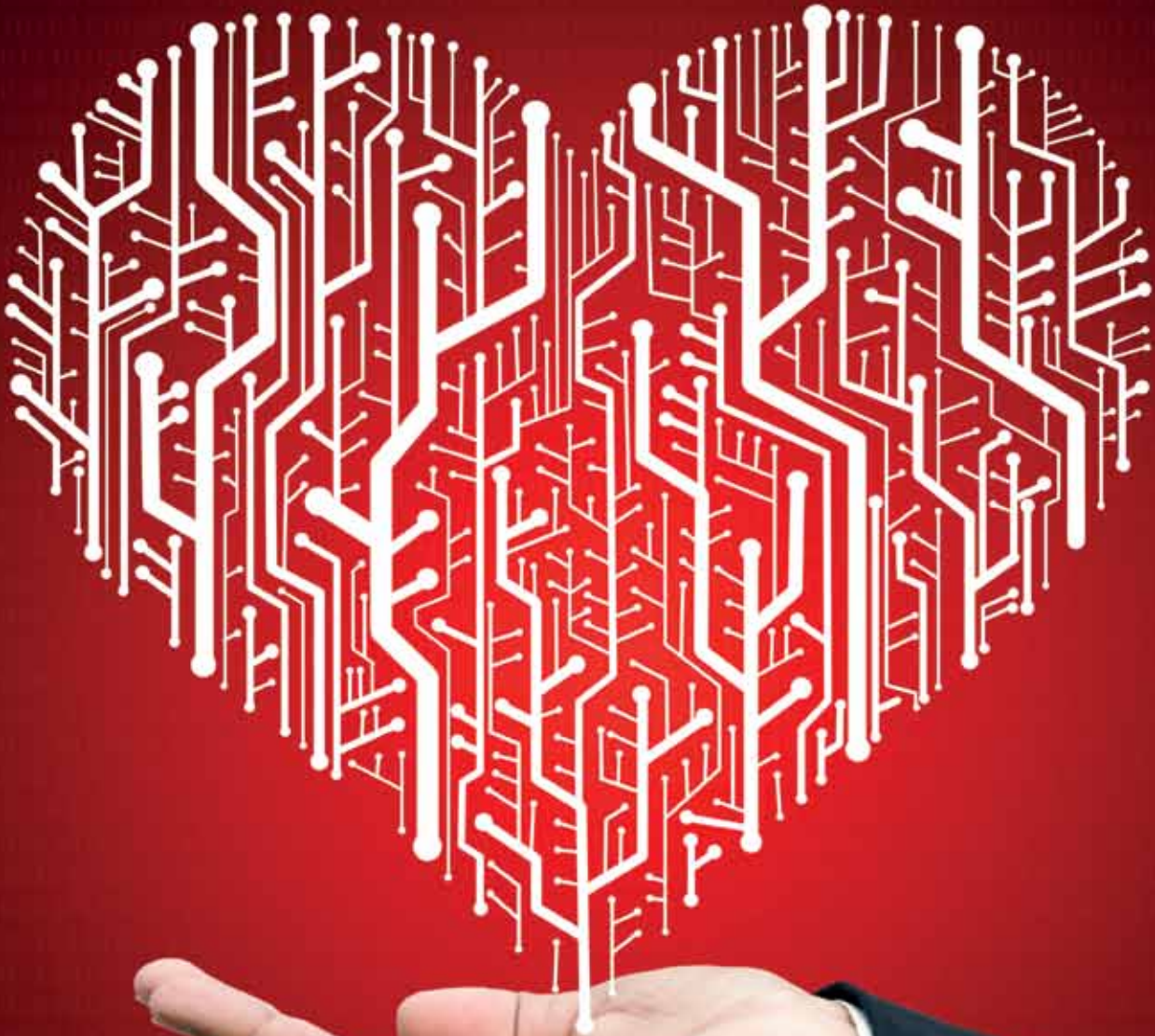


# EUROHEALTH



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## ➤ Incentivising Integrated Care

- Quality and outcomes framework
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Published by the European Observatory on Health  
Systems and Policies, with the financial support  
of the European Federation of Pharmaceutical  
Industries and Associations (EFPIA).

*Eurohealth* is a quarterly publication that provides a forum  
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Organization Regional Office for Europe, the Governments  
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Design and Production: Steve Still

ISSN 1356-1030



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### Eurohealth Monitor

**44 NEW PUBLICATIONS**

**45 NEWS**



Health systems are subject to a number of pressures that impact on their ability to deliver effective services, not least those stemming from ageing populations and the growing number of patients living with chronic conditions and co-morbidities. In a number of countries, integrated care models are being explored as a means of meeting the challenges of changing disease burdens, delivering effective health care as well as bolstering the sustainability of their health systems. However, there are many possible ways of promoting the better integration of care, with the use of (appropriate) financial incentives being one method to achieve this goal.

This issue's **Observer** section starts with an overview that examines some innovative integrated care schemes, payment models and financial incentives that are being implemented in several countries.

The authors report on the current state of evidence and highlight that in many cases, rigorous evaluations of implemented models are needed before their suitability and effectiveness can be more accurately determined. Eight case study articles follow, providing more in depth information on incentive mechanisms, and importantly, placing them within their specific country and health system contexts.

In the **Eurohealth International** section, Thomas Plochg discusses why the existing health workforce in Europe is poorly fit for purpose when it comes to chronic diseases and especially multi-morbidity. He provides suggestions on how a reconfiguration strategy could be successfully developed and implemented to support more sustainable health systems.

**Eurohealth Systems and Policies** showcase articles on the United Kingdom, the Republic of Moldova, Canada and the Netherlands. Anita Charlesworth presents the rapid increase in UK health spending over the last decade, which has recently been halted to include tighter controls on public health spending. She then discusses the fiscal sustainability challenge that the UK and other governments will face over the long-term. Since 2010, the Republic of Moldova has provided universal access to primary care irrespective of citizens' insurance coverage. In their article, Domente and colleagues detail the network

of primary care facilities that have been central to improved access, but also identify where additional improvements can be achieved through future reform.

Despite many positive health system outcomes in Canada, Greg Marchildon offers evidence on why primary care has been shown to be weak when compared internationally. He argues that the protected status of doctors, as independent contractors paid by fee-for-service, is not generally suited to primary care practice. Finally, Nucciarelli and Ivanovic discuss how Dutch health system reform has radically modified the role of hospitals in a managed competition market. The article then proposes potential trends by analysing changes in the dealings of hospital management towards insurers and patients.

In **Eurohealth Monitor**, we share with you two new books, one on the changing role of health system governance and the other on divergent trends in health policy, while the news section provides timely developments in health policy, both nationally and internationally.

We hope that you find this issue informative and interesting – we welcome comments to the editors.

*Sherry Merkur, Editor*

*Anna Maresso, Editor*

*David McDaid, Editor*

Cite this as: *Eurohealth* 2013; 19(2).

# PAYING FOR INTEGRATED CARE: AN OVERVIEW

By: Cristina Hernández-Quevedo, Rayden Llano and Elias Mossialos

**Summary:** Population ageing and the rising prevalence of chronic diseases challenge health care systems, underscoring the need for new approaches to population health management, such as integrated care. Financial incentives are used in many countries to encourage the implementation of integrated care schemes. Here, we review innovative integrated care schemes, payment models and financial incentives implemented in several countries at the forefront of integrated care. The review shows that further assessment of the effectiveness of these incentives is required; caution also should be taken when translating cost-effective incentives from one country to another, as they may not be transferable.

**Keywords:** *Integrated Care, Financial Incentives, Payment Models, Pay-for-performance*

**Acknowledgement:** *The articles in this Observer section are based on a wider report, “Integrated care: assessing economic impact and payment methods”, which was commissioned by the European Commission’s Directorate-General for Health & Consumers to the European Observatory on Health Systems and Policies.*

## Introduction

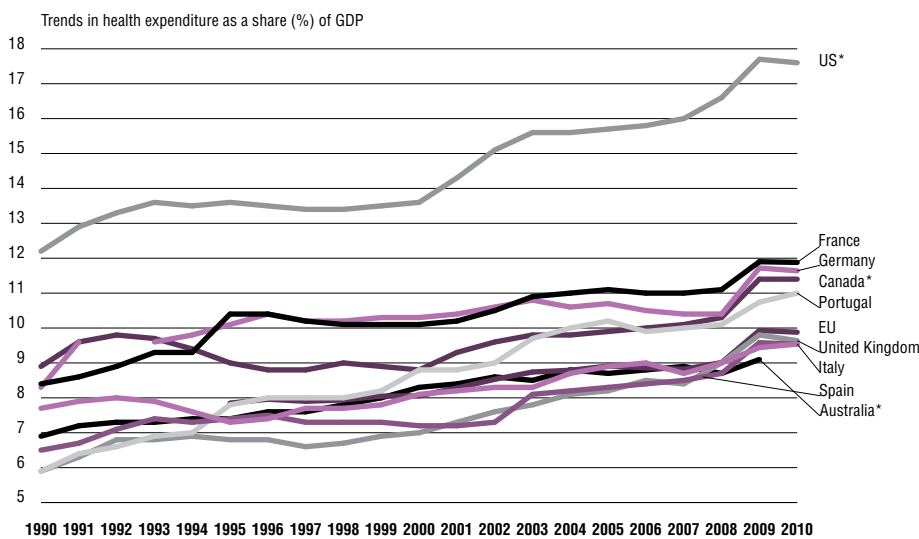
Increasing health expenditure is a matter of great concern in many countries, with the percentage of Gross Domestic Product (GDP) devoted to health rising substantially over the last two decades (see Figure 1). This trend is expected to increase in the coming years with the ageing of the world’s population and the rising prevalence of chronic diseases. New models of chronic care and approaches to population health management have been developed to respond to the changing burden of disease. In recent years, the use of integrated care models has gained renewed attention as an important

mechanism to promote the on-going viability and sustainability of health care systems.

A key factor in the integration of care is the adoption of payment systems that incorporate appropriate financial incentives. In many countries, financial incentives are used to encourage the implementation of integrated care schemes, recruit and enrol patients into these schemes, implement better systems of data collection, mandate the use of clinical practice guidelines and ensure that they are followed, and reach process and outcome targets.▣ Indeed, financial incentives can be used to influence the structure, processes, and outcomes

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**Figure 1:** Trends in health expenditure as a share (%) of GDP in several OECD countries, 1990 to latest available year



Source: [2] and [3]\*

of integrated care. Presently, the vast majority of payment schemes used in most high-income countries focus on the structure and processes of care, with some exceptions, such as in the United Kingdom (UK) where certain payment incentives for general practitioners (GPs) are linked to specific patient health outcomes. [4] While most incentives and payment systems in integrated care schemes have targeted health care providers, various financial incentives have also focused on health insurers and patients as well.

An assessment of the effectiveness of these incentives and payment models in integrated care remains crucial, however. In particular, several empirical questions need to be addressed: Are financial incentives able to improve the integration of care, and if so, in which contexts? Are some incentives more effective than others? To whom should they be directed? Here, we review some of the existing evidence on payment systems and incentives for integrated care services, in an attempt to determine the extent to which the available evidence currently allows for these questions to be addressed.

In particular, this review focuses on innovative integrated care schemes, payment models, and financial incentives in some countries at the forefront of integrated care, including Australia, Canada, Denmark, France, Germany,

the Netherlands, the UK, and the US. Country-specific case studies complement this article but caution should be taken regarding the evidence available as it is descriptive and may be difficult to translate to other settings due to cultural and organisational differences among health systems.

### Incentives and payment mechanisms for providers

We first describe various types of financial incentives that reward providers with additional (performance-based) payment for participating in integrated care schemes and/or achieving certain integrated care goals but that do not substantially alter provider remuneration (e.g. fee-for-service, capitation, etc). Subsequently, we present several innovative integrated payment models that more fundamentally change the ways health care providers are paid.

#### Financial incentives

Pay-for-performance (P4P) schemes are widely used to incentivise health care providers to develop appropriate structures and processes for integrated care and chronic care delivery. [5]

One example is the Quality and Outcomes Framework (QOF) that was introduced in England in 2004, with the main aims

of improving the quality of primary care, embedding preventive measures in the health system and stimulating an improvement in chronic disease management. The QOF rewards GP practices with financial incentives for meeting quality targets, with more than half of all indicators referring directly to the management of common chronic diseases. However, the current evidence base for the impact of the QOF remains patchy and inconclusive and there is no consensus on whether the QOF has changed the underlying overall rate of quality improvement, despite some significant, albeit small, improvements for some conditions such as diabetes, asthma and cardiovascular care for diabetic patients (see case study article).

Performance-based incentives are also used in the ‘Gesundes Kinzigtal’ Integrated Care initiative in Germany, a population-based integrated care system introduced in 2005 that covers all sectors and indications of care for members of two sickness funds (see case study article). While health care providers continue to be reimbursed by health insurers, providers participating in the scheme are given additional P4P reimbursement for services not normally covered but considered important to achieve better quality of care. In addition, all providers are given a share of the company’s profit on the basis of individual provider performance. While an overall evaluation of the system is still underway, various safeguards to mitigate the potential for risk selection have been put in place, which have been shown to be successful not only in preventing traditional risk selection, but in achieving an “inverted” risk selection, such that the scheme has primarily enrolled members with above average morbidity and costs [6] (see case study article).

In 2005, the Australian Government also introduced a series of additional financial payments for health care professionals if they created Team Care Arrangements (TCAs) for chronically ill patients who require on-going care from at least three health care providers (see case study article). Under this scheme, health professionals are paid for performing activities related to an individual’s care plan. While a comprehensive evaluation of this initiative has not been carried out

as yet, the initiative has been criticised as being too prescriptive and cumbersome, potentially discouraging health care professionals from creating, reviewing or contributing to a TCA<sup>5</sup> (see case study article).

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resulting in lower  
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hospital services

Moreover, physicians in Ontario, Canada, are provided with financial incentives to work in Family Health Teams (FHT), which enable primary care providers to work in cooperation with other specialists to treat chronically ill patients within one health care practice. Under this scheme, physicians are paid according to a blended funding model that includes payment by capitation, some fee-for-service payments, bonuses for achieving preventive care targets, and payments for extending the range of services (see case study article). In addition, the Ministry of Health increases the incentives for physicians to work in FHTs by paying the salaries of interdisciplinary team members and providing funding for the development of electronic medical records (EMR). At present, the Conference Board of Canada is conducting a formal external evaluation of this initiative to determine the extent to which it has achieved its objectives.

In various countries, providers are also receiving financial support and/or incentives to use health care information technology (IT) for the purpose of: proactively managing patients with chronic conditions (e.g. diabetes, asthma); achieving specific clinical quality of care targets; providing enhanced preventative care; and coordinating care with other health provider organisations or for non-face-to-face interactions with patients (e.g. via email or telephone).

In Denmark, for example, the government introduced payment innovations for physicians who use EMRs and for primary care practices that conduct telephone and email consultations. From 2003 to 2004, GPs and pharmacists in the Italian region of Lombardy also received financial incentives for actively promoting and using the region's electronic health and social care information system in patient consultations. Similarly, while rewarding primary care providers for both quality measurement and quality improvement, the QOF in England also incentivises the adoption and use of health care IT.

#### *Payment models*

Beyond the use of additional financial incentives that can augment providers' regular sources of income, several countries are currently experimenting with various innovative integrated care payment models that more fundamentally change the ways in which health care providers are paid.

For example, the Medicare Severity Diagnostic Related Groups (MS-DRGs) that the Centers for Medicare and Medicaid Services (CMS) adopted in 2007–2008 in the US was a new scheme replacing the existing 538 DRGs in Medicare's Inpatient Prospective Payment System (IPPS) for acute care inpatient hospital stays with 745 DRGs that were adjusted for severity of illness<sup>6</sup> (see case study article). Each MS-DRG now has a flat payment weight that is assigned to each inpatient stay using the principal diagnosis, up to eight secondary diagnoses, the main procedure performed, up to six additional procedures, age, sex, and discharge status. By reimbursing providers at a higher rate for more severe cases, MS-DRGs provide a financial incentive for hospitals to improve the clinical integration of health care. However, an evaluation assessing whether this change has increased clinical integration has not been conducted. It has been argued that the cost-control incentives created by DRGs may present an obstacle for the integration of care in that hospitals only have an incentive to work towards clinical integration, rather than more general integration of care, and

to collaborate with physicians inside the hospital rather than those working outside of the hospital.

For outpatient care, various countries, including Denmark, the Netherlands and the UK, have piloted innovative schemes providing an annual payment for the complete package of care required by patients with chronic diseases.<sup>7</sup> Under the bundled payment scheme for diabetes care in the Netherlands, for instance, health insurers are able to purchase all of the health care services needed to manage diabetes through the payment of a single fee to newly created contracting entities called “care groups” (see case study article). Comprised of multiple health care providers, care groups are clinically and financially responsible for all assigned patients in the diabetes care programme. In principle, this payment structure incentivises the care groups to achieve greater value for money, thereby potentially resulting in lower use of more expensive specialist and hospital services. Preliminary evaluation of bundled payments for diabetes care indicated that these had higher cost increases than for patients not enrolled in a disease management programme (DMP)<sup>8</sup> (see case study article). Nevertheless, it is still too early to draw definitive conclusions about the long-term impact of bundled payment schemes on the costs and quality of diabetes care.

Similarly, a pilot programme introduced in Denmark in 2007 offered GPs additional remuneration for coordinating care for diabetes patients. Upon joining the scheme, GPs are paid a relatively high up-front annual fee of £125 (€156) per diabetic patient listed, with the practice to cover the various elements of disease management (see case study article). Importantly, entering into this new form of reimbursement is voluntary and the GPs are free to stay under the traditional fee-for-service reimbursement scheme. The implementation of the scheme is not complete and has therefore not yet been evaluated.

#### **Incentives for purchasers**

While most financial incentives flow from purchasers of care (i.e. sickness funds and health insurers) to health care providers,

financial incentives can also be targeted at purchasers of care. In practice, few such incentives exist, but some noteworthy examples include the use of funding allocation formulas that account for patient enrolment in DMPs<sup>1</sup> as well as morbidity criteria.<sup>2</sup> In Germany, for instance, sickness funds receive an additional flat rate (€180) for patients enrolled in DMPs, providing sickness funds with an incentive to develop such programmes.<sup>3</sup>

“limited evidence on the effectiveness of financial incentives”

### Incentives for patients

With regard to patients, several financial incentive schemes have been introduced throughout Europe. In Germany, co-payments may be reduced or waived for patients enrolled in certain DMPs, who are also given access to additional services for which non-DMP patients are not eligible.<sup>4</sup> In the ‘Gesundes Kinzigtal’ Integrated Care model, for instance, while there are no direct financial incentives offered to patients, enrolled patients receive a number of enhanced services such as improved care coordination across all sectors, individualised treatment plans, additional health check-ups relative to normal care and discounts for gym memberships. Meanwhile, in France, co-payments are waived for DMP care if patients bring their care protocol to every physician visit.<sup>5</sup>

Also fundamentally changing the nature of paying for integrated care is the implementation of personal health budgets (PHB) in the Netherlands and the UK, which incentivised patients to take charge of their care needs. Seeking to improve the integration of social care, these programmes provide patients with cash or vouchers that they can use for home care, with patients able to choose what care is most appropriate for them (see case study article). In the Netherlands, PHBs were

introduced in 1996 for the older people and for people with disabilities to empower them and provide more flexibility as they receive a set amount of money that they can use for health care at their convenience within a regulated framework. The major challenges of the scheme, however, are that the number of PHBs has increased exponentially over time and cases of fraud have been reported. By January 2014, the government expects to reduce the number of PHBs by 90% and to restrict the scheme to people who would otherwise move to a nursing or residential home. In theory, PHBs may increase competition between service providers and increase quality; however, little evidence is available, and the available evaluations show a high level of patient satisfaction but a weak impact on health improvement.<sup>6</sup>

In the UK, as the result of a series of pilot projects starting in 2005, PHBs were also introduced throughout the country. Individuals are able to spend a discretionary allowance on a variety of services, which allows them to determine the quantity and type of service appropriate for their own needs. Evaluations in 2008 and 2012 have shown positive results, concluding that PHBs can be used as a vehicle to promote better integration and that further integration may lead to additional changes in the balance of services used by individuals.<sup>7</sup> Although the results indicate that PHBs change the use of primary and secondary care, no change was found in the use of social care services.<sup>8</sup>

### Discussion

At present, there is limited evidence on the effects and effectiveness of financial incentives and other payment models in integrated care. Most of the incentives have been applied in very specific settings or are at an early stage of implementation, with little or no evaluation available as yet. Countries should therefore take a cautious approach when designing and implementing integrated care schemes with the use of financial incentives and innovative payment models, particularly as success in one setting may not be transferable elsewhere due to different cultural and organisational contexts across systems.

A key requirement for the development of effective payment schemes is the availability of information systems that can be used to measure and assess the structure, processes, and outcomes of care. If used, financial incentives need to be designed carefully so as to reduce the likelihood of unintended negative consequences.<sup>9</sup> This requires careful selection of incentive-linked, risk-adjusted performance measures, which should be closely associated with improvements in health. A combination of both process and outcome measures may represent the best approach. In addition, the size of the incentive is likely to be important in influencing provider behaviour in integrating care. Given the dearth of research in this area, it seems prudent not to offer very large financial incentives.

Ultimately, however, financial incentives in isolation are unlikely to be a sufficient condition for success. The successful uptake and on-going viability of integrated care models is more likely to depend on the complementary use of financial and non-financial incentives.

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# THE ‘GESUNDES KINZIGTAL’ INTEGRATED CARE INITIATIVE IN GERMANY

By: Rayden Llano

**Summary:** The Gesundes Kinzigtal Integrated Care initiative is a population-based integrated care system that covers all sectors and indications of care for members of two statutory health insurers in the Kinzigtal region of Germany. Actively enrolled members receive enhanced care coordination across all sectors, access to physicians outside normal hours, and discounts for gym memberships among other benefits. Profit is derived solely from realised savings relative to the average costs of care, which is then shared between the management company and the sickness funds on the basis of a negotiated shared savings contract. Health care providers receive additional pay-for-performance reimbursement and are given a share of the company’s profit on the basis of individual provider performance.

**Keywords:** ‘Gesundes Kinzigtal’, Integrated Care, Pay-for-performance, Germany

## Background

The German health care system historically has been characterised by significant financial and organisational fragmentation across health care sectors and providers, resulting in substantial inefficiencies.<sup>1</sup> In an effort to encourage greater integration of care and lower health care costs, the *Statutory Health Insurance Modernisation Act* (2004) allowed German sickness funds to spend 1% of their overall expenditure on integrated care programmes.<sup>2</sup> Contrary to the expectations of health policy-makers, however, most of the integrated care programmes that were established focused on specific indications (e.g. knee surgery) and usually integrated only two sectors (e.g. rehabilitation and inpatient care).<sup>3</sup> The Gesundes Kinzigtal Integrated Care initiative is one of the

few population-based integrated care systems in Germany that covers all sectors and indications of care for a specified population.<sup>4</sup>

Based in the Kinzig valley in Southwestern Germany, Gesundes Kinzigtal Integrated Care is managed by a regional integrated care management company called Gesundes Kinzigtal GmbH, which was founded by a local physicians’ network and a health care management company in 2005.<sup>5</sup> As part of its contract agreement with two German sickness funds (AOK and LKK), Gesundes Kinzigtal GmbH is tasked with managing the health care budget for all of their members (31,000 people) in the Kinzigtal region. Importantly, however, most of the integrated care services and

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additional benefits described below are offered only to members who voluntarily decide to *actively* enrol in the programme free of charge. As of May 2010, 6,870 insured members have become active enrolled members.

Striving to achieve population health gains while lowering costs, the *Gesundes Kinzigtal Integrated Care* model is characterised by five key components: 1) individual treatment plans and goal-setting agreements between physician and patient; 2) patient self-management and shared decision-making between doctor and patient (doctors receive training in shared decision-making); 3) follow-up care and case management (with clearly defined care coordinators); 4) “Right care at the right time” (whereby tailored arrangements are made for patients that need to be seen urgently despite long waiting times for certain services); and 5) a system-wide electronic patient record (which is used to regularly analyse patient data and identify high-risk patients).<sup>1</sup>

As part of its prevention and health promotion strategy, *Gesundes Kinzigtal* offers programmes targeting common high-burden chronic diseases to patients who have been identified to be at-risk or who have already developed certain chronic illnesses.<sup>2</sup> Some initiatives include active health promotion for the older people, intervention programmes for patients with chronic heart failure, and a physician-led smoking cessation programme, as well as “Healthy Kinzigtal moving”, which offers vouchers and discounts to members for sports and gym clubs.

One of the more important innovations of the *Gesundes Kinzigtal Integrated Care* initiative is its financial model.<sup>3</sup> Profit is derived solely from realised savings relative to the average costs of care, which is then shared between the management company and the sickness funds on the basis of a negotiated shared savings contract. Importantly, health care providers continue to be reimbursed in the same way by statutory health insurers, with additional pay-for-performance reimbursement provided by *Gesundes Kinzigtal GmbH* for services not normally

covered but which are considered important to achieve better quality of care. In addition, all providers are given a share of the company’s profit on the basis of individual provider performance – an innovative alignment of the interests of health care providers and health insurers to achieve efficiencies. Collectively, these additional payments comprise 10%–15% of providers’ other income.

With regard to patient incentives, there are no direct financial incentives offered for active enrolment. Recruitment of patients relies instead on explanation of the additional benefits that actively enrolled patients receive due to the unique components of the model (discussed above).

### Objective of the scheme and link to performance indicators

The main objective of the *Gesundes Kinzigtal Integrated Care* model is to encourage greater integration of care and lower health care costs through an innovative financial model whereby health care providers are incentivised to emphasise prevention and health promotion as well as improve coordination of care. Key provider financial incentives are linked to performance indicators, with providers also receiving a share of the company’s profit on the basis of individual performance.

### Potential success and evaluation of the incentive

A key concern of the *Gesundes Kinzigtal Integrated Care* model is the potential for risk selection and under-provision of care. Accordingly, various precautions have been put in place which have been shown to be successful not only in preventing traditional risk selection but also in achieving an “inverted” risk selection, such that *Gesundes Kinzigtal* has primarily enrolled members with above average morbidity and costs.<sup>4</sup>

To assess the possible under-provision of services, *Gesundes Kinzigtal* has voluntarily allocated a sizeable budget for independent evaluation of the system by a newly established agency, EKIV.<sup>5</sup> The evaluation consists of a

quasi-experimental, population-based controlled cohort trial, which seeks to compare service utilisation and health outcomes between the *Gesundes Kinzigtal Integrated Care* model and usual care.

### Challenges

One potential challenge relates to whether the financial incentives given to providers are strong enough to result in greater efficiency given the fact that they are still largely reimbursed on a fee-for-service system with capped budgets; as mentioned above, the additional payments given by *Gesundes Kinzigtal GmbH* account for only 10–15% of providers’ other income. Nevertheless, the first financial results of the system counter the suggestion that the new incentives are too weak. In 2007, *Gesundes Kinzigtal GmbH* realised an increase of 3.38% in the region’s overall contribution margin, exceeding expectations.<sup>6</sup> While the realised savings cannot be attributed directly to any one component of the system, it is likely that the use of goal-setting techniques, individualised treatment plans, and additional health check-ups may have “contributed to an enhanced ‘health mindfulness’ on the part of both physicians and patients which then again might have led to lower costs”.<sup>7</sup>

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# THE QUALITY AND OUTCOMES FRAMEWORK IN ENGLAND

By: Anna Maresso

**Summary:** The Quality and Outcomes Framework (QOF) is a pay-for-performance scheme that rewards general practitioner (GP) practices with financial incentives for meeting quality targets measured against specific indicators, many of which are clinical and related to disease management. The scheme was introduced to improve the quality of primary care, and to stimulate an improvement in chronic disease management. Overall, the evidence base for the impact of the QOF remains patchy and inconclusive. Major challenges include the financial sustainability of the QOF and ensuring it represents value for money for the National Health Service; vigilance against potential gaming; and ensuring that non-incentivised disease areas are not neglected by GP practices.

**Keywords:** *Quality and Outcomes Framework, Chronic Disease Management, Pay-for-performance, England*

## Background

In 2004, the Quality and Outcomes Framework (QOF) was introduced in England with the main aims of improving the quality of primary health care (PHC), embedding preventive measures in the health system and stimulating an improvement in chronic disease management within PHC for relevant targeted patient groups. The QOF rewards general practitioner (GP) practices with financial incentives for meeting (process and outcome) quality targets measured initially against 146 indicators and later revised to 142. The 2011/2012 QOF covers four 'domains': clinical, organisational, patient experience and additional services. The clinical indicators for chronic disease management were designed originally to measure quality across eleven clinical sub-domains, and subsequently were increased to twenty, including asthma, cancer,

coronary heart disease, stroke, diabetes, hypertension, mental health, chronic kidney disease, learning disabilities, obesity, palliative care and smoking.<sup>1</sup>

The QOF forms part of the General Medical Services Contract (GMSC) that links pay to performance. Under the QOF, GP practices are awarded points according to the proportion of eligible patients for whom each indicator target is met. Originally, in 2004 a maximum score of 1,050 points was fixed but a revision from 2006 now sets the maximum score at 1,000. For 2011/12, practices were paid on average £130.51 (€153.26) for each point they achieved.<sup>2</sup> The 87 indicators in the clinical domain account for 661 of the available 1,000 points and thus determine around two thirds of the extra payments made to GP practices under the QOF.

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Martin et al.<sup>2</sup> estimate that about 20% of GP practice income is tied to QOF financial incentives.

“mean achievement scores were higher than expected”

### Objective of the scheme and link to performance indicators

The QOF is an ambitious scheme with the main aim of improving the overall quality of PHC throughout the country, and in particular to reduce variations in the quality of services. In turn, quality improvement is seen to contribute to the achievement of a number of other inter-related goals, including stimulating an improvement in chronic disease management, reducing avoidable hospital admission rates, contributing to improvements in national mortality rates and helping to bridge the gap in health inequalities.<sup>3,4</sup> Explicitly defined indicators and targets across the four domains are used to measure GP practices' performance and financial rewards are directly linked to the level of achievement of each target.

### Potential success and evaluation of the incentive

In terms of its implementation, the QOF has been deemed a success.<sup>5</sup> Although participation by practices in the QOF is voluntary, participation rates are very high<sup>6</sup> and since the QOF's inception, the clinical categories covered have expanded from eleven to twenty. Moreover, mean achievement scores by GP practices were higher than expected when the QOF was introduced and despite several revisions, scores have continued to improve.<sup>4</sup>

While the QOF is the subject of an ever increasing body of research, in their review of the literature Steel and Willems<sup>5</sup> conclude that the evidence base for the

impact of the QOF remains patchy and inconclusive. Their analysis of 35 studies highlights that standards have risen each year approximately in line with pre-existing trends and while findings vary between studies and indicators, there is no consensus on whether the QOF has changed the underlying overall rate of quality improvement. However, there have been some significant, albeit small improvements for some conditions such as diabetes and asthma. There is also some weak evidence of cost-effectiveness and reductions in inequalities.<sup>4</sup>

Despite expected improvements in the management of some conditions, for example, patient with diabetes, Ashworth and Kordowicz<sup>4</sup> point out that benefits must be counterbalanced against the fact that the weighting of QOF points (since they reflect the pay deal reached for GPs in the GMSC) are driven by the assumed workload attached to achieving each indicator and not necessarily to patient benefit. Most studies concur that the QOF has contributed to improvements in GP practice procedures and better monitoring of patients with (the targeted) chronic conditions, not only through better data recording and electronic records but also with effective alerts or reminders to call in patients when a health check is due (See<sup>4</sup>).

“does not capture all the domains of quality”

### Challenges

Now in its eighth year of operation, the QOF is accepted as an integral part of routine GP practice management in England. It is widely seen to have improved the monitoring of patients with chronic diseases as well as encouraged better clinical team work. It is important to note, however, that the QOF only measures a small proportion of PHC or GP activity and thus does not capture all the domains of quality, such as continuity

of care, patient-centred consultation skills, diagnostic skills or care of diseases not included in the QOF.<sup>4</sup>

Three key challenges have been identified towards ensuring the appropriate use of the QOF. The first is its high cost and ensuring that the QOF remains an appropriate means of rewarding GPs for delivering real improvements in the quality of PHC and represents value for money for the National Health Service.<sup>4</sup> The second challenge is to ensure proper auditing procedures to identify any cases of potential gaming through either removing patients from disease registers or by increasing levels of 'exception reporting', a process which allows certain patients, who are deemed to be unsuitable (according to set criteria) to be excluded from the overall target for patients registered at a practice. This process not only allows for the more efficient achievement of targets but also impacts on patient care by shifting GP practices' focus away from harder to reach patients.<sup>4</sup> And lastly, there has been some reported concern among GPs that the QOF could potentially result in the neglect of non-incentivised areas such as acute care, preventive care, care for specific groups (e.g. children or older people) and care for patients with multiple comorbidities.<sup>4</sup>

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# TEAM CARE ARRANGEMENTS IN AUSTRALIA

By: Ruth Young

**Summary:** Financial remuneration for health care professionals who form Team Care Arrangements for the treatment of chronic conditions varies according to the level of input placed into multidisciplinary care plans. There is yet to be an extensive evaluation of the effect of financial remuneration to health professionals at the level of integrated care and whether this ultimately has led to better patient outcomes. Some of the literature has criticised how prescriptive the formulation of multidisciplinary care plans are.

**Keywords:** *Team Care Arrangements, Financial Incentives, Chronic Care Management, Australia*

## Background

In July 2005, the Australian government introduced a series of financial payments for health care professionals, especially targeting general practitioners (GPs), which remunerated providers if they formed Team Care Arrangements (TCAs) for the treatment of chronic conditions.<sup>1,2</sup> These rebates fell under categories within the universal health coverage system in Australia, known as Medicare. Health care professionals can claim for certain services within the Medicare Benefit Schedule. In this case, if TCAs are planned, reviewed or coordinated, health care professionals are remunerated.

TCAs are defined as individual, formal, collaborative care plans for those with chronic conditions that involve the GP and at least two other health or care professionals associated with the patient's on-going care.<sup>3</sup> A TCA is generally recommended for those who have: i) at least one condition that has been or is predicted to be present for at least six months or is terminal; and ii) requires on-going care from at least three health care

providers and one of these parties should be a medical practitioner. Remuneration is also given for reviewing TCAs.

The TCA is a formal document that describes the goals and the parties collaborating to treat the patient. It also should outline any actions that will be undertaken by the patient and have a date for review. The TCA should be kept on the patient's record. It is recommended that TCAs should be updated and reviewed every six months. This would provide an opportunity for the patient and the health care professionals to discuss any issues that could be addressed through revising the TCA.

The Medicare Benefit Schedule lists all possible payments that can be received by the practitioner. The government sets a price for each health service that the health care professional can claim and they are remunerated for this amount. Health care professionals can charge whatever price they choose, but they will only be paid the government price, with any excess to come from out-of-pocket

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**Table 1:** List of relevant Medicare Benefit Schedule items, suggested fee and associated benefit, 2012

Description	Item No.	Fee	Benefit
Preparation of TCA	723	AUS\$112.05 (€88.50)	75% = AUS\$84.05 (€66.40) 100% = AUS\$112.05 (€88.50)
Coordination of a review of TCA	732	AUS\$70.65 (€55.80)	75% = AUS\$53.00 (€41.87) 100% = AUS\$70.65 (€55.80)
Contribution to a multidisciplinary care plan	729	AUS\$69.00 (€54.50)	100% = AUS\$69.00 (€54.50)
Contribution to a multidisciplinary care plan by an aged care facility	731	AUS\$69.00 (€54.50)	100% = AUS\$69.00 (€54.50)

Source: <sup>2</sup>

payments or private health insurance. The percentage of the government price that is paid is determined by the context of care. For example, care could be provided as part of primary care or by a specialist, in a hospital setting or through a general practice. **Table 1** provides a list of the relevant item numbers and their reimbursement levels.

In **Table 1**, 'Fee' is the price that Medicare will use to calculate the associated benefit. The benefit proportion received is dependent on the care context. For example if care is provided by a GP then the reimbursement will be 100%. If the GP charges the patient AUS \$120.00 (EUR €94.76) for the preparation of a TCA (Item 723) then the GP would get back AUS \$112.05 (EUR €88.50) from Medicare and the patient would need to pay the difference (AUS \$7.95/ EUR €6.26). Contribution to a multidisciplinary plan involves written communication between the contributor and the coordinator of the care plan who reviews or advises on the patient's health care; or preparing part of the plan or changing part of the plan and then recording it in the patient's record.

### Objective of the scheme and link to performance indicators

This initiative aims to encourage integrated care for those with chronic conditions by providing financial incentives for health professionals to help coordinate or contribute to care plans. The new items under the Medicare Benefits Schedule also encouraged uptake of allied health services (to a maximum of five appointments in total).<sup>3</sup> GPs do not necessarily need to be the primary coordinator or organiser for the

multidisciplinary care plans, suggesting greater involvement of other health professionals, such as the practice nurse. It is assumed that a care plan would lead to greater integrated care resulting in greater satisfaction with care and improve the quality of care for those with complex, chronic conditions.<sup>4</sup>

### Potential success and evaluation of the incentive

Over time, there have been an increased number of claims for TCA related items.<sup>5</sup> From 2005/06 to 2011/12 there was an increase in the total number of claims listed against the items in **Table 1** from 489,528 to 2,870,903 representing a 486% increase over seven years and an average increase of almost 70% per annum. Further evaluation is required to determine if the increase in the number of claims for TCA-related items resulted in increased integrated care as current evaluations generally focus on a small subset of claims.

One randomised control trial suggested that TCAs have improved patient satisfaction, but are less likely to be used in rural areas and for male patients.<sup>6</sup> Of the 1,752 patients with records available at the twelve month follow-up stage, only 22.7% had TCAs in place. This suggests that the uptake of TCAs may not be equitable across the population.<sup>7</sup> It also has been suggested that the restricted number of allied health visits would limit the quality of care provided under a TCA as those with chronic conditions may need more visits.<sup>8</sup>

### Challenges

It has been suggested that TCAs do not encourage integrated care but rather a checklist of items to be able to benefit from the claim. This critique is based on the rigid requirements placed on health care professionals to outline the steps needed to achieve a TCA; this focuses on the process of planning integrated care rather than implementing a real behaviour change by health care professionals.<sup>9</sup> Further critiques suggest that restrictions on TCAs, such as the number of allied care visits, are barriers to achieving integrated care.<sup>10,11</sup> Moreover, allied health professionals involved in a TCA will not be remunerated for the initial consultation, thus limiting the incentive for allied health professionals to coordinate and contribute to a TCA.<sup>12</sup> Overall, the lack of evaluation means that the success of the programme is unknown, but some studies suggest that its success may be limited due to the policy's lack of flexibility.<sup>13,14</sup>

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# INTEGRATED CARE PROGRAMMES IN CANADA

By: Teresa Bienkowska-Gibbs

**Summary:** Several Canadian provinces have implemented integrated care initiatives. Alberta and Quebec have both implemented integrated care programmes for the frail elderly population. Integration of primary health care has also been conducted in Ontario. The main objectives of these programmes are to improve the health of the population, increase patient satisfaction, and substitute the use of institution-based services for community-based services. Where these programmes have been evaluated, results show some success in achieving the projects' objectives but it is not clear whether this success is due to effective incentivising of stakeholders or other factors. The fragmentation of the Canadian health care system and the lack of a centralised electronic medical records database pose significant challenges to the successful integration of health care.

**Keywords:** *Integrated Care, Primary Health Care Integration, Family Health Team Model, Canada*

## Background

There have been a number of initiatives to enhance the integration of care in Canada. The Comprehensive Home Option for Integrated Care of the Elderly (CHOICE) programme was piloted in Alberta in 1996 and subsequently scaled-up across the province. CHOICE is a full integration programme that integrates health and social care through the provision of transportation, day centres, health and social services, and home support.<sup>1</sup> Similarly, the Programme of Research on Integration of Services for the Maintenance of Autonomy (PRISMA) project in Quebec was piloted in 1997–1999 and was subsequently expanded across the province. The PRISMA project is a coordinated-integration model that integrates tertiary

care, long-term care, home care, and social services. The province of Quebec also piloted the SIPA (*Services intégrés pour les personnes âgées en perte d'autonomie*) project from 1999–2001.<sup>2</sup> This programme is a full integration model that uses community-based primary care services to integrate health and social services, acute and long-term care, and community and institutional services such as hospitals and nursing homes.<sup>3</sup> These three projects focus on the integration of care for the frail elderly and have benefits that include cost savings and efficiency gains for to providers, enhanced quality for clients as well as improved health outcomes.

There have also been a number of projects to improve the integration of care at the primary health care (PHC) level

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which involve the payment of financial incentives. Ontario's Family Health Team (FHT) model is a good example. The FHT model, implemented in 2005, integrates all levels of PHC through the formation of interdisciplinary health care teams.\* In contrast to the other three programmes described above, the province of Ontario has looked to improve health care integration through broader reforms to the delivery of PHC. These reforms include financial incentives to increase integration of care.

“the goals of FHTs are far-reaching”

Government support for this programme derives from its potential to improve efficiency and quality of care. Physicians in Ontario are given financial incentives to work in FHTs to improve PHC. Physicians are paid according to a blended funding model that includes capitation, some fee-for-service payments, bonuses for achieving preventive care targets, and payments for extending the range of services provided to include prenatal care, deliveries, home visits, and palliative care.<sup>5</sup> For example, additional annual payments are provided for patients with chronic diseases: CAN \$60 (€45) per patient with diabetes or a serious mental health condition, and CAN \$125 (€94) per patient with heart failure.<sup>6</sup>

In addition, the Ministry of Health increases the incentives for physicians to work in FHTs by paying the salaries of interdisciplinary team members (such as nurses, dieticians, occupational therapists, and social workers) and providing funding for the development of electronic health records. Funding is also available for consultations with other specialists that collaborate with FHT members. FHTs allow physicians to work in cooperation with other specialists to care for patients with chronic conditions, all within one health care practice. The FHT model

also facilitates the involvement of family physicians in all stages of patient care regardless of whether the patient is in hospital, at home, or in a nursing home.<sup>7</sup> The incentives for patients to seek care from an FHT are the potential benefits of enhanced care and the decreased opportunity cost of using fragmented PHC.

### Objective of the scheme and link to performance indicators

The objectives of the three projects are to improve the health of older people, increase patient satisfaction, and substitute institutional services for community services.<sup>8</sup> The goals of FHTs are far-reaching. The stated objectives that relate to improving integrated care include: provision of family health care services through an interdisciplinary team; development of community-based chronic disease management and self-care programmes; care coordination with links to other parts of the health care system; improvement of links with other community health care organisations; and use of electronic health records that allow patient records to be accessed from different levels of the health care system.<sup>9</sup>

### Potential success and evaluation of the incentives

The CHOICE, PRISMA, and SIPA models have all demonstrated progress towards achieving their stated objectives in the pilot projects, as attested by full evaluations conducted in 1998, 2005 and 2009, respectively.<sup>10, 11, 12</sup> The FHT scheme has not yet been evaluated. The Conference Board of Canada is currently conducting a formal external evaluation of the FHT initiative to determine the extent to which it has achieved its objectives.<sup>13</sup> Meanwhile, the Government of Ontario reports that 200 FHTs have been created in Ontario since April 2005, serving 2.8 million patients. This suggests that the incentives for joining FHTs are sufficient for health care providers and patients to participate in the initiative. Nevertheless, it is not yet possible to determine whether increased participation in FHTs is due to the incentives to integrate care specifically or whether it is due to the overall incentives to improve

PHC more broadly because the incentives to integrate care are embedded within the wider framework of PHC reforms.

### Challenges

Health care systems in Canada are fragmented as each province is responsible for the provision of services within its territory. Although health is publicly financed, health authorities, hospitals, and primary care doctors are all financed separately. This poses an additional challenge for health care integration because each of these systems has different priorities and thus requires different incentives to integrate care. In addition, since health care is provincial, none of these programmes can be implemented at a national level. Therefore, integrated care is geographically limited at the provincial level, as well as constrained by the programme's ability to integrate within the respective health care system in each province. Lastly, the lack of a comprehensive centralised electronic medical records database is an impediment to health care integration on a larger scale.

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\* In addition to the integrated care projects mentioned in this case study there are a number of other on-going integrated care initiatives in Alberta, British Columbia, Ontario and Quebec.



# BUNDLED PAYMENTS FOR INTEGRATED CARE IN THE NETHERLANDS

By: Rayden Llano

**Summary:** Bundled payments have been approved nationwide for implementation for diabetes care, chronic obstructive pulmonary disease (COPD) care and vascular risk management in the Netherlands. Under the bundled payment scheme, health insurers are able to purchase all of the health care services needed to manage, for instance, diabetes, through the payment of a single fee to care groups. Preliminary evaluation of bundled payments for diabetes care indicate that bundled payment patients had higher cost increases than patients not enrolled in a disease management programme. Nevertheless, it is still too early to draw definitive conclusions about the long-term impact of these schemes on the costs and quality of diabetes care.

**Keywords:** *Bundled Payments, Diabetes Care, Disease Management, the Netherlands*

## Background

Faced with rising health care costs and an increase in the burden of chronic diseases, the Netherlands has been experimenting with various integrated care initiatives over the past several years. In 2007, the Dutch Minister of Health piloted the use of bundled payments for integrated care, focusing initially on diabetes.<sup>1</sup> Under this scheme, health insurers are able to purchase all of the health care services needed to manage diabetes through the payment of a single fee to newly created contracting entities called “care groups”.<sup>2</sup> Comprised of multiple health care providers, care groups are clinically and financially responsible for all patients enrolled in the diabetes care programme.<sup>3</sup> In principle, this payment structure incentivises the care groups to

achieve greater value for money, thereby potentially resulting in lower use of more expensive specialist and hospital services.

The care group can either provide the various components of care itself through one of its own general practitioners (GPs), or it can subcontract other health providers to deliver the care, such as other GPs outside the care group, dietitians, specialists and laboratories.<sup>4</sup> The services to be covered in the generic care bundles are set by national disease-specific health care standards, but the price for each bundle of services is negotiated individually between insurers and care groups to spur competition.<sup>5</sup> Similarly, subcontractor fees are also set through negotiations between the care group and the subcontractor.

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Following some initial indications of better collaboration among health care providers, in 2010, the bundled payment scheme for diabetes was approved for nationwide implementation and was expanded to include bundled payments for COPD care and vascular risk management.<sup>2</sup> While there are no explicit financial incentives to form care groups, the bundled payment rates appear to be attractive enough to health care providers such that by the end of 2010, close to 100 care groups were operating diabetes care disease management programmes throughout the country under the bundled payment programme.

“ 25% fewer bundled payment patients utilised specialist care ”

Importantly, however, the bundled payment scheme remains voluntary. Some insurers prefer an alternative integrated care payment scheme in which they continue to pay GPs on a capitated basis, but offer a separate fee for the coordination of care, which covers overhead costs as well as information and communication technologies.<sup>2</sup> Others still continue to provide diabetes care outside the realm of integrated care on a fee-for-service basis.

### Objective of the scheme and link to performance indicators

The main objective of the bundled payment model is to improve the quality of diabetes care by incentivising health care providers to improve coordination of care and achieve better process quality and more transparency.<sup>2</sup> In principle, these process improvements would then result in fewer diabetes patients needing to utilise more expensive specialist care, thereby reducing costs.<sup>2</sup> While the recording and reporting of care-related data are stipulated in contracts between care groups and insurers, to date, most care groups do not have information

technology systems that are able to deliver the information needed by providers, care groups and health insurers to monitor and assess process and outcome indicators.<sup>2</sup>

### Potential success and evaluation of the incentive

In 2012, the National Institute for Public Health and the Environment (RIVM) evaluated the bundled payment scheme for diabetes care using nationwide health insurance claim data from 2008 and 2009. The evaluation indicated that the costs for curative care increased the most for patients enrolled in a bundled payment disease management programme. Between 2008 and 2009, cost increases for such patients were €288 higher than the cost increase of care-as-usual patients not enrolled in a disease management scheme.<sup>2</sup> Meanwhile, the increase in the cost of curative care for management fee patients (i.e. patients enrolled in disease management schemes where the insurer pays the GP a coordination of care fee) did not significantly differ from that of care-as-usual patients.

On the other hand, 25% fewer bundled payment patients and 12% fewer management fee patients utilised specialist care in 2009 in comparison to care-as-usual patients. With regard to diabetes-specific specialist care, bundled payment patients utilised 40% less care than patients receiving care as usual. This contributed to a saving of €36 per patient in the cost of diabetes-specific specialist care in 2009. Nevertheless, when non-diabetes costs are included, total specialist costs for bundled payment patients increased by €142 more than the costs for care-as-usual patients, and decreased by €128 for management fee patients.

The reasons for these trends remain unclear, and the evaluation report suggests that the two-year time frame of the study was likely to have been too short to fully assess the impact of bundled payment.<sup>2</sup> Nevertheless, some possible explanations have been proposed. First, the higher costs associated with bundled payment could be due to possible start-up costs, as care groups and health insurers were just beginning to gain experience in managing the scheme. Second, given that diabetes

complications often take a long time to develop, the short-term findings may be underestimating the long-term effects of bundled payments. Lastly, the predicted effects of bundled payments on care costs may be less likely to materialise for diabetes care than for other chronic illnesses given the already high standard of diabetes care, even for care-as-usual patients.

### Challenges

Aside from questions over the potential of bundled payment schemes to lower the cost of care for diabetes patients, several other challenges remain. From the perspective of patients, many of them are not aware that they are enrolled in bundled payment integrated care schemes as the bills go directly to their insurer. A key premise of effective integrated care, however, is the adoption of a patient-centered approach, which is currently lacking. Moreover, under the bundled payment system, patients were only allowed to receive diabetes care from preferred providers affiliated with the care group, effectively limiting patients' freedom of choice.<sup>2</sup>

Furthermore, while insurers are supportive of the aims associated with integrated care, many see bundled payments as a “black box” in that they pay a fixed price per patient but do not know what services patients receive at the individual level.<sup>2</sup> This has led to concerns that care groups may be double billing the insurer for the same services (both through bundled payment and through the traditional fee-for-service payment that GPs can charge for each consultation). As more chronic diseases are added to the bundled payment scheme, it will also become increasingly challenging to determine under which bundle certain services should be billed if the service provided applies to more than one bundle. Compounding this is concern over the dominant position of care groups in certain regions, which may result in lower incentives for care groups to provide high-quality care at reasonable prices.<sup>2</sup>

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# ENHANCING CHRONIC CARE MANAGEMENT IN DENMARK

By: Cristina Hernández-Quevedo

**Summary:** A fee for a type 2 diabetes management programme was introduced in Denmark following major health care reforms in 2007. The main objective of the scheme is to improve integration of care in chronic conditions and coordination of care by strengthening the role of general practitioners. The implementation period is still on-going and the incentive scheme has not been appropriately evaluated. The fragmentation of the Danish health care system and the lack of appropriate communication systems among providers pose some challenges to the programme's success.

**Keywords:** Chronic Care Management, Type 2 Diabetes, Financial Incentives, Denmark

## Background

In 2007, the introduction of a major reform in Denmark increased the focus on integration of care in chronic conditions and coordination of care. Different initiatives to favour continuity within primary care have been implemented, such as the introduction of pathway coordinators and a special fee for general practitioners (GPs) to act as coordinators of care for specific groups of chronically ill patients.

One such example is the introduction of a financial incentive for GPs for the delivery of care to type 2 diabetes patients. Once a GP joins the scheme, they are paid a relatively high up-front annual fee in the region of £125 (€156) per diabetic patient listed within the practice to cover the various elements of disease

management.<sup>1</sup> Entering into this new form of reimbursement is voluntary and if they wish, GPs are free to remain within the traditional fee-for-service reimbursement scheme with a reimbursement per consultation of £13.50 (€17).

Under the type 2 diabetes management programme, GPs have to regularly assess the appropriateness of each patient's management and document consultations. The care delivered must follow the guidelines provided by the Danish College of General Practitioners (the scientific college for general practice). Follow-up visits must be agreed between the GP and the patient, and the GP must follow up on non-attendance. A key element of the policy is that following the annual consultation and corresponding fee, the next three consultations are provided without further reimbursement for the GP.

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An additional requirement to receive the annual fee for diabetic care is the installation of a sentinel data capture system. The system collects key data from the electronic health record system, generates reports for each practice and benchmarks the GP's performance against that of other GPs.

### Objective of the scheme and link to performance indicators

The financial incentive for coordinating care for diabetic patients is a pilot project constituting part of a general policy to improve care by strengthening the role of GPs. The purpose of the policy, as stated in the agreement between the Danish regions and GPs, is to develop and ensure quality in the treatment of chronic diseases in general practice and to give GPs a tool to systemise care and quality assurance in the treatment and monitoring of patients with chronic diseases.

In the longer term, the objective is to expand the concept from diabetes to all relevant patient groups in general practice and to develop the fee system so that not just process quality but also performance becomes a reward parameter. The policy has not been extended to other disease areas so far but if the incentive scheme proves to be successful, it will be expanded to other chronic diseases.

### Potential success and evaluation of the incentive

The parties implementing the programme (the Organisation of General Practitioners in Denmark and the Danish Regions) agree that the incentive scheme is an experimental project, and that it is essential to evaluate it properly before the model is expanded into other areas. However, the policy has not yet been evaluated in terms of quality improvement, better coordination, patient experiences or economic impact.

By early 2013, only 487 out of 2,102 general practices in Denmark had adopted use of the incentive. However, the implementation period is not over and there is still an increasing number of GPs signing up to the scheme. Although implementation of the scheme is not

complete, it has been reported that the policy is not functioning as envisioned with monitoring rates per annual fee being far too low, making the policy more expensive (if GPs charge for the controls) or with fewer monitoring visits (if GPs fail to monitor patients). Given the lack of evaluation, it is unclear whether this incentive mechanism to improve integrated health care delivery has led to higher quality care at a lower cost while maintaining or improving patients' health and satisfaction.

“it is essential to evaluate the model properly before it is expanded”

However, a small part of the policy, the installation of a sentinel data capture system, which was required to obtain the annual fee for diabetic care, has been shown to improve quality of care significantly.<sup>2</sup>

### Challenges

Since 2007, major health reforms were introduced in Denmark with the overall objective of strengthening coordination of health care services. Differences in access to health services across the country, concerns over the quality of services provided by municipalities, and the unclear distribution of tasks between the state, regions and municipal levels were the main drivers of those reforms, which focused on centralising specialist services as well as providing greater central government involvement in monitoring and planning.<sup>3</sup>

However, it remains unclear whether the reforms, including payment incentives, improve the continuity and quality of care that is required for patients with chronic diseases. In 2008, Strandberg-Larsen and Krasnik<sup>4</sup> reported that only 50% of

managers and health professionals in the Danish health care system perceived the integration of health care to be satisfactory. In particular, it has been argued that the reforms have done little to stimulate new approaches to health promotion and disease prevention because they have transferred the main responsibility for these tasks from the regions to the municipalities, which do not have the necessary funding experience.<sup>5</sup> While the primary care sector has historically been quite strong with the role of GPs as gatekeepers and coordinators, the fragmented structure of the Danish health system poses some challenges to providing high-performing integrated care. The lack of appropriate communication systems among providers also has been highlighted as one of the limitations.

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# MEDICARE SEVERITY DIAGNOSTIC RELATED GROUPS IN THE UNITED STATES

By: Teresa Bienkowska-Gibbs

**Summary:** Medicare Severity Diagnostic Related Groups (MS-DRGs) give hospitals a financial incentive to pursue clinical integration by adjusting DRG payments for comorbidities. The primary objective of DRGs is to improve quality of care while controlling costs, which may pose a significant challenge for the integration of care. A gap in the literature seems to exist regarding the effect of MS-DRGs on clinical integration as well as the potential role for DRGs to improve the integration of care more generally.

**Keywords:** Medicare Severity Diagnostic Related Groups (MS-DRGs), Integrated Care, USA

## Background

The Centers for Medicare and Medicaid Services (CMS) adopted the Medicare Severity Diagnostic Related Groups (MS-DRGs) in 2007–2008. These 745 new Diagnosis-Related Groups (DRGs) replaced the existing 538 DRGs in Medicare's Inpatient Prospective Payment System (IPPS) for acute care inpatient hospital stays with groups that were adjusted for severity of illness. Each DRG has a flat payment weight that is assigned to each inpatient stay using the principal diagnosis, up to eight secondary diagnoses, the main procedure performed, up to six additional procedures, as well as age, gender, and discharge status.▣

Hospitals use the International Statistical Classification of Diseases and Related Health Problems Clinical Modification 9 (ICD-9-CM) to code diagnoses and procedures. The MS-DRG system classifies DRGs according to the presence and severity of secondary

diagnoses. The highest level of severity for secondary diagnoses is Major Complication/Comorbidity (MCC), the next level of severity is Complication/Comorbidity (CC), and the lowest level of severity is the Non-Complication/Comorbidity (Non-CC). **Table 1** illustrates how hospital inpatient Medicare national average payments differ according to the severity level of the condition.

However, individual hospitals are not reimbursed at the Medicare national average payment rate. The hospital's reimbursement rate is determined by multiplying the hospital's base rate, which reflects the input-price level in a particular region, by the MS-DRG weight. In addition, the operating and capital payment rates are increased for hospitals that treat a disproportionate number of low-income patients or that run a resident training programme and are decreased for certain transfer cases. Lastly, additional outlier payments are added for unusually costly cases.▣

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**Table 1:** An example of hospital inpatient Medicare payment

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment (US\$)
435	Malignancy of hepatobiliary system or pancreas with MCC	\$10,108
436	Malignancy of hepatobiliary system or pancreas with CC	\$6,738
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	\$5,242
438	Disorders of pancreas except malignancy with MCC	\$10,013
439	Disorders of pancreas except malignancy with CC	\$5,555
440	Disorders of pancreas except malignancy without CC/MCC	\$3,813
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC	\$10,628
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC	\$5,404
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	\$3,684
444	Disorders of the biliary tract with MCC	\$9,057
445	Disorders of the biliary tract with CC	\$6,013
446	Disorders of the biliary tract with CC/MCC	\$4,067

Source: <sup>2</sup>

Note: Major Complication/Comorbidity (MCC), Complication/Comorbidity (CC), Non-Complication/Comorbidity (Non-CC).

As demonstrated in **Table 1**, MS-DRGs provide a financial incentive for hospitals to improve the clinical integration of health care by reimbursing providers at a higher rate for more severe cases. For example, the hospital inpatient Medicare national payment for disorders of the biliary tract without complications is US\$4,067 (€3,108). This payment increases by US\$1,946/€1,487 (47.8%) if the patient presents a CC. If the patient presents MCC, the payment increases by US\$4,990/€3,813 (122.7%).

### Objective of the scheme and link to performance indicators

DRGs were originally implemented in the US in 1983 to provide hospitals with incentives to control costs for services provided to hospital inpatients in the Medicare programme. Prior to the introduction of DRGs, hospitals providing treatment to Medicare patients employed a retrospective payment system. As hospitals were reimbursed for the services that they provided, even if they were costly and inefficient, retrospective payment provided little incentive for hospitals to contain costs. As a result of these perverse incentives, Medicare introduced a new DRG-based system of prospective payment for hospitals whereby a fixed rate is set for reimbursement prior

to the patient's admission to hospital. Thus, a DRG payment system introduces competition into the hospital market and incentivises hospitals to contain costs. However, it also gives providers a negative incentive to increase readmissions and to engage in risk selection.

The 2007–2008 changes to Medicare's inpatient prospective payment system were enacted as part of the Deficit Reduction Acts of 2005.<sup>3</sup> These changes were designed to improve the efficiency and quality of care by linking payments to quality. By adjusting payment for severity of illness, the MS-DRGs should reduce the payments for the less severely ill and increase the payments for the more severely ill compared to payment under the previous DRG system. The net effect should be to improve the distribution of payments.<sup>4</sup> In addition, the new IPPS is designed to reduce payment for conditions that were contracted during the hospital stay rather than as a result of deterioration of a particular condition after admission. For example, hospitals do not receive reimbursement for certain conditions if they were not recorded as present on admission.<sup>5</sup> Therefore, the objectives of the MS-DRGs are primarily to improve quality and efficiency of care. Improvement in clinical integration is

not a primary objective of MS-DRGs but rather a positive bi-product of adjusting DRGs for severity.

### Potential success and evaluation of the incentive

An evaluation of the impact of the financial incentives created by MS-DRGs for the clinical integration of care does not seem to have been conducted. This may be because clinical integration is not the primary objective of the new DRGs.

### Challenges

The cost-control incentives created by DRGs may present an obstacle for the integration of care. This conflicts with the objective of integrated care in so far as integration may increase input costs without increasing reimbursement under DRGs. For example, payment by DRGs does not directly provide incentives for health promotion and disease prevention that may form important components of integrated care models. Unless this is correctly accounted for in an integrated care model, hospitals will only have the incentive to work towards clinical integration, as described above, rather than integration of care more generally. Similarly, MS-DRGs do not present an incentive for hospitals to collaborate with

physicians outside of the hospital, which may present a further challenge to the integration of care.

There seems to be a gap in the literature on integrated care regarding the scope for DRGs to improve health care integration. DRGs do not seem to be an important payment mechanism for integrated care in general. This may stem from the negative incentives for DRGs to expand services beyond those that are specified under the prospective reimbursement system. However, MS-DRGs in the US do provide some scope for the clinical integration of care. Moreover, there is potential for other recent innovations in payment mechanisms for integrated care, such as episode-based bundled payments and gain-sharing, to be more effective at increasing the level of integration in health care markets.

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# PERSONAL HEALTH BUDGETS IN THE NETHERLANDS AND ENGLAND

By: Ghislaine Grasser, Ruth Young and Liana Rosenkrantz Woskie

**Summary:** The Netherlands and England have introduced personal budgets for long-term care as patient incentives with the general objective of providing more choice and flexibility to recipients. In the Netherlands, the number of personal budgets increased substantially from 2002 to 2010, prompting a drastic cut to reduce costs. In England, personal budgets were implemented in 2005 as pilot projects in thirteen local authorities, and scaled up throughout the country in 2012. Currently, little evidence is available on the role of personal budgets in integrated care. However, in the Netherlands, personal budgets were shown to increase patient satisfaction, choice and influence over care. Different evaluations following the pilot programmes in England show that personal health budgets can be used as a vehicle to promote better integration.

**Keywords:** *Personal Budgets, Direct Payments, Long-Term Care, the Netherlands, England*

## Background

Over the last twenty years the United States and several European countries, such as Austria, England, Finland, France, Germany, Ireland and the Netherlands, have introduced “personal health budget” programmes (also known as “consumer-directed care”, “cash-for-care”, “service vouchers”, “home-care grants”, “direct payments” or “person-centred budgets”) in their long-term care systems for older people and for people living with disabilities. These programmes provide cash or vouchers that patients can use for

home-care, i.e. to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Personal health budgets enable patients to choose what care is the most appropriate for themselves and avoid top-down situations where similar care and services are provided to all patients, irrespective of their personal context. Long-term care patients thus become “consumers” and have greater freedom to select services and providers.<sup>1</sup> Here we focus on the personal health budget programmes introduced in the Netherlands and England.

The Netherlands introduced personal budgets (*Persoonsgebondenbudget*) in 1996 for older people and people with disabilities. Recipients can choose between receiving care in kind through standard providers or applying for a personal budget. With the personal budgets, patients can pay and choose the provider of their choice (professional or non-professional) for personal care (ADL), nursing care (e.g. injections, dressing wounds) and support services (such as day care, help with life management and coping with disabilities).<sup>\*</sup> Medical care is not paid for by personal budgets but covered by national health insurance in the Netherlands.

“65% of all personal budget expenditures were spent on informal care”

In the case of England, a series of pilot interventions on personal budgets were introduced in 2005, and scaled country-wide in 2012. In this case, individuals are able to spend a discretionary health allowance on a variety of services, which allows them to determine the quantity and type of service for their own needs. In England, this excludes part-funding treatment alongside patients' own money, primary medical services and emergency services.<sup>■</sup>

### Objectives of the scheme and link to performance indicators

The general objectives of personal budgets are:

- To offer better choice of services and more flexibility to persons in need of care (older people and people with disabilities);

- To give patients more control and autonomy over their care;
- To create jobs and give recognition to informal carers;
- To shift the balance of power from professionals to care recipients, with patients becoming consumers;<sup>■</sup>
- To increase competition between service providers and improve efficiency and quality of care as consumers become an important pressure group.

Personal budgets in the Netherlands are financed through social insurance contributions and entitlements criteria are relatively broad compared to other countries.<sup>■</sup> In 2011, the average annual personal budget was €43,000 for patients with residential care needs and €12,000 for others. The average age of personal budget holders has fallen over time: 45% were aged under 18 in 2011, which is explained by the increased uptake by young people with learning and/or intellectual disabilities and autistic diagnoses.<sup>■</sup> According to research conducted in the early 2000s, 65% of all personal budget expenditures were spent on informal care and largely paid to people known by the patient (76% of informal carers were partners, children or parents).<sup>■</sup>

Personal budgets became so popular in the Netherlands that they increased tenfold between 2002 and 2010, from 13,000 to 130,000 personal budget holders, representing a cost increase from €0.4 billion to €2.2 billion.<sup>■</sup> Faced with this exponential increase, the government planned a significant reform to reduce the number of personal budget holders by 90%: as of January 2014, the allocation of personal budgets will be restricted to people who would otherwise move to a nursing or residential home.

The personal budget scheme was introduced in England through a three-year pilot, from 2005 to 2007: thirteen local authorities, which are responsible for delivering social services, were funded by the Department of Health to implement these budgets.<sup>■</sup> Each site was given funding between £350,000 and £400,000 (c. €414,900–€474,100) over a two-year period.<sup>■</sup> Individual budgets were allocated to patients (in the intervention) through a

resource allocation system which used an algorithm to assess need at the individual level. The mean support provided was £280 (€332) per week per individual, which covered services that were agreed upon in the individual's care plan.<sup>■</sup> Care plans were individually drawn up with the patient, in conjunction with primary care trusts, stipulating the amount for which the individual was eligible, and how their budget would be spent.<sup>■</sup>

### Potential success and evaluation of the scheme

In the Netherlands, evidence shows positive outcomes for personal budgets in terms of patient satisfaction, increased choice, and influence and control over services compared to traditional agency-provided care.<sup>■</sup> In 2004, statistics noted that 95% of budget holders felt the care they had purchased was of good quality.<sup>■</sup> However, a more recent study from the Health Foundation provides evidence that personal budgets have a weak impact on health improvement.<sup>■</sup>

In England, the initial evaluation of the personal health budget pilot programme was evaluated in 2008; twenty sites (out of 70 sites in total) were evaluated in depth. A subsequent report was released in November 2012.<sup>■</sup> Although the 2008 results were largely positive, they lacked specificity with regard to outcomes. The 2012 evaluation tried to further determine if personal budgets were linked to better patient outcomes and greater quality of care.<sup>■</sup> Results regarding integration were twofold: personal health budgets can be used as a vehicle to promote better integration, and further integration may lead to additional changes in the balance of services used by individuals.<sup>■</sup> Further, it was found that overall, individuals with budgets changed the mix of services they utilised. The pilot found a significant increase in the use of well-being services and other health services, such as specialised continuing health care.<sup>■</sup> There was also a reduction in the use of hospital care by the intervention group compared to the control. The study did not, however, show a change in the use of social care services.

<sup>\*</sup> Given cost constraints, several support services and day care activities will no longer be funded by personal budgets respectively from 1 January 2013 and 1 January 2014. See Van Ginneken, et al.<sup>■</sup>



## Challenges

The main challenge regarding personal budgets is sustainability: in the context of the Netherlands, where eligibility criteria were broad, personal budgets became victims of their own success, with an exponential increase in costs over the decade. These increases led to government reforms that actively cut the number of personal budget holders.

“personal health budgets can be used to promote better integration”

Other challenges associated with personal budgets include:

- Difficulties in managing personal budget funds experienced by less educated families who often required support from professionals to navigate bureaucracy and administration;
- Cases of fraud have been reported; and
- The quality of home-care provided by non-professionals is difficult to assess.

There is, however, a consensus that social care cannot be approached in isolation, i.e. exclusively through personal budgets, and is most successful in incentivising integration if located

within other policy efforts. These may include: personalisation, self-direction, career support, anti-stigma, access to employment, social participation, as well as structural efforts such as those outlined in a review conducted in 2012.<sup>6</sup> Structural arrangements might include, but are not limited to: streamlining historically separate commissioning budgets for health, social care, housing and other services,<sup>9</sup> a move towards cost and volume contracts between providers and purchasers,<sup>10</sup> and a single regulating body over health and social care markets.<sup>11</sup>

In addition, both the Nuffield Trust and the King's Fund emphasise the importance of *appropriate* financial incentives when encouraging integrated care.<sup>11</sup>

In particular, they focus on the need for flexible systems, so that care models are genuinely adaptive for the individual.<sup>11</sup> One way to address issues that arise from increased individual choice is to provide educational resources on appropriate utilisation to individual purchasers. This would allow patients to better navigate the system and address issues of imperfect information (faced by some older patients in the English pilot). As more people in need of social care are responsible for purchasing, accessing and resourcing their own services, the more they will need information and advice on how to do so effectively.<sup>6</sup>

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## Health system performance comparison. An agenda for policy, information and research

**Edited by:** Irene Papanicolas and Peter C. Smith

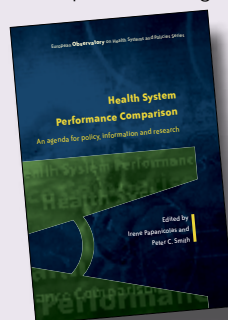
**Published by:** Open University Press

**European Observatory on Health Systems and Policies Series, 2013**

**Number of pages:** 416 pages, ISBN 978 0 33 524726 4

**Available to purchase at:** <http://mcgraw-hill.co.uk/html/0335247261.html>

This timely and authoritative book offers an important summary of the current developments in health system performance comparison. It summarises the current efforts to compare systems, and identifies and explores the practical and conceptual challenges that arise. It discusses data and



methodological challenges, as well as broader issues such as the interface between evidence and practice. The book outlines the priorities for future work on performance comparison, in the development of data sources and measurement instruments, analytic methodology, and assessment of evidence on performance.

# RECONFIGURING HEALTH PROFESSIONALISM TOWARDS ADDRESSING MULTIMORBIDITY

By: Thomas Plochg

**Summary:** Delivering more and better health services with less human and financial resources is key to more sustainable health systems. Health reforms in certain countries tend to focus on enforcing intrusive regulation, management and market mechanisms within health provision whilst preserving the existing nature and type of health professionals, and their way of working. However, it is increasingly acknowledged that the existing health workforce is poorly fit for purpose when it comes to chronic diseases, in particular multimorbidity. Therefore, it would be better to reconfigure the health professions as one way towards more sustainable health systems. The sociology of professions provides clues on how such a reconfiguration strategy could be successfully developed and implemented.

**Keywords:** *Health Professionalism, Health Policy, Sustainable Health Systems, Multimorbidity*

## Background

The future sustainability of health systems is a very pressing issue. Delivering more and better health services with less human and financial resources is the key challenge for health systems across the world. Governments worldwide are struggling to reform their health systems for the better by introducing more intrusive regulation, management, and market mechanisms in health provision. More recently, the global economic crisis has forced many governments to impose austerity measures and to cut health budgets seriously.<sup>1</sup>

However, evidence fuels the impression that the reforms that have been implemented so far are partial as they

fail to tackle deeper rooted problems arising from fragmentation, which in turn, results from over-specialisation. The piecemeal organisation of the health professions, driven by on-going scientific and technological advances, economic considerations and professional preferences, has distracted health professionals from the new realities of patients suffering from more complex and multiple chronic problems and illnesses, i.e., multimorbidity.<sup>2,3</sup>

The majority of the health workforce thinks and acts as single-condition experts rather than addressing multiple chronic conditions. As a consequence, patients suffering from multiple conditions must consult a broad range of specialists – one

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for each condition – which is arguably the root of the unsustainable functioning of health care systems. Societies simply run out of human and financial resources to adequately staff and operate these health systems, even when they succeed in achieving high levels of integrated care. Apart from that, it is doubtful whether the mere sum of single contributions leads to optimal health outcomes for patients suffering from multimorbidity.

“make  
them better fit  
for purpose

Arguably, one path that can be taken to rise to the challenge of unsustainable health systems is to reconfigure health professions in order to make them better fit for purpose, i.e., multimorbidity-proof. Such a reconfiguration refers to the rethinking of the nature and type of health professions, and how they organise themselves in the 21st century. This article outlines why such a reconfiguring of health professionalism is relevant, what this reconfiguration should entail, and how health policy-makers could successfully nurture it.

### Why reconfigure health professions?

The basic need to reconfigure health professionals stems from their minimal adaptation to changing circumstances. Doctors, nurses and allied health professionals essentially work and organise themselves as they did 50 years ago.<sup>1</sup> The movement from generalist to specialist (i.e., sub-specialisation) that was set in motion a hundred years ago is still the dominant, if not the only, way to gain a foothold as a health professional.

Sociological research provides a good understanding of why this would be the case. In sociology, professions are defined as groups of institutions that permit the members of an occupation to make a living while controlling their own work.<sup>2</sup> Internal control is a basic characteristic, as professions perform non-routine tasks requiring expertise

based on abstract knowledge and practical apprenticeship that is inaccessible to those lacking the required training and experience. The pursuit of internal control over health labour, i.e., the process of professionalisation, is appealing for occupations as it is associated with more prestige and higher incomes.

Thus far, the professionalisation of health labour seems to be synonymous with sub-specialisation. Newer professions must outperform other (“rival”) occupational groups to obtain the status of a profession. They have to demonstrate the superiority, exclusiveness and the discretionary nature of their knowledge to support their jurisdictional claim for a new health domain alongside, or at the expense of, other professions with a vested interest. This has led to the situation where it seems almost impossible to successfully claim jurisdiction over a health domain superseding (or generalising from) multiple vested ones; the vested professional institutions and academy would not allow for it.

Now the critical issue is that patients suffering from multimorbidity would arguably benefit from health professionals whose expertise is underpinned by more generalised health domains. It would allow them to individually deal with the complex interplay between multiple diseases and conditions within one person without the need to involve many other health specialists. The potential gains in terms of effectiveness and efficiency are huge.

Epidemiological data show that people with multiple chronic conditions already represent 50% of the burden of disease in most OECD countries.<sup>3</sup> Having multiple, complex and overlapping health problems is associated with poor outcomes in terms of quality of life, psychological distress, longer hospital stays, more postoperative complications, higher mortality and higher costs of care. In the US, for example, two-thirds of all spending in the Medicare program (the programme that insures people over 65 or who are disabled) is for people with more than five chronic conditions.

In other words, any successful effort that addresses the resource use of patients

suffering from multimorbidity, will likely contribute significantly to more efficient health systems. In this context, the reconfiguration of the health professions – essentially innovating the way that health expertise is professionally organised – is worth considering as one policy option.

### Three interrelated steps

The reconfiguring of health professions requires a comprehensive agenda; one that focuses on designing out wasted resources that occur from the current way of treating people with multimorbidities, and adapting the professional organisation of health expertise accordingly. Three interrelated steps are suggested.

The first step entails defining and categorising patients and populations according to their burdens of morbidity. New categories are needed in order to classify patients with multimorbidity that provide the basis for gathering and organising health expertise.<sup>4</sup> For example, what expertise is needed to deliver optimal medical care to patients with multi organ disorders or a frail elderly person with multiple diseases or a teenage girl who smokes, suffers from diabetes and depression, and is pregnant? There are categorisations that explicitly aim to characterise the degree of total morbidity burden from a clinical and epidemiological perspective (see <sup>5</sup>). Moreover, primary care, public health, intensive care medicine, paediatrics, occupational medicine, emergency medicine and geriatrics mark fields in medicine where more superseding or “integral” health professions would be advantageous. Nevertheless, which categories will ultimately be used to categorise populations will depend on research studying the potential of the different alternatives to deal with multimorbidity. This research seems now booming, as illustrated by the paper by Barnett et al. in *The Lancet*.<sup>6</sup>

The second step requires that the professional work of doctors, nurses and allied health professionals be organised around the newly defined categories of health needs. This essentially means merging or rearranging specialty domains or establishing new domains and roles. For

example, geriatrics might be established more generally as a fully approved medical specialty, thus making geriatricians the frontline staff for frail older patients in all countries, which is now not the case. Existing medical specialists (such as internists, cardiologists, and neurologists) would then be aligned to better support the “integral” function of geriatricians.

But a rearrangement of specialty domains and non-physician roles is unlikely to occur by decree; it has to be established from within the health workforce itself, strategically supported and stimulated from the outside and based on a vision of health system design with special reference to the blurring of the interfaces between primary, secondary and tertiary care for people with multimorbidity. Focusing on tasks to be provided by the different professionals and how they best support the integrative function is a critical step in the process of re-aligning skills to better meet new health needs.

The third step is then to reorganise the work of doctors, nurses and allied health professionals practicing in these integral knowledge domains. A major challenge will be to devolve tasks and responsibilities to the type of health worker most accessible to patients and which is consistent with the achievement of excellent quality and outcomes. This will require a careful reconsideration of sharing or redistributing tasks between different occupations, in particular between doctors and nurses in more advanced roles. Even so, tasks can also be left to the patients themselves – with backup from the professionals – as illustrated by the developments in telemedicine, eHealth, and self-management.

### Nurturing the desired reconfiguration

The challenge of the proposed reconfiguration is daunting. It will run counter to the existing *status quo*, as it rearranges professional domains, resources and incomes. This creates winners and losers and one can expect prospective losers to oppose such change. Nevertheless, the basic idea for change is straightforward: restore the view that ‘health-is-the-business-of-healthcare’,

**Table 1:** Strategies to nurture the reconfiguration of health professions

Strategy	Description
Elevating health as the core professional value	Emphasise that health is the business of health care, i.e., the <i>raison d'être</i> of the health professions.
Targeted research funding	Establish an enhanced portfolio of multidisciplinary research (e.g., public health, health services, and sociological research) that provides the credentials for health professions better suited to 21st century requirements.
Targeted technology funding	Invest in the development of health technologies (e.g., eHealth, medical devices, pharmaceuticals) that favour generalisation rather than (sub) specialisation.
Targeted infrastructure investment	Invest in infrastructure (including real estate) that does not block, but preferably initiates and facilitates, the future health professions to incorporate the three capacities.
More flexible professional bodies	Ease the requirements that health professions need to satisfy in order to become a recognised field. This implies that professionalisation not only allows for specialisation but also generalisation.
System and multimorbidity based health curricula	Include expert decision making based on the principles of systems thinking and multimorbidity in the health curricula.
Balanced performance assessment and management	Develop performance-based instruments related to the health outcomes of patient groups, i.e., multimorbidity, that are served rather than for individual diseases.
Supportive payment models	Developing pay-for-population-health-performance schemes that reward health professionals for their contributions in maximising health outcomes.
Policy rich human resource planning	Adjust the models for human resource planning in such a way that they facilitate the desired reconfiguration rather than codify vested health professions.
Support self-organising patients	Use the self-organising power of (multimorbid) patient populations to trigger health professions to adapt to the reconfiguration agenda.

Source: Adapted from [6](#)

and then emphasise that ‘systems thinking’ and ‘connectivity’ are required capacities for health professionals to actually implement this in the 21st century.

Now the critical challenge for policy-makers is to promote such change in practice by moderating the negatives of health professionalism (e.g., unconstrained self-interests, distancing from the client, limited client accountability/ responsiveness, professionalism tribalism) while strengthening the positives of

professionalism (e.g., a strong educational base, certified expertise/ expertise, evidence-based practice, ethical codes).

Therefore, there is a need to nurture leadership from within the health professions, as the health workforce itself is largely responsible for the way in which health expertise is organised and it has the powerbase to lead change. Health leaders must recognise that the proposed reconfiguration is a more promising route towards sustainable health systems and that it better serves to protect the values and principles of health professionalism

against the countervailing forces of the free market and bureaucracy.<sup>2 3</sup> In concrete terms, policy-makers can draw them in by targeting at least ten key assets of health professionalism (see Table 1).

## “target ten key assets of health professionalism”

If appropriately, timely and systematically governed, initiatives could nurture professional self-regulation amongst the health professions, annexing the proposed agenda for reconfiguration. For example, sociological research shows that (medical) professions follow a common pattern when it comes to professional self-regulation. Profession-owned instruments are developed and implemented in order to ease external pressures and their underlying agendas. For instance, the implementation of peer review in the 1990s was a profession-owned response to ease fierce external quality and safety pressures.<sup>4</sup> Similarly, the sky-rocketing issue of professionalism in health education can be interpreted as the profession-owned response to the upheaval relating to badly-performing individual health professionals.

### Conclusion

The central thrust of this article is that a reconfiguration of health professions is needed to get 21st century-proof health professions, and ultimately more sustainable health systems. The health professions are no longer fit for purpose, since they are based upon the acute single diseases of the past. Due to the successes of modern health care, the burden of disease has shifted towards multiple chronic diseases and conditions, hollowing out the predominant organisation of health expertise into health specialities.

However, the call for a reconfiguration of health professions does not entail the rejection of health specialist activities. After all, during the period 1875–1920,

successful sewage systems were not abolished when burdens of disease shifted from declining infectious diseases towards non-communicable diseases. Nor does it mean the championing of general practitioners and primary care physicians: it is questionable whether these physicians have fully incorporated the three suggested steps into their capacities yet. Besides, it is naïve to assume that general practitioners can do the job on their own. The likelihood of success is probably improved when all health professions rise to the challenge, and thus all become more responsive and accountable to the changing circumstances in health provision.

For health policy-makers, the key message is to stop exploiting the existing single-condition based health professions. By introducing more intrusive regulation, management, and market mechanisms in health care, health policy is codifying the vested health professions in their way of organising health expertise and related processes of health service delivery. This is a counterproductive policy strategy. Rather, health policy-makers could better recognise and use the positive strength of self-regulating health professions. It seems better to start a constructive collaboration; one that leads to the professional adaptation to the multimorbidity challenge. Arguably, such a strategy could turn out to be a more fertile way to achieve the goal of improving how health professions meet the challenges of multimorbidity, and ultimately achieving more sustainable health systems in the 21st century.

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# DEVELOPMENTS IN PRIMARY CARE IN THE REPUBLIC OF MOLDOVA: ESSENTIAL STEPS FOR IMPROVING ACCESS TO SERVICES

By: **Silviu Domete**, **Ghenadie Turcanu**, **Jarno Habicht** and **Erica Richardson**

**Abstract:** In the Republic of Moldova there have been far-reaching reforms in primary care since the country's independence from the Soviet Union. In 2010, primary health care coverage was extended to the whole population irrespective of health insurance status. This has improved some aspects of access, but barriers remain. Quality improvement initiatives are on-going with clinical guidelines and protocols now available, but further reforms are in the pipeline to strengthen the recognition of family medicine, the autonomy and role of primary care in the health system, the equitable availability of human resources, and continuity of care.

**Keywords:** *Primary Care; Republic of Moldova; Family Medicine/ General Practice; Access; Gate-keeping*

Since gaining independence from the Soviet Union in 1991, the Republic of Moldova has undergone a social, political and economic transformation but new socio-economic conditions have threatened the health status of the population and necessitated changes in the inherited expansive health system. From WWII to 1991 the Moldovan health system was part of the Soviet Semashko health system, but reforms since independence have sought to introduce fundamental changes to the system so that it is better suited to the changed socio-economic and epidemiological reality, as well as to the country's aspirations towards integration with the European Union.<sup>1</sup>

The inherited system was characterised by an extensive infrastructure, curative focus and a large health workforce. In this system success was measured in quantitative terms such as the number of beds or doctors per capita rather than qualitative measures such as health outcomes. Inpatient specialised services were also favoured over primary or preventive care which remained under-resourced. This meant that at independence, the Moldovan health system was large (in 1990, the Republic of Moldova had the highest number of hospital beds per capita in Europe), but under-funded and ill-equipped to deal with the resurgence of communicable diseases and increasing non-communicable disease (NCD) burden that the country faced.

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The system's infrastructure was also very expensive to maintain, particularly given the parlous economic downturn the country experienced throughout the 1990s.

de-concentrating services and bringing them closer to the population

Financial constraints and the resistance of many nostalgic decision-makers and managers delayed health care reform in the Republic of Moldova so that although reforms of the primary care system began in the mid-1990s,<sup>2</sup> efforts have intensified since the introduction of social health insurance (SHI) in 2004.<sup>3</sup> Policies have sought to develop the primary care system based on family medicine, thereby balancing the hospital orientation of the inherited system.<sup>4</sup> The roll-out of extended general practice has proved challenging in many countries of the former Soviet Union, but in the Republic of Moldova concerted reform efforts now mean that the whole primary care system is based on a family medicine model which is funded prospectively using weighted capitation, and 'gatekeeping' is a meaningful aspect of the system. The financial sustainability of the system is ensured under the mandatory health insurance system.

### Organisation of primary care

There is an extensive network of primary care providers across the country and the key actors in the provision of primary care are family doctors and family medicine nurses. The family medicine model is most developed in rural areas where primary care infrastructure corresponds better to population needs, and is more efficient as it relies solely on family doctors and nurses. Primary care in rural areas has also benefited from considerable foreign and domestic investment during the last decade. In urban areas, including the

capital city (Chisinau), reforms are lagging behind and there is much inefficiency related to the overuse of specialised outpatient care. Family Medicine Centres in urban/district areas and Territorial Medical Associations in the capital still play the central role in managing funds for primary care provision all over the country. Territorial Medical Associations are big and include Consultative and Diagnostic Centres employing many specialists.

Family Medicine Centres are located in district towns and serve a population ranging from 40,000 to 80,000, including any rural population in their catchment area who are also served by Health Centres, Family Doctors Offices and Health Offices. A Health Centre should serve at least 4,500 inhabitants and have at least three family doctors and they can be organised as subdivisions of the Family Medicine Centres or as autonomous entities (either public or private). Family Doctors Offices and Health Offices are subdivisions of Family Medicine Centres and Health Centres. A Family Doctors Office serves a population of 900–3,000 inhabitants and can have one or two family doctors. Health Offices are organised in communities with fewer than 900 inhabitants and are staffed only with family medicine nurses. For each family doctor position there are two positions for family medicine nurses in urban areas and two to three in rural areas.<sup>5</sup>

Patients can choose their family doctor, and are free to register with any primary care facility, although patients are recommended to register with their closest facility and for members of the same family to register together. If a patient chooses to register with a doctor outside their catchment area, they have to cover the doctor's transport costs for any home visits.

The services provided at the primary care level are divided into basic primary care services (medical emergencies; prevention services including immunisations, health promotion and health education; management of chronic diseases; routine consultations for children, adolescents, elderly and socially vulnerable people and for pregnant and postpartum women;

family planning services; minor surgery; and medical–social services such as home care and palliative care) and additional medical services, which are beyond the traditional scope of primary care and may be provided only when staff have additional qualifications and the necessary equipment is available. These additional services include diagnostic, rehabilitation and pharmaceutical services. In rural areas, the family doctor and the family medicine nurse are available 24 hours a day and also provide some emergency care, especially when they live in the same community. Most of the Health Centres have special cars that can be used for home visits and the transfer of patients if necessary.

### Purchasing primary care services

The package of services provided in primary care under SHI is defined by Government Decree and the National Health Insurance Company (NHIC), which purchases services covered under SHI, can contract with both public and private primary care providers. The Family Medicine Centres are directly contracted by the NHIC for the provision of basic and additional services to the district town and the surrounding area and are supposed to serve as a methodological and organisational centre for all primary care facilities in the district. They also collate all the statistical data for primary care in the district.

Autonomous Health Centres are contracted directly by the NHIC for the provision of basic services in their catchment area. Their number has been continuously increasing and by 1 April 2013 there were 137 centres. Of the 35 District Family Medicine Centres in 2012, six were transformed into Local Health Centres in 2013, meaning that they have lost the role of "channelling" primary care funds in the district. The Ministry of Health plans to make all Health Centres autonomous by the end of 2013 and to gradually reorganise Family Medicine Centres as Health Centres, thus further de-concentrating services and bringing them closer to the population.

Since 2004, primary care services have been purchased on a per capita basis,

but the incentives have been refined to better reflect variations in need. Initially, primary care services were funded prospectively according to a simple unweighted capitation estimate, using the resident local population as the denominator. From 2005, the per capita funding was combined with retrospective extra payments for achieving certain quality indicators, but since 2009 the capitation formula has been risk adjusted (by age) and estimated based on the number of patients registered at a given practice. Retrospective ‘bonus’ payments were made for (a) detecting and monitoring TB patients for care, (b) care of women in the first trimester of pregnancy, providing gynaecological cytological screening examinations, and (c) care of children in the first year of life.<sup>11</sup>

## development of clinical protocols for primary care

This quality bonus system was put on hold in 2010 due to the financial crisis, but also because resources were shifted to other priorities, such as ensuring universal primary health care coverage to the whole population. In January 2013, a ‘Pay-for-Performance’ mechanism was put in place in addition to the age-adjusted capitation mechanism. According to the new system, the performance-related share of total allocations to primary care (which excludes allocations for reimbursed medicines), reached 14.9% in 2013, compared with 4% in 2012. This allows primary care staff to receive additional payments for the achievement of certain performance indicators, which include referrals to hospitals and those related to NCD control, such as monitoring high blood pressure, diabetes and cancer screening.

The quality of primary health care services is increasingly treated as a priority issue. The NHIC evaluates the quality of services in order to validate treated cases in accordance with performance

indicators. Part of the quality improvement process has been the development of clinical protocols for primary care services. Recently, around 150 clinical protocols have been developed within assistance projects supported by USAID, the EU and the World Bank, and another 60 clinical protocols are under development. However, the challenge remains of how best to ensure that such protocols are applied in everyday practice to achieve better health outcomes.<sup>12</sup>

### ‘Gatekeeping’

The family doctor is the coordinator and integrator of all health services provided to patients, acting as “a filter” in the population’s access to other levels of care, unless they have one of a limited number of conditions for which they can access specialised outpatient care directly (such as TB and STIs). The way in which health services are purchased through the SHI system means that family doctors act as genuine gatekeepers to specialist and inpatient services for pre-paid services. In order to fully benefit from the service package, every person facing a health problem should first consult his/her family doctor, who will decide if a further referral is needed. In rural areas, this is usually the pathway as there are simply no other services available; if specialist care is required, the rural family doctor will refer the patient to the district hospital. In urban areas, the pathways may differ as the spectrum of available services is much wider, including a larger number of private providers.

While most patients will go to their family doctor in a public health care facility in the first instance, some will look for a family doctor in a private institution (many of them are contracted by the NHIC). In urban areas, people also have recourse to emergency health care (ambulances) more readily, being directly transported to secondary or tertiary hospitals in case of need. Finally, some patients may directly self-refer to secondary and tertiary care facilities even though they have to cover the full costs of the treatment. Some patients from rural areas also choose to self-refer directly to tertiary care facilities in the capital. In 2010, half of those who had accessed health services in the

last four weeks went to a family doctor and one third went to a specialist.<sup>13</sup> The choice of provider depends also on health insurance status and socio-economic status. Therefore, insured patients prefer to go to their family doctors, while uninsured patients tend to go directly to a specialist; also, the wealthier the person, the more inclined they are to self-refer directly to a specialist.

### Access to services

The network of primary care facilities is extensive; therefore geographical access to primary care facilities is quite good. At the end of 2010, there were 37 Family Medicine Centres covering 216 Health Centres/Family Doctors Offices and 359 Health Offices as well as 46 autonomous health centres covering 57 Family Doctors Offices and 44 Health Offices; in Chisinau there were five Territorial Medical Associations covering twelve Family Medicine Centres as well as some specialised outpatient service providers.<sup>14</sup> The number of outpatient contacts has risen since it reached its nadir in 2004 at 5.5 per person per year and in 2011 it reached 6.4. Moreover, the number of people (both insured and uninsured) who did not consult a doctor when they needed to has fallen since 2008, suggesting a dynamic improvement in access to services.<sup>15</sup> Among those who did not consult a doctor, only 2.9% gave distance as the main factor.<sup>16</sup>

Although the shortage of public transport and poor roads in rural areas also limit access, the geographical discrepancies in access are mostly related to the limited availability of family doctors and family medicine nurses in some areas.<sup>17</sup> There is a deficit of family doctors nationwide, although the problem is more acute in rural areas. There is also a shortage of primary care nurses, particularly in rural areas but government incentives to encourage health workers to work in rural areas have proved more successful for attracting primary care nurses than primary care doctors. However, it is not just a question of increasing salaries or bonuses – the major determinant is the perceived quality of schools, roads and the overall quality of life.<sup>18</sup>



From 2010, access to primary care has been universal in that citizens can access most primary care services whether or not they are covered under SHI; however, the “uninsured” (around 20% of the population) still access services less readily than the insured and many attribute this to the anticipated costs involved.<sup>5</sup> Even where patients are insured, they still pay significant amounts out-of-pocket at all levels of the system as the insurance package does not cover all costs, particularly the cost of outpatient pharmaceuticals.<sup>6</sup>

There is a strong patient preference for receiving specialist care rather than staying at the primary care level, even if they have to pay out-of-pocket to do so, and paying patients do not have to wait for an appointment; long waiting times are a leading cause of patient dissatisfaction with primary care services.<sup>5</sup> Patients also often believe that paying out-of-pocket is the only way of ensuring access to high-quality and sympathetic care. Moreover, survey data have shown that the perceived poor quality of services deters people from accessing care and encourages them to self-treat.<sup>5</sup>

## Conclusions

Reforms of primary care in the Republic of Moldova introduced a radical change in the Soviet-Semashko health system inherited at independence and have been the

backbone supporting the health system’s development, envisaged in the *Health System Development Strategy 2008–2017*. A family medicine model is now employed across the country. However, there is still a very high referral rate to specialist care, and this is something that patients still seek. The main objective for future reform efforts is to improve the quality of services provided as well as broadening access to care for the entire population. A crucial element of this is the efficient planning of human resources for health in order to ensure proper coverage in rural area in parallel with addressing the mobility of professionals. Policies emphasise the need to increase the institutional and financial autonomy of primary care; to improve the payment mechanism at the primary care level by taking into account demographic, geographic and performance aspects; to implement systems of quality management in all health facilities; and to implement information systems for the evaluation of health facilities based on quality and performance indicators.

Ensuring the quality of primary care services will be central to building patient trust in family medicine, which is now a necessary step for improving access to primary care services. A strong family medicine based primary care system will also provide an opportunity for necessary reforms in both public health services and hospital sector restructuring.

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## New HiT for Latvia

**By:** U Mitenbergs, M Taube, J Misins, E Mikitis, A Martinsons, A Rurane and W Quentin

**Copenhagen:** World Health Organization 2012 (acting as the host organisation for, and secretariat of, the European Observatory on Health Systems and Policies)

**Number of pages:** 191, ISSN 1817–6127, Vol. 14 No. 8

**Available online at:** [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/186072/e96822.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/186072/e96822.pdf)

The new HiT (Health Systems in Transition) health system review for Latvia has just been released. The Latvian health system, based on general tax-financed statutory health care provision, provides coverage to the entire population and

access to a basic service package, but still leaves patients exposed to substantial user charges and direct payments. The financial crisis means the government faces a huge struggle to prevent deterioration of the health status. Important reforms such as moving service provision away from hospital care, and increasing provision of ambulatory care have been implemented successfully, along with a social safety net to protect the poor from the negative consequences of user charges. But the lack of financial resources poses the main challenge, and an increase in public expenditure is needed to ensure adequate funding of the health service.



# HEALTH SYSTEM PERFORMANCE IN CANADA: THE GOOD, THE BAD AND THE UGLY

By: Gregory P. Marchildon

**Summary:** Although Canada's health system outcomes have been good as measured by relative fiscal sustainability, financial protection, equity of access, the burden of disease, and amenable mortality, there is some evidence that its performance has slipped in recent years. Primary care is one of Canada's key weaknesses, identified in a number of recent comparative studies led by the Commonwealth Fund. Primary care is in need of substantial improvement, and perhaps fundamental reform, to allow Canada to become, once again, one of the highest ranked health systems with some of the best health outcomes in the world.

**Keywords:** *Amenable Mortality, Fiscal Sustainability, Health Outcomes, Health System Performance, Primary Care Reform, Canada*

In recent years, much attention has been focused on the fact that health system performance has slipped in Canada relative to a number of wealthier Organisation of Economic Co-operation and Development (OECD) countries that have historically been used as a point of comparison. Although the picture is mixed, there are some worrisome trends as pointed out in a recent Health System in Transition study by the author.<sup>1</sup> This article presents some of the key findings of that study.

## Fiscal sustainability

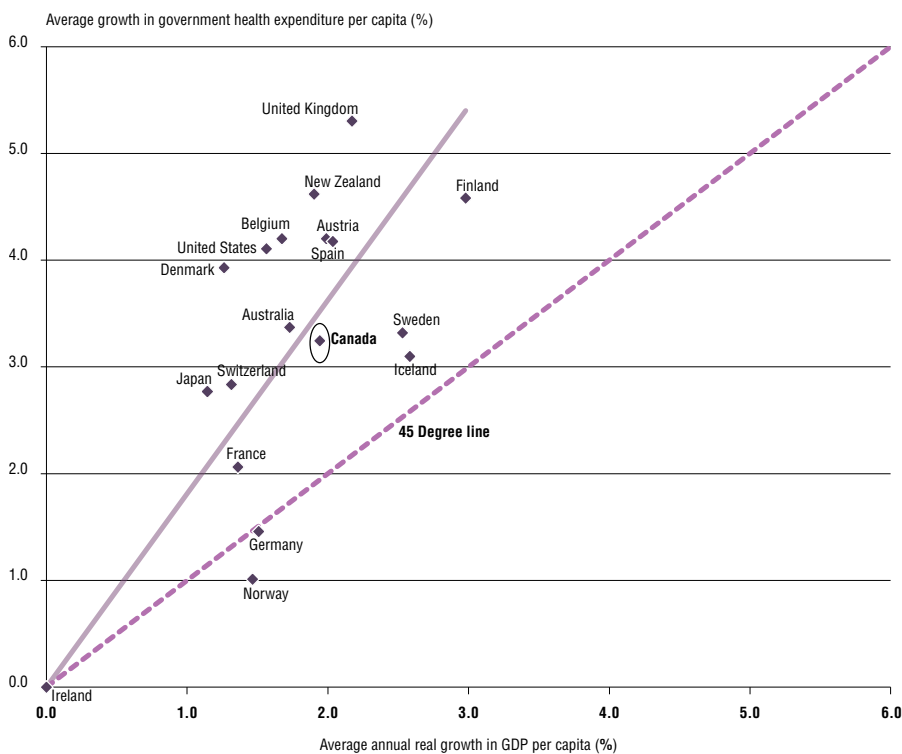
One of the consistent complaints about the Canadian system concerns the escalation in public sector health spending, almost all of which is financed through general taxation. In particular, critics have argued that government health spending has

outstripped economic growth and therefore the revenue capacities of government. While it is true that health spending has consistently exceeded economic growth, Canada is hardly an outlier among member countries in the OECD.

**Figure 1** plots economic growth against the health spending of all OECD governments that spent more than US\$2,000 (€1,540) on health care in 2008. As can be seen, only resource-rich Norway saw health spending grow slower than economic growth during this decade. In fact, Canada sits below the average trend line made up of OECD country health spending to economic growth ratios. Based on this evidence, Canada could hardly be considered profligate in its government health spending relative to the OECD average.<sup>2</sup>

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**Figure 1: Average growth in government health expenditure per capita and GDP per capita, 1998–2008**



Source: <sup>1</sup>

### Financial protection and equity of access

Financial protection measures the extent to which individuals are protected from the fiscal consequences of illness and injury. Historically, financial protection was the key reason behind the introduction of what is known as universal Medicare in Canada. While the scope of Medicare is narrow – limited to medically necessary hospital, diagnostic and physician services – it is also deep. Access to Medicare services is universal and user fees of any type are not permitted. Although provincial governments are responsible for administering their own single-payer Medicare systems, national standards or principles are provided through a federal law known as the Canada Health Act, buttressed by conditional federal government transfers to the provinces. Regional equity, in the sense of redistribution of tax revenues from wealthier regions and provinces in Canada to less wealthy regions and provinces, is delivered through federal transfers. Central government revenues are redistributed to provinces through a

dedicated Canada Health Transfer and an unconditional equalisation transfer based on a calculation of the relative tax capacity of individual provinces.

Beginning in the 1970s, provincial governments began to fill some of the public and private gaps in coverage for non-Medicare services including targeted prescription drug therapies and social care (long-term care, including home care). Access is not universal and co-payments are common, thus limiting financial protection and equity of access for these services. Administrative costs have been higher and governments have had more difficulty with cost containment more generally in these non-Medicare sectors. Other health services, including dental care and vision care, are largely private and access is highly skewed to ability-to-pay rather than need. Over the last three decades, the growth in private health spending has outstripped the growth in public sector health spending. In any event, the quantum and growth of health

spending is simply an input, and it is essential to examine outcomes in order to draw any value-for-money conclusion.

### Health system outcomes and performance

In terms of population health, Canada has historically had among the best health outcomes in the OECD, ranking second in the world in terms of health-adjusted life years (HALE) in 1990, an aggregate measure of the burden of disease.<sup>2</sup> While Canada still occupies one of the top positions on the United Nations' Human Development Index and the health of the Canadian population continues to improve, Canada's overall burden of disease ranking as measured by HALE has slipped to fifth position in the world after Spain, Italy, Australia and Sweden. While this burden of disease ranking remains quite good, and considerably better than the 2010 ranking for the United Kingdom (12) and the United States (17), it is nonetheless a comedown for a country once universally admired for the extremely high health status of its population.

“primary care in Canada is of suboptimal quality”

Unfortunately, burden of disease outcomes can tell us little about the performance of the health care system, and it is extremely difficult to assess the contribution of the health system's programmes, policies and interventions to health outcomes. Given these difficulties, successive researchers have developed a methodology known as amenable mortality to isolate the impact of the health system from the other determinants of health. Amenable mortality (AM) refers to death from selected diseases where death would not occur if those individuals could have had access to timely and effective health care. By isolating where death could be avoided and the condition in question treated, AM seeks to capture the extent to which a health system has, or has not, been

effective. The AM index itself is based on a host of age-standardised AM death rates per 100,000 that are aggregated into a single scale.

## “doctors as independent contractors paid by fee-for-service”

Based on the AM approach developed by Nolte and McKee,<sup>5</sup> Canada ranked sixth (after France, Japan, Australia, Spain and Italy) among nineteen high-income OECD countries in 2002–03. In contrast, the United Kingdom ranked 16th and the United States 19th. A subsequent study conducted by the OECD that adopted the Nolte and McKee approach showed roughly similar results even though a much larger sample of 31 OECD countries was used for a slightly later time period: France at the top, Canada ranked 11th, the United Kingdom ranked 19th, and the United States ranked near the bottom in 24th position.<sup>6</sup>

While AM produces a more mixed result for Canada than the burden of disease, it is a more direct and robust indicator of health system performance. Determining what is preventing better performance is difficult but considerable evidence points in the direction of primary care. In any event, primary care forms, or should constitute, the spine of most health systems, and any poor performance in this sector has a potentially large impact on other sectors. In Canada, as in the United Kingdom, primary care physicians act as gatekeepers in terms of referrals to consultants and further diagnostic tests. In addition, primary care physicians are responsible for prescribing the majority of prescription drugs therapies.

### Primary health care

Based upon a number of comparative studies conducted by the Commonwealth Fund in the last five years, it would appear that primary care in Canada is of suboptimal quality as measured by patient

and physician self-reports. In the 2010 Commonwealth survey of patients, Canada had the poorest outcomes in terms of access to a doctor or nurse and, consequently, a greater reliance on the use of hospital emergency departments.<sup>7</sup> The 2011 survey of sicker patients reflected poor coordination between primary care physicians and consultants. Canada's middling performance in terms of coordination – at least as perceived by patients – stands in stark contrast to, for example, the United Kingdom's much more positive outcome on this indicator.<sup>8</sup>

In an eleven country comparison on the use of information and communications technologies, primary care physicians did least in terms of electronically sending their patient summaries and test results to consultants and other doctors outside their practice. They also were the least responsive in allowing patients to email medical questions or request appointments or referrals. They were the least likely to request refills for prescription drugs online. Canadian doctors also had the second lowest (after Swiss doctors) standing in their use of electronic medical records.<sup>9</sup>

So, why does primary care in Canada compare so poorly to other OECD countries? There are at least two institutional reasons. The first can be traced back to when universal medical care coverage (as opposed to hospital coverage) was first introduced in the province of Saskatchewan in 1962. At the time, the majority of physicians in that province were opposed to the introduction of a universal scheme in which the provincial government was to become the single-payer of all medically necessary services provided by physicians. They were joined in their opposition by organised medicine throughout Canada as well as the American Medical Association. A 23-day doctors' strike ensued which was only brought to an end with a deal that protected the status of all doctors as independent contractors paid by fee-for-service. This compromise – known as the Saskatoon Agreement – subsequently became the social compact on which universal medical care insurance was introduced in the rest of Canada when the

federal government offered to cost-share “Medicare” expenses with all participating provincial and territorial governments.<sup>10</sup>

Fee-for-service payment encouraged a volume-driven, transactional practice not generally suited to primary care practice that requires time to assess, diagnose and treat patients, to discuss and evaluate patient histories, as well as encourage patients in terms of illness prevention and health promotion activities and behaviours. In addition, since fee-for-service reimbursement was restricted to doctors, it has made it very difficult for provincial ministries to encourage a team-based and inter-professional approach to primary care.

By the beginning of the 21st century, the lack of progress on primary care reform was obvious to experts in the field as well as governments in Canada despite a host of smaller pilot projects.<sup>11</sup> Primary care was identified as a national priority by federal, provincial and territorial governments in 2000 and 2003 and the federal government provided money to provincial governments and organisations initiating reform. In 2004, in return for a long-term commitment for federal transfers for health care, the premiers signed a *10-Year-Plan to Strengthen Health Care*, agreeing to work on ensuring that at least 50% of Canadians would receive 24-hour-a-day, 7-day-a-week access to team-based primary care by 2011. This goal was not achieved. While experiments in primary care reform have been scaled up,<sup>12</sup> no provincial government has changed the fundamental governance of primary care. The vast majority of physicians remain independent contractors with the provincial ministries of health, and despite major payment reforms in Ontario for example, most continue to be paid on a fee-for-service basis.

### Conclusion

Although Canada's health system outcomes have been good relative to most OECD countries, at least based on indicators of fiscal sustainability, financial protection, equity of access, the burden of disease, and amenable mortality, there is nonetheless some evidence that its health system performance has slipped in

recent years. Indeed, based on a number of recent comparative studies led by the Commonwealth Fund, primary care consistently appears as a major weakness. Primary care is in need of substantial improvement to allow Canada to become, once again, one of the highest ranking health systems in the world. This will likely require a revisiting of the difficult political compromise between government and organised medicine that was reached over a half century ago when universal Medicare was first introduced in Canada.

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# FISCAL SUSTAINABILITY AND HEALTH CARE IN THE UNITED KINGDOM

By: Anita Charlesworth

**Summary:** Health spending in the United Kingdom increased rapidly over the last decade but growth has now come to a halt as fiscal consolidation leads to tighter controls on public health spending. Longer term, the UK – in common with other European countries – faces a fiscal sustainability challenge. Health spending now accounts for more than one-sixth of total government spending. The pressure to increase spending on health is expected to outpace projections for government revenues. The pressures reflect demographic change – an increasing and ageing population – but other factors, such as the prevalence and management of chronic disease, relative pay and prices, new technology and productivity are more significant drivers of health spending. The success of countries in mitigating these pressures will be an important determinant of whether health systems can be fiscally sustainable without increasing tax or finding new sources of funding for health care.

**Keywords:** Health Spending Projections, Fiscal Sustainability, Productivity, Public Spending, United Kingdom

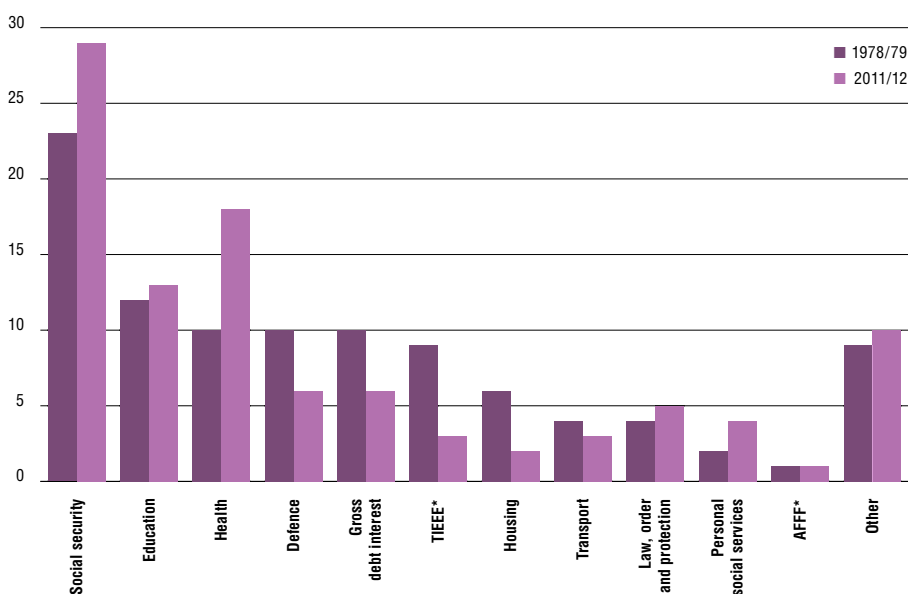
## Introduction

Spending on health in the United Kingdom is broadly in line with the OECD average. The UK spent 9.6% of Gross Domestic Product (GDP) on health in 2010 compared to the OECD average of 9.5%. This is the result of a rapid increase in spending over the last decade. In 2000, total spending on health in the UK was 7% of GDP, below the OECD average of 7.8%.<sup>1</sup> In the decade that followed, spending increased in real terms and as a share of GDP. This increase in health spending has been driven by

increased public spending on health, which grew from 5.5% of GDP in 2000 to 8% of GDP in 2010. Over the same decade, private health care spending went from 1.5% of GDP to just 1.6% of GDP.<sup>2</sup>

In 2010/11, the rapid increase in health spending came to a halt and spending in the UK fell in real terms in each of the last two years. Currently, the National Health Service (NHS) faces a budgetary challenge as the Government seeks to reduce the UK's fiscal deficit. Beyond

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**Figure 1:** Public spending, 1978/79 and 2011/12 (% of total)

Source: <sup>1</sup> TIEEE – Trade, Industry, Energy, Employment and the Environment; AFF\* – Agriculture, Fisheries, Food and Forestry.

the current period of austerity the outlook for health spending is less certain. But analysis of health spending projections alongside fiscal projections suggests that the UK faces a long-term fiscal sustainability challenge.

### Public health spending

Health spending in 2011/12 accounted for 17.5% of all government spending in the UK. Health spending has increased rapidly over the last three decades from 10% of government spending in 1978/79. The rapid growth in health spending has not been accompanied by an increased tax burden. Rather, this increase was made possible as the composition of public spending changed significantly. There has been a significant reduction in the share of GDP spent on other public services (including defence and housing) and welfare spending and debt interest fell as a share of GDP. This compositional change is clear from a comparison of the main areas of public spending in 1978/79 and 2011/12, as shown in **Figure 1**.

### The outlook for health spending

The vast majority of public health spending in the UK is spent on the English NHS while the remainder is spent by the devolved governments in Scotland, Wales and Northern Ireland

on their health services. The NHS in England is subject to an aggregate budget cap – the UK Treasury sets a fixed global budget for health as part of the regular cycle of planning in government spending (these are known as spending reviews). In 2010, the UK Government set out the government's spending plans for 2011/12 to 2014/15 and in June 2013, the Government will announce spending plans for a further year (2015/16). For the period 2011/12 to 2014/15, the English publicly-funded health budget is fixed and will rise by less than 0.5% per annum in real terms.<sup>2</sup>

The UK government's macroeconomic forecast is to reduce cyclically-adjusted net borrowing from 6% of GDP in 2011–12 to 0.6% of GDP by 2017–18.<sup>3</sup> This requires a reduction in total government spending from 45.5% of GDP to 40.5% of GDP. Receipts will also contribute to fiscal consolidation. Receipts are forecast to increase but by a relatively small amount from 37.5% of GDP to 38.3% of GDP. With rising debt interest and spending on social protection, government spending on public services will continue to fall in real terms beyond 2014/15. Spending on social protection and debt interest is forecast to increase by more than 2% a year in real terms between 2010/11 and 2017/18. Public service spending, which includes

spending on health, education, policing and transport, is forecast to fall by over 3% a year in real terms over the same period.<sup>4</sup>

This puts pressure on the health budget. Work by the Nuffield Trust has examined the impact of demographic changes, rising chronic disease and input costs on health spending pressures. This research shows aggregate funding pressures on the NHS in England continuing to increase by around 4% a year in real terms up to 2021/22. If health service funding is held constant in real terms throughout this decade, this would result in a gap between the pressure on the health budget and funding available of around £44 billion (€52 billion in 2010–11 prices).<sup>5</sup>

“funding pressures on the NHS in England continuing to increase”

Within the hospital sector, we can examine the relative contribution of demography, chronic disease and input costs. The next decade will see significant demographic change. The population of England is projected to increase by 4 million people from 52.1 million in 2010 to 56.4 million 2021. In addition, England has an ageing population: over the same period the percentage of the population over 65 will rise from 16 to 19%. Although these changes are significant, during the next decade they are expected to result in funding pressures of just over 1% a year for hospital care (**see Figure 2**). If recent trends in the treatment and management of chronic disease continue there would be additional pressures of a further 1% a year for hospital care. The combined effect of population change and rising admission for chronic condition produces demand pressures on acute services in England equalling 3% a year in real terms. If pay pressures return to their historic trend before the economic crisis (2% per year in real terms) this would add a further 1% a year to hospital costs.

**Table 1:** The 2002 Wanless Review Projections of English NHS Funding Pressures

	2002–03 <sup>1</sup>	2007–08	2012–13	2017–18	2022–23
<b>Total health spending</b> (percentage of money GDP) <sup>2</sup>					
Solid progress	7.7	9.4	10.5	10.9	11.1
Slow uptake	7.7	9.5	11.0	11.9	12.5
Fully engaged	7.7	9.4	10.3	10.6	10.6
<b>Total NHS spending</b> (£ billion, 2002–03 prices)					
Solid progress	68	96	121	141	161
Slow uptake	68	97	127	155	184
Fully engaged	68	96	119	137	154
<b>Average annual real growth in NHS spending</b> (percentage) <sup>3</sup>					
Solid progress	6.8	7.1	4.7	3.1	2.7
Slow uptake	6.8	7.3	5.6	4.0	3.5
Fully engaged	6.8	7.1	4.4	2.8	2.4

Source: <sup>1</sup><sup>1</sup> Estimate. <sup>2</sup> All figures included 1.2 per cent for private sector health spending.<sup>3</sup> Growth figures are annual average for the five years up to date shown (Four years for the period to 2002–03).

These estimates assume no underlying productivity growth in the NHS. In 2002, the UK Government published a review of the funding pressures on the health service in England commissioned from Sir Derek Wanless.<sup>1</sup> The review examined funding pressures up to 2022–23 and developed three scenarios with regard to health seeking behaviour, the prevalence of risk factors for chronic disease and productivity. The ‘fully engaged’ scenario assumed productivity growth between 2012–13 and 2022–23 of 3% a year compared to productivity growth of 1.75% a year in the ‘slow uptake’ scenario. These different assumptions about productivity combined with different demand-side assumptions produce significant differences in the pressures on health funding. **Table 1** compares the funding pressure projections for the three scenarios from the Wanless Review. The low productivity, high demand scenario (slow uptake) results in pressure on health funding which are 2 percentage points of GDP higher in 2022–23 than the high productivity, low demand scenario (fully engaged).

### Fiscal sustainability in the long-term

The Wanless review looked at pressures up to 2022/23. For fiscal sustainability we also need to examine the long-term. The UK’s Office of Budget Responsibility

(OBR) produces long-term fiscal projections over a 50 year horizon.<sup>2</sup> The OBR latest assessment concludes that:

- Public spending other than on debt interest is projected to increase from 35.6% of GDP in 2016–17 to 40.8% of GDP in 2061–62.
- Public health spending is a key contributor to risking spending pressures. It is expected to increase by at least 2.3% of GDP by 2061–62 but that this is very sensitive to assumptions about productivity. If health sector productivity remains relatively low, public spending on health could increase by a further 7.5% of GDP.
- Revenues are also projected to increase but at a slower rate, from 37.3% of GDP in 2016–17 to 38.2% of GDP in 2061–62.
- With spending pressures increasing above projected revenue growth, the overall fiscal position would deteriorate. Public sector net debt is projected to be 74% of GDP in 2016–17. This is projected to fall to 57% of GDP in the mid-2020s but would rise rapidly again to reach 89% of GDP in 2061–62.
- If health productivity remains low and the government increases funding in line with health service funding pressures (by 3.6% a year in real terms

per capita) public sector net debt would reach in excess of 200% of GDP by the late 2050s.

As mentioned, the OBR long-term fiscal projections illustrate the sensitivity of health spending as a share of GDP to assumptions about productivity. **Figure 3** shows that even if it is unrealistic to expect health service productivity to match the average productivity of the whole economy as a result of what Baumol called the ‘cost disease’ hypothesis, if health care productivity were to grow 0.8% a year rather than broadly zero it would have a substantial impact on fiscal sustainability.<sup>3</sup>

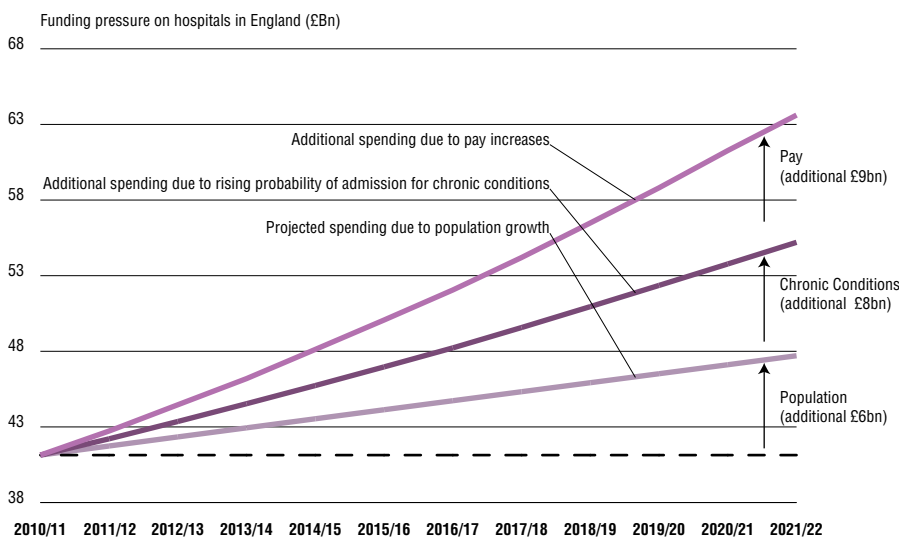
“rate of growth in health spending has been sharply reduced

The OECD also has produced long-term projections of public spending on health and long-term care.<sup>4</sup> The OECD study shows that over the next 50 years health and social care spending will drive up public spending. If countries implement reforms to contain costs, public spending on health would increase by 2.5% of GDP by 2060 but if cost pressures continue in line with recent trends across the OECD public health spending as a share of GDP is projected to rise from 5.5% between 2006 and 2010 to 11.8% in 2060. The pressures in the UK are slightly lower but without effective cost-containment the OECD projects public health spending will increase from 6.5% of GDP to 12.4% by 2060. The OECD work also finds that demographic changes account for a relatively small component of the total projected growth in public health spending.

Recent research by the King’s Fund has examined the factors which influence health and social care demand over a 50 year period. The King’s Fund research reviewed a range of medium-term projections for health.<sup>5</sup> This highlights the uncertainty about the path of spending in

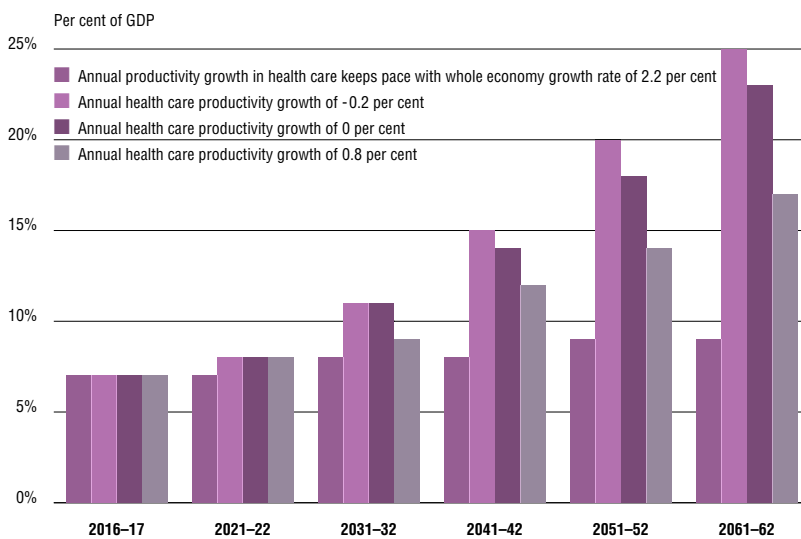


**Figure 2:** Funding pressures on acute services in England attributable to population change and to the rising probability of admission for chronic conditions



Source: <sup>6</sup>

**Figure 3:** Impact on the proportion of GDP spent on health care under different assumptions of productivity growth



Source: <sup>6</sup>

the long-term. However, as Appleby notes for health spending as a share of GDP, “the OBR’s highest spending projection suggests that it will have reached 16.6% of GDP by 2061/62. Although this is 2.4 times more than the OBR’s estimate for spending in 2016/2017, it is worth noting that this would still be lower than US health care spending was in 2010”.<sup>10</sup>

## Conclusions

Spending on health in the UK is in line with the OECD average. In response to

the economic crisis the rate of growth in health spending has been sharply reduced. Moreover, spending on health, in real terms, fell in the last two years. The UK has robust measures in place to contain health spending in the short term, including a budget cap on public spending on health which provides for health spending to increase broadly in line with whole-economy-wide inflation until at least 2015. The government has also put in place measures to reduce cost pressures, including limits on administrative spending and a national

public sector pay policy to limit pay growth. It is also seeking to protect access to care and quality of services through a programme to improve the productivity of the NHS. Although headline savings are being achieved and the NHS is living within its budget, evidence that underlying productivity has been improved is limited.

Beyond the current economic crisis, however, the UK faces a fiscal sustainability challenge. Health is an increasing share of total public spending. Health spending (along with pensions) is a major driver of the long-term growth in public spending. At present, health is projected to increase at a faster rate than government receipts. The scale of the potential fiscal gap is very dependent on assumptions about the long-run trend rate of growth in health service productivity.

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# EUROHEALTH OPINION

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# HOSPITALS IN THE REFORMED DUTCH HEALTH CARE SYSTEM: BALANCING PRODUCTS AND SERVICES

By: **Alberto Nucciarelli** and **Ana Ivanovic**

**Summary:** Dutch health system reform has radically modified the role of hospitals. Cost containment and quality improvement have led the government to establish a managed competition market where four main variables (i.e. volume of patients treated, costs of medical treatments, quality of services and insurance prices) impact on the relationship among hospitals, patients and insurers. This article analyses changes in hospital management in view of hospital-insurer dealings and the hospital-patient relationship. This analysis leads to elaborating on short-, medium- and long-term trends and to identifying products and services as new concepts to run a sustainable hospital business.

**Keywords:** Health System Reform, Hospitals, Managed Competition, the Netherlands

## Introduction

The Dutch health care system has been in transition since 2001 when the government passed the “*Vraag aan bod*” document.<sup>1</sup> It aimed at controlling the rising health care budget and setting stimuli for high quality services. However, between 2005 and 2006 the introduction of a form of managed competition<sup>2,3</sup> shifted the system from being supply-led to demand-led. The two main planks of this shift were the implementation of diagnosis-treatment

combinations (*Diagnose Behandel Combinaties*, DBCs) as the main hospital payment system and the approval of health insurance laws that brought radical changes to hospital management. In fact, management was pushed, on the one side, to enter a complex system of negotiations with insurers to determine the volume of patients treated, costs of treatments, and quality levels; and on the other side, it was forced to attract patients based on improved quality of services and customer-centred treatments.

In this article, we analyse changes to hospital management via-a-vis hospital-insurer dealings and hospital-patient relationships to elaborate on short-, medium- and long-term trends and identify products and services as new concepts to run a sustainable business. To perform this analysis, we shed light on some competitive settings that hospitals have to cope with. Then, we look at two main trends that hospitals are currently experiencing when negotiating with insurers and providing specialised care to patients.

### Patient-insurer-hospital: a virtuous relationship?

As already mentioned, managed competition is the market form resulting from the introduction of DBCs and the radical reform of the health insurance scheme. The DBC system has broken down the health care offered by hospitals into separate and pre-defined products, divided into A- and B-segments.<sup>4</sup> A-segment DBCs referred to care products with a maximum price fixed by the health care regulator NZa (*Nederlandse Zorgautoriteit*), while B-segment ones designated combinations negotiated in the market between hospitals and insurers. To stimulate a market-based approach, the number of negotiable B-segment codes has gradually increased over the years: from about 7% in 2007 to 34% in 2009 and 50% in 2011.<sup>5</sup>

“managed competition is the market form

Since January 2012, DBCs have been replaced by 3,000 DOTs (i.e. *DBC op weg naar transparantie*). Based on the international ICD10 standard, these diagnoses-based codes are meant to reinforce the correspondence between diagnosis and treatment(s), avoid the duplication of treatments and facilitate inter-department reimbursement procedures. Each DOT, assigned to

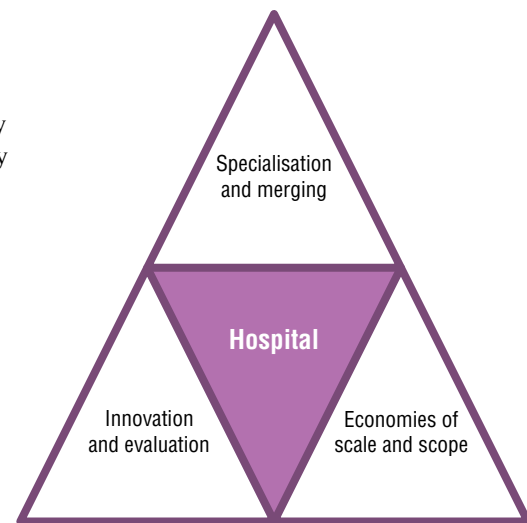
a particular diagnosis, identifies hospitals' and medical specialists' activities and is linked to their costs and fees. Moreover, it is noteworthy that service quality matters within the DOT-based reimbursement paradigm. In fact, the level of reimbursement also depends on the quality of care, which is measured with mandatory indicators according to standards set internationally by the National Quality Forum. Treatments below the quality threshold generate lower reimbursements.

The transition of the system towards managed competition was also enabled by making health insurance mandatory for all residents in the Netherlands (i.e. the Single Compulsory Health Insurance Scheme). The health insurance reform aimed at gradually reducing waiting times and facilitating hospital choice on the basis of quality of care<sup>6</sup> by eliminating the existing dual system of public and private insurance<sup>7</sup> and requiring insurers to provide coverage to all residents, independently of their health conditions (i.e. no risk selection or price discrimination is allowed). Such an obligation prevents insurers from contracting with healthy residents rather than competing on quality and price. Finally, as argued by Reitsma-van Rooijen, de Jong and Rijken,<sup>8</sup> the insurance system reform is based on the assumption that unsatisfied patients can switch insurer on the basis of the quality of care that is contracted and the premium paid. Accordingly, the transition from a supply- to a demand-side market setting requires patients making consumption choices depending not only on quality levels but also on budget constraints and willingness-to-pay.

Building upon the characteristics of managed competition in the Dutch health care market, we aim now at visualising the three variables that impact on a hospital's business (i.e. volume, cost and quality), each with its main key driver (i.e. specialisation and merging, economies of scale and scope, innovation and evaluation) (see Figure 1).

In theory, managed competition encourages hospitals to raise the volume of patients treated and drive down costs while keeping high levels of quality. In

Figure 1: Main factors in the evaluation of Dutch hospitals

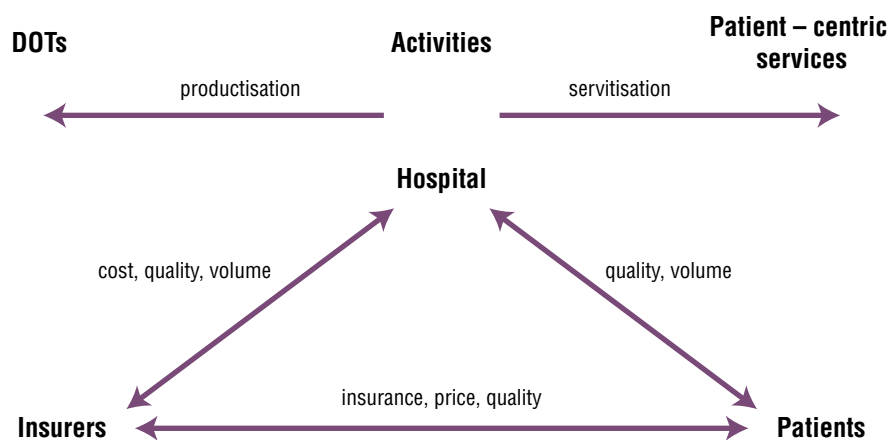


Source: Authors' own analysis

fact, increasing the number of patients will drive higher reimbursement flows from insurers (and, as a consequence, remuneration of doctors and specialists), substantially reduce costs per treated patient (i.e. economies of scale and scope) and develop specific competences to achieve best practices. However, the goal of treating more patients will most likely depend on the ability to attract them because of quality standards or merging strategies with other health care providers (e.g. general and university hospitals as well as private treatment centres) to reach high levels of specialisation, treat more remunerative diseases, or combine patients volumes. In any case, hospitals will be forced to increase the quality of services with the two-fold effect of making them competitive in the negotiation with insurers<sup>9</sup> and attracting more patients. Businesses that are run sustainably will lead them to invest in new technologies and tailored care programmes with further benefits in terms of costs, quality of care and volumes. To handle the complexity of changes successfully, there is a need to streamline internal processes by

\* Hospitals regularly publish quality outcomes (e.g. length of stay, readmission rates, infection rates) in a national database only accessible to insurers and government agencies. These outcomes are among the most relevant levers to negotiate contracts with insurers.

**Figure 2:** Productisation and servitisation as main drivers of hospital management



Source: Authors' own analysis

implementing IT-solutions aimed at data gathering and processing to facilitate fact-based management decisions.

### Managing hospitals: productisation and servitisation

The paradigm for hospital management centred on costs, volume and quality (see Figure 1) has highlighted possible moves that hospitals need to take to tackle the consequences of health care reform. However, in addition to costs, quality, and volume, insurance prices also impact on market dynamics through patients' freedom of choice. As explained by Brabers et al.,<sup>†</sup> competition among insurers is based more on prices rather than quality.

The magnitude of hospitals' challenges – based on the simultaneous effect of costs, quality, volume and prices – motivates us to broaden our analysis by looking at the overall trends shaping their strategic action in the health care market. As the main driver of medical treatments, Dutch hospitals are now squeezed between two extremely different tendencies (see Figure 2). On the one side, the implementation of DOTs has led them to handle medical services as products with a fixed price (i.e. 'productisation') bringing about data processing and reimbursement procedures from insurers. The codification of treatments into DOTs is leading to the

standardisation of hospital care where the relationship between hospitals and insurers tends to be defined according to the yearly patient volume rather than costs and quality levels.<sup>‡</sup> On the other side, hospitals need to follow a strategy of delivering treatments that are pre-defined by DOTs (i.e. products) as patient-centric services to meet patients' expectations in terms of quality (e.g. safety, patient experience, clinical outcomes, waiting times) (i.e. servitisation). This also allows hospitals to increase their rating on ad hoc supply-side Internet platforms.<sup>†</sup> As a consequence, publicly available quality outcome results increase their importance in the competitive health care market by enabling patient choice in terms of both insurance prices and the quality of services.

Some main consequences will affect hospitals' business in the short-, medium- and long- term. In the short-term, hospitals will need to grasp opportunities within reimbursement policies – regardless of incentives to merge or change their patient mix. To do so, hospitals will focus on more accurate planning of yearly volumes for each disease, volume increases, or remuneratively more risky treatments.

<sup>†</sup> Kiesbeter ([www.kiesbeter.nl](http://www.kiesbeter.nl)) was launched and financed by the Ministry of Health, Welfare and Sport. It aggregates data and information including the costs of treatments and provides a list of general quality measures (e.g. communication with doctors and accessibility to medical information), illness-specific quality measures (e.g. methodologies of treatment), and waiting times per department.

Moreover, they will need to streamline internal processes with IT solutions to raise costs transparency and monitoring. However, we believe that these solutions will incentivise cooperation once hospitals' Boards address intra-department cooperation as an asset. Thereafter, to take informed and data-driven decisions, hospitals will be asked to invest in collecting relevant data and mapping them according to the current reimbursement procedures (i.e. transparency). Once data is available, predictive analytics<sup>¶</sup> will drive forecasting of the impact of market trends (e.g. progressing diseases, new competitors) on hospital business to develop new market strategies. Data analytics might also help with negotiating contracts with insurers to maximise profits.

“hospitals will be forced to increase the quality of services”

Furthermore, hospital management will need to build trust with patients by providing the best quality medical services and making this information available to the public. New services will require better care coordination strategies, the identification of new protocols for high risk patients and providing patients with educational resources through online portals. Ultimately, better cost monitoring and engagement in quality improvement programmes at national level will lead then to the development of best practices to balance opportunities in the product and service markets.

In the medium term, hospitals will be forced to change their business model significantly. Extending Christensen's (2009) thesis on North American hospitals<sup>¶</sup> to the Dutch context, we argue that disrupting the standard hospital business model might also

unlock significant potential for Dutch hospital care providers. The pressure on volume, quality and cost levers will make hospitals aware of being unable to reach both high volumes and levels of specialisation within a wide portfolio of complex treatments. Accordingly, it is most likely that care providers would be incentivised to split either into general or value-adding hospitals, which will then merge with other general and value-adding ones to widen their catchment area and experience significant economies of scale and scope. Volumes (and consequently, in theory, higher quality standards) will rise in the short-term, increasing hospitals' bargaining power against insurers in the negotiation process.

In the long-term, it is highly likely that the best quality performing hospitals will benefit from insurers' incentives as already seen in the US value-based purchasing programme.<sup>12</sup> In fact, the delivery of health care services is being increasingly perceived as a process of value creation for both patients and care providers. Accordingly, hospitals aim to generate value not only to fuel their own and the stakeholders' business but also to provide patients with high quality services. According to Porter,<sup>13</sup> value commonly refers to the output achieved relative to the cost incurred. In health care, value is defined as the patient health outcomes achieved (e.g. quality of services, safety) per monetary unit spent. It is likely that value will be measured in terms of both volume (e.g. number of insured patients treated yearly), quality (e.g. degree of effectiveness of health care service) and costs (e.g. cost per patient treated) and linked to a quantitative analysis of economic and financial flows within the value network (e.g. amount of insurers' reimbursements, hospitals' balance sheets, investments plans) or a qualitative assessment of medical services (e.g. patients satisfaction, readmissions rates).

## Conclusions

This article has looked at the latest Dutch health care reforms to highlight the main challenges of increased competition now driving hospitals' business. Specifically, we have focused on hospitals' relationships

with insurers and patients to elaborate on hospitals' strategic challenges and opportunities.

Dutch hospitals' business models rely on three main variables: volume, costs and quality. According to these levers, hospitals set yearly volumes with insurers, as well as allocate economic and medical resources to improve medical procedures and protocols, and ultimately aim to achieve high margins and quality standards. We forecast that from the short to medium and long run, hospitals will gradually restructure their business model. Throughout this long-lasting process, the relationship between hospitals and insurers will change, increasingly leading hospitals to view their activities as products for streamlining cost-data processing and reimbursement procedures. This productisation of activities will be progressively matched to the delivery of patient-centric services. In fact, the relationship between hospitals and patients will be driven by patients' expectations in terms of quality, safety, and experience of care. As a consequence, services that are more patient-centric will most likely drive value creation for both hospitals and patients.

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# NEW PUBLICATIONS

## The changing national role in health system governance. A case-based study of 11 European countries and Australia

**Edited by:** E Jakubowski and RB Saltman

**Copenhagen:** World Health Organization 2013 (acting as the host organisation for, and secretariat of, the European Observatory on Health Systems and Policies). Observatory Studies Series No. 29.

**Number of pages:** xxii + 74 pages

**ISBN:** 978 92 890 0003 1

**Freely available online at:** [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/187206/The-Changing-National-Role-in-Health-System-Governance.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/187206/The-Changing-National-Role-in-Health-System-Governance.pdf)

How do national governments currently view their responsibilities for directing health care systems? Are governments increasing or decreasing their role in both the design and supervision of particular governance activities?



This volume seeks to answer these questions and to provide an overview of recent changes in the role that national governments play in governing their health systems. Assessments from twelve countries focus on efforts to reconfigure responsibilities for health policy, regulation and management; the resultant policy priorities; and the

initial impact. One core objective for the extension of central government authority has been better alignment of sub-national health administrations and other health actors towards common strategies, visions and national objectives. These new approaches also seek better targeting of increasingly constrained human and financial resources.

### Contents:

Foreword; Acknowledgements; List of tables and figures; Abbreviations; Executive summary; Introduction; Part I: Comparative governance themes and issues - Governance overview, Summarising key themes, Additional issues; Part II: Country governance profiles – Australia, Denmark, England, Finland, France, Germany, Italy, Netherlands, Norway, Spain, Sweden, Switzerland; References.

## Successes and Failures of Health Policy in Europe: Four decades of divergent trends and converging challenges

**Edited by:** J Mackenbach and M McKee

**Open University Press:** European Observatory on Health Systems and Policies Series, 2013

**Number of pages:** 408

**ISBN:** 978 03 352 4751 6

**Available for purchase at:** <http://mcgraw-hill.co.uk/html/0335247512.html>

In the last 40 years the health of Europeans overall has improved markedly yet progress has been very uneven from country to country. This new book considers the impact health policy has had on population health in Europe. It asks key questions about mortality trends and health policy activity, such as: i) Do between-country differences in rates of smoking-related diseases reflect differences in tobacco-control policies? ii) What would be a country's health gain if it implemented the policies of the best-performing country? And iii) Which social, economic and political

factors influence a country's success in health policy?



This book fills an important gap by offering a comparative analysis of the successes and failures of health policy in different European countries. In doing so it helps readers identify best practices in health improvement from which other countries can learn. The book explores how policy impact can be quantified and identifies which aspects of policy we can learn from when tackling the determinants of

health in our populations. Written by experts and based on the latest evidence-based research, this volume is aimed at policy-makers and those working in health care such as professionals, researchers and students alike.

### Contents:

Introduction; Tobacco; Alcohol; Food and Nutrition; Fertility, Pregnancy and Childbirth; Child Health; Infectious Disease; Hypertension; Cancer Screening; Mental Health; Road Traffic Injuries; Air Pollution; Comparative Analysis of National Health Policies; Past and Future Health Gains; The Will and the Means to Implement Health Policies; Conditions for Successful Health Policies; Conclusions.

# NEWS

## International

### 66th World Health Assembly

The 66th World Health Assembly (WHA) was held in Geneva from 20 to 28 May. Addressing participants at the closing ceremony, World Health Organization (WHO) Director-General Dr Margaret Chan thanked delegates for their efficiency and productivity during the debates. At the same time, she sounded an alarm on a new threat that she warned requires urgent international attention. “Looking at the overall global situation, my greatest concern right now is the novel coronavirus. We understand too little about this virus when viewed against the magnitude of its potential threat. Any new disease that is emerging faster than our understanding is never under control,” Dr Chan said. “These are alarm bells and we must respond. The novel coronavirus is not a problem that any single affected country can keep to itself or manage all by itself. The novel coronavirus is a threat to the entire world.”

The President of the 66th World Health Assembly, Dr Shigeru Omi, spoke after Dr Chan. “Together we achieved a lot,” said Dr Omi. “One of the key outcomes of this Assembly is the universal health coverage that is now recognised as the key concept to underpin the work of global health in many years to come.”

In all, 24 resolutions and five decisions were adopted by around 2000 delegates representing the WHO’s Member States. Some of these actions include:

#### **Disability**

A resolution on disability which urges Member States to implement as States Parties the Convention on the Rights of Persons with Disabilities; and develop national action plans and improve data collection. Member States are encouraged to ensure that all mainstream health services are inclusive of people with disabilities; provide more support to informal caregivers, and ensure that people with disabilities have access to services

that help them acquire or restore skills and functional abilities as early as possible.

The resolution also requests the Director-General to provide support to Member States in implementing the recommendations of the World Report on Disability; to mainstream the health needs of children and adults with disabilities in WHO’s technical work; to ensure that WHO itself is inclusive of people with disabilities; and to support the High-Level Meeting of the UN General Assembly in September 2013.

#### **Mental Health Action Plan: 2013–2020**

A resolution on WHO’s comprehensive mental health action plan 2013–2020 sets four major objectives: strengthen effective leadership and governance for mental health; provide comprehensive, integrated and responsive mental health and social care services in community-based settings; implement strategies for promotion and prevention in mental health, and strengthen information systems, evidence and research for mental health. The plan sets important new directions for mental health, including a central role for provision of community-based care and a greater emphasis on human rights. It also emphasises the empowerment of people with mental health problems and the need to develop strong civil society and health promotion and prevention activities. The document proposes indicators and targets such as a 20% increase in service coverage for severe mental disorders and a 10% reduction of suicide rate in countries by 2020 that can be used to evaluate levels of implementation, progress and impact.

#### **e-Health**

A resolution on e-Health standardisation and interoperability notes the importance of standardised, accurate, timely data and health information to the functioning of health systems and services, while also highlighting that the security of this information, and privacy of personal clinical data, must be protected. The evaluation of information and communications technologies in health interventions was also noted.

The resolution further emphasises that health-related, global, top-level domain names, (including “.health”) should be operated in a way that protects public health and is consistent with global public

health objectives. Names and acronyms of intergovernmental organisations, including WHO, should also be protected.

#### **Universal health coverage**

The WHA adopted a resolution on the importance of educating health workers as part of universal health coverage. Member States expressed their ongoing commitment to ensuring that all people obtain the health services they need without the risk of financial ruin. They emphasised that universal health coverage is not just about health financing but requires strong health systems to provide a range of quality, affordable services at all levels of care.

Member States expressed strong support for WHO’s action plan and reiterated their call for a monitoring framework to help them to track progress towards universal health coverage. Many delegates expressed support that universal health coverage should feature in the post-2015 development agenda.

Providing access to health services for people with non-communicable diseases (NCDs) was the subject of a side event organised by the Ministry of Health of Chile and WHO headquarters. It was suggested that three different dimensions of fairness should be considered when providing access to health services: equality in coverage, prioritisation of the most vulnerable, and prioritization for what gives greatest benefit at low cost. Discussions covered how poorer countries can ensure scarce resources are invested in ethics, the importance of sensitising patients, and the need for legal frameworks to ensure that ethical considerations are taken into account.

#### **Non-communicable Diseases**

The WHA approved a resolution endorsing the WHO global action plan for the prevention and control of NCDs 2013–2020. The action plan comprises a set of actions which, when performed collectively by Member States, United Nations organisations, other international partners and WHO, is intended to set the world on a new course to achieve nine globally agreed targets for NCDs, including a reduction in premature mortality from NCDs of 25% by 2025. The action plan also contains a monitoring framework, including 25 indicators to track

mortality and morbidity; assess progress in addressing risk factors, and evaluate the implementation of national strategies and plans. From the WHO European Region, the delegation of the Russian Federation expressed strong support for the resolution

WHO is now requested to develop draft terms of reference for a global coordination mechanism through a consultative process culminating in a formal meeting of Member States in November 2013. WHO was also tasked to provide technical support to Member States and to develop a limited set of action plan indicators to inform on the progress made with the implementation of the action plan in 2016, 2018 and 2021.

### *Health in the post-2015 global development agenda*

The Secretariat reported substantial progress towards the Millennium Development Goals (MDG) and their targets – notably in reducing child and maternal mortality, improving nutrition, and reducing morbidity and mortality due to HIV infection, tuberculosis and malaria. Progress in many countries that have the highest rates of mortality has accelerated in recent years, although large gaps persist among and within countries. The Assembly approved a resolution urging Member States to sustain and accelerate efforts towards the achievement of the health-related MDGs and to ensure that health is central to the post-2015 development agenda. The resolution calls on the Director-General to ensure that WHO consultations on the issue are inclusive and open to all regions, and to advocate for resources to support acceleration of the health-related MDG targets by 2015. WHO is requested to include discussion of health in the post-2015 development agenda in the 2013 meetings of the WHO regional committees and to present a report to the sixty-seventh World Health Assembly. The resolution was co-sponsored by the European Union and Switzerland.

### *Social determinants of health*

The Secretariat noted improved performance in the four areas highlighted in a resolution on the outcome of the World Conference on Social Determinants of Health: consideration of social determinants of health in the assessment of global needs for health; support to

Member States in implementing the Rio Political Declaration on Social Determinants of Health; work across the United Nations system on advocacy, research, capacity-building and direct technical support; and, advocating the importance of integrating social determinants of health perspectives into forthcoming United Nations and other high-level meetings related to health and/or social development.

### **More information on the World Health**

**Assembly at:** <http://www.who.int/mediacentre/events/2013/wha66/en/index.html>

### **Oslo conference on health systems and the economic crisis**

Four years after Norway hosted the high-level meeting “Health in times of global economic crisis: implications for the WHO European Region”, the WHO brought together on 17–18 April in Oslo senior policy-makers from ministries of health, finance and health insurance funds, as well as patient organisations, international partners and researchers, to review the situation across the European Region. They examined the impact of the global economic crisis on health and health systems, discussed various policy responses and shared lessons learned. Broad agreement was reached on the policy responses needed to address the health impact of the economic crisis at the high-level meeting.

Despite a macroeconomic outlook with very low growth for most of the WHO European Region, resulting in restricted fiscal space and limitations on health spending, governments can still choose where to allocate funds. Participants said that the focus should be on areas and services that encourage economic growth and that reinforce solidarity and equity (such as health, unemployment, social benefits, and education). Experts agreed that fiscal balance has to be restored in the medium term, but this does not necessarily require cuts in health and social spending during the crisis, when needs for these services rise.

The evidence available indicates that the crisis has had a negative impact on important health outcomes and

health determinants, and (although further scientific and policy analysis is needed) health ministers must be part of the negotiations on macroeconomic policies, social policies and even austerity measures.

### **Crisis as opportunity for health reform**

Most countries have used the crisis as an opportunity to implement overdue reforms in health policy, aimed at increasing efficiency while preserving equity and protecting the poor and vulnerable. Participants identified key elements of these reforms, including:

- focusing on disease prevention and health promotion;
- strengthening primary health care to improve service delivery;
- updating pharmaceutical policies to focus on cost-effectiveness to reduce inefficiencies and increase the use of generic medicines; and
- streamlining benefit packages.

Despite pressure to introduce and increase user fees in many countries, participants labelled them the “sledgehammer” of health financing reform: both inefficient and inequitable. They agreed that other instruments should be used, even in crises and even when savings are made at a slower pace.

The WHO Regional Office for Europe will consult with Member States to develop a series of policy recommendations based on the discussions, to be submitted for endorsement to the sixty-third session of the WHO Regional Committee for Europe in September 2013.

**More information at:** <http://www.euro.who.int/en/what-we-do/event/oslo-conference-on-health-systems-and-the-economic-crisis>

### **European Medicines Agency publishes guideline on clinical investigation of medicines for depression**

On 30 May the European Medicines Agency published a guideline on the clinical investigation of medicines for the treatment of depression. This guideline is a revision of a previous version, which came into operation in October 2002. It went through



a six-month public consultation before being adopted by the Agency's Committee for Medicinal Products for Human Use (CHMP).

This guideline focuses on antidepressants under development specifically for major depressive disorder (MDD). While many treatment options are available for patients with MDD, there is a need for medicines with a better efficacy profile, including a faster onset of action, higher rates of response and remission, and an improved safety profile.

Up to a third of patients with MDD only respond partially to treatment and up to 20% are considered treatment-resistant. The revised guideline addresses the specific issues related to these patients and provides recommendations on how to investigate medicines in these two patient populations.

The revision clarifies the requirements for long-term efficacy data and advises on the most appropriate study designs to obtain them. It outlines the fact that the randomised withdrawal study is the design of choice to show maintenance of effect during an episode of depression.

The revised guideline also provides more guidance on the requirements for clinical trials in children and adolescents. The document stipulates that complete extrapolation of adult efficacy and safety data is not considered appropriate. As the clinical characteristics may vary between children and adolescents, separate studies are recommended. The revised guideline also provides specific recommendations with regards to clinical evaluation in older people. It will come into effect on 1 December 2013.

**The guideline is available at:** <http://tinyurl.com/kc7o7yp>

## Country news

### Ireland set to become second country in the world to introduce plain pack cigarettes

On 28 May, in advance of World No Tobacco Day "Ban tobacco advertising, promotion and sponsorship", Irish Health Minister James Reilly stated that "it is with great pleasure that I announce that I have received government approval to begin the process of introducing standardised/plain packaging of tobacco products in Ireland. While many arguments will be made against such an introduction, I am confident that this legislation will be justified and supported purely by the fact that it will save lives".

"The introduction of standardised packaging will remove the final way for tobacco companies to promote their deadly product in Ireland." the Minister said. Cigarette packets will no longer be a mobile advertisement for the tobacco industry. Research has shown that packaging has been used effectively to reassure consumers about the risks of smoking for example with the use of the words "mild" or "light" on packs in the past. Research has also shown that imagery and colours are also used to influence consumers. Pack shape and design are also key measures with packets available that resemble a lipstick box.

Over 5,200 people die every year from tobacco related diseases in Ireland – one in two of all smokers will die from their addiction. To replace the smokers who quit, the tobacco industry needs to recruit fifty new smokers in Ireland every day just to maintain smoking rates at their current level. In a survey 78% of smokers said they started smoking under the age of 18.

Standardised packaging of tobacco products will remove all form of branding – trademarks, logos, colours and graphics. The brand name would be presented in a uniform typeface for all brands and the packs would all be in one plain neutral colour.

There is strong evidence that standardised packaging will:

- Increase the effectiveness of health warnings;

- Reduce false health beliefs about cigarettes; and
- Reduce brand appeal particularly among youth and young adults.

Minister Reilly concluded "plain packaging is one of a number of measures that are required to effectively denormalise smoking in our society. As such this initiative should not be looked at in isolation. Education and awareness, cessation services and extending the smoking ban to other areas are just some of the other measures which I am currently progressing."

**An informative video by Cancer Research UK on the power that cigarette packaging has on children is available online at:** [www.youtube.com/watch?v=c\\_z-4S8iicc](http://www.youtube.com/watch?v=c_z-4S8iicc)

### European Health Insurance Card: Commission expresses concerns about refusals by Spanish public hospitals to recognise EHIC

The European Health Insurance Card (EHIC) certifies that the holder has the right to receive emergency health care during a temporary stay in any EU country, as well as in Switzerland, Liechtenstein, Norway and Iceland. This right is guaranteed to all persons who are covered by the public health care systems of these countries. The EHIC holder has the right to receive necessary treatment in the host Member State's public health care system on the same terms and at the same cost as nationals of the state concerned.

Where citizens require health care, but do not have an EHIC, or do not have it with them, they can also request a Provisional Replacement Certificate (PRC) from the relevant health body in their home Member State and this can usually be faxed or e-mailed to them. The PRC will show that they are entitled to benefit in the host country from the right to necessary healthcare given by EU law and can be used in the same way as the EHIC. The aim is always to prevent citizens having to return home before the end of the planned duration of stay.

However, on 30 May the European Commission requested information from Spain about complaints that Spanish hospitals providing public health care are refusing to recognise the European Health

Insurance Card (EHIC). The Commission is concerned that Spain might be failing to fulfil its obligations under EU law to provide emergency health care to temporary visitors from other Member States on the same terms and conditions as are available to Spanish nationals under the public health care scheme.

The Commission's request for information follows an increasing number of complaints it has received concerning hospitals providing public healthcare services, mainly in tourist areas of Spain, which refuse to treat citizens on the basis of their EHIC and instead request a travel insurance policy and credit card details. Public health care is generally free of charge in Spain and the EHIC entitles its holder to be treated on the same terms as Spanish nationals. However, in some cases, citizens have been erroneously informed that their European Health Insurance Card is not valid if they have travel insurance. Other patients believed they were being treated on the basis of their EHIC, but later found out that their travel insurance company had been sent a bill for treatment.

The actions of the hospitals concerned means that EHIC holders are being denied access to public health care on the same terms as Spanish nationals, and are being offered only private treatment. The much higher cost of such private treatment is being passed on to the travel insurance companies or, increasingly, is being billed to the citizens directly. The travel insurance industry has underlined to the European Commission that in most cases travel insurance will not cover private health care.

The European Commission has been in contact with the Spanish authorities about this issue since 2010. The Spanish authorities have indicated to the Commission that they have taken certain actions to tackle the issue. Nonetheless, the Commission continues to receive complaints about this practice by hospitals providing public healthcare services in tourist areas. The Commission's request for information takes the form of a letter of formal notice, the first step in EU infringement procedures. Spain has now two months to respond to the concerns expressed by the Commission.

### ***Scotland wins court case on minimum pricing of alcohol***

The Scottish High Court ruled on 3 May that the government has the right to introduce a legally binding minimum price on alcohol, the first of its kind in the EU. The spirits industry says it will appeal the court ruling. The court refused the petition by the Scotch Whisky Association, Spirits Europe and wine producer association CEEV, holding that the minimum pricing act was not outside the legislative competence of the Scottish Parliament. The court also stated that the proposed order setting a minimum price per unit of alcohol was within devolved competence and within the powers of Scottish ministers.

Scottish Health Secretary Alex Neil welcomed the decision, saying: "We have always believed minimum unit pricing is the right thing to do to tackle Scotland's problematic relationship with alcohol. Minimum unit pricing will target cheap alcohol relative to strength that is favoured by hazardous and harmful drinkers and which contributes to much of the alcohol-related harm we see in Scotland." He added that "we now look forward to being able to implement minimum unit pricing and making that transformational change in Scotland's relationship with alcohol."

### ***Appealing decision***

In May 2012, the Scottish Parliament passed legislation to introduce minimum pricing for alcohol. It was originally due to come into force in Scotland in 2013. This was set at £0.50 (€0.63) per unit of alcohol. However, it has been put on hold as the measure was legally challenged by the Scottish Whisky Association and the European wine and spirits producers. The alcohol industry said it would appeal the court decision.

"We are disappointed by this decision and will appeal it, believing that it contravenes not only 30 years of European case law on minimum unit pricing but also the views expressed by the European Commission and 11 Member States," said Paul Skehan, director general of Spirits Europe, a trade group. Skehan added that the spirits industry was confident that, on appeal, the measure will be proven illegal and contrary to the rules underpinning the single European market. Not only does the

industry believe the policy to be illegal, it also expects it to be ineffective in tackling alcohol misuse, penalise responsible drinkers and put more pressure on household budgets and discriminate companies within the market.

In contrast, health campaigners applauded the court ruling. The European Public Health Alliance (EPHA) said minimum pricing would reduce binge drinking in Scotland, and have a positive impact on the region's health and crime levels. "This move by the Scottish high court is a recognition of the baseless – and undemocratic – attempt by the alcohol industry to prevent an elected government from protecting the health of its population," EPHA Secretary-General Monika Kosińska said. "It is heartening to see the Scottish government prevail in this landmark case, and hopefully the alcohol industry will refrain from wasting more taxpayers money in delaying this process further," she added.

**More information on minimum pricing in Scotland at:** <http://www.scotland.gov.uk/Topics/Health/Services/Alcohol/minimum-pricing>

### **France: Sunshine Act Implemented**

The decree implementing French Law No. 2011–2012 on the Strengthening of Health Protection for Medicinal and Health Products (the decree), known as the Loi Bertrand or the French Sunshine Act, was issued on 21 May 2013. Its aim is to prevent conflict of interests between stakeholders by specifying the scope of disclosure obligations, which affect all agreements concluded between health care professionals and companies, as well as every benefit in kind or in cash exceeding €10.

The decree affects a broad range of health care companies, including any company manufacturing or distributing products listed in Article L. 5311–1 of the French Code of Public Health. In addition to pharmaceuticals these include products such as contraceptives, medical devices, medical software, cell products, organs or tissues and biomaterials. The disclosure obligation affects any agreement concluded between these companies and health care professionals including research and

development contracts, e.g., clinical trials and observational studies; hospitality at conferences; other consultancy agreements, e.g., speaking positions or positions on advisory boards, as well as any benefit in cash or in kind provided to French health care professionals exceeding €10, inclusive of all taxes. The only exceptions to the broad scope of this disclosure obligation are commercial sales agreements of goods and services concluded between companies and health care professionals and agreements with companies manufacturing or distributing non-corrective contact lenses, cosmetic or tattoo products, as long as these do not relate to the conduct of health and safety work assessments and biomedical or observation research on these products. According to the Sunshine Act, failure to fulfill the disclosure obligation is subject to penalties, including a fine of up to €45,000 and additional sanctions.

The Sunshine Act provides that agreements concluded between companies manufacturing or distributing health care products and French health care professionals must be submitted to the board of the relevant medical profession. According to the decree, the relevant board then has two months to issue an opinion on agreements aimed at promoting scientific research and one month for all other agreements. If no reply is received from the board within this period, the opinion will be deemed to be favourable. All unfavourable opinions will be addressed by the relevant board to the contracting company, which will pass them on to the health care professionals. The relevant board must be told of the implementation of the agreement within a month of giving its opinion. The decree does not, however, specify the content of the information that the company must provide regarding the implementation.

According to the decree, a free public website will be launched to provide a platform for information subject to the disclosure obligation. A public authority will be given responsibility for the website. The information regarding agreements should be passed on to this responsible authority, in French, within 15 days of the signing of each agreement. The information on benefits granted and agreements entered into should be provided to the responsible authority no later than 1 August for benefits

granted and agreements entered into during the first half of the year and no later than 1 February for those granted and entered into during the second half of the preceding year. The authority will publish this information no later than 1 October and 1 April respectively.

Welcoming the agreement, Minister of Social Affairs and Health Marisol Touraine hoped that the new Act would ensure the greatest possible level of transparency within the existing legal framework, with all relevant information made public.

**More information on the act (in French) is available at:** <http://tinyurl.com/mttf56m>

### **Netherlands: Working group to review use of advance directives by law on euthanasia**

Euthanasia was reported by the Dutch National Statistics office to account for 2.8% of all deaths in the Netherlands in 2012. The Royal Dutch Medical Association (KNMG) met with Health Minister Edith Schippers on 16 May to discuss the possibility of limiting the scope of the law on euthanasia that has been in place since 2002. Euthanasia is only legal under strict conditions. For example, the patient must be 'suffering unbearably' and the doctor must be convinced the patient is making an informed choice. The opinion of a second doctor is also required.

A large proportion of doctors believe that euthanasia should not be used in cases where people with serious dementia are no longer able to communicate, even if they have previously signed a request for euthanasia. Currently the law states that doctors can act on an earlier advanced directive once a patient becomes incompetent. Now some doctors are calling for euthanasia to be restricted to cases where patients can confirm — verbally or otherwise — they want to put an end to their lives.

The medical profession remains divided on the issue, with some doctors still in favour of the full application of the law. As a general practitioner cited by the Dutch newspaper *Volkskrant* stated, "in respecting his or her will, we pay homage to a patient who was once alive, and not to

a human being who no longer knows if he or she exists."

A working group including the KNMG, the ministries of health and justice, and former health minister Els Borst who introduced the 2002 law, will now work to provide clarity under the present law on the validity of advanced directives for patients with dementia. It is hoped that it will report within 6 months.

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