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► Perspectives on the Professional Qualifications Directive

- Regulator's perspective: General Medical Council
- Physicians' perspective: Royal College of Physicians
- Nurses' perspective: Royal College of Nursing
- Pay-for-Performance does not always pay
- Health care fraud and corruption in the EU
- Belgium: Cross-border shopping for medicines
- Norway: Monitoring provider fraud
- Scotland: Counter fraud strategy
- Out-of-pocket spending in the FSU



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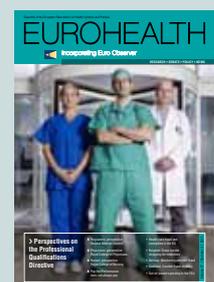
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Welcome to the new design of Eurohealth. In this issue, we launch a new look that we hope you find more modern and easier to navigate. The redesign consists mainly of restructuring the content under new section headings including: Observer, International, Health Systems and Policies, and Monitor, and providing pull-quotes within the articles. We welcome your feedback on the improvements; so if you'd like to be in touch please email the editors.

The first section, draws attention to the integration of Euro **Observer** within this journal. In this issue, we provide perspectives from different stakeholders on the June 2011 Green Paper from the European Commission on Directive 2005/36/EC on the recognition of professional qualifications. Niall Dickson at the General Medical Council (GMC) represents the regulator perspective, while Andrew Goddard at the Royal College of Physicians (RCP) and Tom Keighley and Susan Williams at the Royal College of Nurses (RCN), represent the physician and nurse perspectives respectively. These articles originate from presentations at a roundtable meeting held at the RCP in London. We welcome contributions from patient groups and also look forward to presenting the Commission perspective on their legislative proposal in the first issue of 2012.

The **International** section contains articles on topics with relevance to countries beyond Europe's borders. An overview article sets the scene by defining health care fraud and corruption and identifying how health care systems may be affected. Country case studies flag key issues of national relevance. Maggie Worsfold discusses the Scottish National Health Service's clear strategy centred around deterring, detecting, disabling and dealing with fraud through its Counter Fraud Services Agency. In Norway, Leidalen et al. provide an example of how provider fraud has been detected through annual monitoring by the Norwegian Health Economics Administration. Furthermore, Depraetere and Cylus identify motivations for cross-border purchasing of medicines between Belgium and the Netherlands.

In the **Health Systems and Policies** section, the data collection methods for determining out-of-pocket spending are identified in twelve countries of the Former Soviet Union. The authors, Markova and Stanley discuss the advantages and disadvantages of demand-side, supply-side and amalgamated approaches. In addition, Katharina Janus discusses the theoretical arguments and conflicting motivations and incentives to consider when looking at performance management in health care.

In our final section, **Monitor**, we continue to highlight new publications, along with a streamlined news section.

As before, we are open to submissions. Because the aim of *Eurohealth* is to bridge the gap between the scientific community and the policy-making community, we welcome evidence-based articles, debates, and discussions on contemporary health system and health policy issues. Authors' guidelines are available at <http://tinyurl.com/eurohealth>.

Sherry Merkur, Editor

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THE FREE MOVEMENT OF PROFESSIONALS – A UK REGULATOR'S PERSPECTIVE

By: Niall Dickson

Summary: The Recognition of Professional Qualifications Directive (2005/36/EC) guarantees the free movement of doctors in the European Economic Area. It requires regulators, such as the General Medical Council, to automatically recognise other European qualifications. Although there are significant benefits to high-levels of mobility, and as a result the UK has received many dedicated professionals, it can present some challenges to patient safety. This article looks at some of the regulatory gaps with the Directive and outlines a UK regulator's perspective on the forthcoming legislative review.

Key words: *General Medical Council, Patient Safety, Free Movement of Professionals*

Background

For many years the UK has been a net importer of doctors. Currently, more than a third of registered doctors qualified outside the UK. In the European Economic Area (EEA), the single market and the Recognition of Professional Qualifications Directive (hereafter the "Directive") enable doctors and other professionals to move freely around Europe to pursue their profession.

There are significant benefits to such mobility. Health care in the UK has benefited greatly from the thousands of dedicated and skilled professionals who have provided care and treatment over the last fifty years. Indeed doctors trained abroad have been essential for meeting significant shortfalls in the National Health Service (NHS) – given

the numbers involved the service could not have been sustained without their contribution^{1, 2}.

However, without adequate safeguards, mobility is a risk to patient safety. In recent years, several cases involving doctors and other health care professionals from the EEA have exposed a number of regulatory gaps linked to the free movement of professionals.

The European Commission (EC) is currently revising the Directive and plans to bring forward new legislation for the European Parliament and Council by the end of 2011. The review presents an important opportunity to address the inadequacies of the current arrangements in protecting patients.

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“
openness and
transparency are
essential to
ensuring patient
safety and
effective medical
regulation

Doctor mobility in the EU

According to the EC, since 2007, 85,000 EEA professionals have been able to have their qualifications recognised¹ under the Directive. Of these, more than 27,000 were doctors², making medicine one of the most mobile professions in Europe.

Under the provisions of the Directive, the vast majority of European doctors are able to have their qualifications automatically recognised when they move to another Member State. This is the result of legislation dating from the 1970's which established minimum training requirements for primary medical and specialist qualifications. As long as a doctor has a qualification listed in the Directive, he or she benefits from automatic recognition and is entitled to pursue the profession elsewhere in Europe.

The GMC's role in the process

The General Medical Council (GMC) is the regulator for doctors in the UK and the “competent authority” for the recognition and registration of medical qualifications. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We control entry to the medical register, set and assure standards for medical education throughout a doctor's career, and have a responsibility to ensure that only doctors that are safe and fit to practise gain access to the profession.

The Directive presents a number of challenges for the GMC and other UK

health regulators in its current form. It assumes all medical qualifications are equivalent and meet some minimum standards, but the reality is that education and training, ethical standards, as well as the health systems in which doctors train and practice, differ markedly across the Union.

This places regulators in a difficult position. On the one hand, we have a statutory responsibility to protect the public. On the other, under automatic recognition, we are required to accept a doctor's qualification at face value, without being able to assure ourselves of the education, training or practical experience that underpin it and without knowing whether the professional is adequately prepared for practice in the UK.

Reviewing the Directive

The Commission has committed itself to a legislative review of the Directive and, in June 2011, published a Green Paper³ outlining its plans. Although a number of the proposals highlighted in the Paper acknowledge the importance of patient safety, the overarching aim of the Commission's review is to encourage more mobility and make it easier for professionals to work in other EU countries.

Our view is that patient safety should not be compromised or undermined in any way to meet the objective of increased mobility. The European Single Market needs to encourage the free movement of professionals but it must also protect the public.

European Professional Cards

The EC has proposed the introduction of a European professional card to facilitate mobility. It has been suggested that the card would offer an immediate entry gate for professionals wishing to practise in another Member State. At first sight a card may seem like a useful device but it carries serious risks and its value is questionable.

The high number of EEA qualified doctors coming to and already practising in the

UK – in 2010 we granted registration to over 2,900 doctors under the provisions of the Directive – does not suggest that there are any problems in doctors moving to this country. This in turn begs the question as to what problem the professional card is required to solve. Instead, it may create an additional bureaucratic and financial barrier for the professional and restrict the already limited identity and document checks competent authorities are allowed to undertake on migrating European doctors

There is also a danger that a card would provide false assurance about the doctor's fitness to practise if a professional was able to register on the basis of information held on a card alone. It could also create confusion among employers and patients who may trust the status of a doctor based on the card they hold. And of course, if not linked to a regularly updated register, it could quickly become out of date. For these reasons the GMC does not issue cards or paper copies of doctors' licences – and instead we encourage employers and patients to check the live online GMC register of doctors.

As a net-importer of doctors, our experience is that professionals often face delays in having their qualifications recognised as a result of poor communication between the home and host Member States. We believe that a more efficient and safer way of facilitating mobility would be to improve the exchange of information between competent authorities. Current practice could be improved either through a more comprehensive use of the Internal Market Information (IMI) system, a secure online application that allows national, regional and local authorities to communicate quickly and easily with their counterparts abroad, or by encouraging authorities across the EEA to make web-based searchable lists of registration and disciplinary information freely available to the public.

The Directive's review should not create unnecessary and ineffectual bureaucracy, particularly if it does not add value to mobility or patient safety. A wide variety of organisations and individuals have expressed concerns with the plans to

introduce a European professional card. We believe it is time for the Commission to consider more effective and safe alternatives.

Proactive information sharing

Although the current Directive includes a requirement to exchange information about the good standing of applicants at the point of registration, there is no requirement on regulators to proactively disclose information about the actions they take or have taken on a professional's fitness to practise. Unfortunately this has led to situations where doctors have been disciplined or suspended in one Member State, while continuing to practise in another. This poses a serious risk to patient safety.

“we believe an urgent audit of medical qualifications needs to take place

Although this information is proactively shared and publicly available in the UK, other Member States are often not as transparent. Encouragingly, the Commission acknowledges the importance of proactive information sharing in its Green Paper. It suggests introducing a requirement on competent authorities to trigger an “alert” if and when a professional has been suspended from practice. This is a positive development but it needs to go further.

The alert should apply to all restrictions placed on a doctor's right to practise. Conditions, warnings and undertakings on a doctor's registration can indicate significant concerns about a particular area of practice and it is in the public interest for this information to be exchanged among competent authorities.

We appreciate that this approach to information sharing might not be shared and supported across Europe, particularly in countries where information about doctors is not already in the public domain and where national data protection rules get in the way. However, we think that openness and transparency are essential to ensuring patient safety and effective medical regulation.

The revision of the European Data Protection Directive, which is also currently underway, provides a further opportunity to improve the proactive exchange of information between Member States, particularly where it impacts on patient safety.

Language and communication

We believe that the ability of a professional to communicate effectively lies at the heart of good medical practice. International Medical Graduates in the UK are required, by law, to demonstrate that they have the necessary knowledge of the English language to practise. However the GMC is prevented from testing the language skills of doctors applying for registration from the EEA. This, in our view, is an unacceptable gap in current regulation.

The vast majority of European doctors would not come to work in the UK if they did not have a good command of English, but there is evidence that a small number lack insight and the language skills required to practise in the UK and thus they pose a risk to patients.

We are currently working with the UK government to improve this in national legislation but the language provisions in the European Directive also need to be strengthened. The legislation needs to make clear that, for health care professionals, all applicants for registration should be required to demonstrate their knowledge of the host country's language.

Although the Green Paper acknowledges the importance of language skills, it suggests limiting this to a “one-off assessment” and only for health care

professionals having direct contact with patients. Our view is that this would not adequately protect patients.

First, effective communication with colleagues and the wider health care team is just as important in making sure that patient safety is not compromised. Secondly, checking language knowledge at the point of registration should not prevent an employer satisfying themselves of an applicant's skills to perform a particular job. A professional needs to be both fit for practise, a decision for the regulator, and fit to do a particular job, a decision for an employer.

Updating the automatic recognition system

As highlighted earlier, qualifications benefit from automatic recognition on the basis that they meet the minimum training requirements. This assumes comparability of medical education across the EEA. From an administrative perspective, this makes automatic recognition relatively straight forward for both the professional and the competent authority. However, in many cases, the criteria drawn up in the 1970s no longer reflect current practices in medical education and training.

Comparability is largely based on length of training (inputs) rather than the range of competences that medical education develops (outputs). The criteria are so broad that they are of limited practical value in providing assurances about the standards of medical education and training that have been undertaken by migrant doctors and their preparedness to practise in the host country.

To remedy this, we believe an urgent audit of medical qualifications needs to take place. This would both help identify ‘content comparability’ and could be used as the basis from which to develop the minimum training requirements in terms of learning outcomes.

The Commission has identified updating the minimum training requirements as a key priority in the Green Paper but it is far from clear how it plans to carry out the review and whether it will be transparent and inclusive. This will be a crucial part

of a new Directive and it is essential that Member State representatives, regulators, professionals, and educators are invited to participate in the process.

Looking to the future

We are mindful that any new Directive will not come into force for a number of years. Once the Commission adopts its proposal, there will be extensive negotiations among European institutions which will take a number of months to complete. These will be followed by a lengthy implementation period to allow Member States to incorporate the Directive into their national legislation. In the meantime, we must look for ways to better protect patients in the UK.

In the coming months, we will be working closely with the UK government, employers and professional organisations to support doctors new to UK practice. In our first annual *The state of medical*

education and practice in the UK report⁵, we announced our intention to develop a basic induction programme. This will help doctors gain an early understanding of the ethical and professional standards they will be expected to meet, as well as familiarity with how medicine is practiced in the UK.

Ideally, we believe that all doctors should have completed the programme before they practise, whether they are trained in the UK, elsewhere in Europe or further afield, as everyone who treats patients needs to be supported to do that safely.

There is a lot at stake in this Directive. We need a valid system for professional mobility that is both effective and efficient and must protect the safety of patients. This is not easy but we are committed to working with the Commission, other regulators and the profession to deliver this.

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Health professional mobility and health systems. Evidence from 17 European countries

Edited by: M Wismar, CB Maier, IA Glinos, G Dussault, J Figueras

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Number of pages: 632

Freely available to download at: http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf

Despite increasing mobility of labour, by 2020 there will be a shortfall of one million professionals in the European Union. Health professional mobility impacts on the performance of health systems by changing the composition of the health workforce in both sending and receiving countries in addition to affecting the skill mix. However, knowledge on this topic in Europe is limited.

This new book from the Observatory considers the impact of these shortages and the role of health professional mobility. This study also serves as a follow up to the 2010 World Health Assembly which adopted the WHO Global Code of practice for the International Recruitment of Health Personnel. The Code discourages recruitment from countries with workforce

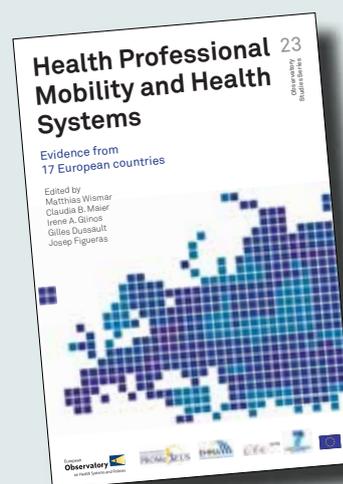
shortages and provides guidance to strengthen the workforce and health systems internationally.

The book stresses the importance of education and training, monitoring and coordination of labour market activities and

addresses the maldistribution of health professionals. The volume gives an analysis of mobility patterns and impacts of migration on health systems by exploring the following questions: What are the scale and characteristics of health professional mobility in the EU? What are the effects of EU enlargement on professional mobility? What are the motivations of the workforce? What are the positive and negative impacts on

performance of health systems from these flows? What is the policy relevance and the options/regulatory mechanisms available to countries?

Part one of the volume sums up general findings. Parts two, three and four analyse mobility by dividing countries into case studies according to their year of EU membership. Illustrations are used throughout for increased readability.



THE PROFESSIONAL QUALIFICATIONS DIRECTIVE **GREEN PAPER** – A UK PHYSICIANS' PERSPECTIVE

By: Andrew F Goddard

Summary: The recent Professional Qualifications Directive (2005/36 EC) Green Paper proposes significant changes to the Directive which will improve health professional mobility. Key amongst these changes will be: the facilitation of electronic communication between Member States regarding the qualifications and standing of doctors; recognition of smaller medical specialties; and ensuring consistency in recognition of 'qualifications' based on competence rather than time. Health professional bodies in the UK welcome the changes but remain concerned about the assessment of continuing professional development across the EU and the language skills of doctors crossing borders. Both of these need considerable attention and clarity within the Directive.

Key words: *Professional Qualifications Directive, Continuing Professional Development, Health Professional Mobility*

Background

The right of an EU citizen to work in another Member State is one of the core principles of the Single Market. The rules governing the mobility of health professionals within the EU are well defined and based on their qualifications as laid out in Directive 2005/36/EC¹. This Directive is currently under review by the European Commission (EC) with a view to modernisation². Proposed changes include: introduction of a European Professional Card, improved communication between Member States regarding information held on professionals and modernising automatic recognition. The principle underlying all

of these changes is to make recognition to allow working in another Member State simpler and faster.

EU mobility and medicine in the UK

Mobility and ease of mobility have risks in all professions but arguably medicine is unique in the scale of risk to members of the public. Such risk requires that very careful assessment should be made of a doctor's ability to practice in another Member State. Currently, the UK media is very sensitive to the issue of doctors' abilities and training given the huge public awareness of high profile cases such as those of Harold Shipman, Rodney Ledward and Daniel Ubani. It is a key

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principle of the UK National Health Service (NHS) that all patients have a right to expect their doctors to be skilled, safe and caring no matter where they have been born, trained or worked previously.

“40% of doctors registered were trained outside the UK”

The NHS has traditionally been heavily reliant on overseas doctors to support services. In 1990, 43% of doctors working in UK hospitals were trained overseas. Despite the huge increase in medical school places that occurred in the 1990s, a reduction in doctors' hours and increased service needs have resulted in an on-going reliance on international medical graduates (IMGs). Recent data from the UK regulator, the General Medical Council (GMC) show that 40% of doctors registered were trained outside the UK, and 2,900 EEA (European Economic Area) doctors were granted registration under the directive in 2010⁸.

The need for additional doctors in hospitals is highest in areas outside of London, but all large cities rely on overseas doctors in primary care. There is a huge variation in the number of vacant posts in parts of the UK and between the medical specialties. Particular hospital grades are also more dependent on such labour, such as the medical registrar grade, which has a current vacancy rate of nearly 9% in England⁴.

The mobility of UK trained doctors to work in other EU Member States is small, although there are very valuable training opportunities throughout Europe, especially in the 'craft' (procedure based) medical specialties, such as cardiology and gastroenterology. Therefore, the UK should welcome increased mobility of health professionals in both directions across the border with the rest of the EU.

The European professional card

Initially, this was perceived by most as being an actual physical card which could be handed over by mobile professionals, and upon which were stored data on qualifications and other information to facilitate recognition of those qualifications. Such a card would be highly susceptible to fraud and misuse (as has been found in nursing and midwifery in the UK) as well as not holding real time information. There has been fairly unanimous opposition by most UK health professional organisations to such a card^{9, 5-7}.

It now appears, though, that the card is envisaged as a digital and virtual entity, although its relationship with the current Internal Market Information System (IMI) remains very unclear. The IMI is already widely used by Member States and it would appear preferable to improve this system by reducing deadlines and increasing the information on the system (such as alerts regarding an individual) rather than developing a new card or system.

Communication between Member States

Prior to the Green Paper being published, the EC undertook a large consultation on the current Directive⁸. One of the strong themes from this consultation is that there is considerable confusion about the documents needed by competent authorities (as well as where to submit them) within Member States in order for a professional's qualifications to be recognised.

The Green Paper therefore proposes a central access point for each Member State outlining all the requirements for recognition and possibly (at a later stage) completing all procedures on line. The EC proposes that 'National Contact Points' (NCPs) are used to organise these processes. Whilst increasing the role of NCPs is a good idea, there are significant concerns about their expertise to deal with the medical profession given its huge diversity of specialties, as well as their use in adding a further layer of bureaucracy.

An alternative solution would be to make competent authorities responsible for this facilitation and from the perspective of a doctor wishing to work abroad it would also allow the doctor to be made aware of their responsibilities to the competent authority. However, the GMC is unique amongst competent authorities in the EU in its size, constitution and efficiency. Thus, whilst doctors wanting to work in the UK may find it easier to know who to contact and the processes that need to be undergone, movement in the other direction may be less simple.

Modernising automatic recognition of medical qualifications

The revision of the Directive provides an opportunity to reconsider how medical qualifications are recognised. Many of the qualifications laid out in the original Directive are outdated and some not fit for purpose. The Green Paper proposes a three-phase approach to modernising processes:

- Clarification of minimum training requirements, specifically length of training
- Developing sets of competences to update training requirements
- Harmonisation and optimisation of minimum training requirements to include competences.

The use of length of training alone as a measure of the ability of a doctor to do their job is flawed and the proposed changes are both timely and necessary. This is particularly true for 'craft' medical specialties, where the recent hours reduction necessitated by the Working Time Directive has resulted in UK hospital doctors getting far less experience of day-time based out-patient procedures⁹. Surgeons in the UK have called for a 65 hour week to correct for this, although that seems extremely unlikely¹⁰. Changing to a competency-based recognition will allow trainees to develop at their own pace and ensure that all doctors are trained to the same standards. Some trainees may only be required to do a procedure 100 times to be competent, others 200 times. If training was only

based on time to do 150 procedures, both trainees would complete training but only one would be safe to practice.

The introduction of such recognition though is likely to be extremely difficult and it may be that more uniform EU-wide measures will be needed. Many medical specialties already agree on standards across the EU, but many do not and achieving this will be problematic. Early success of some measures (e.g. European Credit Transfer and Accumulation System – ECTS) will be vital in ensuring the success of competency based recognition.

Continuing Professional Development

The Directive as it stands has one significant omission with regard to the medical profession. It is clear that holding a qualification does not mean that an individual's skills are still valid. For example, this author is a gastroenterologist and 'certified' to perform complex biliary procedures, including therapeutic endoscopic ultrasound and endoscopic retrograde cholangiopancreatography (both associated with significant complication rates even in the best of practitioners' hands). However, having not performed either for ten years, the qualification is meaningless. Currently, nothing prevents this author from practising these procedures in other Member States.

“an opportunity to enshrine CPD as a mandatory requirement

Many EU Member States, including the UK, therefore attach a huge amount of importance to the maintenance of professional competencies (Continuing Professional Development – CPD)¹¹ and the Green Paper acknowledges this, proposing that an individual has to demonstrate they have the right to practice in their home state (i.e. have performed

CPD according to that Member State's regulations). However, it could be argued, given the huge variability in the use of and type of CPD across the EU, that they should demonstrate they have fulfilled the criteria to practice in the host state.

The Directive would also be an opportunity to enshrine CPD as a mandatory requirement for medical professionals throughout Europe. This will improve patient safety and outcomes.

Automatic recognition

The recognition of certain types of professionals under the current Directive allows some to be granted 'automatic recognition' which allows ease of mobility and this is the case for most large medical specialties. Many smaller medical specialties are not currently recognised by this system, probably because they are only recognised in a limited number of Member States, e.g. rehabilitation medicine. Currently, for a specialty to be recognised within the Directive it has to be supported by two-thirds of the Member States and the Green Paper proposes that this is reduced to one-third (i.e. 9 of 27). This change, if introduced, will make mobility of doctors in these specialties much simpler and can only be of benefit to the UK and all other EU Member States.

Language assessment

Revision of the Directive has raised the difficult issue of language assessment for doctors. Currently in the UK, doctors from outside of the EU have to demonstrate language competencies by passing the International English Language Test (IELT) to a defined level, whilst this is not required of EU doctors. The Directive, as it stands, does allow for assessment of language by employers (as adequate communication skills are required to perform the job of a doctor and thus 'testable') but not by regulators. This testing, therefore, is variable and inconsistent which is good for neither doctor nor patient.

There has been considerable pressure for strengthening the role of language assessment in the Directive from health professional bodies in the UK.

The Daniel Ubani case¹² highlighted the importance of language skills for doctors communicating with patients and colleagues, and there are numerous reports of language problems with short term locums working within the NHS including doctors trained elsewhere in the EU.

Within the Royal College of Physicians and other similar professional organisations in the UK, there is support for allowing regulators to be able to assess language competence at the registration stage^{13, 14}. Indeed this is a long established practice for doctors recruited outside of the EU and certainly is not perceived by the large numbers of IMGs that work in the UK as a barrier to professional mobility. Instead, it is perceived as an important part of ensuring patient safety.

“protect patient safety by requiring evidence of language skills

A balance is therefore needed between the regulator, which needs to be satisfied of general language competence at the registration stage, and the employer, which needs to assess whether the doctor has the skills specific to a particular post. The UK Secretary of State for Health has recently announced plans to reinforce the employer's responsibilities which should be welcomed¹⁵. Importantly, many health professionals in the EU are self employed (although this is less of an issue in the UK). Therefore, the Directive will need to allow for the competent authority to protect patient safety by requiring evidence of language skills in the absence of an employer safeguard.

In summary, the Green Paper should be welcomed as it proposes many changes which will improve the mobility of health professionals. However, some significant changes need to be incorporated within a new Directive to ensure that patient safety

is protected, especially with regard to Continuing Professional Development and language skills.

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New Observatory publication

Governing Public Hospitals Reform strategies and the movement towards institutional autonomy

Edited by: Richard B Saltman, Antonio Durán, Hans FW Dubois

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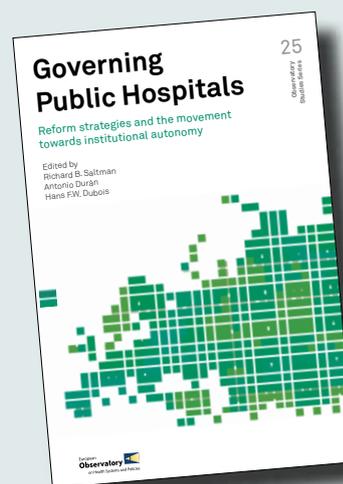
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The governance of public hospitals in Europe is changing. Individual hospitals have been given varying degrees of semi-autonomy within the public sector and empowered to make key strategic, financial and clinical decisions. This study explores the major developments and their implications for national and European health policy.

The study focuses on hospital-level decision-making and draws together both theoretical and practical evidence. It includes an in-depth assessment of eight different country models of semi-autonomy. The evidence that emerges throws light on the shifting relationships between public sector decision-making and hospital-level organisational behaviour

and will be of real and practical value to those working with this increasingly important and complex mix of approaches.

Part I of the volume analyses the key issues that have emerged from developments in public-sector hospital governance models and summarises the general findings. Part II looks in detail at hospital governance in eight countries.



Contents:

Foreword;
Acknowledgements; List of tables, figures and boxes;
List of abbreviations; List of contributors;
Introduction; Part I: chapters on the evolving role of hospitals and recent concepts of public sector governance, a

framework for assessing hospital governance, mapping new governance models for public hospitals, conclusions and remaining issues; Part I: hospital governance in eight countries presented as case studies on the Czech Republic, England, Estonia, Israel, The Netherlands, Norway, Portugal and Spain; Appendix: eight case study responses to key governance questions.

REGULATING NURSING QUALIFICATIONS ACROSS EUROPE – A CASE OF UNINTENDED CONSEQUENCES

By: Tom Keighley and Susan Williams

Abstract: The European Union’s regulatory framework covering the recognition of professional qualifications, including those for health professionals, is currently under review. Since the late 1970s, under this framework, nurses working in general care have enjoyed automatic recognition of their qualifications based on harmonised standards of nurse education. With the expansion of Europe the legislation has not only enhanced free movement of nurses but has had a number of wider consequences, including enhancing women’s education and professional life, the development of new regulatory bodies for nursing and midwifery, and a rationale for EU discussions about the role of health professionals and quality of patient care.

Key words: *Mutual Recognition, Nursing Qualifications, Professional Mobility, Equality*

Introduction

From its earliest days, nursing has been a migratory profession. The nursing pioneer Florence Nightingale sent nurses around the UK and then increasingly overseas. At first this was to the countries of the British Empire, but also on request, wider afield. She herself learnt her nursing in Germany and France and modern nursing therefore was raised to see itself as an international phenomenon.

Firstly, the Council of Europe in the 1960s and then the European Commission (EC) in the 1970s undertook work to achieve the harmonisation of pre-registration general nurse education in Europe. The resulting sectoral directive¹ was one of

those swept up in the revision that created the much broader Directive 2005/36 covering the mutual recognition of most professional qualifications, including those harmonised health professional qualifications previously covered under separate Directives.

This paper will address areas of particular significance for nursing that have become paramount in the discussion about the revision of this Directive, which impacts not only on the free movement of professionals and patient safety, but also on women’s professional life in an expanding Europe.

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Table 1: Current Directive 2005/36 and proposed revisions relating to nurses in general care

Current Directive	RCN's position on revision of Directive ²
<ul style="list-style-type: none"> List of minimum content for nurse education programme Minimum 4,600 hours or 3 years' length At least 50% hours practice/minimum 30% theory Minimum 10 years general education to enter nurse education Recognition based on qualification 	<ul style="list-style-type: none"> Update minimum content and move towards competences Retain 4,600 hours as minimum and theory/practice split Testing of language competency Minimum 12 years' general education Continuing professional development made mandatory Recognition based on qualification and right to practice in home Member State

Table 1 presents the main provisions of the current Directive 2005/36 relating to nurses working in general care and the Royal College of Nursing's (RCN) proposed revisions.

Numbers

Eight hundred different professions are addressed in the EC's Green Paper Modernising the Professional Qualifications Directive³ issued in June 2011 and some 6.4 million professions are covered by automatic recognition following harmonisation of minimum training requirements. Of these, around four million are nurses, more when the countries aspiring to EU membership are included. This makes nurses the single largest professional group covered. So while the Directive is designed to have sufficient breadth to cover all of these professions, it is clear that health care professionals, and nurses in particular, are a special concern when it comes to free movement.

According to a rough estimate from the EC, by 2020 there will be a shortage of one million health care professionals in the EU, of which over half a million will be in nursing⁴. This is compounded by active recruitment in Europe from North America and in Australia and New Zealand. The US alone is estimated to have its own shortfall of one million nurses by 2020⁵ – with the UK a potential recruiting ground.

Meanwhile the trend in recruiting nurses into the UK from the British

Commonwealth and North America has been reversed, partly due to changes in UK immigration policy and pressure to recruit ethically and partly because of stricter UK nurse registration requirements and changing labour market conditions. In parallel, since the accession of ten countries to the EU in 2004 followed by Romania and Bulgaria in 2007 migration of nurses into the UK from other EU countries has been increasing (see Table 2).

“nurses are the single largest professional group covered

Wider implications of the Directive for nursing

Nursing is essentially a female profession. One of the un-envisioned but positive outcomes of the current Directive is that the requirement for a minimum of ten years general education prior to entry into nurse training has given extended access to education for girls and women in many countries where eight years was the norm. Throughout central Europe unless a profession was listed as requiring education that qualified the individual for university, then training started at the age of 14 years. This effectively excluded

nurses, predominantly women, from higher education and the educational and social opportunities that went with it. So the Directive has played to the equality agenda in aspiring EU Member States and has had, and continues to have, a dramatic impact on internal social mobility as well international mobility. A further extension of this period of general education to twelve years, or equivalent, to access higher (university based) education, is important given the increasing complexity of health care delivery and the ever more sophisticated role of nurses. The World Health Organization has supported this position on general education since 2001 when it became apparent that one of the major barriers to the implementation of Health for All was the low level of education and training provided for nurses, linked to educational attainment prior to entering nurse education and training⁶. But the impact of raising general education will have been much wider given the link between enhanced general education and social mobility^{7, 8, 9}, and between higher education based nurse education and staff retention¹⁰. It also enhances the status of women in society^{11, 12}, and can bring improvements in the quality of health care delivery^{13, 14}.

The second wider implication of the Directive for nurses has been the impetus given to the establishment of regulatory functions /competent authorities where they have not previously existed. This development has played a key public protection and professional development function and includes the protection of the title “nurse”. The lack of a competent authority to regulate the profession, or one that was severely under resourced was a further indication of the lack of status of nurses and women in these societies.

However, there are many concerns for the EC about the competency of the multiplicity of regulators, as the Green Paper focuses on achieving so much through this resource. Teething problems with emerging regulators are not limited to newer EU Member States, with France's newly formed “ordre” struggling to survive politically and financially¹⁵.

The third of the wider implications for nursing is the Annex to the Directive

Table 2: New entrants to the nursing and midwifery register in the UK, 2000–2009

From area	2000	2002	2004	2005	2006	2007	2008	2009
UK	14,035	14,538	19,462	19,982	20,940	21,388	21,661	19,320
EU/EEA	1,416	1,091	1,033	1,193	1,753	1,484	1,872	1,936
Overseas	5,945	15,064	14,122	11,477	8,709	4,830	2,309	775

Source: NMC¹⁰

which covers the minimum content of nurse education and training. Significant interest exists in the profession in updating it and indeed examining the possibility of shaping it into a set of competencies. The issue here is that while for the Western parts of the EU, the Annex may seem outdated; it remains the gold standard that many accession countries struggle to attain. It is important therefore to retain a balance which allows progress in developing the profession and beginning the journey towards competencies without forcing those in the process of joining the EU onto a side road. Unlike for doctors, the nursing provisions do not cover specialisms, which mean that the Annex is key to the harmonisation process.

“extended access to education for girls and women”

The recent Green Paper also opens a different debate about continuing professional development (CPD) and the relationship between CPD and possible mandatory re-registration. This is still evolving within the EU for nurses but is very high on the agenda. The proposals in the Green Paper indicate a shift in thinking by the EC in clearly acknowledging that the EU professional qualifications regime is not just about recognition of qualifications but also the right to practise, which in some countries includes the need to demonstrate continuing competence and CPD. In fact,

eighteen of the 27 countries in Europe already have some form of mandatory CPD for nurses¹⁶.

Conclusion

The Directive and its predecessor have achieved a number of things. They have ensured the harmonisation of pre-registration nursing, the establishment of competent authorities and the framework within which governments and the profession could discuss nurse education and training at European level and begin to build greater trust, understanding and some convergence of education systems. This is all within the expectations of such a piece of legislation. However, under the law of unintended consequences, the Directive has also driven a significant social mobility agenda, as well as provided a mechanism to reinforce patient safety and influence the quality of patient care when previously no other mechanisms existed to do these things. Interestingly these have now come onto the EU agenda in different ways, particularly through European Court of Justice rulings on access to and reimbursement of care in other countries and the subsequent EU patients' rights to cross-border care legislation and patient safety recommendations.

The review of the Directive, with legislative changes due to be proposed by the EC in December 2011, is therefore a deeply significant matter. It has enormous potential for influencing the culture of care and status of women in much of Central Europe and in the neighbourhood countries. The decisions taken therefore need to reflect the sensitivities of the nursing profession and the impact changes might have beyond the specific details of nursing education.

“reinforce patient safety and influence the quality of patient care”

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HEALTH CARE FRAUD AND CORRUPTION IN EUROPE: AN OVERVIEW

By: Paul Vincke and Jonathan Cylus

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Summary: Preventing, detecting, and ultimately putting an end to health care fraud and corruption is important to ensure that scarce health sector resources are put to good use. This article provides an overview of fraud and corruption in Europe by focusing on how they are defined and how health care systems are affected. Fraud and corruption can be committed by patients, providers, payers, or anyone else involved in the health care sector. To combat these activities, anti-fraud organisations follow a chronological process to deter, identify, investigate, and punish criminals. Losses due to fraud and corruption in Europe have been estimated at up to €56 billion per year or over 5% of national health budgets.

Key words: *Fraud, Corruption, Waste, Health Spending*

Introduction

Numerous studies have shown that across Europe health care costs are growing faster than the overall economy. In 2008, health care expenditure consumed slightly under 9% of GDP (Gross Domestic Product) in the European Union (EU) – over 1% above the health sector's share of GDP a decade before¹. While much of this spending has gone towards necessary health care goods and services, a significant proportion – potentially up to 30% – may have been lost to wasteful spending². Perhaps at no other time in recent memory have citizens and politicians been so worried about wasting public funds. Particularly in countries implementing austerity measures following the global financial crisis, it is essential that public expenditure reaches those that it is intended to serve. While there are many types of waste in the health

care system – including care that provides low value-for-money or unnecessary treatments – spending lost to fraud and corruption is most easily and universally characterised and agreed upon as gross misuse of funds. In this article, we aim to define fraud and corruption and describe why they are of such great concern to European health systems. We will then briefly discuss different types of fraud and corruption, including the issue of cross-border fraud which is a relatively new and perhaps under-discussed issue, and highlight the process by which countries can combat these sorts of activities.

Defining fraud and corruption

The importance of clear definitions of health care fraud and corruption has become increasingly evident for

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identifying areas of the health care system that are most vulnerable to illicit activities, aiding in law enforcement, and international comparison. Because reliable and comprehensive definitions that are universally accepted across countries did not exist previously, in 2004 the European Healthcare Fraud and Corruption Network (EHFCN), an organisation representing twelve countries that provides information, tools, training and assistance for fighting fraud and corruption, sent out a survey to authorities of EU Member States requesting information on their legal frameworks and methods to counter fraud and corruption. The results of this survey found that while every state had legislation against corruption, many Member States did not have legislation defining fraud as an offense in itself despite the prevalence of both fraud and corruption in all health sectors. A majority of countries also did not have an organisation specifically tasked with combating health care fraud⁹.

“It is essential that public expenditure reaches those it is intended to serve

In response, the Swiss Institute of Comparative Law conducted research in EU Member States, as well as Croatia and Turkey, to find common definitions of “civil fraud” and “corruption” that would be acceptable under all legal systems for the purpose of risk measurement in health care⁴. While they found that the legal systems of countries are heterogeneous, they were able to provide a common definition for civil fraud:

the use or presentation of false, incorrect or incomplete statements and/or documents, or the non-disclosure of information in violation of a legally enforceable obligation to disclose, having

as its effect the misappropriation or wrongful retention of funds or property of others, or their misuse for purposes other than those specified.

Regarding corruption, the legal systems of these countries contain a provision explicitly forbidding corruption in the public sector. Corruption is best understood as practices by public officials that request or receive any undue advantages for themselves or a third party in order to exercise (or refrain from exercising) their official duties. Moreover, the laws of several but not all countries also specifically forbid corruption in the private sector, including private hospitals and insurance companies.

Even when fraud and corruption are well defined, grey areas which are left open to interpretation remain. For example, at what point should redundant performance of ineffective and expensive medical procedures be considered as fraudulent overconsumption? It is important, when measuring the extent of health care fraud and corruption, that a clear distinction between fraud, corruption and error and abuse is made. Even though error and abuse generate considerable

Box 1: Focus on cross-border fraud

Cross-border health care fraud is a relatively unknown issue. The movement of patients or health care providers across borders and the subsequent transfer of services⁸ have the potential for fraud in a number of ways. On the one hand, there is the risk of fraud that already exists on a national level. For example, an uninsured patient may commit identity fraud in order to obtain reimbursement for health care that happened to be received and paid for abroad. Likewise, a GP may submit claims for treatment of foreign patients that never occurred. On the other hand, there is the fraud risk related to non-compliance with specific international rules regulating cross-border health care.

A good example of the latter is abuse of the European Health Insurance Card (EHIC) by patients who travel with the purpose of obtaining health care, when the EHIC only permits urgent and unplanned health care for those traveling abroad. Easy access to free medication or low-cost surgery has been found to be an incentive for foreign patients to travel to other countries to receive care⁹. The counterfeit medicine market is also a typical and hard to tackle cross-border phenomenon that is made worse through internet sales.

According to one Report from 2000 to 2004, €2.5 billion related to cross-border care was left unpaid between Member States of the European Economic Area¹⁰. Evidence from Belgium shows that many of these transfers involve fraud but are left undetected and/or unresolved¹⁰. A EHFCN pilot study beginning in 2011 aims to map more accurately the occurrence and effect of fraud on cross-border health care in Europe.

financial losses in health care as well, they cannot be countered with the same legal enforcement procedures and should be tackled with different tools. As a result, they have so far only been tackled systematically amongst anti-fraud units.

How is the health care system susceptible to fraud and corruption?

The health care system is particularly vulnerable to fraud and corruption because of the often pluralistic or multidimensional set of payers, providers, and patients which operate to some extent at their own discretion, the large sums of money involved, and other system complexities, such as high decentralisation with limited oversight, which make it comparatively easy and appealing for offenders. For example, because the payer of health care is generally different from the recipient of services, there is no natural check on the actual provision of goods and services. The payer has no way of verifying that the service was provided and the consumer has no way of knowing if the insurance provider has billed for a service that the consumer did not receive.

Fraud and corruption activities can take place in any health care system⁹; however, particular institutional structures may make certain forms of fraud more or less attractive. For example, fee-for-service payment systems may incentivise providers to file claims for services that were not rendered in order to receive additional payments. The EHFCN has identified various types of fraud, which can be committed by the various stakeholders in the health sector.

“each year €56 billion is lost due to health sector fraud”

Patients

Fraud committed by patients can be difficult to detect because it often involves small amounts of money. The proliferation of electronic health records and other data collection mechanisms has made it easier to spot potential outliers. One example is a patient in England who was sentenced to imprisonment for defrauding the National Health Service after falsely obtaining large amounts of the painkiller Co-Proxamol for illicit sale and consumption. Other examples include: claiming false exemption from prescription co-payments; falsely registering with a number of doctors to obtain prescriptions; trying to obtain refunds of medical costs that were never incurred; obtaining medication or narcotics by means of irregular procedures for consumption, drug trafficking or selling prescriptions; presenting false reports to obtain a disability allowance; using the identity of a registered patient in order to obtain health care benefits from a health insurer.

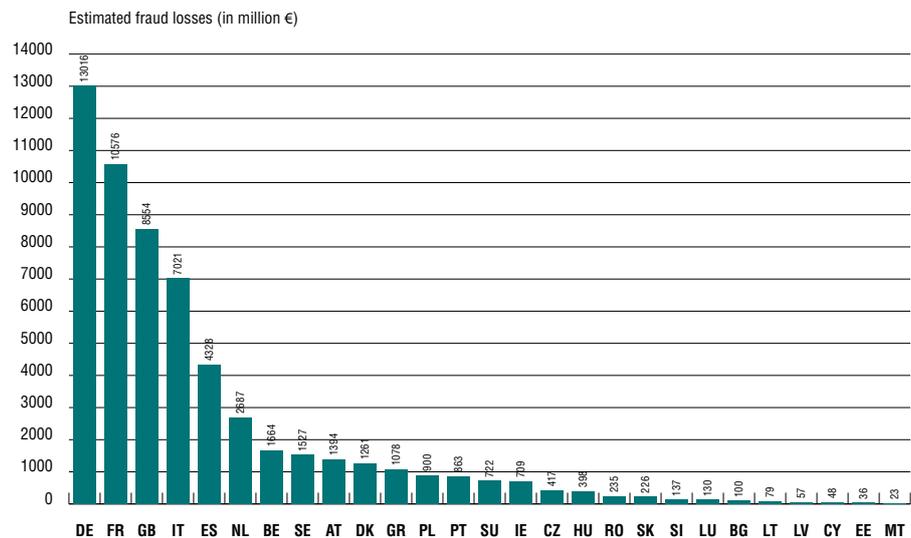
Providers

Providers may have many incentives and opportunities to exploit their position in the health system for illicit gain⁹. Fraud from providers often falls into two categories, inappropriate billing or inappropriate care. Where the first

Figure 1: The process of combating fraud and corruption



Figure 2: Estimates of losses due to health care fraud in the EU27, 2008



category is relatively easy to detect and prove and requires no medical skills for investigators, the second category generally requires medical skills in order to build a strong case based on good medical practice and clinical guidelines. As mentioned earlier, these types of activities pertain to a vast grey zone of overconsumption that cannot be categorised as fraud *sensu stricto*.

Illicit provider activities can be uncovered by reviewing consultation registers and reviewing invoices in health insurance databases. Other actions such as upcoding patients into higher cost diagnosis-related groups (DRGs) for the purpose of receiving greater compensation in case-based payment systems is more complicated to expose and may require complex statistical models⁷. One example of provider fraud concerns a Belgian dentist who stole €1 million and was sentenced to prison. Between 2000 and 2008, he falsely billed for expensive treatments for nearly 200 patients whose contact details he stole from a database he had had access to while working with two other dentists. Additionally, health care staff may claim payments or hours worked with no evidence that the work has been

done, forge signatures in order to submit false invoices to support reimbursement requests, or work without having the proper qualifications.

Suppliers of health care goods

One example is a Spanish company that was found to be delivering inferior quality wheelchairs to patients at a discounted price, even though the wheelchairs did not match the brand that was ordered by doctors. The director of the company was found guilty of fraud, sentenced to imprisonment, and his contract with civil services was cancelled. Additionally he had to compensate the Catalan Health Inspectorate for losses of €23,775.

Corruption

Health care stakeholders face a complex mix of incentives that can lead to corruption, which may include¹¹:

- *Embezzlement and theft* from the health budget or other health funds. Medicines, medical supplies or equipment may also be stolen for personal use, use in private practice, or resale.
- *Corruption in procurement*. Engaging in collusion, bribes and kickbacks in procurement which may result in

Table 1: Cases of suspected fraud identified in EHFCN survey, 2009

Country	Suspicious cases	Cases investigated	Referred for prosecution	Successfully prosecuted	Pending
Belgium	1,075	944	176	112	50
France	n/a	n/a	230	n/a	n/a
Latvia	3	n/a	n/a	n/a	n/a
The Netherlands	2,884	2,884	<20	<5	n/a
Northern Ireland	18	9	2	1	2
Norway	n/a	n/a	3	1	32
Portugal	38	38	38	6	n/a
Slovenia	170	n/a	n/a	n/a	n/a
Total	4,188	3,875	<469	<125	84

Source: Reference 16. Note: n/a = Data not available.

overpayment for goods and contracted services, or in failure to enforce contractual standards for quality. In addition, hospital spending may include large investments in building construction and purchase of expensive technologies, areas of procurement that are particularly vulnerable to corruption.

- *Corruption in the pharmaceutical supply chain.* Products can be diverted or stolen at various points in the distribution system; officials may demand ‘fees’ for approving products or facilities, for clearing customs procedures or for setting prices; violations of industry marketing code practices may distort medical professionals’ prescribing practices; demands for favours may be placed on suppliers as a condition for prescribing medicines; and counterfeit or other forms of sub-standard medicines may be allowed to circulate.
- *Corruption at the point of health service delivery* can take many forms: extorting or accepting informal payments for services that are supposed to be provided free of charge; soliciting payments in exchange for special privileges or treatment; and extorting or accepting bribes to influence decisions on hiring staff licensing, accreditation or certification of facilities.

Some countries, like Serbia, have had significant problems with informal provider payments. Moreover, groups that officially should not pay user charges still pay for pharmaceuticals, disposable health

care goods, and orthopaedic materials¹². In another example from Romania, the president of the Romanian National Agency for Medicines and Medical Devices, along with other well-known figures in the health care system, were recently accused of receiving bribes in exchange for allowing a drug distributor to continue its business after having its license withdrawn¹³.

“
a complex mix
of incentives
can lead
to corruption”

The process of combating fraud and corruption

To tackle fraud and corruption, anti-fraud organisations follow a standard process which can be summarised in seven steps (see Figure 1). To begin, regulators must identify those parts of the health care system which are most vulnerable to fraudulent activities. Next, actions are taken that are intended to try and make sure fraud does not occur, such as closing loopholes in the health care system that may be easily exploited. However, because some fraud does still occur, anti-fraud organisations will try and prevent criminals who have committed fraud from actually profiting. This may

be accomplished, for example, by creating software that analyses payment data before payments are actually incurred, i.e., in Norway and France.

Criminals who have successfully committed and profited from fraud are sometimes detected through data analysis (e.g., reviewing payment data) or whistleblowing by others who are aware of the illegal activities. When a potential case of fraud is identified, law enforcement agents or the anti-fraud organisation itself then conduct an investigation to determine whether fraud has in fact occurred. After building a case, if the individual(s) involved are found to be guilty, they will often be fined and/or imprisoned. Ultimately, regulators will work to recover the funds that have been lost due to the illicit activities.

The level of fraud and corruption

The EHFCN has estimated that each year, €56 billion is needlessly lost in the EU due to health sector fraud (see Figure 2), the equivalent of approximately €80 million every day¹⁴. A study based on six countries found that each year, the total resources lost to fraud amount to around 5.59% of national health care budgets¹⁵. Moreover, according to an EHFCN survey in 2009, 4,188 instances of suspected fraud were identified in six countries, with the Netherlands and Belgium reporting the highest number of cases (see Table 1)¹⁶. Of those identified, a total of 3,875 (93%) cases were investigated further, resulting in 469 (11%) being referred for prosecution. Of those referred for prosecution, about one-quarter have been successfully prosecuted.

In terms of corruption, there are no exact figures available on its scale in health care in Europe. However, one EU funded research project assessing the nature and scale of informal payments in Eastern and Central European countries revealed that these could be as high as 40% of household income in countries such as Romania and Serbia¹⁷.

Conclusions

Fraud and corruption in the health sector divert resources away from the

patient. Although their precise levels are unknown, fraud and corruption are tangible, definable and largely preventable factors contributing to excessive health care spending. There are steps that countries can take in order to identify areas most likely to experience fraud, prevent fraud from occurring, and reprimand those who commit fraudulent and corrupt practices.

Perhaps one of the largest barriers to discovering fraud is that it most often occurs in small amounts, which makes it easy for cases to go undetected. The proliferation of electronic health records and other registries has made it easier for organisations tasked with identifying fraud and corruption to identify and pursue offenders. Most often, such cases are discovered because they have been reported by concerned citizens. Ultimately, successful prosecution of guilty parties requires some sort of further investigation to build a case.

The presence of specific laws against fraud and corruption, as well as organisations dedicated to combating such activities, acts to some degree as a deterrent. Cooperation across countries to make certain that laws and regulations are created, followed and enforced is essential for combating fraud and ensuring the appropriate use of health care system resources.

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The European Healthcare Fraud & Corruption Network (EHFCN)

EHFCN is the only European organisation dedicated to combating fraud and corruption in the health care sector across Europe. EHFCN was formally established in 2005 as a result of the first pan-European conference held in London in October 2004. Its foundations lie in the European Healthcare Fraud and Corruption Declaration agreed upon by its delegates. Today, the network represents eighteen member associations in twelve countries, which provide health care services to millions of people in Europe.

Annual health care spending across the European Union totals approximately one trillion Euros. It is estimated that approximately 56 billion Euros are lost every year to health care fraud and corruption. EHFCN's primary objective is to reduce these unacceptable losses: lowering losses will help bring back money to health care services for the benefit of every patient.

EHFCN provides information, tools, training and assistance in fighting fraud and corruption as well as a platform for its members to exchange information and ideas. EHFCN is a not-for-profit organisation financed through subscription fees. Its members are health care and counter fraud organisations in Europe.

Additional information about the Network can be found at: <http://www.ehfcn.org/>



CROSS-BORDER SHOPPING FOR MEDICINES IN **BELGIUM AND THE NETHERLANDS**

By: **Jo Depraetere** and **Jonathan Cylus**

Summary: Cross-border care presents a unique set of challenges for those tasked with combating health care fraud. This article discusses the issue surrounding patients who travel from Belgium to the Netherlands to purchase pharmaceuticals at cheaper prices using the European Health Insurance Card (EHIC). The EHIC is intended to permit patients to purchase health care outside of their home country so that they may continue their stay abroad, but does not allow patients to travel abroad solely with the intention of obtaining care. Because Belgian patients who travel to the Netherlands to purchase medicines are more costly to the Belgian health care system, it is necessary to ensure that all cross-border medicine purchases are legitimate.

Key words: *Cross-Border, Fraud, Medicines, EHIC, Belgium, the Netherlands*

Introduction

Travelling across borders to receive health care has become increasingly prevalent, particularly as people, goods, and services have been granted greater ease of mobility across the European Union^{1, 2, 3}. For example, in 2010 Belgium received over €200 million from patients who travelled from other countries in the European Economic Area and Switzerland to obtain health care in Belgium. Meanwhile, Belgium paid just under €200 million for its citizens to receive care abroad (**see Table 1**). Nevertheless, crossing borders on a regular basis with the explicit purpose of purchasing pharmaceuticals becomes a concern when patients circumvent national rules to purchase medicines abroad. A motivation for obtaining

medicines outside the home country may be cheaper prices abroad; however, this can be financially damaging to local pharmacies and insurers. Cross-border sale of pharmaceuticals is controversial in many parts of the world, including within Europe, the United States and Canada⁴. In this article, we discuss how the European Health Insurance Card (EHIC), which permits cardholders to obtain health care while travelling outside of their home country, may inadvertently facilitate this sort of gaming. Due to their close geographic proximity, there have been recorded instances of unauthorised cross-border pharmaceutical purchases by Belgian patients in Dutch pharmacies⁵.

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Use of the European Health Insurance Card

The EHIC enables card holding insured individuals to receive any necessary medical treatment “*that [their] state of health requires in order... to be able to continue [their] stay under safe medical conditions.*” during a temporary stay abroad⁹. In Belgium, insured people are able to request an EHIC from their local insurer. The card is valid for obtaining care anywhere in the European Union, Iceland, Norway, Liechtenstein and Switzerland. The card contains information such as the patient’s name, date of birth, a patient identification number, the insurance institution identification number, and an expiry date of a maximum of two years.

“cross-border purchases led to 41.5% more expenditure by the NIHDI

While beneficial for patients travelling abroad, this type of arrangement can also be susceptible to fraudulent activities or gaming. For example, a hypothetical individual who is insured in Belgium may travel to a pharmacy in the Netherlands with his or her EHIC and a prescription from a Belgian physician and receive pharmaceuticals at the Dutch pharmacy without making a co-payment. The Dutch pharmacist will then send an invoice requesting reimbursement to the Dutch insurer, which invoices the Belgian insurance institute affiliated with the patient using a form called an E-125 (submitted twice per year by each pharmacy). This form contains the name and address of the patient, date of birth, name of insurance institute, whether the purchase occurred in the first or second half of the year, and a section describing the purchase as either for medical care, dental care, pharmaceuticals, hospital care, other. However, in respect of

Table 1: Cross-border purchasing of health care, Belgium and selected countries, 2010

	Amount (€) paid to Belgium	Amount (€) paid by Belgium
Netherlands	83,009,992	23,068,185
France	74,174,007	111,828,773
Luxembourg	31,786,181	7,983,082
Germany	11,266,869	14,800,654
Poland	4,940,971	229,155
Spain	3,034,729	26,679,097
Portugal	856,984	642,133
United Kingdom	260,973	1,094,339
Norway	164,041	n/a
Czech Republic	157,458	48,22
Slovenia	88,374	30,103
Total from selected countries	209,740,579	186,403,741

Source: Department of International Relations, Belgian Institute for Health and Disability Insurance (NIHDI)

pharmaceuticals, no details other than the amount spent are recorded. Ultimately, the National Institute for Health and Disability Insurance (NIHDI) in Belgium pays the Health Care Insurance Board (CVZ) in the Netherlands, which reimburses the Dutch insurance company after approval of the E-125 form by the Belgian insurance institute.

Cost to Belgian health insurers

Due to concerns over the level of cross-border pharmaceutical purchases, a brief analysis of E-125 forms was conducted in Belgium in 2006. A random small sample of 57 forms from thirteen patients who visited five Dutch pharmacies was studied. In total, the pharmaceutical purchases reviewed amounted to €8,787 in spending by the Belgian insurance institute, an average of €675 per patient, with no other types of purchases recorded. The Dutch insurance company was also asked to review the corresponding invoices from the different pharmacies which contain information on the pharmaceuticals purchased and the pharmacy that delivered the medicines to the patient. The actual expenditure by the NIHDI on the Dutch pharmaceuticals was compared to the cost if the pharmaceuticals had been purchased at a Belgian pharmacy, assuming the lowest available Belgian price as a reference.

This analysis found that cross-border purchases led to 41.5% more expenditure by the NIHDI than if medicines had been purchased by patients locally in Belgium. While not illegal in and of itself, because of potential high costs, regulators must ensure that cross-border pharmaceutical purchases are limited to those that are permitted under EHIC regulations. This has prompted an increased focus on individual patient cases.

“the cross-border sale of pharmaceuticals is controversial

An individual example

After reviewing individual examples of Belgian patients purchasing pharmaceuticals at Dutch pharmacies, some cases have been determined to be in violation of European regulations. In one such case, a Belgian patient with a preferential tariff (i.e. a retired person) travelled to the Netherlands on multiple occasions – more than once a month – to purchase medicines using the EHIC. As this individual had a preferential

Table 2: Calculation of cost differences for a Belgian patient filling prescriptions in the Netherlands, 2006

Medicine	Number of units	Patient contribution in Belgium (€)	Insurer contribution in Belgium (€)	Total cost in Belgium (€)	Total cost in the Netherlands (€)
Atrovent spray 0,5mg/2ml	840	94.50	536.34	630.84	n/a
Serevent inhaler 120 doses	10	52.00	294.60	346.60	n/a
Pulmicort spray 0,5mg/ml 2ml	840	302.82	1,715.70	2,018.52	n/a
Lamotrigine Effervescent tablet 50mg	720	0.00	335.84	335.84	n/a
Salbutamol spray 5mg/ml	360 ml	16.63	94.32	110.95	n/a
Total cost for pharmaceuticals	–	465.95	2,976.80	3,442.75	3,191.48
Additional cost if purchased in the Netherlands	–	–	–	–	218.68
Final cost	–	465.95	2,976.80	3,442.75	3,410.16

Source: National Institute for Health and Disability Insurance (NIHDI).

tariff, he or she would be entitled to the lowest co-payment in Belgium, which would shift the majority of costs onto the NIHDI if he or she were to purchase medicines domestically.

Because this individual travelled to the Netherlands to purchase medicines, he or she did not have to pay the €465.95 co-payment that they would otherwise pay in Belgium (see Table 2). In addition, due to cost differences and an extra charge of €218.68 because the patient was not registered at a Dutch physician's practice, the final cost to the NIHDI was €433.36 more than if the medicines had been purchased in Belgium, where it would have paid just €2,976.80 – the insurer share (as opposed to € 3,410.16) (See Table 2).

Another issue involves different reimbursement exemption conditions in the two countries. While this particular patient purchased an assortment of medicines, some of those purchased fall into categories that would only be reimbursed in Belgium under specific conditions. For example, to purchase the pharmaceutical Pulmicort, patients must prove that they suffer from bronchial asthma. In this case, Belgian rules were bypassed for the purchase of Pulmicort as well as for Serevent (asthma treatment) as no proof of illness was provided. Likewise, the medicine Lamotrigine (LAMICTAL) (anticonvulsant medicine) is subject to conditional reimbursement. In Belgium, a specialist in neurology or neuropsychiatry must prove that the patient meets the conditions of reimbursement and the patient must obtain

an authorisation from the medical adviser of his or her insurance institute; in this case, the patient never visited a Belgian doctor to obtain this referral. Therefore, NIHDI reimbursed medicines purchased in the Netherlands that it would not have reimbursed domestically without necessary referrals and documentation.

Conclusion

Although the precise level of wasted spending due to the unlawful cross-border purchase of medicines is unknown, this article showcases the potential for abuse, especially as Belgians are purchasing more and more pharmaceuticals in the Netherlands¹. The case highlighted above illustrates how some patients take advantage of the EHIC system to acquire pharmaceuticals without making a co-payment. This is at increased cost to insurers while local pharmacies lose out on potential domestic purchases. Additionally, it demonstrates the incentives that exist for unintended usage of the EHIC, as these types of purchases are clearly not with the purpose of continuing an individual's stay under safe medical conditions in a foreign country. As an aside, since June 2008, suppliers of generic pharmaceuticals have reduced prices considerably in the Netherlands, with prices of the most common generics dropping by 85% in 2008². While this may appear to be favourable to Belgian insurers in terms of reducing the costs that they ultimately reimburse for medicines purchased in the Netherlands, this may not be the case if cross-border utilisation by Belgians were to increase significantly.

Some tangible steps have been taken in the hopes of preventing further misuse of the EHIC system. At a meeting between the NIHDI, Dutch insurers and the CVZ, it was decided that Dutch pharmacists and Belgian health insurance institutions would be instructed to better inform Belgian patients on the correct use of the EHIC. The Dutch insurers, the NIHDI and Belgian health insurance institutions also agreed to enhance their cooperation by sharing and reviewing E-125 reports on a more frequent basis. Continued monitoring of cross-border care is needed to prevent wasteful spending and the unintended use of the otherwise valuable EHIC system.

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COMBATING HEALTH CARE FRAUD IN SCOTLAND

By: Maggie Worsfold

Summary: NHS Scotland has developed a clear strategy to combat health care fraud through its dedicated Counter Fraud Services (CFS) agency. Based on the '4Ds', the counter-fraud strategy centres on deterring, detecting, disabling and dealing with fraud. It also incorporates a strong role for communications to raise awareness of fraud across the National Health Service and to actively seek publicity as a means of deterrence. Since its inception, CFS has generated gross savings of £42.3 million.

Key words: *Counter Fraud Strategy, Fraud Prevention, NHS Scotland Counter Fraud Services (CFS)*

NHS Scotland Counter Fraud Services (CFS) provides a specialist service to NHS Scotland and is solely focused on counter fraud activities. While it is difficult to determine how much fraud exists, a report in 1994 by the Audit Commission and subsequent updates in 1996, 1998 and 1999¹ resulted in the Fraud Investigation Unit (FIU) being established to investigate fraud in the health service in Scotland². With Scotland's health budget currently at £11 billion, even 1% of this being lost to fraud detracts from the funding which should be spent on patient care.

The original remit of the FIU was to investigate fraud in the Family Health Services by primary care contractors and patients. Gross savings generated in the period 2000 – 2004 equated to £8.6 million. In 2004, Scottish Ministers extended the remit of the FIU and changed its name to CFS to reflect its new role which would include proactive investigations and deterrence as well as reactive investigations and patient exemption fraud³. The new remit

broadened the scope of CFS's activities to encompass secondary as well as primary care and to use intelligence and statistical analysis to identify areas of fraud risk. The extended remit also incorporated a communications role to raise awareness of fraud across the NHS and to actively seek publicity as a means of deterrence.

Strategy against fraud

Since that time, the Scottish Government has developed a clear strategy to combat health care fraud where the core elements include:

- changing perceptions and attitudes to fraud to make it unacceptable and motivate ethical conduct;
- deterrence to stop fraud from happening in the first place;
- prevention by implementing strong internal controls to counter fraud;
- incorporating fraud proofing within policy design as far as possible;

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- detection at the earliest possible stage;
- investigation which is objective and professional;
- zero tolerance of NHS fraud;
- triple tracking, i.e., the application of sanctions by means of criminal and disciplinary proceedings in tandem with action to recover monies defrauded;
- disruption of fraudsters' activities by identifying high risk areas pro-actively and addressing resulting weaknesses identified in procedures, guidance and controls; and
- dissemination and application of lessons learned from individual cases.

The full strategy can be found on the CFS web site⁴. From this Strategy, CFS has developed the 4Ds to tackle fraud within and against NHS Scotland (see Box 1).

“
Detection is
maximised by
utilising
statistical tools

Deterrence is delivered using several tools: face to face awareness sessions and presentations, e-Learning packages, training tools, including DVDs, and advertisements on intranets and internets. In all cases where a successful criminal prosecution is the result of an investigation, CFS' Communications Team seeks publicity via print and electronic media. For example, one case involved a theatre assistant who stole £23,000 of medical supplies, including cranial drill bits, which he sold on eBay. The resulting publicity equated to £152,000 of advertising space and the print media circulation was 2 million⁵.

Detection is maximised by utilising statistical tools, including Risk Assessment Methodology and Family Health Service Toolkits which interrogate hospital and primary care data

Box 1: The 4Ds

- **Deter.** By raising awareness of the impact of fraud and of the sanctions applied to those who commit such offences against NHS Scotland.
- **Detect.** By improving sharing knowledge and intelligence about fraud, enhanced data mining and a proactive approach to countering fraud.
- **Disable.** By improving NHS Scotland's long-term capability to prevent fraud.
- **Deal With.** By investigating the most serious and harmful threats and seeking to apply all relevant sanctions.

respectively to identify aberrant patterns in the data. Scoping exercises are being undertaken which analyse data and intelligence to identify the potential scale of procurement and locum fraud in the NHS in Scotland, after which proactive work will be undertaken to tackle fraud in these specific areas. A proactive work plan is agreed annually with all Scotland's Health Boards and sets out the areas where CFS will actively seek out and tackle fraud. The use of intelligence provides smarter handling of fraud referrals and better preparation for full investigations.

Disabling fraud is the cost effective way to prevent fraud happening as it identifies areas where fraud could occur and puts measures in place to stop it happening. For example, CFS has a representative in the group charged with revising the *Statement of Dental Remuneration* which is the method by which dentists claim payment for treatment and services provided to NHS patients. Health groups developing new policies are encouraged to use CFS expertise to fraud-proof policies during development and CFS is currently involved with many of the e-Health Strategy developments in particular. All of these methods contribute to disabling fraud. Moreover, proactively working with other public sector organisations identifies common approaches to prevention and

Box 2: Fraud example

One successful prosecution was of an administration assistant who was jailed for eight months for falsifying the number of shifts worked and fraudulently obtaining £40,000. The woman had two jobs within the Health Board, one as a domestic and the other as an administration assistant with the finance department. She was in a position where her availability was recorded on time sheets for payroll and she added shifts she had not worked as a domestic to the payroll sheets. This was identified by managers and referred to CFS for investigation. Consequently, systems were changed within the Health Board to ensure this could not happen again.

shares intelligence. Current collaborations include liaising with the UK Border Agency in relation to regulations and entitlements concerning overseas visitors.

Dealing with fraud covers all the actions available to CFS to respond to fraud when it is identified and this includes criminal investigation by CFS investigators, leading to prosecution by the Crown Office & Procurator Fiscal Service (COPFS), civil and disciplinary action by the contractual Health Board and referral to professional governing bodies such as the General Medical Council and the Nursing and Midwifery Council for disciplinary action (see Box 2). In relation to patients who have claimed exemption from NHS charges, penalty charges will be applied.

Teams implementing the strategy

The teams within the CFS which deliver the strategy have clearly defined remits but all interact with each other to deliver comprehensive services.

The Proactive and Intelligence Team work closely with the CFS Statistical Team to identify areas of risk. Training workshops are held with relevant health care staff to educate Health Board staff on how to identify fraud, how to handle suspected frauds without destroying

evidence and training staff in GP practices on aspects of overseas visitors regulations and entitlements.

The Reactive Investigation Team undertake investigations into allegations of fraud. They ensure that evidence is gathered, witnesses are interviewed and suspect interviews under caution* are all carried out in accordance with the relevant legislation. CFS is a Specialist Reporting Agency which means that on completion of investigations, a Standard Prosecution Report is prepared for submission to the COPFS. In Scotland it is the COPFS which decides whether a case should go forward to court for prosecution and it is essential that CFS Investigators produce reports to the highest standard of criminal evidence. In the NHS in Scotland, CFS is the only organisation that can, in statute, undertake covert surveillance. This is carried out in accordance with the Regulation of Investigatory Powers (Scotland) Act, 2000⁶.

In Scotland, patients who are in receipt of certain benefits or who have a low income are entitled to help with health costs for dental and ophthalmic treatment. The Patient Claims Team deliver a national programme of patient exemption checking where sample claims are checked every month to confirm that a patient who has not paid dental or optical charges is genuinely entitled to that exemption. If found not to be exempt, a Penalty Charge and a subsequent Surcharge will be applied in accordance with the Penalty Charge (Scotland) Regulations 1999⁷. This Team also works closely with the Statistical Team to identify high risk areas for exemption fraud and error so that patient information can be produced and, in conjunction with the British Dental Association Scotland and Optometry Scotland, advice can be made available to patients through Scottish dentists and optometrists.

* It is standard practice for CFS to interview a suspected person under tape-recorded conditions. A suspected person is cautioned before an interview commences, the caution informing them that they have the right to silence, i.e., to make no comment on any of the questions put to them. If the suspect is an employee, he or she is informed that the recording may be used in criminal, disciplinary and civil recovery cases. CFS calls this an Interview Under Caution (IUC).

“ CFS
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The Communications Team is key in delivering fraud awareness sessions and electronic awareness tools to alert Scotland's health care staff to the types of fraud being perpetrated and to raise the profile of CFS and of the Fraud Liaison Officers within Health Boards in relation to the reporting mechanisms for fraud. The NHS is the largest employer in Scotland, with staffing levels of approximately 150,000 staff across 22 Health Boards. Another significant feature of the Communications Team's work is to actively seek publicity for all successful prosecutions. To pay for advertising space in the media to promote deterrence is extremely expensive and so publicity for prosecutions is an effective way of achieving public awareness of the role of CFS and the impact of fraud against the NHS. The CFS website⁴ highlights publicity and provides information on all aspects of CFS' work, including video clips to raise awareness.

Conclusion

Since its inception, CFS has generated gross savings of £42.3 million. It is difficult to measure the impact of deterrence activities but by alerting NHS staff, primary care contractors and their staff and the wider Scottish public to the adverse effects of fraud, the organisation promotes a zero tolerance approach to fraudulent activity. The key message is that fraud will not be tolerated and anyone found to have committed fraud within or against the NHS in Scotland will be treated equally, whether it be a consultant, a nurse or an administrator. The savings generated mean that funding intended for health care for the Scottish people will be used for this purpose.

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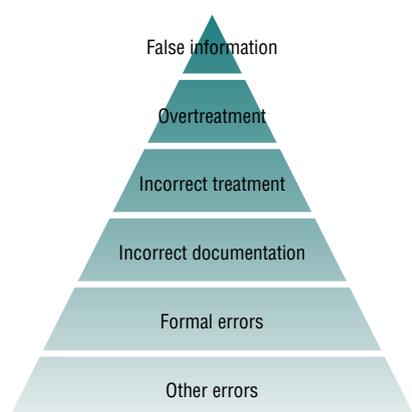
MONITORING PROVIDER FRAUD IN NORWAY

By: Elin Leidalen, Rino Skarpnord and Stig E. Omre

Summary: The Norwegian Health Economics Administration (HELFO) is responsible for direct payments to health service providers and reimbursing patients for treatment expenses. Its corporate control strategy includes guidance on tackling the challenges of fraud, corruption and other types of waste. Annual monitoring plans include different types of pre- and post-payment controls, both at national and regional level. A vignette provides an example of a fraud case involving a general practitioner that was detected during a regional monitoring activity, demonstrating how a defined corporate control strategy and professional anti-fraud competencies can efficiently detect subtle methods of unjustified claims by a provider.

Key words: Provider Fraud, General Practitioner, Monitoring, Norway, HELFO

Figure 1: Classification of incorrect claims and payments



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The Norwegian Health Economics Administration (HELFO), founded in 2009, is an agency under the Norwegian Directorate of Health with an annual budget of approximately €3 billion¹. Since its inception it has been responsible for making direct payments to health service providers and reimbursing patients for treatment expenses, including medicines and health services provided abroad. In addition, HELFO manages the Regular General Practitioner (GP) Scheme, which entitles individuals to a regular GP, and is responsible for issuing the European Health Insurance Card. HELFO has around 600 employees working in its head office, six regional offices, the HELFO Patient Referral Unit, HELFO Service Centre and HELFO Foreign Services.

To ensure that its budget is used correctly and efficiently, HELFO has a ‘corporate control strategy’ which includes tackling the challenges of fraud, corruption and other types of waste. The main objective of this strategy is to provide guidance on

resource allocation and implementation of measures to reduce fraud and waste-related risk. Annual monitoring plans provide priority setting benchmarks for different professional fields, outline what types of monitoring should be conducted, and provide the specifications for dossiers that document monitoring activities. Annual monitoring plans include different types of pre- and post-payment controls, both at national and regional level. HELFO’s different monitoring activities detect a high number of incorrect claims and payments each year; in 2010 this amounted to approximately €55 million. Based on past experience, the majority of incorrect claims and payments falls into the categories of formal errors, incorrect documentation, incorrect treatment, overtreatment and false information. The vignette in this article is an example of an outright fraudulent claim. This is the least common type of incorrect claim and falls into the category of ‘false information’ (see Figure 1).

Box 1: Vignette: Unjustified payment claims by a GP

The HELFO east region investigated possible cases of fraud among GPs who sent their payment claims on paper (as opposed to electronically). This entailed manually auditing all the monthly 'multiple claims forms' which summarise the total amount a GP is claiming for payment in a given month, based on the total number of single claim forms submitted for that month.* One of the randomly chosen GPs had a normal patient profile (in terms of patient age and gender) and approximately 1,200 patients on her regular GP-scheme list. She worked four days a week with reimbursement from HELFO and her average payment was €64,100 per year.

At first glance this GP seemed to have a normal claims history. However, during the random manual audit, a discrepancy was found between the GP's multiple claim forms and her underlying documentation (the single claim forms), indicating that there was a possibility that false claims were being made. When asked to explain these discrepancies the GP claimed that she had bought an optical scanner the previous year and that it had malfunctioned after a big thunderstorm, causing one of the scan-pointers to read the single claims incorrectly. This would account for the divergence between what she had registered on a multiple claim and the underlying single claims. However, when asked why the same discrepancy had occurred before the date of the thunderstorm, and also even before the scanner had been purchased, she had no adequate reply and referred to her husband who was her accountant and who had more computer skills than herself.

Since the GP's explanation seemed rather unlikely it was decided to manually audit 18,000 of her single claims. The in-depth audit revealed the multiple claims wrongfully billed for more patient contacts than had actually occurred. The pattern of presenting claims was one that can be seen in almost all cases where HELFO press charges: the discrepancies start out being quite small, almost innocent divergences, and as time passes they significantly increase both in number and size.

Following the findings, the GP was notified of a possible 'settlement withdrawal'. Ultimately charges were filed without the GP's knowledge; this is done to avoid the risk of evidence

being destroyed or altered. Under the Civil Penal Code, Section 270, two of the main terms are "unlawful gain" and "loss or risk of loss". To be found guilty it must be proven beyond reasonable doubt that the action was motivated by illegal profit and to be sentenced it is sufficient that the action caused a risk of loss, i.e., it is not necessary for an actual economic loss to have occurred.

While investigating the charges, the police searched the GP's home as well as her office; they also made copies of the data found on her husband's computer. The husband claimed to have used the scanner and that he had downloaded software that could translate handwritten numbers and transfer them to an excel-sheet. He further explained that he had since deleted the software but no trace of such software was ever found on the computer, adding further to suspicions that payment claims had been falsified.

The indictment had three counts: i) committing fraud, ii) as a self-employed person, not keeping proper accounts, as obligated by law; and iii) tax evasion. The GP pleaded guilty on one count (not keeping proper accounts) and the husband pleaded not-guilty to all counts. The actual trial lasted two days and during the proceedings the case took a rather surprising turn. The prosecutor changed the indictment in his closing arguments, lessening the charges against the GP, who was now regarded as having been grossly negligent (rather than intentionally fraudulent) and instead focusing on the husband as the main perpetrator. The court believed the GP's statement that every month she had handed her single claim forms over to her husband for processing. In contrast, her husband claimed that the GP was entirely responsible for making the payment claims. During sentencing the court emphasised that the husband's motive for the fraud was economic dependency on the GP as he had no independent income. The court sentenced the husband to eight months in prison, while the GP was given a three-month custodial sentence. In the settlement withdrawal, HELFO claimed back €67,179 which the GP repaid, along with penalty interest.

* One single claim represents one patient contact. The provider fills in a single claim to document what was done during the contact and the rates for the service. At the end of each month, the amounts on the single claim forms are transferred to a multiple claim form. As standard procedure, HELFO will process the multiple claim form, without having to go through each single claim.

In the case of providers, one of the sanctions that can be applied by HELFO is a 'settlement withdrawal' where a provider found to have made false claims is required to repay the full amount. HELFO also has the authority to report criminal situations, but after that point the police are responsible for further investigation and eventual prosecution. A major rule in the Norwegian legal landscape is that if a provider is found guilty of fraud, the civil sanction of 'refusal of the right to maintain

practice' may be imposed which means that the provider will not be allowed to submit claims to the national health system and be reimbursed by HELFO.

The vignette included here provides one example of a fraud case involving a GP that was detected during a regional monitoring activity. The case demonstrates how a defined corporate control strategy and professional anti-fraud competencies can efficiently detect

subtle methods of making unjustified claims by a provider, even though initially there was no obvious pattern of fraudulent behaviour.

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STATISTICS FOR **OUT-OF-POCKET SPENDING** ON HEALTH CARE OF THE FORMER SOVIET UNION COUNTRIES

By: **Nora Markova** and **Richard Stanley**

Summary: The countries of the Former Soviet Union rely heavily on out-of-pocket spending (OOPS) for health financing. However, OOPS statistics are difficult to compare due to different data collection methodologies. Data are collected either through demand-side data collection, via household surveys, or supply-side data collection, via health clinics, pharmacies, and other suppliers' data. Demand-side methods are generally unable to distinguish between formal and informal payments, while supply-side methods may capture formal but not unofficial payments. Amalgamated approaches appear highly effective in capturing the extent of OOPS.

Key words: *Out-of-Pocket Payments; Health Care; Former Soviet Union; National Health Accounts*

Introduction

Out-of-pocket spending (OOPS) by households has become the major source of health financing in several countries of the former Soviet Union (FSU). The literature on OOPS for health care observes that the need to pay is a primary cause of individuals not seeking care, including among the seriously ill^{1, 2, 3}. OOPS further impoverish low income households, and can also push the near-poor into poverty^{4, 5}.

OOPS is broadly defined as private payments for private services and outpatient medicines (private services outside of publicly regulated regimes), patient cost-sharing, such as co-payments and deductibles for health insurance,

and informal payments, such as for public services and to health workers⁶. While statistics on OOPS are essential for defining the financial protection and equity of health systems, there is no international standard for the production of OOPS statistics and legal requirements differ markedly.

The countries of the FSU report large differences in OOPS, in part due to differences between different experiences with the fiscal shock of transition and recovery, which has affected the share of OOPS in overall health expenditures. However, we also find that an important factor behind varying OOPS statistics are different estimation strategies. We

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highlight the opportunities available to improve the collection of statistics for health care and, therefore, provide a more informative base for understanding the extent of the dependence of health system financing on OOPS.

Analysis

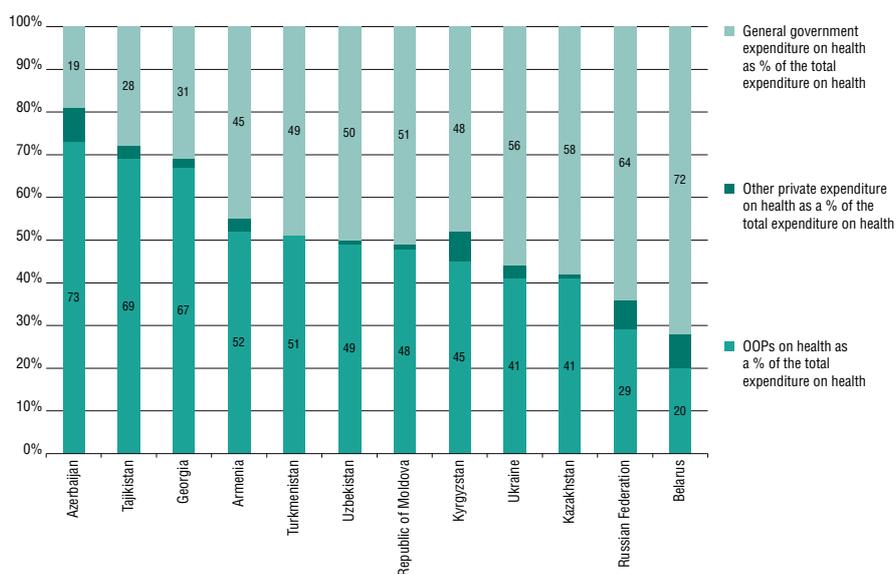
Upon request, key informants from countries of the FSU provided detailed explanations of the methodologies that they use in OOPS data collection, examples of their survey questionnaires, definitions and detailed explanations of their sampling methods. Following an analysis of the data, a group interview was conducted with the relevant health statistics officers appointed by the Ministers of Health of the countries at the Eurasian National Health Accounts (NHA) workshop in Yerevan, November 2009 organised by the World Health Organization (WHO).

NHA are one of the largest international efforts to standardise and improve the quality of information about financial flows in health systems. For those countries that have not yet implemented a methodology such as NHA, internationally reported data such as the WHO NHA database is usually based on either general questions of health expenditure that are usually associated with large non-sampling bias, or from partial supply-side data, which captures only part of OOPS. However, even among those countries with sustained commitments to NHA, statistics for OOPS are not collected in a unified manner.

According to the WHO NHA database, in FSU countries the share of private expenditure to all health expenditures varied between 28 and 81% in 2008, while the share of OOPS in total health spending ranges from 20 to 73% (see **Figure 1**). This variation is primarily due to the differences in health financing in the countries but is also a result of the differences in conceptualising OOPS and methods of data collection.

Figure 1 shows significant variations in the share of OOPS in total health spending in the FSU countries, as well as in the composition of private health spending.

Figure 1: Structure of total health expenditures (%) in FSU countries, 2008



Source: WHO. World Health statistics, 2011. Note: The Baltic states have been excluded from this analysis as they follow the EU standards for health expenditure reporting.

NHA does not always distinguish between the major categories of payments, such as private payments for private services, payments that are associated with cost-sharing, and informal payments such as fees provided to health workers and for treatments in public facilities.

Statistics for OOPS are derived through two approaches: demand and supply-side collection. Demand-side collection is via one of a wide range of household surveys that can vary significantly with regard to the focus of the survey, level of detail in the health-related module, actual questions, and recall period. Supply-side collection can include information from the financing institutions, provider surveys or reporting, such as from clinics, pharmaceutical retailers, and other service providers as well as insurers' surveys or reports. The national statistics offices of all FSU countries carry out supply and demand-side surveys within their national statistical programmes; however, for the purpose of reporting OOPS, some countries apply only one or both of these approaches. This does not imply that consistent methods are being applied to calculations over time. Table 1 provides an overview of the collection approaches used in the countries of the FSU for reporting of OOPS.

Demand-side approach

The demand-side approach usually utilises the Household Budget Surveys (HBS) with a general short health section, or additionally includes a specialised, detailed module on health expenditures, or a module designed in a way that is directly aligned with NHA. During the Soviet era, statistical agencies carried out HBS, applying similar methodologies. HBS continue to be the main sources of data in the region; however, there are now considerable methodological differences with regard to gathering data between the countries of the FSU, as well as differences within countries when HBS questionnaires differ between survey years.

The general questions included in the HBS ask broad questions on health care expenditure. It is left to the respondent to make the determination as to which payments should be included in survey responses. In other words, such questionnaires leave the interpretation of OOPS up to the respondents. Such an approach is applied in Azerbaijan, Belarus, Moldova and Uzbekistan (see **Table 1**). This problem tends to be more prominent in generalised questionnaires because the level of detail in the health expenditure section is limited.

Table 1: Data Collection approaches in the FSU countries for reporting OOPS

Country	NHA	Supply	Demand General survey	Demand special module	Demand NHA specific	Surveys
Armenia	2004–2008	X	X	X (LSMS 1996)	X (2006, 2009)	HHIS, LSMS, NHA special survey
Azerbaijan	NO		X			HBS
Belarus	NO		X			HBS
Georgia	2001–2008		X	X (SHINDA 1996–2010) (SHEUMS 2000)	X (HUES 2007, 2010)	SHINDA, SHEUMS, HUES
Kazakhstan	2006–2008	X	X	X (2001, 2007, 2008)		HBS, Health module
Kyrgyzstan	2004; 2006–2008		X	X (2001, 2004, 2007, 2010)		KIHBS, Health module
Moldova	NO		X			HES
Russia	2001–2008	X		X (2004)		SRT
Tajikistan	2007–2008		X	X (2007)		LSMS
Turkmenistan	NO	X				
Ukraine	2003–2008		X	X (2004)		HBS, Health module
Uzbekistan	NO		X			HBS

Abbreviations:

HHIS: Household Integrated Survey; HBS: Household Budget Survey; HES: Household Expenditure Survey; KIHBS: Kyrgyz Integrated Household Budget Survey; HUES: Health Utilization and Expenditure Survey; LSMS: Living Standards Measurement Survey; SHINDA: Household Integrated Survey; SHEUMS: Survey on population's healthcare expenditures and unrecorded medical service; SRT: Survey of the Russian Treasury.

Some countries have overcome this problem by including specialised modules with more detailed questions, usually carried out as part of HBS for certain selected years. Kazakhstan, Kyrgyzstan and Ukraine have developed detailed health expenditure modules. Armenia and Georgia have developed a specialised module that falls into the framework of NHA to capture OOPS. The difference between NHA specific surveys and the detailed health modules is that the former questionnaires are designed particularly with the purpose of feeding data into the NHA tables, while the latter might be more focused on answering other specific policy questions. Regardless of their primary purpose, both types provide detailed analyses of financial protection and equity of the health system in place.

HBS are carried out monthly, quarterly or annually, thus providing more systematic data series. The specialised surveys and modules are usually carried out once every two or three years depending on the availability of funding. Often, in these cases sustainability of the process may be challenging because it is dependent on external funding. Armenia and Georgia have managed to overcome this

issue by shifting from Living Standards Measurement Surveys to an NHA module integrated into the HBS, which is funded domestically (**see Table 1**).

It is too expensive to produce detailed OOPS data every year and rectifying the results can be challenging. Countries usually conduct general OOPS surveys regularly and create “correction factors” from the less frequently administered OOPS-specific surveys. However, there are naturally discrepancies between surveys and not all countries estimate the correction factors on the basis of the National Accounts, which is the international standard.

Even when carried out less often, as long as they are regular, OOPS-specific surveys, combined with methods of triangulation, provide reliable data. In general, countries that have developed specific surveys have more accurate data in comparison to countries where no attempts to measure OOPS have been made and where estimates can be expected to be underestimations of true OOPS. When surveys are discontinued, extrapolated figures become less reliable

over time. For example, in Ukraine and Russia the last specific OOPS surveys were conducted in 2004 (**see Table 1**).

Some countries try to capture all possible payments by asking the respondent to itemise different types of expenses (i.e. HUES, KIHBS, **see Table 1**). Lu et al. (1) found that this approach gives significantly higher level of OOPS compared to single item measures. Itemised questions are relatively more accurate because they remind the respondent of categories which may otherwise be omitted, but health expenditures may be over-reported. Thus, there is likely to be an overstatement of the magnitude of the difference in the share of OOPS in total health spending reported for countries that base their estimates on detailed itemised questions.

All types of demand-side data collection suffer from a series of limitations. For example, differences in the recall periods reduce the comparability of the data. In the case of Belarus, the recall period is not specified. In some of the questions in the survey in Georgia, the time period is referred to as “usual monthly costs”. Other

countries use very long recall periods, such as Armenia, where the expenditure data relate to the entire preceding year.

Other issues further increase non-sampling errors, such as the usage of terms which may be unclear to the respondents; for example, distinctions between treatments versus prophylactics and sanitation (HBS Belarus). Another type of under-reporting may occur in the general categories, where respondents might not recall all payments, or relate them to health, such as transportation, gifts, and informal payments (HES).

Sampling errors increase with the detail of the analysis and decrease with the size of the sample¹. Because it is challenging in some low-income countries to obtain high response rates it is not an uncommon practice to pay the respondents. The monetary incentive may raise the response rates of low income households, thereby affecting the sampling strategy. Another source of error arises in the use of proxy respondents – when the respondent and the patient (or person paying) differ. Biases are also introduced when questionnaires inquire about sensitive illnesses or illegal behaviours such as the giving and taking of bribes.

Supply-side approach

Supply-side data collection is based on the legally-mandated gathering of information from service providers and pharmaceutical retailers. Only a few countries in the region, such as Armenia, Russia and Kazakhstan, apply this approach when reporting the OOPS within the framework of NHA. A limitation of the supply-side survey instruments is that they do not capture informal payments, and often only capture formal co-payments and fees for service. Supply-side collection also excludes payments that are not properly accounted for, such as payments without a receipt. Another issue with this approach is that the coverage of the private sector could be incomplete. In Uzbekistan for example, private health care providers are registered under the law as small companies and there are legal barriers to expanding the reporting burden imposed on such enterprises.

Amalgamation approach

Only a few countries in the region, such as Armenia and Kazakhstan combine information from both sources. In Armenia, data from pharmacies is collected to capture pharmaceutical OOPS. These data are comprehensive, providing a view of health expenditures from the perspective of all agents involved in the health system. It contrasts the data sources with each other, identifies and assesses discrepancies, and takes into account their respective strengths and weaknesses, in order to obtain a composite estimate of actual expenditures². Although it entails more effort and expense than relying on a single data source, it yields results that are more robust, consistent, comprehensive, and of a higher quality than the individual data sources.

Discussion

The comparability of OOPS statistics are constrained due to differences in estimation techniques, with broad-based household surveys introducing various biases, and provider surveys unable to capture informal payments or, in some cases, expenditures in the private sector, which in some countries represents a large proportion of health expenditures. Equally important are the lack of changes in the reporting system, which may no longer be capturing the changes in health expenditure.

Methods of data collection should generally be chosen on the basis of the structure of the payments in a particular country. In general, the demand-side approach can ensure that all types of payments are included in the data, while the supply side approach provides a more precise estimate for the type of expenditure it intends to capture. For example, a country that has primarily a cost-sharing mechanism for drugs may put in place a system of data collection in pharmacies, while a country that has a large proportion of informal payments would only be able to capture them using household surveys. Where feasible, both methods could be applied and data reconciled in an effort to 'triangulate' and weigh an estimate of OOPS, though there are no international standards to conduct

this procedure. Moreover, household expenditures are often calculated by multiple ministerial departments, with one reporting data without using the data produced by the other.

Given their commonalities, the FSU countries could benefit from the continued or intensified exchange of information, and cross-country learning in questionnaire design, survey design, and methods to calculate OOPS. In the production of such data there is a constant trade-off between price and quality, but regularity of the survey cycles and their integration into national statistical policy is essential for sustaining quality and capturing trends.

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PAY-FOR-PERFORMANCE DOES NOT ALWAYS “PAY”

By: Katharina Janus

Summary: Pay-for-performance (P4P) has dominated medicine for the last decade although evidence from economics and psychology has shown that it can entail fundamental risks and side effects, especially in knowledge-intensive and complex situations. This article, thus, questions the comparability of medicine to Tayloristic factory work where P4P has been the preferred control mechanism. It then offers alternative solutions to managing motivation of doctors that focus on strengthening competence, autonomy and social relatedness to professional culture.

Key words: *Pay-for-Performance, Incentives, Principal-Agent Relationship, Crowding Effects, Knowledge-Intensive Work*

Incentives aim at enticing agents to act in the best interest of the principal. In this way, doctors should make decisions for the patient, but they are also expected to consider the interests of health insurance/budget holders in tax funded systems and the health care system at-large. Additionally, doctors might factor in some interests of their own – they also have to pay their rent. Reconciling the plethora of interests in one agent (the doctor) seems impossible and “side effects” inevitably result. As a consequence, the contract between principal and agent cannot be exactly defined and is affected by continuous mistrust that is intensified by information discrepancies (information asymmetry) between principals and agents. Thus, designing the perfect incentive system that controls the “relationship of mistrust” was and remains one of the fundamental questions in health care management.

Approaches to incentive system design have to date largely focused on experimenting with various monetary incentives. Although “money as a motivator” for behaving in the best interest of the principal was first employed more than 3000 years ago, it is still the predominant tool for influencing agents’ “proper” behaviour. This long, but not always laudable, history of paying agents for desired performance raises the question as to whether performance-based payment is an adequate concept for incentivising high quality in medicine.

A careful review of nearly all pay-for-performance (P4P) initiatives in health care by Rosenthal and Frank comes to the conclusion that “money works” if quantity determines performance. If, however, quality is the desired performance objective, there exists no evidence in favour of money as an effective motivator for achieving better quality care¹. Human decision-making, problem-solving and

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in particular experience then determine performance. But when do we solely target “quantity” in medicine? The number of immunisations and preventative exams has increased as a result of P4P. A nice effect, but unfortunately, the main medical and economic benefit as well as costs are generated in the daily complexity of medical examinations and treatment. If overall quality of care is the performance objective, then piecemeal, monetary incentives encounter problems.

“no evidence in favour of money as an effective motivator for achieving better quality care”

This finding is – as is P4P – not new, but has been a topic in economic and psychological research for decades. P4P works well for simple tasks², but “it does not always pay” and thus only less than 5% of performance of senior managers can be explained by monetary incentives³. On the contrary, obligation-based or intrinsic norms determine more than 30% of performance⁴. Under certain conditions, paying professionals for performance can even produce unwanted “side effects” and may then reduce intrinsic motivation that is based on the pure interest in the work itself or the obligation that is felt towards the profession.

This interaction between intrinsic and extrinsic (monetary) motivation has been coined by Frey as the “crowding-effect” of human motivation which postulates that extrinsic and intrinsic motivation are not merely additive, but systematically depend on each other under certain conditions⁵. Thus, individual behaviour depends on personal preferences on the one hand and external restrictions (prices) on the other. Crowding-theory combines both and suggests that extrinsic monetary incentives can have positive (“crowding-

in”) or negative (“crowding-out”) effects on intrinsic motivation, depending on whether the payments are perceived as controlling (negative) or supportive of professionals’ work. Crowding-out is based on the reduction (or increase, if crowding-in) of perceived autonomy and is in particular detrimental to work morale if knowledge-intensive – and difficult-to-measure – work is treated like simple factory work and, thus, is reimbursed “by piece accomplished”. This is the fundamental problem of what is known as Taylorism.

Taylorism

Frederick Taylor developed his “principles of scientific management” in the early 20th century when automobile production was on the rise and designing efficient factory work processes was the overarching objective of management⁶. Taylor’s approach was based on the idea of the division of labour: the work process consists of definable and dividable tasks that can be standardised, rehearsed and therefore optimised. Deviations from the norm are sanctioned through incentives, which also apply to production workers. In this way, rules of thumb and heuristics are replaced by standard operating procedures that are monitored hierarchically and incentivised monetarily.

Taylor’s approach to performance enhancement has been the “hippest thing” in medicine for about ten years and every day another P4P-programme sees the light of the day. However, Taylor developed his concept for classical factory workers, who assemble cars or produce other industrial goods. Machines produce machines in classical manufacturing. If high-quality health care delivery is the objective, standardised operating procedures that resemble classical factory work and are incentivised monetarily seem to be flawed. But why? What is different in medicine and why do classical incentives that have proven successful in manufacturing lose their power and even entail risks and side effects in health care?

Both factory work and knowledge-intensive work are based on the interdependence of team members who create a higher value-added together than they would each create by themselves.

This is the fundamental reason why the creation of “firms” in general has proven to be a superior way to organise production and the exchange of goods and services in comparison to direct spot-market exchange⁷. In this way, a collective good is created within firms, but at the same time social dilemmas arise because agents might withhold information or act as free riders. Under Tayloristic conditions, this misbehaviour could easily be sanctioned or punished by the principal in the hierarchy because responsibilities for tasks are clear and principals can monitor agents’ proper behaviour. A variable and performance-based reimbursement is then employed as a sanctioning incentive.

However, only few activities in medicine resemble manual factory work in the Tayloristic sense and knowledge-intensive work processes call for a more sophisticated management approach. Just imagine a transplant surgery where the chief of staff offers the consulting attending a certain Euro amount if she contributes her expert knowledge in a critical situation. Just a joke? No, this would be the application of P4P in the classic sense.

But we do not have to take recourse to critical examples such as surgery. A “simple” multi-morbid patient who shows up every day in a primary care practice also does not fit into the Tayloristic framework. If complexity rules, cross-professional teams are the fundamental learning entities in health care organisations where collective team work is crucial to the further development and application of knowledge⁸.

The fundamental difference between manual factory work and knowledge work has significant implications. Firstly, the productivity of knowledge-intensive teams increases only if knowledge is distributed unequally among team members. Secondly, the results of knowledge-intensive teamwork generate at least partly new explicit knowledge that can be disseminated easily and developed further by all team members. When individual team members contribute their implicit knowledge to the team, it is transformed from a private into a collective good that can be “observed” by

other team members and principals. Thus, there exists an incentive for knowledge workers to hide their knowledge to maintain their “personal unique selling proposition (USP)”. This means, thirdly, that knowledge workers have higher negotiating leverage with respect to their principals than factory workers have because the former are more difficult to replace. The star cardiologist, for example, is crucial to a medical centre’s reputation and competitive advantage. In this case, the specific capabilities of the knowledge worker are essential for the productivity of the organisation and non-dividable or replaceable as postulated by scientific management. Hence, if teamwork is complex and knowledge-intensive, traditional Tayloristic approaches that are based on sanctioning and control fail and new management approaches are required that tackle the inherent social dilemma. They can either target the structural or motivational aspects of the work environment.

“entice organisational members to contribute their knowledge in teams and refrain from opportunistic behaviour”

While structural approaches change “the rules of the game” and make cooperation more attractive for selfish agents, motivational aspects relate to the preferences of individuals that are determined by the work content itself or the profession. Structural approaches refer to ground rules that set the framework for the activities of knowledge workers, but do not interfere with the actions they undertake to accomplish their tasks. We can think of it as a playing field that has boundaries and basic rules that define

interactions, but do not prescribe the detailed steps to shoot a goal. Similarly, in medicine we can think of basic rules and preconditions that need to be in place to successfully accomplish a surgical procedure. This does not only refer to tools and a clean operating theatre, but also to rules of conduct, communication and respect. While this sounds pretty self-evident, reality frequently shows a different picture.

Motivational approaches are far more complex to achieve in comparison to structural changes, although they are closely related. However, research has shown that it is worth the effort and that “management by motivation”⁷ actually saves expenditure for monitoring and controlling the principal-agent relationship because highly motivated workers “contribute much more to goal achievement than the minimum that could be extracted from them by supervisory enforcement”⁸. Management by motivation also creates the basis for the disclosures of tacit knowledge in teams that cannot be monitored or sanctioned in the classic sense, but is key for the dynamic development of performance.

But how can we enhance or rather speak to doctor’s motivation? Or, thinking about the playing field again, how can we coach the doctor? Assuming that doctors are intrinsically motivated to a certain degree and have an interest in the work they do and assuming, furthermore, that this work bears a certain level of complexity and knowledge-intensity, paying doctors for performance does not seem to be the appropriate incentive (as described above). Under these conditions, P4P would lead to the crowding-out of intrinsic motivation because doctors perceive the piecemeal payment as a controlling mechanism that implies a loss of autonomy. In addition, the implicit psychological contract for the delivery of certain services is then changed. While, for example, providing preventative care was “part of the doctor’s job” and well appreciated by society and colleagues, P4P changes this ethical obligation towards the professional code of conduct into a pure exchange transaction. This might even entice doctors to play a different game altogether: focusing on those services that are paid extra (for performance) and

neglecting other services that remain in the professional package of services that doctors are supposed to provide. This strategy of “gaming the system” once they have figured out the rules leads to fragmentation and increases the quantity of services provided, but quality effects remain unclear.

In order to coach doctors, we have to find out what motivates them and how we can enhance this motivation. What is meant by intrinsic motivation in medicine and how can we influence it? Motivation is intrinsic if an activity contributes to the satisfaction of an individual’s needs¹⁰. But what are doctors’ needs? Are doctors intrinsically motivated by healing patients or rather through their professional role, aiming for a certain level of professional recognition and status? The former refers to the so-called enjoyment-based recognition, while the latter is obligation-based and determined by professional culture. Both forms of intrinsic motivation have an impact on how doctors make sense of the environment in which they work, i.e. how they shoot the goals on the playing field. In order to manage motivation strategically, side-effects of monetary incentives such as crowding-out need to be minimised, while intrinsic motivation has to be strengthened. The objective of managing individual motivation in health care organisations is to entice organisational members to contribute their knowledge in teams and refrain from opportunistic behaviour in order to make the principal-agent relationship work. This can be achieved through strengthening competence and autonomy, and enhancing the social relatedness to the professional culture.

Competence

In knowledge-intensive teams, P4P bears the risk of interrupting teamwork and alienating professionals because the willingness to contribute knowledge and exchange information decreases as a result of selective incentives¹¹. In these situations, a salary that is based on individual competencies and is supported by non-monetary incentives such as social recognition and institutional branding has been supportive of strengthening competence of team members in prominent health care organisations in the

United States, such as Kaiser Permanente and the Mayo Clinic. If the competence of team members is strengthened, they contribute their knowledge voluntarily to the work of the team¹². However, they have to receive positive feedback for their contributions or for fulfilling professional norms, and they have to perceive that their contribution is essential for the collective work and its successful accomplishment¹³.

Autonomy

Closely related to strengthening individuals' competencies is maintaining autonomy as an essential prerequisite for creativity and complex problem-solving¹⁴. Instructions and sanctions in the form of monetary incentives reduce perceived self-determination and, hence, intrinsic motivation. Individuals feel "controlled" externally and lose interest in the work content itself: the fulfilment of the controlling factor becomes the centre of attention and "managing the measures" becomes essential.

Social relatedness to the professional culture

Finally, it is essential to strengthen the perceived social relatedness among team members and towards their professional culture that defines the sensemaking process of the team and its identity. Medicine becomes more and more a team sport, but team members are socialised by their professional culture during their education. This professional culture overrides organisational cultures in many situations and, thus, has to be the hook for management to intervene in order to strengthen intrinsic motivation. Professional culture has undergone changes due to external pressures such as litigation and lobbying that has shifted some professional norms in the minds of doctors. However, talking to professionalism is still the strongest measure to enact obligation-based intrinsic motivation and, thus, to coach the team. But how?

If we believe what we read in the press, doctors are "after the money." Hence, focusing on non-monetary incentives, as suggested, seems futile and the focus on P4P does not come as a surprise. At least,

we have to credit P4P for shifting attention towards the outcomes of medical care and for creating awareness for the return-on-investment in medicine ("do we get what we pay for?"). However, P4P's effect on quality of care is ambiguous which – again – does not come as a surprise because of the knowledge-intensive and complex character of many transactions in health care that do not resemble simple factory work. The more serious side effect of the activities around P4P has been that it has led to a public discussion solely around monetary incentives, inadequate or insufficient reimbursement for services and the "wrong" incentives in general. However, the profession of medicine relates to more than just to money. What is the price tag for a patient who says thanks to a doctor for saving her life? Can we measure this in monetary units at all? Is the sense of practicing medicine and its appreciation assessable monetarily or does the recognition in society play a role?

It seems as if the monetisation of medical care has changed the perception of medical practice and its professional profile. Instead of coaching the medical team through positive leadership that focuses on the rewarding and intrinsic aspects of medicine, public propaganda focuses on negative aspects that are solely based on monetary factors. On the contrary, studies have actually shown that doctors are in fact not so dissatisfied as the press tries to make us believe¹⁵. Rather, what is essential is the "package" of various monetary and non-monetary incentives and how the agents perceive them.

But how can we replace P4P and reduce its associated side effects? The most recent management literature provides insights into the management of knowledge-workers in teams. In the past, management innovations took years to gain a foothold in medicine. Without blaming the past, principal-agent relationships in health care would benefit from a fast adoption of these concepts. Today's medical teams cannot be coached by selective incentives such as P4P – side effects inevitably result. Health care systems of industrialised countries are now at a crossroad after years of monetisation and economisation based on classic Tayloristic management

approaches. There is urgent need for action in academia and practice. If we don't learn how to manage performance in medicine, we might – in fact – have to pay for it in the end.

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NEW PUBLICATIONS

Good health at low cost. 25 years on – What makes a successful health system?

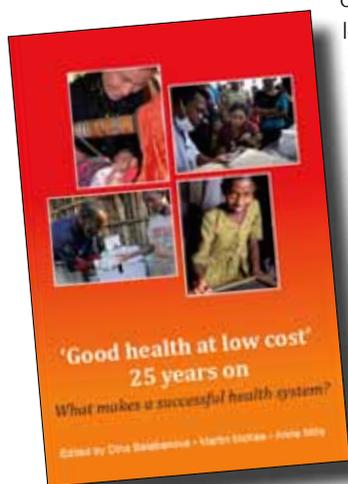
Edited by: D Balabanova, M McKee, A Mills

London: London School of Hygiene & Tropical Medicine, 2011

Number of pages: 369

Freely available to download at: <http://ghlc.lshtm.ac.uk/>

This new book re-evaluates a question first posed 25 years ago: 'why are some poor countries able to achieve better health



outcomes than others at similar levels of income?' In 1985, the Rockefeller Foundation published a report looking at how Sri Lanka, Costa Rica, China and the Indian state of Kerala achieved levels of health comparable to those seen in wealthier countries, but at significantly lower levels of income, convincingly dispelling the myth that economic growth was a sufficient driver of development and better population health. Today, this book uses a similar

framework but with different country case studies from Bangladesh, Ethiopia, Kyrgyzstan, Tamil Nadu (India) and Thailand and authors pose fresh arguments on how even countries with a relatively low income can make big improvements to the health of their populations (particularly visible in the area of maternal and child health) by adopting a winning formula for strengthening health systems.

Authors identify key 'success factors', which include: leadership by individuals with a commitment to health gain; capacity within the individuals and institutions necessary to design and implement health reform; continuity to provide the stability that is required for reforms to succeed; the ability to seize windows of opportunity; and the ability to take context into account in order to develop appropriate and relevant policies. Further, long term commitment to health system building is argued to be the central requirement for good health at low cost.

Findings within the book are arranged in a reader friendly manner with colour illustrations and graphs. Throughout, the book makes important policy recommendations and the concluding section provides an interesting overview.

Contents:

Introduction; Research approach and methods, highlights from study countries; Health transcends poverty: the Bangladesh experience; Ethiopia: placing health at the centre of development; Kyrgyzstan: a regional leader in health system reform; Tamil Nadu 1980s–2005: a success story in India; Why and how did Thailand achieve good health at low cost?; Good health at low cost revisited: further insights from China, Costa Rica, Kerala and Sri Lanka 25 years later; The contribution of health systems to good health; Improving the lives of 'half the sky' – how political, economic and social factors affect the health of women and their children; Conclusions; Annex.

Public health in Austria. An analysis of the status of public health

Edited by: J Ladurner, M Gerger, WW Holland, E Mossialos, S Merkur, S Stewart, R Irwin, J Soffried

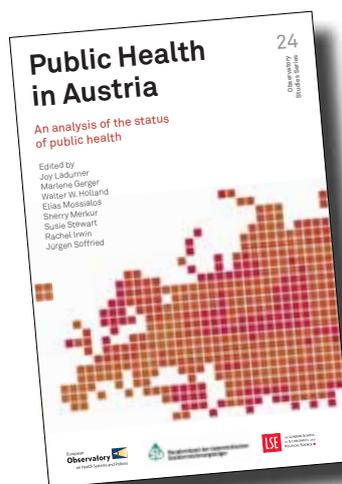
European Observatory Study Series No. 24

Copenhagen: World Health Organization, 2011

Number of pages: 355

Freely available to download at: http://www.euro.who.int/_data/assets/pdf_file/0004/153868/e95955.pdf

This new book explores some of the key challenges facing Austria's public health system. It examines how, over the last 50 years, the Austrian system has developed and adapted, how improved standards of living and education, and important advances in health care and medicine, have benefited the population. But the study also questions some of those developments and poses significant questions as to how the system needs to adapt to deal with the challenges presented by life in the 21st Century.



The book sets Austria firmly within context by outlining

the history of public health in developed countries, and examining the scope, functions and responsibilities of public health. The relevant structures and actors, and key sectors, are discussed and an up-to-date overview of education, training and research in the field is presented.

The Austrian public health system is then analysed in detail and the book draws on national research and expert interviews to present a fully-rounded picture of the current situation within the country. The resulting research finds that the public health system, which is still at a comparatively early stage of development, is struggling to maintain essential services and develop policies for improvement. The study suggests ways in which strategies and policies can be formulated to tackle these developments, and looks, in particular, at change within the fields of education, research and training.

This book is essential reading for policy-makers, advisers and analysts interested in developing a public health strategy and competence in both developed and developing countries, as well as researchers interested in the Austrian health system.

Contents:

Methodology; 1. Introduction; 2. Analysis of the Austrian public health system; 3. Information management and health reporting; 4. Health targets; 5. Addressing disadvantaged and special needs groups; 6. Health professionals and public health; 7. Recommendations; 8. Annexes.

New HiT – Health system review on Portugal

By: Pedro Pita Barros, Sara Ribeirinho Machado and Jorge de Almeida Simões

Freely available to download at: www.healthobservatory.eu

The new HiT on Portugal has been published to coincide with the completion and the beginning of the two phases of the National Health Plan (2004–2010; 2011–2016). It provides information on key points such as the National Health Service (NHS), co-payments, health insurance coverage, health care delivery by public and private providers, and on-going reforms.

The Portuguese population enjoys good health, but there is an overall awareness and concern about the rise in health care expenditure. Challenges remain and the effects of the reforms are still to be seen. The Portuguese health system has not undergone any major changes on the financing side since the early 1990s, despite the steady growth of public health expenditure. On the other hand, many measures have been adopted to improve the performance of the health system, including public private partnerships (PPPs) for new hospitals, a change in NHS hospital management structures, pharmaceutical reforms, the re-organisation of primary care and the creation of long-term care networks. Some of these measures have faced opposition from



the local population, namely those related to the closure of health care facilities. There is an overall awareness, and concern, about the rise in health care expenditure in Portugal.

New HiT – Health system review on Hungary

By: Péter Gaál, Szabolcs Szigeti, Márton Csere, Matthew Gaskins and Dimitra Panteli

Freely available to download at: www.healthobservatory.eu

The new HiT on Hungary provides key information on all aspects of the health care system, including the unitary health insurance system, out-of-pocket payments, health care delivery by both public and private providers and attempted reforms.

Despite significant improvements in recent years, many health outcomes remain poor when compared with European Union averages. Lifestyle factors – especially the traditionally unhealthy Hungarian diet, alcohol consumption and smoking – play a very important role in shaping the overall health of the population.

Having achieved a successful transition from an overly centralised, integrated Semashko-style health care system to a purchaser-provider split model with new payment methods, challenges with sustainable health care financing remain. Moreover, there are considerable variations in service delivery both geographically and by specialisation, which impact on equity of access and result in differing health outcomes for different population groups. A further challenge is the need to tackle informal payments, which are a deeply rooted characteristic of the Hungarian health system.

Since 2004 a variety of reforms aimed at reshaping the stewardship and organisation of the health care system have been attempted with varying success. Cost-containment has remained the dominant health policy objective, and public expenditure on health has declined substantially in recent years. This, in turn, has had a direct impact on the growing human resource crisis in the health system. On the other hand, Hungary is a target country for cross-border health care, mainly for dental care but also for rehabilitative services, such as medical spa treatment. The health industry can thus be a potential strategic area for economic development and growth.



NEWS

International

UN General Assembly Summit on non-communicable diseases

Non-communicable diseases – or NCDs – like heart attacks and strokes, cancers, diabetes and chronic respiratory disease account for over 63% of deaths in the world today. Every year, NCDs kill nine million people under 60. Thus the spread of NCDs was proclaimed as a socio-economic and development challenge of “epidemic proportions”, at a landmark General Assembly Summit held on 19–20 September in New York. Governments pledged to work with the United Nations to adopt targets before the end of 2012 to combat major chronic disease and to devise voluntary policies that cut smoking and slash the high salt, sugar and fat content in foods that contribute to the problem.

“The prognosis is grim,” warned Secretary-General Ban Ki-moon, who noted that only once before had the Assembly convened at the ministerial level to sound the alarm on a global health issue, when it had held its first summit on HIV/AIDS. Citing statistics from the World Health Organization (WHO), which saw deaths from non-communicable diseases increasing by 17% in the next decade, he said that in Africa, that number would jump by 24%.

A 65-paragraph Political Declaration formed the centrepiece of the two-day meeting. It acknowledged that the global burden and threat of non-communicable diseases “constitutes one of the major challenges for development in the twenty-first century” and notes the Assembly’s profound concern at the sharp increase in deaths and disability they caused. It also recognised that many chronic disease risk factors were driven by obesity, and that mental and neurological disorders, including Alzheimer’s disease, also added to the global non-communicable disease burden “for which there is a need to provide

equitable access to effective programmes and health-care interventions”.

In her address, Margaret Chan, Director-General of WHO, said medical professionals had long been aware of the “ominous” trend of non-communicable diseases that encircled the globe. They saw the patients, managed the complications, wrote the medical bills and agonised over the huge costs to families. “We plead for lifestyle changes and strict tobacco legislations,” she said. “The high-level meeting must be a wake-up call for Governments at the highest level — a watershed event that replaces ignorance and inertia with awareness and right actions immediately,” she declared. Heads of State and Government must be responsible because the problem was too big: the response must come with equal power that commanded the right protective policies across all sectors of Government.

The Political Declaration is available at: http://www.un.org/ga/search/view_doc.asp?symbol=A%2F66%2FL.1&Lang=E

Global commitment to addressing social determinants of health

The last day of WHO’s World Conference on Social Determinants of Health, held in Rio de Janeiro, Brazil on 19–21 October 2011, saw the Rio Political Declaration on Social Determinants of Health finalised. The Declaration expresses global political commitment to implement an approach that addresses the social determinants of health in order to reduce health inequities and achieve other global priorities. It will help to build momentum within WHO Member States to develop dedicated national strategies and action plans.

Around 1,200 people – including over 60 health ministers and representatives of United Nations partners and civil society – took part in the Conference, convened to build support action on the social determinants of health. During the opening, Margaret Chan, WHO Director-General, recognised the role

of civil society in advocating health and reduced health inequalities, noting that health inequities exist because “the wrong policies are in place”.

European health ministers took part throughout the event. For example, Andreas Loverdos, Minister of Health and Social Solidarity in Greece, explained how he is addressing national health issues in light of the economic crisis. Reporting on developments in his country, Dorjan Marušič, Minister of Health of Slovenia, underlined the vital support received from WHO/Europe and the value of the South-eastern Europe Health Network in undertaking multicountry activities to address the social determinants of health. The Minister of Health and Care Services of Norway, Anne-Grete Strøm-Erichsen, also described the country’s new public health act, which places the commitment to tackle health inequities at the centre of its public health strategy.

The Rio Declaration is available at: <http://www.who.int/sdhconference/declaration/en/index.html>

European Commission calls for clearer rules for information on prescription medicines

On October 11, the European Commission adopted revised proposals clarifying the information that industry can supply to the public on prescription-only medicines. Patients are increasingly interested in learning more about the medicines they take and want more of a say in how they are treated. At the same time, they are confronted with a growing volume of information from various sources and often find it difficult to identify reliable information about medicines. The increased use of the internet over recent years makes the need for clarity even more important. Online information on medicines must be accurate and reliable.

In its revised proposals, the Commission amends its original proposals of 2008 and responds to requests from the European Parliament. The proposals maintain the current advertising ban on the prescription-only medicines and foresee that only certain information on prescription-only medicines would be allowed. For example, information on the label and in packaging leaflets, as well as information on prices, clinical trials and on instructions for use.

Moreover information on prescription-only medicines would only be allowed through limited channels of communication. For example, information on officially registered internet websites; or printed information made available when specifically requested by members of the public. Publication in general print media will not be permitted.

The information must fulfil recognised quality criteria. For example, it must be unbiased; it must meet the needs and expectations of patients; it must be evidence-based, factually correct and not misleading; and it must be understandable. As a general principle, information which has not been approved before needs to be verified by competent authorities prior to its dissemination.

The revised proposals will now be debated by both the European Parliament and the Council of Ministers.

More information at: http://ec.europa.eu/health/human-use/information-to-patient/legislativedevelopments_en.htm

Public consultation on measures for improving the recognition of prescriptions issued in another Member State

The European Commission (EC) Directorate General for Health & Consumers (DG SANCO) is asking for views on what type of action will enable the EU to improve the recognition of medical prescriptions issued in another Member State. The results of this consultation will feed into an impact assessment the EC is currently preparing. Article 11 of the Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application

of patients' rights in cross-border health care addresses the recognition of prescriptions issued in another Member State. The EC is now working on a number of measures to implement the recognition of prescriptions by 25 October 2012.

The Commission has outlined a number of policy options in a roadmap. Among the options considered are the inclusion of the name and phone number of the prescriber; the Anatomical Therapeutic Chemical classification used for the classification of drugs to ensure the correct identification of the product/device and safe substitution practices; and the introduction of electronic registers of prescribers at either Member State or EU level.

The consultation closes on 8 January 2012. More information at: http://ec.europa.eu/health/cross_border_care/consultations/cons_prescriptions_en.htm

Migrants in an irregular situation: access to health care in ten EU Member States

On October 2011 the European Union Agency for Fundamental Rights (FRA) presented a report on migrant access to health care to the European Parliament's Committee on Civil Liberties, Justice and Home Affairs in Brussels. The report explores access to health care both in law and practice for irregular migrants in ten EU Member State and proposes ways to improve access. The report notes that among the ten countries reviewed, only five provide free of charge emergency care to migrants in an irregular situation. In the five remaining countries, migrants are required to pay for medical care that is available cost free to nationals.

Four Member States are particularly inclusive and entitle migrants in an irregular situation to access primary and secondary health care at similar conditions as nationals. Nevertheless, in some Member States reporting duties or practices prevent migrants from seeking necessary health care. The risk of detection and deportation is a particular barrier and the report recommends disconnecting health care from immigration control policies.

The report is available at: <http://tinyurl.com/d7t3vfu>

Country news

New Public Health Act in Norway from 1st January 2012

A new Public Health Act comes into force in Norway on 1 January 2012. Its purpose is to contribute to societal developments that promote public health and reduce social inequalities in health. One of the main features of the Act is that it gives responsibility for public health work to the whole-of-government and the whole-of-a-municipality rather than a responsibility of the health sector alone. Instead of detailed requirements, the Act prescribes procedural requirements that will provide the municipalities and counties with a foundation for systematic and long term public health work across the sectors, based on the municipalities' own planning and administration systems.

Each municipality shall then implement the measures that are necessary for meeting public health challenges. A starting point for this will be local assessment of need. This may, for example, mean implementing measures relating to childhood environments and living conditions, such as housing, education, employment and income, as well as the physical and social environments.

Municipalities must involve all sectors in the promotion of public health, not just the health sector. They, in cooperation with county authorities and central government health authorities, must implement measures and coordinate their public health activities. Promotion of participation and collaboration with stakeholders such as the non-governmental sector is another important goal. Central government health authorities will also have a duty to support the public health work of municipalities by making available information and data to monitor public health and health determinants at local level.

More information on the Act can be found at: http://www.regjeringen.no/upload/HOD/Hoeringer%20FHA_FOS/123.pdf

UK: independent review recommends changes in procedures for certifying sickness absence

General practitioners (GPs) should no longer have to issue fit notes for workers who are on long-term leave from their jobs, a UK-based review published on 21 November states. Written by Dame Carol Black, National Director for Work and Health, and David Frost, former Director General of the British Chamber of Commerce, the review recommends a new Independent Assessment Service (IAS) that employers and GPs can refer long-term sickness absence cases to for bespoke advice. Employers stand to gain around £100 million a year from reductions to sick pay bills from using this service. GPs would still certify up to four weeks of absence.

As the system currently stands, for employers tackling sickness absence in the workplace, a key barrier to getting people back to work is that the vast majority of fit notes declare employees to be completely incapable of work. This leaves the employer with no options or advice to help the employee back into work.

Welcoming the independent review, Lord Freud, Minister for Welfare Reform said that “the Government is committed to supporting more people with health conditions to work. The economy loses £15 billion in lost economic output each year due to sickness absence and we cannot continue to foot this bill. But even more important is the impact of needless inactivity on people’s lives; the damage to their aspirations and their health and the damage to their families and communities.”

The Minister confirmed that the government would undertake a comprehensive assessment of the findings of the review with a view to publishing a response in 2012.

More information at: <http://www.dwp.gov.uk/policy/welfare-reform/sickness-absence-review/>

French government adopts draft law on modernisation of the drugs and health products system

On October 27 the French Senate (upper house of Parliament) agreed to a tightened version of the draft law on the modernisation of the drugs and health products system, “*relatif à la modernisation du système des produits de santé*”, which had been adopted in September by the French National Assembly (the lower house of Parliament). The new measures introduced in the Senate include a collective redress system or ‘group of victims’ litigation mechanism, similar to class actions in the US. It will impact governance and reorganisation of the French Health Products Safety Agency (AFSSAPS), pre-market approval, control and post-market evaluation of drugs, and promotion and advertising of medical devices.

Part of the law dedicated to transparency and conflict of interests between health care professionals (“Title I”) is similar to that seen in the United States and is often billed as the “French Sunshine Act”. Such an act makes it obligatory, among other things, to make public all direct and indirect benefits drugs and medical device companies provide to health care professionals, patient associations, hospitals, students, scientific societies and specialised media. Even though the questions about its implementation are to be specified by an “implementation decree”, the French Ministry of Health indicated, during the debates in the Parliament, that the threshold for reporting by companies on their relationships with health care professionals should be €1. The exact threshold will be determined in the upcoming regulation.

The two Houses will now try to reach an agreement on the final text. Should they be unable to do so, the National Assembly will have the final say. The French government intends to adopt this law by the end of the year.

Portugal: health reimbursement rules breach EU law – says ECJ

Portugal's limits on obtaining reimbursement for non-hospital medical care in another Member State breach EU law, the European Court of Justice (ECJ) ruled on October 27 (Case C-255/09). While Portuguese legislation provides for the reimbursement of non-hospital medical care that it considers to be ‘highly specialised’, where this cannot be provided in Portugal, the reimbursement is subject to a threefold prior authorisation: (i) a detailed medical report in favour of the treatment, (ii) approval of that report by the medical director of the hospital service, and (iii) the consent of the Director General for Hospitals. For other non-hospital medical care, Portuguese law provides no possibility of reimbursement.

In its judgment the Court recalled that medical services supplied for consideration fall within the scope of the provisions on the freedom to provide services. Accordingly, the freedom to provide services precludes the application of any national rules which have the effect of making the provision of services between Member States more difficult than the provision of services in a purely national situation. The Court found that the prior authorisation system constitutes a restriction of the freedom to provide services. It also ruled that the restriction cannot be justified by overriding reasons and, in particular, by the supposed existence of a risk that the financial balance of the social security system would be seriously undermined.

The Court therefore concluded that Portugal has failed to fulfil its obligations under the principle of the freedom to provide services, by making the possibility of obtaining reimbursement for medical expenses connected with the provision in another Member State of ‘highly specialised’ non-hospital treatment, not involving the use of major and costly equipment, subject to prior authorisation.

More information at: <http://tinyurl.com/cfmkceh>

NEWS IN BRIEF

Launch of the European Portal for Action on Health Inequalities

On 14 November the European Portal for Action on Health Inequalities was launched. Developed by EuroHealthNet on behalf of the Equity Action Programme and funded by the EU Joint Action on Health Inequalities, the new website is an exhaustive source of information on health inequalities at EU, national and regional level, as well as on the social determinants of health and on Health in All Policies. It provides visitors with over 300 examples of policies and good practice implemented at EU, national and regional level. It also allows visitors to promote their own work.

The website is available at:

<http://www.health-inequalities.eu>

Health Protection from radioactive substances in water intended for human consumption

The European Commission has proposed a Directive laying down requirements for the protection of the health of the general public with regards to radioactive substances in water intended for human consumption. The Council, having regards to this proposal, underlined that the risk of exposure of the population to the risk of ionising radiation must be kept as low as possible.

More information on the Council position and the measures requested from Member States at:

<http://register.consilium.europa.eu/pdf/en/11/st13/st13648-re03.en11.pdf>

EU Budget 2014–2020: Commission unveils new Health for Growth Programme

On November 9 the European Commission adopted proposals for a new Health for Growth Programme. The programme

aims to foster a Europe of healthy, active, informed and empowered citizens who can contribute to economic growth. The programme will run from 2014–2020 with a budget of €446 million. The focus will be on fewer concrete actions that offer clear EU added-value. The proposal will now be discussed by the European Parliament and Council of Ministers, with a view to adoption by the end of 2013, to allow for the start of the new programme in 2014.

More information at:

<http://tinyurl.com/73am6fh>

European Medicines Agency: information on geriatric studies and new active substance claims

The EMA has updated its templates for assessment reports on human medicines to include information on how medicines were studied in older people and on claims that a medicine contains a new active substance. The new templates now aim to make sure that assessment reports include information on the number of older people involved in a medicine's clinical-trial programme more clearly, as well as on side effects that are of significance in older patients. From now on, the Agency will be asking applicants to supply this information in the list of questions at day 120 of the assessment procedure if they fail to include it in their dossier.

More information on the work of the EMA at: www.ema.europa.eu

Futurage Roadmap published

The final report of the European Research Framework funded Futurage Roadmap project sets out recommendations on a research agenda that will enable Europe to respond successfully to the unprecedented demographic challenges it faces and is the most extensive ever research consultation undertaken in the field over a two year period. It calls for ageing research to be multidisciplinary, life-course focused, user engaged and emphasise knowledge exchange. It promotes possibilities rather than deficit models of ageing, inclusion and citizenship within a central mitigating concept of active ageing.

The report is available at:

<http://www.futurage.group.shef.ac.uk/>

OECD Health at a Glance 2011

The quality of medical care is improving in OECD countries, with higher survival rates for life-threatening diseases, according to a new OECD report. Health at a Glance 2011 shows that, on average, only 4% of people hospitalised after a heart attack now die within 30 days following hospital admission, down from 8% in 2000. Survival rates for different types of cancer are also increasing, thanks to earlier detection and better treatments. The report also shows that obesity rates have doubled or even tripled in many countries since 1980. In more than half of OECD countries, 50% or more of the population is now overweight, if not obese. In 2009 the United States was, by far, spending most on health care, devoting \$7,960 per capita, 2.5 times the OECD average. The next highest spending countries, Norway and Switzerland, spend around two-thirds of the per capita level of the United States, but this is still more than 50% above the OECD average.

More information at:

<http://www.oecd.org/health/healthataglance>

Wales: Presumed consent organ donation to be Welsh law by 2015

The Welsh government has announced plans for an Organ Donation Bill. Implemented by 2015, it would assume presumed consent for organ donation. Unless an individual were to make an objection their organs and tissues would be available for donation after death. A White Paper for consultation has now been published with comments due by 31 January 2012.

More information at: <http://wales.gov.uk/topics/health/nhswales/majorhealth/organ>

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Diagnosis-Related Groups in Europe

Moving towards transparency, efficiency and quality in hospitals

Reinhard Busse, Alexander Geissler, Wilm Quentin and Miriam M. Wiley (Eds)

Diagnosis Related Group (DRG) systems were introduced in Europe to increase the transparency of services provided by hospitals and to incentivise greater efficiency in the use of resources invested in acute hospitals. In many countries, these systems were also designed to contribute to improving – or at least protecting – the quality of care. After more than a decade of experience with using DRGs in Europe, this book considers whether the extensive use of DRGs has contributed towards achieving these objectives.

Written by authors with extensive experience of these systems, this book is a product of the EuroDRG project and constitutes an important resource for health policy-makers and researchers from Europe and beyond. The book is intended to contribute to the emergence of a 'common language' that will facilitate communication between researchers and policy-makers interested in improving the functioning and resourcing of the acute hospital sector. The book includes:

- A clearly structured introduction to the main 'building blocks' of DRG systems
- An overview of key issues related to DRGs including their impact on efficiency, quality, unintended effects and technological innovation in health care
- 12 country chapters – Austria, England, Estonia, Finland, France, Germany, Ireland, the Netherlands, Poland, Portugal, Spain and Sweden
- Clearly structured and detailed information about the most important DRG system characteristics in each of these countries
- Useful insights for countries and regions in Europe and beyond interested in introducing, extending and/or optimising DRG systems within the hospital sector

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