are taken into account***

Reasons related to the quality of care hardly play a role: between 0% (in 2014, 2016 and 2018) and 4% (in 2015 and 2019) indicated the reason 'I'm dissatisfied with the care arranged by my health insurer'. The reason 'I'm dissatisfied with the service of the insurer' was indicated by 0% in 2016 and 9% in 2019. People do take their expectations related to health care use into account when switching: between 9% (2018) and 19% (2017) indicated the reason 'Because I expect that my health care use will be different'.

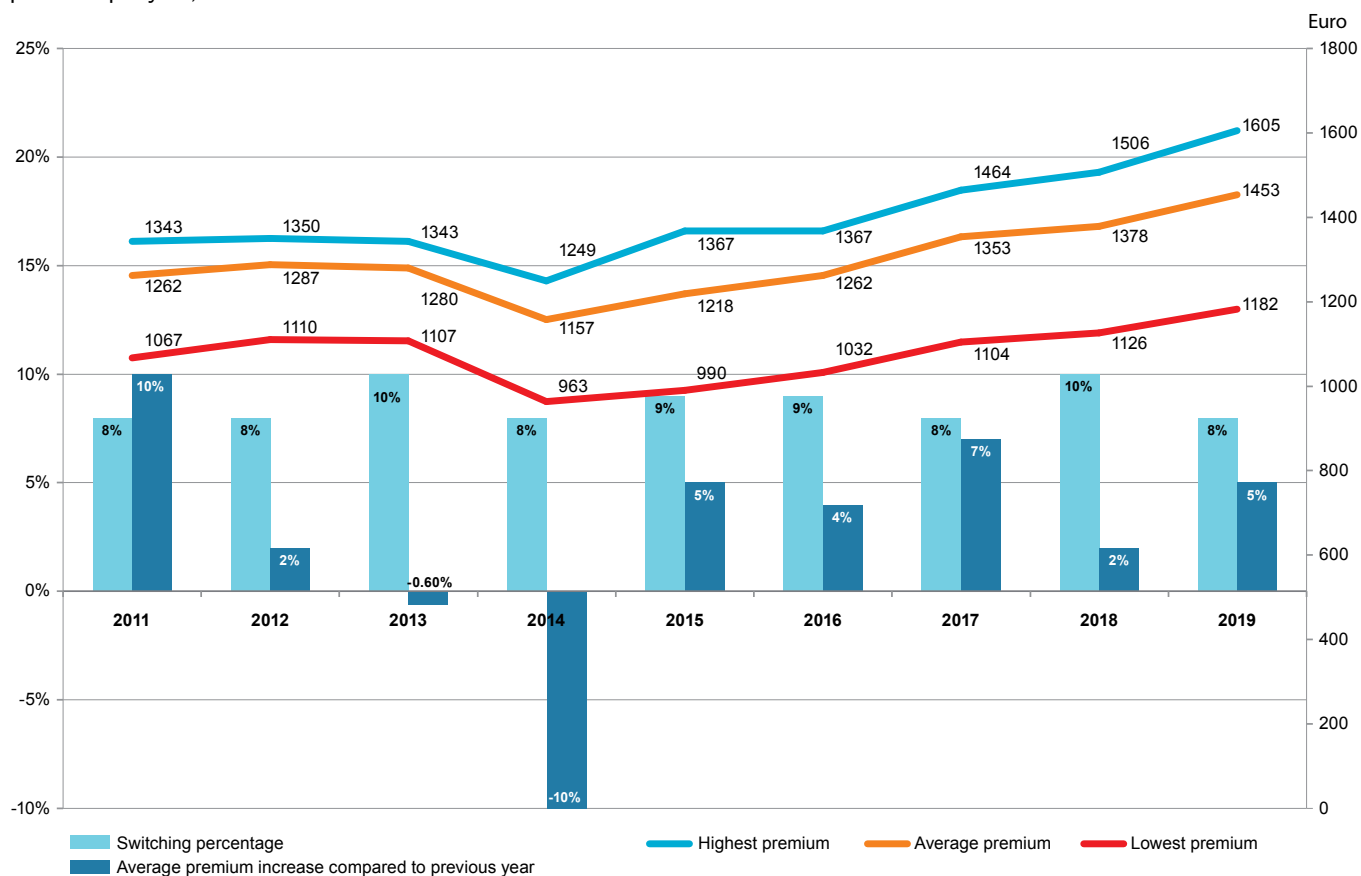
#### ***People do not switch because they are satisfied***

The most important reason for not switching is satisfaction. On average half of the insured who do not switch health insurer, do not switch because they are satisfied with the coverage of their insurance plan (range 36%–59%). Other reasons that are frequently indicated are: 'I'm insured with the same insurer for years (range 30%–40%)', 'I'm satisfied with the service of my health insurer' (range 20%–42%), and 'I'm satisfied with the coverage of the basic insurance' (range 14%–23%).

#### ***People report barriers to switching***

People mostly indicate that they do not switch because they are satisfied. This could be framed as 'positive reasons'. However, some people also perceive barriers preventing them from switching. These barriers are important to monitor, because they might indicate inequalities in the system. Some people might experience more barriers than others, and as a consequence these barriers might

**Figure 1:** Switching percentage, average premium increase compared to previous year, and lowest, average and highest premium per year, 2011–2019



Sources: Source of switching percentage <sup>1</sup>; Sources of lowest premium, average premium and highest premium <sup>2</sup>

prevent certain groups from switching. For the system to work, it is important that all insured have the possibility to switch, irrespective of their health status and other characteristics. Therefore, the system in the Netherlands contains safeguards. For instance, insurers are obliged to accept everyone for the basic package. In addition, switching services are introduced, making it easier for insured individuals to switch. Nevertheless, the insured may still perceive barriers for switching. One reason provided for not switching includes fear of getting into (administrative) problems (range 2%–8% in the period 2011–19). Furthermore, the supplementary insurance could be a barrier for switching. Health insurers are not obliged to accept everyone for supplementary health insurance. A small percentage of the non-switchers indicated fear of not getting accepted for supplementary health insurance (3%–7% 2011–19) as a reason for not switching, or that they are afraid of being

confronted with a high premium for supplementary health insurance because of their age (3% in 2017–19, only measured since 2017).

### Conclusions

The percentage of people switching insurer was stable from 2011–19. Premiums are still the most important reason to switch health insurer, implying that differences between premiums are big enough to incentivise switching. We can conclude that there is price competition in the system. Competition on quality still seems to be absent. In switching health insurer, quality of care still plays a limited role. This might be explained by the fact that quality of care is more difficult to judge than price. For the health insurance system to work as intended, the idea was that insured choose their health insurance policy both on price and quality. This does not seem to work.

In practice, several problems might hinder this policy to have the intended consequences. First, it might be difficult for those insured to choose their insurance policy based on the quality of care. To be able to take quality into account, people should know what care they will use in the future, they should have information on the quality of care of contracted health care providers, and they should be able and willing to make a decision for their health insurance based on information on both price and quality. These conditions are unfulfilled. Second, it might be difficult for insurers to take their intended role related to quality of care, such as selective contracting of health care providers. To be able to play a role in improving quality of care, they need to have trust from the insured. Trust in health insurers by those insured is low, especially when compared with trust in health care providers.<sup>7 8</sup> This makes it difficult for insurers to channel the insured to selected health care providers. Therefore, insurers are reluctant

to limit choice of health care providers, because they are afraid that insured will then choose another insurer. It therefore remains a question whether choosing a health insurer as an instrument for quality improvement will ever have the intended consequences.

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# IMPLEMENTING ADVANCED PRACTICE NURSES IN SWISS PRIMARY CARE

By: **Beat Sottas, Renata Josi, Stefan Gysin and Stefan Essig**

**Summary:** Switzerland is facing a multimorbid, ageing population and a scarcity of general practitioners (GPs). In Anglo-Saxon and Nordic countries with similar challenges, advanced practice nurses (APNs) appear to be a solution by adding new capacities and suitable competencies. Even though APNs have been established in the hospital sector, Swiss primary care is at an early stage of implementing the role. Despite the lack of regulations, role models and reimbursement schemes, political uncertainties and scepticism from GPs, the first pilot projects are underway. We discuss four of these case studies and assess the achievements and remaining challenges for further implementation.

**Keywords:** *Advanced Practice Nurse, APN, Swiss Primary Care, Family Medicine, Nurse Practitioner*

## Introduction

In Switzerland, GPs have been the single, dominant player in primary care for decades. However, due to retirements and insufficient numbers of young successors, a future lack of GPs is expected.<sup>1</sup> Group practices constitute mainly aggregates of GPs without nurses or other physicians. However, these models are under pressure. Administrative and technological challenges combined with the growing and changing demand for complex health services due to an ageing, multimorbid population call traditional models of care into question. As experienced in many countries, interprofessional models of care are seen as a promising solution to these

challenges.<sup>2</sup> Of particular interest are solutions developed in the United States, the United Kingdom, Australia, Sweden, and the Netherlands which rely on interprofessional teams involving nurses in advanced roles with a master's degree, so-called Advanced Practice Nurses (APNs). The international literature shows that APNs embedded in interprofessional teams lead to high quality and holistic care for older people by bringing in new, specific care competencies.<sup>3</sup> Aside from tackling the needs of older, multimorbid patients, APNs can take over defined tasks that were traditionally attributed to physicians such as diagnosis and treatment with similar or better health outcomes.<sup>4</sup>

## Introducing APNs in Swiss primary care

In the Swiss federalist system, cantons (states) are responsible for the organisation of care delivery to their population. This federalist governance also allows for the implementation of local strategies and models of care, which are tailored to local needs. In terms of introducing APNs in primary care, some cantons referred to this option already around 2006 and started encouraging small scale projects in 2016.

“reinvent Swiss primary care by introducing APNs in interprofessional, collaborative models of care

However, a major challenge was the availability of qualified nurses and – even harder – to convince them to work in the ambulatory sector. Across Switzerland, the number of nurses with Master’s degrees was around 250 in 2015. The first modules focusing on competencies for primary care offered in Swiss universities started only after 2010. Accordingly, the “academic drift” was not home made, and Master degrees were mostly obtained abroad, mainly in United Kingdom, the United States, the Netherlands or Australia). All had good career options and promising workplace development in large hospitals. Given the resistance of GPs, lower salaries and the lack of role models there were no incentives to choose primary care. Recruitment was more successful in cases where APNs had previous experience either in home care services or at clinical interfaces such as outpatient services. Interested nurses usually joined a specifically tailored university programme, based on close collaboration with interested GPs.

Accordingly, new collaborative care models involving APNs have been realised in recent years in a handful of primary care practices (PCPs) only. Moreover, the implementation of collaborative models involving APNs is hampered by a physician-centred fee-for-service system which does not foresee reimbursement of the services provided by APNs.

On the federal level, collaborative practice was endorsed in 2013 when the Federal Government approved the national strategy “Health 2020”. One of the priorities included was the promotion of “collaboration between the various health care professions by adapting initial and post-qualification training, strengthening research, and creating more favourable conditions for exercising health care professions”.<sup>5</sup> As a result, the models involving APNs were discussed in national and regional symposia and shared in a centralised database of interprofessional practice.<sup>6</sup>

In consideration of undertaking evaluation and research, the field of primary care has become more attractive. In the tailwind of rising public awareness of the importance of general health care to reduce costs and over-treatment, health services research has been built in strong links to primary care practitioners and transdisciplinary networks also involving health insurance and policymakers. Hence, the topic of APN introduction is on the research agenda.<sup>7</sup>

### Four pilot projects with different starting points

The four projects outlined in **Box 1** represent about one-third of ongoing projects in Switzerland, though some operate on temporary basis. The case studies provided present the drivers, the conceptual differences and the types of arrangements that are prototypical for different project origins and contexts.

### Obstacles to widespread implementation of new care models

There are factors enhancing and impeding APN integration into PCPs. Based on evaluations of some pilot studies, a review of recent publications on Swiss primary care, the analysis of parliamentary

questions and expert interviews, the benefits and challenges are summarised in **Table 1**.

## Discussion

These pilot projects offer the opportunity to learn from their valuable experiences, in terms of providing proof of concept, indicators for feasibility, evidence for entrustable professional activities to be performed by APNs, and confidence regarding patient safety but also acceptable compensation schemes. The latter is crucial since previous attempts to regulate advanced practice, define the scope of practice with exclusive tasks and set tariffs similar to the physicians were repeatedly rejected in the political arena. Prevailing scepticism and opposition would ultimately lead to very restrictive legislation. Therefore, the pilot projects should be discussed broadly, as they have the potential to show to policymakers and practitioners the forward-looking and patient-oriented framework for APNs.

“Prevailing scepticism and opposition would ultimately lead to very restrictive legislation

The four pilot projects mark a paradigm shift in primary care. They reinvent Swiss primary care by introducing APNs in interprofessional, collaborative models of care giving. The two projects in Uri and Sernftal were arranged in a “top-down” approach by politics (public), whereas the Zürich Oberland and Altstetten cases evolved “bottom-up” by GP entrepreneurs (private). While in the politics-driven projects the role and potential of an APN was not familiar to the GPs at first, the entrepreneurs took an informed strategic choice and aimed at transferring APN models which had work abroad.

## Box 1: Four pilot studies of ANP in Switzerland

### Case 1: “ANP Uri”

“Advanced Nursing Practice Uri” was the first project in Switzerland which was launched and supported by a cantonal government. Uri is a small rural canton along the famous Gotthard Alp trajectory. It has the lowest density of GPs in the country (n=23, 0.63/1000 inhabitants).<sup>1</sup> In order to ensure primary care for its population, the local government initiated and co-financed a three-year pilot project with an APN assigned to a rural family practice with two GPs. A health insurance company co-financed the project which was also scientifically evaluated to assess patient satisfaction, interprofessional collaboration between practice staff, consultation types, costs and legal aspects. The project started in August 2017 with the engagement of the APN who works on a part-time basis (50%) in this remote, potentially underserved area. The main goal of this project was to provide a “proof of concept” of an innovative care model with a focus on older, multimorbid, often home bound patients with complex health care needs. The APN visits patients at their homes as well as in nursing homes. They also take care of non-urgent, small “emergencies”, and offer technical interventions such as infusions or vaccinations. In order to improve clinical skills and competencies, the APN receives mentoring and close supervision by the GPs.

### Case 2: Sernftal

In the neighbouring small rural Canton Glarus, with its deep central valley between mountain ranges, the government approved and financed the pilot project for one year. In 2018, the provision of primary care services in the Sernftal, a remote side valley, was under threat as there were not enough GPs covering this region. In Glarus, the GP density is also low (n=34, 0.84/1000 inhabitants).<sup>2</sup> The project was proposed by the hospital of Glarus which already had employed experienced nurses with Master’s and PhD degrees. The concept was to fill the gap in primary care by sending one of them to the valley. The mission was developed by an APN interested in working in both primary care and the care service management of the hospital. The goals and tasks were similar to Uri, but with significantly higher autonomy of the APN who benefitted from support and indirect supervision by hospital doctors and a GP leaving for retirement. Beyond an internal report, the experience

was not evaluated. It is reported to have good acceptance by patients, the hospital and the government. Despite convincing outcomes, it is combated by the cantonal GPs association not accepting such a substitution. Hence, continuation is not assured.

### Case 3: Primary Care Practice Zürich Oberland

In this PCP, skill mix innovation was based on an entrepreneurial analysis of GPs. The two mid-career owners employed a handful of other GPs on part time schemes, a psychotherapist, a dietician, physiotherapists, and an APN. The project is also located in a remote rural area. The region has a significantly lower GP density than the canton and city of Zurich (n=1448, 0.96/1000 inhabitants which is slightly above the Swiss average of 0.93).<sup>3</sup> This interprofessional setting does not benefit from public subsidies. From the beginning in 2016, it was conducted with a long-term perspective. The APN mission embraces care giving to multimorbid patients with complex needs, home and nursing home visits, small “emergencies”, life style and ethical counselling. The project is evaluated on patient satisfaction, interprofessional collaboration, consultation types, costs and legal aspects. Evaluation is based on the same instruments as in Uri. Results show that the APN perfectly complement the GPs. The APNs scope of practice consists of activities associated in 55% with Nursing, 31% with GP tasks, 21% with psychosocial framing. The case of PCP Zürich Oberland is financially cost-effective and sustainable.

### Case 4: Medix Altstetten

This case is part of a large company which was the pioneer of GP group practices in Switzerland. The practice is located in the outskirts of Zürich. The urban, densely settled area has a significantly higher GP density than the canton Zurich (*see above*). The manager engaged two APNs on a part-time basis in 2016 and 2018. The motivation to introduce them was to relieve GPs from their time pressure due to the increased demand for primary care services. This model of care involving APNs was initiated by the practice itself and is financed through the practice. The case has not been evaluated. However, given the size and economic potential of the company as well as its reputation and the availability of APN in the urban context it will be continued.

## Conclusions

Skill mix innovations in Swiss primary care involving APNs have not yet received great public attention but are slowly gaining momentum. The first pioneers and early adopters independently demonstrated the proof of practice regarding the successful integration of

APNs in primary care. All cases provide valuable and promising results and met the predefined goals. Despite the differences regarding concept, framework, ownership and implementation, the preliminary experiences and results of the projects are similar and largely positive. Experience gained is frequently discussed

in conferences. In fact, these projects have already inspired and endorsed other pioneers to launch similar projects.

However, as shown in **Table 1**, the complex nature of the challenges remaining at various levels does not allow a rapid spreading of APNs in primary care across the country. At present we see

**Table 1:** Antagonistic drivers and forces regarding APN in primary care

|   |   |
|---|---|
| + | GP shortages, higher demand and cost pressure enhance reflection on alternatives                  |
| + | Raising awareness of the need for integrated care provision to multimorbid homebound older people |
| + | Universities and GPs complement each other in shaping education and the scope of practice         |
| + | Enough time for innovation and development of models embedded in local structures                 |
| + | Endorsement of innovative interprofessional models by national policies                           |
| + | Entrepreneurial GPs seizing the “academic drift” in nursing for unconventional models             |
| + | Open-mindedness of health insurance companies regarding compensation of APN services              |
| – | Reluctance of GPs and medical associations  |
| – | Fear of established practice members regarding their role, e.g., with diabetes patients           |
| – | Overhasty and exaggerated demands for regulations and tariffs                                     |
| – | Federal Parliament and Government rejected political proposals to reform primary care             |
| – | At present, only few APN choose to work in primary care   |

two key adverse factors. On the meta level there is a deadlock—the recent referendum launched by the Swiss Nursing Association was completely rejected in parliamentary deliberations in October 2019 but the initiators still aim to bring their exaggerated demands for regulations and tariffs to the public vote. This, in turn, encourages all political and professional opponents, as well as the Government, to freeze reforms aimed at providing flexibility in healthcare provision for chronically ill people, in primary care and care of older people, and also the adjustment of related payment schemes. At the micro level, a number of uncertainties remain – GPs perceive an implicit confirmation of the traditional model, experienced APNs have little attractors to leave the comfort zones reached in hospital settings, and the vagueness regarding payment of their services in comparison to physicians tariffs make a deliberate choice to work in primary care an alternative for the venturesome only.

Encouraging initiatives taken on the meso level (e.g. new training programmes tailored towards primary care in Lausanne and Berne, a handful of cantons revising the physician-focused legislation) might help prepare a future workforce that will become effective in a couple of years.

Taking an optimistic perspective, the stagnation and non-existence of regulations have the advantage to leave room for trials and adaptation. The experiences gained from these projects provide important data regarding chronic care management, role clarity, removing bottlenecks, cost containment, acceptance and patient satisfaction. Furthermore, these cases disseminate a positive message among the medical community about the potential of APNs in primary care. Moreover, the assessment of these cases and the lessons learned allow one to start outlining the blueprint for successful implementation of the APN role in Swiss primary care.

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# CENTRALISING HEALTH CARE ADMINISTRATION IN FINLAND — AN INEVITABLE PATH?

By: Liina-Kaisa Tynkkynen, Ilmo Keskimäki, Eeva Reissell, Meri Koivusalo, Vesa Syrjä, Lauri Vuorenkoski, Bernd Rechel and Marina Karanikolos

**Summary:** The discussion on the optimal degree of decentralisation and centralisation in the organisation of health systems is ongoing. Since the early 2000s, successive Finnish national governments have attempted to reform the health and social care system to increase the size of administrative units that organise services and to strengthen central steering. So far, developments have materialised mostly in the form of bottom-up solutions without being underpinned by a fundamental national level reform. However, the direction is towards more central steering, planning and organisation of services either through national reform or through bottom-up reforms implemented at local and regional level.

**Keywords:** *Centralisation, Structural Reform, Health System Governance, Finland*

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The discussion on the optimal degree of decentralisation and centralisation in the organisation of health systems is ongoing. Many countries have implemented decentralising reforms and again re-centralised their health systems to improve the performance, governance and accountability of services. This is the case in Finland where the debate on the right form of governance and the balance between local governments, regional entities and the state has always been present. However, the discussion has intensified in recent years.

Finland has a health system with a highly decentralised administration, multiple funding sources, and three provision channels for statutory services in first-contact care: the municipal system; private

services partly reimbursed by the national health insurance system; and occupational health care. The core health system is organised by the municipalities (i.e. 311 local authorities) which are responsible for financing primary and specialised care. The municipalities have the right to levy taxes. In addition, they get part of their funding through user fees and state transfers in the form of block grants.<sup>1</sup>

Since the early 2000s, successive Finnish national governments have attempted to reform the health and social care system to increase the size of administrative units that organise services and to strengthen central steering. So far, developments have materialised mostly in the form of bottom-up solutions without being underpinned by a fundamental national level reform.

However, the direction is towards more central steering, planning and organisation of services either through national reform or through bottom-up reforms implemented at local and regional level.

### A series of failed reforms

Achieving greater administrative centralisation has been a long-term national level goal in the Finnish health system. There is broad consensus that the Finnish health system has inherent flaws, such as weak national stewardship and a large degree of fragmentation. The separate organisation of primary and specialised care and social services, particularly in the context of an ageing population, is seen as an obstacle to improving health system performance.

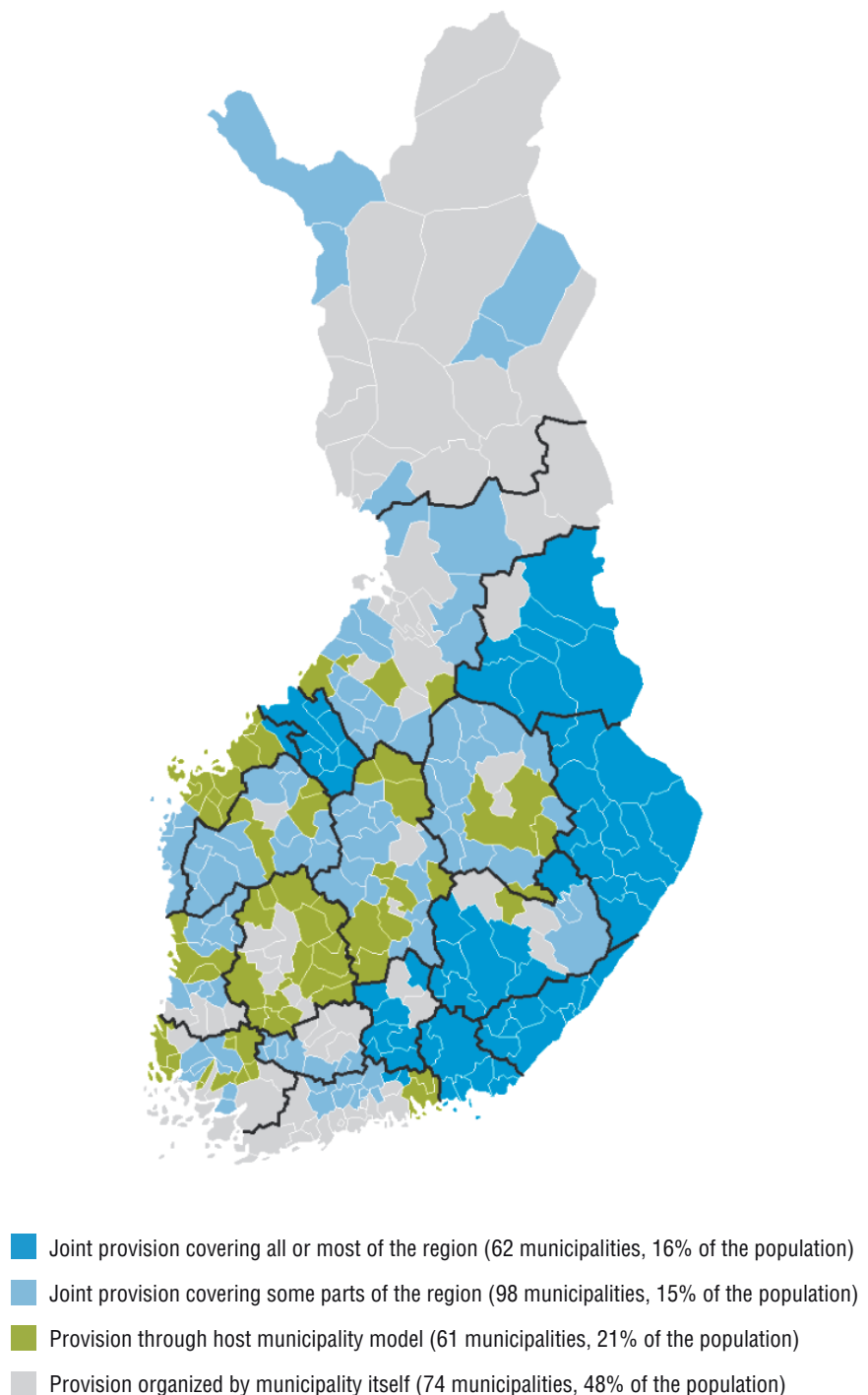
“pledged to continue centralisation of health care”

Over the past two decades, several governments, irrespective of political profiles, have attempted fundamental systemic reforms with three core aims: 1) centralisation of organisational structures; 2) improving access to primary care; and 3) integration of services (both horizontal and vertical). The implementation of these reforms on the national scale, however, has yet to succeed.

Due to the decentralised organisation of health and social care, as well as most other public services, it has been challenging to implement any major reforms without reducing the role of the municipalities. Such arrangements, together with the strong constitutional position of the municipalities, mean that finding a consensus on feasible policy solutions has proved very challenging and resulted in a series of failed reform attempts.

At first, in the early 2000s, the starting point was to reform the system through

**Figure 1:** The organisation of primary health care and social services by region, 2019



Source: Local and Regional Government Finland, 2019; Municipal Boundaries © National Land Survey of Finland 2017; Map image © Association of Finnish Local and Regional Authorities/MS.

municipal mergers. While this only succeeded to some extent, the number of municipalities remains relatively large and the median population size remains small (see below). Subsequently, since 2010,

the idea of transferring the responsibility for health care from the municipalities to regional entities has gradually started to gain ground.

The most recent reform attempt was introduced by the government in power from April 2015–March 2019. It envisaged



**Table 1:** Provision organised by the municipality itself: the number of municipalities and percentage of the total population covered

| Population of municipality | Number of municipalities | % of total population |
|----------------------------|--------------------------|-----------------------|
| > 100,000                  | 5                        | 28%                   |
| 50,000–100,000             | 4                        | 4%                    |
| 20,000–50,000              | 14                       | 8%                    |
| < 20,000                   | 51                       | 8%                    |

Source: Local and Regional Government Finland, 2019.

transferring all responsibilities for financing, organising and providing health care away from the municipalities, and could be seen as the most radical change to date. The plan was to create 18 administrative units (counties) with democratically elected councils, which would have been responsible for a wide range of tasks, including health and social care, emergency services, economic development, transport and the environment, as well as the current functions of the existing regional councils such as regional planning and development. The counties would have been financed entirely by the central government, i.e. they would not have the right to levy taxes. Municipalities in turn would have remained responsible for the promotion of health and well-being, and also for collecting municipal taxes but with a substantially lower tax rate.

Another component of the reform package was offering extensive choice and a competition model, which included the choice of a primary care provider and the freedom to establish practices for any qualified provider.

The bills on regional government and on choice and competition became the central pieces of the proposed reform package, but contained major challenges. Among these were the very tight budget constraints for financing of the counties, conflicts of the choice and competition model with the Finnish Constitution, and the process of integration of services within the planned system of multiple providers. Ultimately, it was the conflict with the provision of the Constitutional Law that, after several revision rounds with the Constitutional Law Committee, formally made the

reform to fail in March 2019, resulting in the Government's resignation five weeks before the general elections in April 2019.<sup>1</sup>

However, the preceding intense preparation process seems to have set the stage for the next phase of the reform and the government in power since April 2019 has pledged to continue the centralisation of health care to 18 or more larger entities.

### Small steps towards more centralisation

While the Finns are still waiting for a nation-wide reform, a lot has already happened in terms of centralisation during the past two decades. In the early 2000s, there were over 450 municipalities in the country. A slow process of centralisation has taken place since, and their number has been reduced to 311 municipalities (295 in mainland Finland) in December 2019. Despite a fall in the absolute number of municipalities by almost a third, the number of small municipalities is still high. In 2019, the average population size of the municipalities is about 18 000 inhabitants and, notably, the median size is 6 000 inhabitants.<sup>2</sup>

Municipalities can organise health care for their populations themselves or transfer this responsibility to another municipality or a joint municipal authority (see Figure 1). The organising function includes being responsible for defining and monitoring service volume and quality, assessing the needs of the population, ensuring equal distribution of services, deciding on the method of provision (e.g. service delivered by municipality, purchased or financed by a client voucher), and acting as public authority in decision-

making. In the statutory health system, specialised medical care is provided by hospital districts. They are managed and funded by the municipalities and are responsible for organising and providing specialist medical services for the residents of member municipalities.

“comprehensive integration of primary and specialised health care as well as social services”

Currently, 74 municipalities in mainland Finland (covering 48% of the population) organise services for their population themselves (see Table 1). In other words, the remaining 221 mainland municipalities have transferred the responsibility for organising services to another municipality or to a joint municipal authority. The median size of the municipalities that are organising the services themselves is around 7500 inhabitants with the smallest municipality having less than 1000 inhabitants and the largest over 600 000 inhabitants.<sup>3</sup>

During the past decade, regional joint organisations have also emerged. One such example is Eksote, which is a joint municipal authority of the South Karelia region (around 130 000 inhabitants). In addition to administrative consolidation, the joint authority has also aimed at comprehensive integration of primary and specialised health care as well as social services.<sup>4</sup> The services provided and organised by Eksote include, for instance, primary health care and specialised medical care, oral health care, mental health care and substance abuse services, diagnostic services, rehabilitation services, social services for adults, special services for disabled people, and services for older people.

In recent years, seven other areas have decided to implement similar arrangements. This indicates that in terms of organisation of services, the Finnish health and social care system has taken some important steps towards a more centralised administration as well as integrated service provision. However, according to the legislation, the municipalities are still responsible for financing of health and social care even if the organisational responsibility for services has been transferred to another municipality or a joint municipal authority.

At the level of specialised care, there also have been developments towards more centralised provision of services. This trend has been more pronounced since 2013, when a Decree on Emergency Care Services defined the overall principles of urgent care and its specialty level requirements.<sup>5</sup> This and subsequent legislation shifted both primary and specialist on-call services to jointly organised emergency care units, specified the requirements for key medical specialties, including the minimum acceptable total number of deliveries annually per hospital and the presence of certain specialists in hospitals with on-call units or performing any type of surgery. The aim of the Decree was originally to improve quality of care, but further amendments in 2014 set a specific national-level cost-saving target. Since 2015, the number of smaller somatic care hospitals has declined from 64 to 27.<sup>6</sup> Some of these facilities have been closed and some operate as satellite units of larger hospitals. In addition, psychiatric hospitals (previously located in separate facilities), were obligated to shift their on-call services and all in-patient care to the same premises as their somatic 24/7 care. Half of the 22 psychiatric institutions have since been closed, with a further six awaiting closure.

The process of centralisation in specialised care continues, with a further revision of the Health Care Act that was implemented in January 2017. The amendment centralised all 24/7 surgical services with on-call duties to 12 major hospitals (which will increase to 13 hospitals in 2020). In addition, in 2017 a Governmental Decree

set volume-based requirements for key surgical procedures that will limit the number of hospitals able to perform these.

### Difficulties in overall steering and in municipalities' abilities to organise adequate services

Even though there have been developments towards a more centralised system, the Finnish health system still remains decentralised and fragmented. The administrative structure makes the overall steering of the system difficult. The central Government's means for steering are based mainly on high-level regulation and soft guiding by recommendations and project funding aiming to develop different aspects of the services.

The municipalities continue to enjoy a high degree of autonomy. However, quite often their capacity to plan and evaluate performance of services and to make decisions on alternative models to organise services is limited. In specialised care, the smaller municipalities do not have enough power and expertise to impact the process of decision-making in their hospital district. A tangible example of challenges in health care governance and planning is well reflected in the stagnated resources in municipal health centres compared with increases in hospitals and occupational health care since 2000, which contrasts with overall Government policy, where the emphasis has been placed on the strengthening of primary care.

The capacity to deliver services that match population needs has also been weakened in the past decade. This has been driven by, for instance:

- the changing demography, namely population ageing, which is contributing to increased costs of health and social services;
- a decreasing birth rate and population growth;
- in-country migration, with working-age population concentrating in big cities and deteriorating local economies in many rural areas; and
- the rising costs of specialist health care.

For patients, this is reflected in long waiting times in primary care (up to

several weeks for a non-urgent GP appointment in some health centres), but also in elective specialist care. The relatively high rates of (self-reported) unmet needs have been associated with long waiting times for the first appointment.<sup>7</sup> This is particularly the case for people outside of employment schemes, who do not have access to occupational health care.

The problems in access are intensified by an uneven distribution of resources across different regions in Finland. For example, the density of doctors is much greater in the capital region and in other big cities in comparison to more rural areas especially in eastern and northern Finland.<sup>8</sup>

### How and when to undertake large-scale structural reform?

Because of the difficulties outlined above, there is relatively wide consensus among politicians and experts that the administration of the Finnish health system needs a large-scale structural reform. The recent steps towards a fundamental reform have laid the foundations, even though the actual reform failed. A notable development in the reform led by the government in power in 2015–19 was that the implementation process was initiated in 18 counties long before the legislation was even close to be passed. These county-level processes were financed from the central government budget. This means that in practice the reform preparations at local level were much more advanced in many counties than they were at the level of legislation. The financing was terminated after the government resignation, but some of the municipalities have decided to continue their preparation for county-level organisation.

It also seems that the current government (in power since April 2019) is following the steps taken by the previous government. In the government programme, it stated that “The health and social services reform will transfer the responsibility for organising health and social services to self-governing regions (counties) that are larger than municipalities. The responsibility for organising rescue services, too, will be transferred to the counties. There will

be altogether 18 autonomous counties. Separate legislation will be enacted on the functioning, finances and governance of the counties. Decision-making power in the regions will rest with directly elected councillors, and we will strengthen participation of county residents and reinforce user democracy.”<sup>4</sup>

That is, in terms of administrative structure the plans of the current government are very similar to the reform that the previous government was pushing forward. However, the current government does not plan for the introduction of any choice and competition model – at least not to any large extent. In addition, the government is carrying out an expert investigation on the status of the capital region. The main reason for this is that Helsinki, the capital city of Finland with over 600 000 inhabitants, is opposing the regional model that would dismantle its power in the organisation of the services. The expert work should be ready by the end of 2019. It is possible that instead of being one county, the capital region would be organised into three to five counties of which Helsinki could be one.<sup>5</sup>

In conclusion, one can observe that while the fundamental reform is still waiting to be realised, the system has not been static and incremental development towards more centralised organisation of health care has taken place. Due to municipal mergers, the number of municipalities has decreased substantially. In addition to organising hospital care through hospital districts, the municipalities are

increasingly organising health and social services in collaboration with each other and more recently, also through regional joint health and social care authorities. In hospital care, the centralisation of emergency services and certain medical tasks, such as deliveries and complex surgical treatments, have obliged hospital districts to collaborate. The process has also strengthened the mandate of university hospital districts to plan the coordination of hospital services in the areas for which they are responsible.

However, these changes have not substantially influenced the formal power of the central Government to steer the system. It remains to be seen whether the current government can succeed in delivering the structural reform, while at the same time there has been movement at the local level towards larger regions through joint municipal organisations in a county-wide manner. While the realisation of the national-level reform is still uncertain, the system is slowly moving towards more centralised organisation. Thus, the question is not whether there will be centralisation but rather when, how and to what extent.

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## Finland: Health system review

**By:** I Keskimäki I, LK Tynkkynen, E Reissel E, et al.

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On the occasion of Finland's Presidency of the Council of the European Union in 2019, the European Observatory on Health Systems and Policies has released a new health system review (HiT) for Finland. Finland's health system has a highly decentralised administration, multiple funding sources, and

three provision channels for statutory services in first-contact care. The core health system is organised by the municipalities which are responsible for financing primary and



specialised care. The health system performs relatively well, as health services are fairly effective, but accessibility may be an issue due to long waiting times and relatively high levels of cost sharing. For over a decade, there has been broad agreement on the need to reform the Finnish health system, but reaching a feasible policy consensus has been challenging.

# NEW PRIMARY CARE POLICY IN THE RUSSIAN FEDERATION

By: Erica Richardson and Igor Sheiman

**Summary:** The Russian government has introduced a new national project to strengthen primary care that will run from 2019 to until 2024. Over this period, there are ambitious targets to further improve population health as well as sector specific targets to improve the supply of health workers in primary care and modernise primary care facilities. A distinctive feature of primary care policy in the Russian Federation is the inclusion of extensive health checks, which will be expanded to cover the whole population in an attempt to address a high burden of non-communicable diseases.

**Keywords:** Primary Care, Public Health, Universal Health Checks, Russian Federation

## Introduction

Primary care in the Russian Federation has retained the polyclinic system, and as a result the boundaries between primary care and specialist outpatient care overlap. This is known as the ‘extended model’ of primary care. In urban areas, polyclinics are still staffed by internists [*terapevty*] and paediatricians and a standard mix of 5–20 specialists who work at the primary care level (most commonly: gynaecologist, general surgeon, ENT specialist, ophthalmologist, neurologist, urologist and dentist). These specialists monitor conditions and might provide an initial diagnosis but confirmed diagnoses are provided mostly at the secondary level. These services cover the adult population – parallel primary care services cover children through dedicated polyclinics and paediatric departments in primary care facilities, which are staffed by primary care paediatricians and sometimes a team of paediatric specialists.<sup>1</sup> Doctors for children and adults at the primary care level have a list of patients they are

responsible for. They refer patients to specialists, but their gatekeeping role is frequently undermined.<sup>2</sup>

Contrary to most other post-communist countries, the Russian Federation has not developed general practice and retained a model based on internists with a limited curative capacity (task profile). This generates demand for specialists. Their number in urban polyclinics is much higher than internists. The latter don’t play a central role in primary care provision.<sup>3</sup>

In 2017, officially one in five primary care facilities were short-staffed,<sup>4</sup> although other estimates which look at the number of patients a primary care doctor covers put the level of short staffing much higher at 32%.<sup>5</sup> There are many challenges facing primary care which complicate the recruitment and retention of staff and which also make it harder for primary care to fulfil its full potential in tackling non-communicable diseases. Working in primary care is not considered prestigious

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**Table 1:** Selected target indicators for the National Project “Health”, 2019–24

|   | Baseline | Targets |       |       |       |       |      |      |
|---|----------|---------|-------|-------|-------|-------|------|------|
|   | 2017     | 2018    | 2019  | 2020  | 2021  | 2022  | 2023 | 2024 |
| <b>Mortality rate at working age (per 100,000 population)</b>         | 484.5    | 455     | 437   | 419   | 401   | 383   | 365  | 350  |
| <b>Mortality from cardiovascular disease (per 100,000 population)</b> | 587.6    | 565     | 545   | 525   | 505   | 485   | 465  | 450  |
| <b>Cancer mortality rate (per 100,000 population)</b>                 | 200.6    | 199.9   | 199.5 | 197.0 | 193.5 | 189.5 | 187  | 185  |
| <b>Infant mortality rate (per 1000 births)</b>                        | 5.6      | 5.5     | 5.4   | 5.2   | 5.0   | 4.8   | 4.6  | 4.5  |

Source: [2]

and has fewer opportunities for career development than working in hospitals. This can make it harder to recruit and retain clinical staff in primary care. Patients prefer to self-refer to specialists who are generally perceived as offering better quality care and there are few disincentives for bypassing primary care doctors. Hospitals have to compensate for weak primary care and the mistrust patients have of primary care doctors. The result is an over-utilisation of inpatient care. All of this contributes to the weakness of primary care in the Russian Federation. [1]

“the health of the Russian population has improved over the past decade”

Overall, the health of the Russian population has improved over the past decade as tobacco and alcohol control policies have borne fruit. Per capita alcohol consumption fell by 40% between 2003 and 2016, and adult daily smoking rates fell from 35% in 2000 to 23% in 2015. [4] Life expectancy at birth for men is the highest it has ever been at

almost 68 years in 2018 – for women it reached 78 years. This means Russian men are expected to live a decade longer than in 1994 when life expectancy fell to just under 58 years. [4] However, despite clear improvements, working age mortality is still very high and much of it is attributable to cardiovascular disease. [5] In response to these specific population health problems, the Russian government focused resources on improving the accessibility and quality of cardiovascular care nationwide. This has involved the rolling out of a universal screening programme (see Box 1) and the modernisation of cardiovascular care – particularly in terms of ensuring people had access to the latest technologies and surgical techniques.

### National Project “Health”

The overall aim of the National Project “Health” [Zdorov’e] (2019–2024) is to increase the size of the Russian population and to increase overall life expectancy to 78 years by 2024 and 80 years by 2030. To achieve this, the Project sets ambitious goals for improving population health, including reducing the mortality rate for the working age population to 350 per 100,000 population, reducing the cardiovascular mortality rate to 450 per 100,000 population, the cancer mortality rate to 185 per 100,000 population, and the infant mortality rate to 4.5 per 1000 births (see Table 1).

Related federal projects for priority areas underpin these overall aims to improve

population health. The Federal Project “Development of the system for providing primary care” [Razvitiye sistemy okazaniya pervichnoi mediko-sanitarnoi pomoshchi] aims to improve the accessibility and quality of primary care services for all citizens, including those in remote and sparsely populated territories. Reforms to improve access focus on ensuring universal geographical access to primary care facilities by 2021. This will involve building 350 new basic primary care facilities for rural populations (feldsher stations) and the renovation of over 1200 more as well as the full reconstitution of air ambulance services to serve remote rural areas. Technological fixes such as using telemedicine for remote consultations are also included in the targets as this would serve to both increase access for sparsely populated and remote territories while also helping to address workforce shortages. The need to ensure the quality of care provided in this way is also emphasised. [2]

The Federal Project “Supply of qualified staff for medical organisations in the health care system” [Obespecheniye meditsinskikh organizatsii sistemy zdavookhraneniya kvalifitsirovannymi kadrami] seeks to address health workforce shortages in primary care by increasing the supply of health workers by around 10%. The target is to increase the proportion of primary care facilities which are fully staffed by doctors from a baseline of 79.7% in 2017 to 95% by 2024 and rural paramedics (feldshers) from a baseline of 88.8% in 2017 to 95% in 2024. This project also seeks to increase the number of specialists enrolled in continuing professional development (including distance learning) from 109,000 in 2017 to 1,880,000 in 2024. This is part of efforts to improve the quality of care and adherence to agreed clinical recommendations on optimal care but it is also a means of improving productivity and the distribution of staff across specialisations.

Investing in basic and IT infrastructure to improve the quality and accessibility of primary health care also features prominently. One target is for the rolling out of a ‘New Model’ of primary care provision nationwide. The New Model

seeks to improve the patient experience by upgrading primary care facilities to give them open and welcoming reception areas, comfortable surroundings in the waiting areas, and clear signage. Developing IT infrastructure, should allow for the introduction of bookable doctors' appointments to reduce waiting times as well as reducing the volume of paperwork that patients and health workers deal with. Previously, appointments were not bookable so a patient had to attend the polyclinic in person and queue up to see an available doctor. Improving the logistics of patient movement through polyclinics is another area for increasing productivity of service provision.

The Project ("Health") also aims to increase coverage of universal health checks (see Box 1), by ensuring all eligible people are made aware of their right to access this service (dispanserisation). The ambitious target is to increase coverage of the adult population in annual health checks, which links to the target of reducing working age mortality. However, there are also explicitly pronatalist targets for ensuring 80% of young people aged 15–17 are given detailed reproductive health checks (in 2017 this programme reached 38.7% of the target population) which are linked to other policies to strengthen maternity and child health services.

“improve the patient experience by upgrading primary care facilities”

While a dispanserisation programme has clear intuitive appeal, its efficacy and cost efficiency have not been demonstrated. The full dispanserisation of the adult population entails a huge amount of clinical time per patient – given the requirements for completing questionnaires, provision of health advice,

### Box 1: Universal health checks

Universal health checks and dispanserisation (i.e. preventive activity on the population level) are not unique to the Russian Federation, they are also a feature of primary care in Belarus, for example, and have their roots in the Soviet era where universal health checks for the working age population were a prominent feature of occupational health and “dynamic dispensary surveillance” was in place for all detected cases of particular diseases.<sup>1</sup>

The Dispanserisation programme is conceived as a two-staged process that is coordinated by the local primary care provider.<sup>2</sup> Firstly, a comprehensive ‘screening’ check based on a questionnaire and basic medical examination is used to identify people at increased risk of ill-health or those with undiagnosed conditions and as an opportunity to provide general health advice. This stage can be conducted by a primary care doctor, a feldsher or a mobile medical team for remote rural areas. The second stage is for the identified risk groups and covers a suite of diagnostic checks with further referrals for treatment if necessary; this stage is performed by the internists and polyclinic specialists where indicated. There is a general requirement that all serious cases detected should be managed with special attention [*dispasneryi uchet*]. However, this requirement is not usually followed due to the overburden of primary care physicians and the lack of resources in polyclinics.

blood tests and full physical examinations, and other screenings. Dispanserisation is also reimbursed by the mandatory health insurance fund only for “completed dispanserisation cases”, that is for a full standard set of services irrespective of patient need. Primary care doctors have no discretion on the scope of preventive services provided at this first stage of dispanserisation. Second stage services are reimbursed on a fee-for-service basis, consequently utilisation has increased substantially but with unclear health outcomes.<sup>3</sup>

It is also hard to capture the target population through dispanserisation; in 2017, only 39.7% of adults were screened – the target for 2024 is 70%. Those who are not screened are often the ones most at risk of ill health. The people most likely to miss out on health checks are vulnerable groups such as the homeless, people with alcohol problems and people in insecure employment.

There are no obvious targets for secondary prevention of cardiovascular disease and this could limit the full potential of the programme for reducing cardiovascular mortality. To include targets such as improving not just the detection but also the control of hypertension, for example,

the programme would also need to ensure access to outpatient pharmaceuticals as an essential part of primary care services. However, the coverage of outpatient drugs is very limited, and they often must be purchased out of pocket. There are, however, plans to expand coverage of essential drugs needed by cardiology patients.

This programmatic or project-based approach to policymaking and implementation, with annual targets and monitoring, is standard in the Russian context. The national projects link together to echo the overarching policy goals of ensuring the security and prosperity of the Russian Federation. The first was the ‘National Priority Project – Health’, 2012–2015, and subsequent plans have sought to build on the achievements of this first plan while acknowledging and addressing the outstanding challenges. The approach is centralised and ‘top down’ with regional leaders expected to do what they can to ensure the federal targets are met. This programmatic approach is a good way of focusing attention on a particular issue and can be a good way of rapidly developing or upgrading the necessary infrastructure. However, the concern is always that such capital investment is seen as a one-off ‘fix’ for the

health system, which will be insufficient to maintain facilities over the longer term – particularly as health in general, and primary care in particular, have historically been very underfunded. The project also does not cover many important issues such as integration of care or quality assurance. Moreover, given the noted staffing shortages, the extra burden of dispensarisation with limited follow-up activities is likely to overstretch services.

## Conclusion

Russian population health has improved greatly over the past 20 years – largely in response to concerted health policy efforts to reduce tobacco and alcohol consumption;<sup>4</sup> increasing investment in the health system is also part of the policy response. After a lengthy period of focusing on strengthening specialist services, health policy is increasingly targeting primary care services and universal health checks. Ensuring access to high quality primary care services is of central importance in providing adequate care for people with chronic conditions but ensuring access to essential medicines for secondary prevention is a key factor that will also need to be addressed to improve care and maximise population health outcomes.

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## WHO Barcelona Course on Health Financing for Universal Health Coverage

**16–20 March 2020, Barcelona, Spain**

The WHO Regional Office for Europe is pleased to announce the next annual **WHO Barcelona Course on Health Financing for Universal Health Coverage** to be held from **16 to 20 March 2020** in Barcelona, Spain. This week-long intensive course is offered by the Division of Health Systems and Public Health of the WHO Regional Office for Europe through the WHO Barcelona Office for Health Systems Strengthening. We invite you and your colleagues to participate in this exclusive training event.

The course will review policy instruments to improve health systems performance through better health financing policy focusing on revenue collection, pooling, purchasing and benefit design. It will explore themes related to universal coverage and place emphasis on policy instruments to achieve efficiency gains. The course will offer many examples and practical experiences from Europe.

The deadline for applications is **16 January 2020**.

This course is exclusively for participants countries from the WHO European Region. The course is delivered in English.

Apply at: [https://extranet.who.int/datacol/survey.asp?survey\\_id=4100](https://extranet.who.int/datacol/survey.asp?survey_id=4100), with **Barcelona2020** as the user name and password.

For any queries, please contact: [eubar@who.int](mailto:eubar@who.int)

# NEW PUBLICATIONS

## It's the governance, stupid! TAPIC: a governance framework to strengthen decision making and implementation

**By:** SL Greer, N Vasev, H Jarman, M Wismar, J Figueras

**Copenhagen:** World Health Organization 2019 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

**Observatory Policy Brief 33**

**Number of pages:** 22; **ISSN:** 1997-8073

**Freely available for download:** [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0012/416100/PolicyBrief\\_PB33\\_TAPIC.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0012/416100/PolicyBrief_PB33_TAPIC.pdf?ua=1)

Governance is vitally important to health policy and implementation, but harder to pin down than almost any other core concept of health policy analysis. It refers to how decisions are



made and implemented – everything from the ability of policy makers to take evidence-based and relevant decisions to their ability to implement policies and create alignment between different actors. While conflicts, contradictions, burdens and mistakes will always be common in human affairs, focused and practical thinking about governance can reduce them.

Given the importance of governance and the multitude of definitions available, all of which cause much confusion, there is a need for a simple, unified approach geared to policy. With this in mind, this policy brief identifies key elements of governance that have been identified and validated in available literature. This analysis finds that the core concepts of governance can be clustered into five domains, which the authors abbreviate to TAPIC: transparency, accountability, participation, integrity and capacity.

The policy brief shows how the framework can be used to facilitate the practical analysis of governance issues and to strengthen governance decisions to improve policy making, policy and services.

**Contents:** Key messages; Executive summary; Introduction; Five domains of governance; The TAPIC Framework; Using the TAPIC framework to strengthen governance; Conclusions: changing how societies make and implement policies can improve health and health care.

## Sustainable health financing with an ageing population: Will population ageing lead to uncontrolled health expenditure growth?

**By:** GA Williams, J Cylus, T Roubal, P Ong, S Barber

**Copenhagen:** World Health Organization 2019 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

**Observatory Policy Brief:** Economics of Healthy and Active Ageing series; policy brief 3

**Number of pages:** 20; **ISSN:** 1997-8073

**Freely available for download:** <https://tinyurl.com/r63sd9w>

This brief considers how population ageing is likely to affect health expenditure growth in countries at different stages of the age-demographic transition over the next 40 years. The authors develop projections of health spending due to population ageing and explore how future health spending patterns could vary if health care costs for older people were markedly higher than they are currently.

Results show that population ageing is not and will not become the primary driver of health expenditure growth. Moreover, in relatively younger countries that still need to scale-up their health systems to deliver adequate care to future older populations, now is a good time to begin investing in the health system to spread costs over a long period of time.

Policy choices related to how health services are delivered, the prices paid (or negotiated) for services, medicines and technologies, and volumes of care will ultimately determine health spending by age trends. The authors conclude by considering policy options that can be implemented to target these factors, helping to moderate growth in health spending as populations age.

This brief was produced jointly with the WHO Centre for Health Development, Kobe, Japan.

**Contents:** Key messages; Executive summary; Introduction; How will population ageing affect health expenditure growth?; How would population ageing affect health expenditure growth if older people were more costly to care for than they are now?; Policy options to control growth in health expenditures, particularly as populations age; Discussion.





# 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 individual country pages for these news items and more: <http://www.hspm.org>**



**Compiled by Gemma Williams based on 2019 reform logs.**

## **Czech Republic: Increasing excise taxes on alcoholic beverages and tobacco**

In January 2020, excise taxes on alcoholic beverages containing 40% alcohol and tobacco products (including cigarettes, cigars and raw tobacco) in the Czech Republic will increase. The government proposed this measure as part of a wider package aiming to boost public budget revenues. The increase in taxes is motivated by their rising affordability: while the average wage rose by 50% from 2009–2018, the excise tax on alcohol was last changed in 2010.

## **Estonia: ePrescription linked with Finland**

The exchange of ePrescriptions between Estonia and Finland has recently started, and Finnish patients can buy a medicine prescribed electronically in Finland at Estonian pharmacies. Estonia has developed a solution that allows Estonian pharmacists to request a digital prescription issued in the Finnish information system. ePrescriptions are visible via the new eHealth Digital Service Infrastructure (eHDSI). Cross-border

exchange of prescription data between EU member states is part of a European Commission eHDSI project under the Connecting Europe Facility (CEF). The project was launched in 2017 with the aim to ensure better quality of care and access to medicines for people abroad by using ePrescription issued in their home country. Finland and Estonia are the first EU countries to put the ePrescription initiative into use. During 2019, the project plans to enable Estonian patients to buy medicine in Finland and later in Cyprus, Greece and Portugal by using ePrescriptions prescribed in Estonia.

## **France: The French social health insurance fund will stop reimbursing homeopathic drugs**

In August 2018, the Ministry of Health mandated the French National Health Authority (HAS) to carry out a scientific assessment of the benefits of homeopathic medicines. The assessment revealed the lack of clinical effectiveness of these drugs on common conditions and also showed that they do not have any public health benefits, in terms of reducing the consumption of allopathic drugs. HAS concluded that the clinical benefits of homeopathy medicines were not sufficient to justify its reimbursement by the social health insurance fund. The Minister of Health announced in July 2019 that homeopathic medicines currently on the list of reimbursed drugs will be banned from this list from January 2021, to give time for adjustment to patients, physicians and manufacturers. As a first step, the rate of reimbursement will decrease from 30% currently to 15% by January 2020.

## **Germany: Federal health minister seeks to ban sexual conversion therapies**

Conversion therapy comprises psychological or spiritual interventions aiming to change an individual's homosexual or bisexual orientation to heterosexual. The German health minister, Jens Spahn, publicly stated that "Homosexuality is not a disease and does not require treatment", and therefore plans a ban on conversion therapies.

He has appointed a commission to develop proposals for an effective ban on conversion therapies that are expected to be published in the autumn. Opposition from his own party, the Christian Democratic Union, is not expected. Germany would become the second EU country to ban conversion therapy after Malta.

## **Greece: New supervised drug use areas target the safety of intravenous drug users**

Newly introduced Supervised Drug Use Areas aim to promote and protect the health of active drug users through a range of services. These include, specially designed areas for injecting, suitable equipment for the safe use of narcotics; information on how to prevent the spread of communicable diseases; emergency care in the case of overdose; outreach programmes; advice on the safe use of drugs; and access to a range of counseling, rehabilitative, medical and social services. This new initiative will be operated by Greece's Organization Against Drugs (OKANA), the Dependent Users Treatment and Rehabilitation Center (KETHEA), and the two psychiatric hospitals in Athens and Thessaloniki.

## **Hungary: Start of a colon cancer screening programme**

Hungary has the highest mortality rate for deaths related to colorectal cancer in Europe, and the fourth highest worldwide. The National Colon Screening Program was launched in 2016 with EU funding support, and aimed to reduce colorectal cancer mortality by 10% in three years by screening 70% of the target population. Due to health workforce shortages and reorganisation of background institutes, the programme was postponed several times, and finally started in 2019. To date, more than 72,000 people out of 223,500 invited persons aged 50–70 have received screening packages from general practitioners. Of these, over 61,000 have sent back their samples, with 1,500 people receiving follow-up colonoscopy appointments and 750 medical

examinations, with 200 positive cases (polyp or adenoma). According to the National Public Health Centre, 600,000 invitations will be sent in 2019.

### Israel: All pharmacies to accept digital prescriptions from all health plans

In November 2018, the Knesset (parliament) approved a law that mandates all pharmacies to accept digital prescriptions from all health plans (HPs). Previously, drugs prescribed by digital prescription could only be purchased by patients at their own HP's pharmacies, or those with contracts with the HP. The main barrier for pharmacies to accept digital prescriptions was the high costs that HPs charged to connect the pharmacy to its computerised system, which limited the market and competition. The Ministry of Health and Ministry of Finance will now set a maximum fee for this connection that will be uniform across pharmacies, regardless of the arrangements with HPs. For pharmacies without contracts with HPs, there will be data limitations to protect the privacy of patients. The law is expected to lower transaction costs, improve access to drugs and increase choice for patients from all HPs.

### Italy: A new system for monitoring the benefit package

The national government has approved a new system for monitoring the country's benefits package (Essential Levels of Assistance (LEAs)), which replaces the previous method dominated by regional self-assessments. The new system will ensure a more objective methodology to guarantee, evaluate and confirm the provision of health care services in all of the country's regions. The new monitoring framework will be piloted for one year. It focuses on quality of care and uniformity of benefits provided across the country, and integrates performance dimensions such as efficiency, appropriateness and safety. The new framework will also estimate the demand for health care services, as well as social and geographical equity. Additionally, more indicators evaluating performance in providing primary care services have been

added, together with specific measures for monitoring critical pathways for specific conditions.

### Lithuania: Further efforts to tackle pharmaceutical costs

From March 2019, repeat prescriptions that are not claimed within 6 months are considered as a new prescription. Pharmacies are then obliged to offer the cheapest equivalent medication. A more expensive alternative is now considered as non-reimbursable, meaning a patient has to cover the full cost of the medication should they opt for the alternative. This measure is aimed at encouraging more rational use of medicines, reducing pharmaceutical spending, and promoting competition between medicines' manufacturers. In this, Lithuania has followed the procedure used in other countries, including Latvia and Estonia.

### Romania: Expansion of tuberculosis screening to reach vulnerable populations

The National Programme for Prevention, Surveillance and Control of Tuberculosis covers passive case finding, diagnostics, epidemiological surveys and preventive treatment of persons who have been in contact with diagnosed cases as well as information, education and communication campaigns. Despite a decreasing trend, Romania has the highest TB incidence among e EU countries, with 9,818 new cases reported in 2018. Since 2018, an active TB screening programme has been introduced among vulnerable populations. The new screening programme was introduced within the project "Organization of early detection (screening), diagnostic and treatment programmes for TB, including latent TB infection" co-financed from EU structural funds. The project will end in 2023 and has a total cost of 64 million lei (approximately €13.6 million). It will cover over 75,010 vulnerable individuals, including people from rural communities, homeless people, people with alcohol and substance use issues and prisoners.

### United Kingdom (England): NHS England launches new workforce plan

The National Health Service in England has published an Interim NHS People Plan because workforce shortages and poor planning are now seen as major issues in the NHS in England. This report is the first step in dealing with these issues and addressing problems in the culture and leadership. The document also has proposals for developing new roles to allow for different skill mix and for improving workforce planning by devolving responsibility for aspects of this to more local bodies.



# State of Health in the EU

## Country Health Profiles 2019

The *State of Health in the EU* aims at making health system information, expertise and best practices easily accessible to policymakers and everyone who helps to shape health policies.

Initiated by the European Commission, the European Observatory on Health Systems and Policies and the OECD have jointly developed Country Health Profiles for all 28 European Union Member States, Iceland and Norway.

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Country health profiles available at:

<http://tiny.cc/SoHEU2019>

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