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Volume 19 | Number 4 | 2013

European Observatory on Health Systems and Policies
a partnership hosted by WHO

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Quarterly of the
European Observatory on Health Systems and Policies
4 rue de l'Autonomie
B–1070 Brussels, Belgium
T: +32 2 525 09 35
F: +32 2 525 09 36
http://www.healthobservatory.eu

Eurohealth is a quarterly publication that provides a forum for researchers, experts and policymakers to express their views on health policy issues and so contribute to a constructive debate in Europe and beyond.

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The European Observatory on Health Systems and Policies is a partnership between the World Health Organization Regional Office for Europe, the Governments of Austria, Belgium, Finland, Ireland, The Netherlands, Norway, Slovenia, Spain, Sweden, the United Kingdom and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

Design and Production: Steve Still

ISSN 1356–1030

LSE Health

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List of Contributors

Ain Aaviksoo • Tallinn University of Technology, Estonia.
Cristina Adroher • Agency for Health Quality and Assessment of Catalonia, Spain.
Despena Andrioti • Frederick University, Cyprus.
Sergio Ariño-Blasco • University of Barcelona, Spain.
Rita Baeten • European Social Observatory, Belgium.
Reinhard Busse • Berlin University of Technology, Germany.
George Charalambous • Frederick University, Cyprus.
Petra Dickmann • The London School of Economics and Political Science, London, UK.
Nora Doering • University of Maastricht, The Netherlands.
Kenneth Eaton • the Platform for Better Oral Health in Europe, Belgium.
Katharine Footman • The London School of Hygiene and Tropical Medicine, UK.
Paula Franklin • Durham University, UK.
Oriol Fuertes • Agency for Health Quality and Assessment of Catalonia, Spain.
Manuel García-Goñi • Universidad Complutense de Madrid, Spain.
Joan Gil • University of Barcelona, Spain.
Irene Glinos • European Observatory on Health Systems and Policies, Belgium.
Ketevan Glonti • The London School of Hygiene and Tropical Medicine, UK.
Cristina Hernández-Quevedo • European Observatory on Health Systems and Policies, UK.
Maria M. Hofmarcher • European Centre for Social Welfare Policy and Research, Austria.
Patrick Jeurissen • Ministry of Health, Welfare and Sport, The Netherlands.
Naheed Jivraj • The London School of Economics and Political Science, London, UK.
Sam Keeping • The London School of Economics and Political Science, London, UK.
Cécile Knai • The London School of Hygiene and Tropical Medicine, UK.
Anna Kotzeva • Agency for Health Quality and Assessment of Catalonia, Spain.
Eszter Kovacs • Semmelweis University, Hungary.
Priit Kruus • Praxis Center for Policy Studies, Estonia.
Stephanie Kumpunen • The London School of Economics and Political Science, London, UK.
Fred Lafeber • Ministry of Health, Welfare and Sport, The Netherlands.
Martin McKee • The London School of Hygiene and Tropical Medicine, UK.
Zlatko Nikoloski • The London School of Economics and Political Science, London, UK.
Roberto Nuño-Solinís • Basque Institute for Healthcare Innovation, Spain.
Dimitra Panteli • Berlin University of Technology, Germany.
Francesco Paolucci • University of Northumbria, UK.
Beatrice Pipitone • the Platform for Better Oral Health in Europe, Belgium.
Isabelle Risso-Gill • The London School of Hygiene and Tropical Medicine, UK.
Christos Rodias • Frederick University, Cyprus.
Lorena San Miguel • Belgian Health Care Knowledge Centre (KCE), Belgium.
Andrea Schmidt • European Centre for Social Welfare Policy and Research, Austria.
Meritxell Sole • University of Barcelona, Spain.
Verena Struckmann • University of Technology Berlin, Germany.
Gabor Szocska • Semmelweis University, Hungary.
Michela Tinelli • The London School of Economics and Political Science, UK.
Lisa Trigg • The London School of Economics and Political Science, London, UK.
Dirk Van den Steen • European Commission, DG SANCO, Belgium.
Efi Vrioni • Frederick University, Cyprus.
Emily Warren • The London School of Hygiene and Tropical Medicine, UK.
Juliane Winkelmann • European Centre for Social Welfare Policy and Research, Austria.
Katharina Wittgens • The London School of Economics and Political Science, London, UK.

EDITORIAL

By 25th October of this year, European Union Member States should have transposed the Directive on the application of patients' rights in cross-border health care into national law, thus promoting a new era of opportunities for patients seeking health care services in an EU country other than their own. This issue's Observer section starts with an overview that examines the complex reasons why Cross-Border Care is needed and the driving factors that have underpinned the eventual passage of the new Directive.

The authors highlight that despite bringing much needed clarity to cross-border health care issues, there are gaps in the Directive that could be addressed fruitfully in the future. Ten case study articles follow, based on the results of research undertaken as part of the *Evaluating Care Across Borders: European Union Cross Border Care Collaboration* (ECAB: EUCBCC) project which has sought to analyse a number of the collateral issues connected to Cross-Border Care and collaboration which are sometimes not fully accounted for in the Directive.

In the **Eurohealth International** section, Dirk Van den Steen discusses in more detail the new common rules for recognising and dispensing prescriptions across EU Member States while Paula Franklin looks at the current state of play regarding Europe's two major public health strategies. Rounding off this section, Beatrice Pipitone and Kenneth Eaton discuss how promoting better oral health in Europe is a good and worthwhile investment in citizen's overall health.

The **Eurohealth Systems and Policies** section showcases articles on The Netherlands, Spain, the region of Catalonia and Cyprus. Fred Lafeber and Patrick Jeurissen introduce a new initiative which asks citizens and service users to report on waste in the Dutch health and long term care systems, via a dedicated online portal, which received a phenomenal number of responses when it was launched earlier this year. From Spain, Manuel Garcia-Goñi and colleagues assess whether the Spanish National Health Service is evolving into a high-performing chronic care system able to meet the growing needs of people with chronic, and often co-morbid, conditions. The use of Information and Communication Technologies (ICT) is one of the fastest growing areas in health care and harbours the potential to enhance patient services. In their article, Anna Kotzeva and colleagues offer us an in-depth look at the strategic framework developed in Catalonia Autonomous Community to make evidence-based decisions on which new e-health initiatives may be productively integrated into the region's public health system. And in a final article, which again focuses on oral health, Despena Andrioti and her co-authors discuss the provision of dental services to migrants in Cyprus, recommending that the implementation of best-practice guidelines would make such provision more efficient and cost-effective.

In **Eurohealth Monitor**, we share with you two new books, one on cross-border collaborations among hospitals in Europe and the other on federalism and decentralisation in European health and social care. The news section provides a snapshot of developments in health policy, both nationally and internationally.

We end this issue with a special tribute to the memory of Johan Calltorp, who passed away in September this year. He was a distinguished health care professional, scholar and advisor, known to many of our readers in Scandinavia and internationally. All will miss his wisdom and thoughtful expertise.

Anna Maresso, Editor

David McDaid, Editor

Cite this as: *Eurohealth* 2013; 19(4).

CROSS-BORDER HEALTH CARE COLLABORATION IN THE EUROPEAN UNION: PLACING THE PATIENT AT THE CENTRE

By: Martin McKee, Reinhard Busse, Rita Baeten and Irene Glinos

Evaluating care across borders
ECAB
European Union Cross Border Care Collaboration

Summary: Since 1971, well-functioning arrangements have been in place within the European Union to enable the vast majority of patients who either need care when abroad, or have a good reason to go abroad for care, to receive it. There are also numerous specific arrangements in place, such as those linking providers in border areas or enabling those living in small countries to obtain specialist care abroad. There were, however, certain outstanding issues, not all of which were addressed in the 2011 Directive on the application of patients' rights in cross-border health care. We argue that while much publicity has been devoted to what has, often wrongly, been presented as ways in which European Cross-Border Care legislation might open up competitive markets, the real issues are much more practical, involving better understanding of what Cross-Border Care means for actual patients.

Keywords: *Cross-Border Care, European Union, Directive on Patients' Rights.*

Martin McKee is Professor of European Public Health at The London School of Hygiene and Tropical Medicine, United Kingdom; **Reinhard Busse** is Professor and Department Head for Health Care Management at Berlin University of Technology, Germany; **Rita Baeten** is Senior Policy Analyst at the European Social Observatory, Belgium; **Irene Glinos** is a Researcher at the European Observatory on Health Systems and Policies, Belgium.
Email: Martin.Mckee@lshtm.ac.uk

Acknowledgments: The work presented in this and the related set of articles appearing in Eurohealth was supported by the European Union 7th Framework Programme – Evaluating Care Across Borders: European Union Cross Border Care Collaboration (ECAB: EUCBCC), Contract Number: 242058. Sole responsibility lies with the authors. The European Commission is not responsible for any use that may be made of the information contained therein.

Complex reasons for needing Cross-Border Care

In recent years seemingly endless discussions have taken place in European fora, including the European Commission, the Parliament, the Council of Ministers and, especially, a seemingly endless series of conferences, on the subject of patient mobility within Europe.[1] At the same time, often oblivious to these discussions about them, many people have simply found a provider in another Member State. If they were aware of the intensity of these discussions they might wonder what the fuss was about.

Yet there are reasons why these political discussions were necessary and why they took so long to resolve. One was that Cross-Border Care is extremely complex; patients seeking care abroad do so for many different reasons.[2,3] For some, such as those in sparsely populated border areas, the nearest facility may be in another country and it makes little sense for both countries to duplicate facilities.

Some live in small Member States, such as Malta, where it is simply not viable to provide all highly specialised services. Even for those in larger countries, some patients will have extremely rare conditions that are treated only in a few European centres of excellence. Some fall ill after going abroad for another reason, such as tourism or business, and need urgent care, while a few, such as people receiving dialysis, can only move freely within Europe if they can obtain treatment at their destination. Others are entitled to care in one country after a lifetime's work there but retire to another, where ageing takes its toll. As Europeans increasingly live, work, study and retire abroad, more also return home to be treated by health professionals in a system they feel familiar with. Others choose to travel abroad to avoid waiting times at home. In some cases, patient mobility was pursued for entirely different reasons; in Ireland it was a spin-off from a process of reconciliation between the divided communities in the north of the island.

Yet, despite this complexity, most people were able to obtain care relatively effortlessly. In 1971, the European Economic Community implemented a Regulation enabling employees and their families to obtain care abroad if needed.[4] In time, it evolved into a system whereby individuals falling ill when abroad could obtain care and where those funding institutions paying for their care could send them abroad if treatment was unobtainable at home. Yet, in addition to these arrangements, and often with little or no reference to them, many individual collaborations developed between providers and payers in different countries to address specific needs.

Driving factors

Not unreasonably, given this complexity, governments had been happy to leave this issue alone. Those who had tried to find a better way of doing things kept facing problems, especially with substantial differences in health systems. In some, a patient would pay for their treatment and be reimbursed later. In others, the individual's insurance fund would be billed directly. However, in some, health care was fully integrated, with health authorities responsible for the needs of a defined population, with no billing and so no means of estimating the cost of the care obtained.

> the Directive brought much needed clarity

In the 1990s, a few people looked at the European Union's commitment to the free movement of goods and services and asked why this didn't apply to health care. Why could they not just get treatment abroad and send the bill to their home insurer?[5] This was a radically different idea from that agreed in 1971, where insurers and health authorities controlled expenditure, in some cases by restricting domestic capacity, even when the consequence was long waiting lists. Should they lose this control there was a risk of unconstrained growth in expenditure, with consequences for equity as the least privileged would struggle to take advantage of care provided elsewhere? Yet it was not just a handful of dissatisfied patients, some seeking redress at the European Court of Justice by invoking the principles of free movement of goods and services that forced the issue onto the agenda. Indeed, in its judgements, the Court was very careful not to say anything that would undermine the right of national health systems to plan services and decide how they operated.

By now these patients were joined by a few governments, such as that in the United Kingdom, which felt unable to challenge what it perceived as an unresponsive domestic monopoly of providers but saw opportunities in creating competition from abroad, whatever the technical challenges and costs involved. For the European Commission, patient mobility provided an opportunity to expand the sphere of the single market and thus its authority. Also, other health care actors saw emerging opportunities from the evolving EU policy discourse and hoped to use it to bring about changes in national health care systems. These included providers hoping to relax the domestic contracting and pricing systems, and sickness funds pushing for more competition.[6] Finally, there was an increasingly powerful lobby in the form of what has become a medical-industrial complex, seeking to cream-skim those elements that were most profitable,[7] including some that took advantage of advances in communication so that the patient and the provider did not even need to be in the same country. All of these groups were united in the desire to open up European health systems to competition and to do so they had to frame their narrative as advancing patient rights, even if, for some, this was very far from their mind. In this way, patient mobility became a solution in search of a problem.

Directive on Cross-Border Care

Finally, after long years of tortuous discussion, the European Union did enact a new directive.[8] Inevitably, it involved compromises between those who would open up all health care to the free market (and indeed had nearly done so in an earlier ill-fated directive on services) and those preferring to retain control over patient flows and public expenditure. However, it brought much needed clarity to many aspects of mobility. It restricted reimbursement of expenses incurred abroad to those that would have been charged at home and while it clarified the circumstances in which patients could seek treatment abroad, it also permitted insurers and health authorities to institute a system of prior authorisation for their care. Yet, despite the complexity of the negotiations, many elements remain unfinished business. It calls for much greater flows of information, but says little about what that information includes and where it might be obtained. Does it, for example, tell patients whether someone labelled a specialist in one country will do the same sort of things in another? For example, a French patient will look in vain for someone called a dermato-venerologist in the United Kingdom, where there are two distinct specialities involved.

ECAB project

The Evaluating Care Across Borders: European Union Cross Border Care Collaboration (ECAB: EUCBCC) project has sought to fill many of these gaps, as can be seen in the papers that appear in this edition of Eurohealth. The first set

reports a series of case studies of various aspects of Cross-Border Care. The first case study asks the seemingly simple question of whether the doctor treating me is subject to the same regulatory procedures as in my own country. It shows how the procedures in place vary considerably, differing in the extent to which physicians must show that their knowledge is up to date, their practice safe, and the professional and ethical standards to which they are expected to adhere. A second article looks at whether the treatment that patients will obtain in one country will be the same as in another. Who will manage their care? Will it be a doctor, a nurse, or another health professional? Will they be treated in hospital or in ambulatory care? If in hospital, how long can they expect to stay? Inevitably, the answers vary. A third asks whether, when a patient is discharged home from a hospital in a different country, their primary care physician will find what he or she expects in their discharge summary. What is, or should be, contained in this important document? A fourth case study notes how, while the Directive calls for prescriptions issued in another Member State to be dispensed, it qualifies this by saying that this is only as a general rule and that it should be in compliance with national legislation, whatever that means. What, in practice, will this mean for a patient with such a prescription? A fifth article takes advantage of a set of surveys of German patients to ask what they want to know about the care they might obtain abroad and how this is changing. A sixth case study looks at the growing number of older people moving to another country on retirement and who may, at some stage, require long-term care, a service that lies on the interface between the health and social sectors. It shows how information is often difficult to obtain, entitlements vary, and there is often considerable local discretion on what is provided. A seventh article recognises that patients crossing borders are not alone. They bring with them a complex microbiological community, most of which is beneficial or, at least, harmless for them, but some of which may be dangerous, especially if the bacteria involved have been rendered resistant to antibiotics by careless prescribing. This article examines the management and communication of the risks involved.

This edition concludes with a second series of articles combining many of these issues to look at what has been learned from established Cross-Border Care projects. The first looks at seven collaborations involving hospitals in border areas to ascertain the circumstances in which the referral of patients and the sharing of health professionals are most likely to work. It reveals that while collaboration can improve patient access, cross-border projects are complex and demanding endeavours susceptible to changes in domestic policy priorities. The second looks at one of the newest elements of Cross-Border Care, telemedicine, seeking to understand its role in health care delivery. Finally, a third paper looks at one of the areas that has experienced the most rapid growth, cross-border provision of dentistry, where some of the newer Member States have taken advantage of their low prices to attract patients from western Europe.

Taken together, these articles (and the more detailed articles on which they are based that have been or will be published elsewhere) provide a wealth of practical information on Cross-Border Care that has long been lacking and actually put the patient at the heart of the policy process.

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PROCESSES AND REGULATORY PROCEDURES OF DOCTORS IN THE EUROPEAN UNION

By: Isabel Risso-Gill, Dimitra Panteli, Eszter Kovacs, Meritxell Sole, Verena Struckmann, Helena Legido-Quigley and Martin McKee on behalf of the Work Package 1 Team for Health Professionals

Summary: Medical qualifications gained in European Union (EU) Member States are now mutually recognised within the EU, encouraging the professional mobility of doctors. However the skills and competencies required to gain such qualifications are not standardised across the EU, and great disparities exist between training programmes, particularly for medical specialities. Differences are likely to increase following the introduction of the European Working Time Directive, which has reduced the number of hours available for training. Regulation of the medical profession also varies greatly in terms of continuous professional development (CPD), revalidation, and professional standards. Standardisation of training programmes and harmonisation of professional standards offer scope to enhance patient safety and quality of care.

Keywords: *Professional Mobility, Regulation, Professional Standards, EU Cross-Border Health Care, Patient Care.*

Isabelle Risso-Gill is a Researcher and **Martin McKee** is Professor of European Public Health at the Department of Health Services Research and Policy, and **Helena Legido-Quigley** is Lecturer in Global Health at the Director's Office of the London School of Hygiene and Tropical Medicine, United Kingdom; **Dimitra Panteli** is Research Fellow and **Verena Struckmann** is a Researcher at the Department of Health Care Management, Berlin University of Technology, Germany; **Eszter Kovacs** is Assistant Professor at the Evaluating Care Across Borders (ECAB) project, the Health Services Management Training Centre, Semmelweis University, Budapest, Hungary; and **Meritxell Sole** is a Researcher at the University of Barcelona, Spain. Email: isabelle.risso-gill@lshtm.ac.uk

Introduction

Professional mobility of doctors within Europe has increased in recent years,[1] stimulated by European Union (EU) enlargement and aided by the EU Directive on the mutual recognition of Professional Qualifications[2] which simplified the process for doctors to practise in other Member States. This Directive assumes that all doctors sharing the same qualifications also share the same competencies and meet the same professional standards, and yet, the diversity in training and registration procedures suggest that this is unlikely to be the case. There is surprisingly little known about how physicians are trained, practise and are regulated in different countries, or what competencies are expected of them. This lack of standardisation has given rise to concern following several high-profile incidents of medical malpractice by doctors practising in Member States that differ from where they were trained, raising questions about the ability of regulatory systems to ensure patient safety and quality of care.

Great variation in training

Our research, which analysed regulatory processes relating to EU-trained doctors

in different Member States indicates that, whilst regulatory systems are in place everywhere, they vary in content, stringency and terminology to a degree that casts doubt on their comparability. First, the length and content of medical and specialist training programmes vary greatly between and within countries, with differing emphases on practical versus theoretical training. Although the EU specifies a minimum length of medical training, it does not specify content, skills, or competencies, leading to variation in the knowledge and experience of medical graduates among Member States. A series of qualitative interview-based studies within the European Union Cross Border Care Collaboration (EUCBCC) looking at the scope of practice and training of medical specialists in Member States showed that, despite holding the same nominal qualifications, the processes of achieving or maintaining basic and specialist medical qualifications are not standardised. The introduction of the European Working Time Directive, which limits a medical trainee's working week to 48 hours, may have increased this variation as implementation seems to have been quite variable and few authorities have adapted the length and content of training to take account of the Directive's provisions.[3] We found widespread concern that doctors in many parts of Europe are graduating with a lower level of training and skills experience than their predecessors.

Diverse standards

Following graduation, the processes of becoming registered and licensed to practise medicine – although regulated by law – also vary in content and applicability.[4] Although all countries have established professional standards to which physicians are expected to adhere if they are to continue to practise, there is great variation in the skills and competencies they are expected to demonstrate. Whilst almost all standards include basic principles of patient safety and quality of care, others extend further to include non-clinical competencies such communication and management skills, and in some countries extend to behaviours outside of the working environment. Consequently health professionals can be penalised for not upholding such competencies or values, meaning that a doctor could be professionally disciplined by a medical regulator for a case of poor management or even a drink-driving charge in one country, but not in another. For example, an analysis of medical regulators' responses to hypothetical scenarios of misconduct found that The Netherlands and Estonia regulated little beyond basic medical errors, suggesting a narrower scope of authority, whilst regulators in the United Kingdom and Germany consider that inappropriate behaviour of a doctor in any setting may have consequences for their professional status.[5]

A few countries require doctors to re-certify or revalidate at regular intervals, but this is not widespread, so some receive "life-long" qualifications whilst others must demonstrate their continuing competence every 3–5 years.[6] Thus, the professional standards by which a doctor is judged to assess their "fitness-to-practise", as well as the disciplinary processes to regulate them, vary considerably. This may result in discrepancies between the training and capacities a doctor holds and what is expected of them when they move between countries.[7]

Impact on patient care

This is important for the growing number of patients seeking care in other Member States following the introduction of the EU Directive on the application of patients' rights in cross-border health care. Patients are rarely aware of variations in the medical training and experience of doctors from different Member States. A paper reviewing patients' rights in the EU has reported that the disparity between expectation and reality can impact on a patient's health care experience, and that variations across countries have implications for patient safety and quality of care.[8] Both patients and doctors crossing borders face challenges in understanding and interpreting professional standards and regulatory processes.

By mapping and analysing the processes by which doctors are regulated across different Member States, the EUCBCC has highlighted the breadth of variation of regulatory processes across Europe and stimulated a discussion on the policy implications. The current European legal framework has been slow to address these disparities, although amendments – such as an alert mechanism to allow countries to exchange information on discredited practitioners – are under consideration. It is clear that greater standardisation of training and regulatory processes of EU doctors are still far off given the scale of diversity across Member States. However, if the safety of patients and quality of care are to be protected, there is a strong case for revisiting the existing Directive to ensure the protection of patients as well as the medical profession.

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DISEASE MANAGEMENT ACROSS BORDERS

By: Cécile Knai, Katharine Footman, Ketevan Glonti, Emily Warren and Dimitra Panteli on behalf of the Work Package 2 Team for the Evaluating Care Across Borders (ECAB) Project

Summary: A four-pronged research programme was undertaken to better understand variations in disease management across Member States and the continuity of cross-border patient care. The use of evidence-based guidelines across the European Union varies, and the medical professionals surveyed had little experience of using care pathways in a cross-border setting. Health professionals most often stated that standardised discharge summaries and compatible information technology (IT) would facilitate Cross-Border Care, while patients raised the importance of good communication between health care professionals and patients.

Keywords: *Cross-Border Care, Continuity of Care, Care Pathways, Clinical Guidelines, Patient Communication.*

Cécile Knai is a Lecturer and **Katharine Footman, Ketevan Glonti** and **Emily Warren** are Research Assistants at the European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, United Kingdom. **Dimitra Panteli** is Research Fellow at the Department of Health Care Management, Berlin University of Technology, Germany.
Email: cecile.knai@lshtm.ac.uk

Introduction

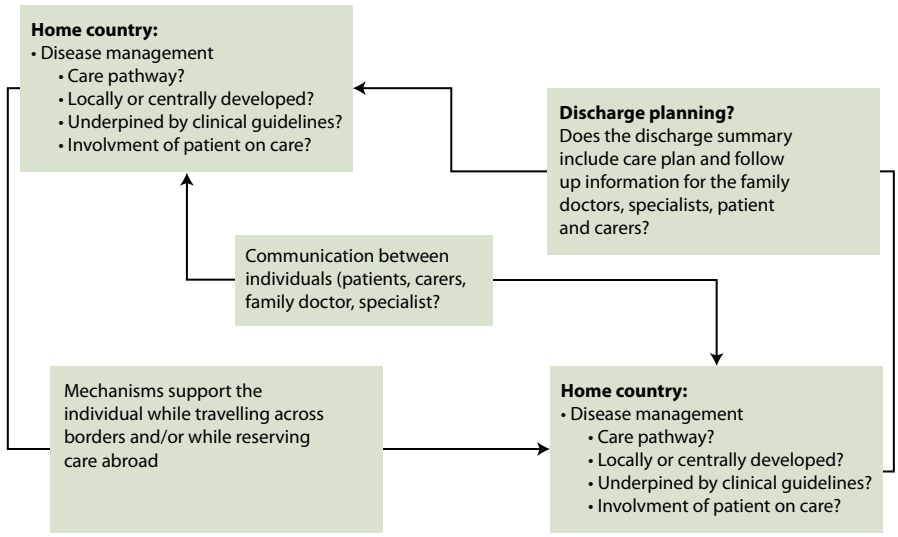
One of the biggest challenges facing disease management is overcoming the fragmentation of care so as to achieve a seamless transition of service users across service interfaces, both within and between countries. The European Directive on the application of patients' rights in cross-border health care encourages enhanced cooperation between health care providers, purchasers and regulators in different Member States, and explicitly identifies the need to ensure that cross-border provision of services appropriately meets the health needs of mobile populations. Underpinning this, however, is the assumption that service models and disease management approaches are similar and compatible across the European Union (EU).

Against this background, we conducted research on commonalities and differences in the management of common conditions in the EU, as this will have important consequences for continuity of care for patients travelling across borders or living in another EU Member State. We developed a conceptual model of the journey from the home country to the host country and back (**see Figure 1**), highlighting the importance of establishing disease management processes in both, so as to enhance transparency, integration, continuity of care, responsiveness to patient needs, and communication between key actors.

Commonalities and variations

This model informed the development of our study, which followed a multi-pronged approach. First, we conducted two systematic literature reviews on the commonalities and differences in the management of common conditions within EU Member States. We found that there is considerable scope for improvement

Figure 1: A model of a patient journey across borders, highlighting key processes of care



Source: Authors.

in the methods used to develop clinical guidelines for the prevention, management and treatment of chronic diseases in Europe.[1] We also found that there is very little primary data on the extent of Cross-Border Care within Europe and its impact on continuity of care.

Then, we looked in depth at an innovation in care coordination, the care pathway, as this is a means to improve the quality, organisation and consistency of care.[2] However, little is known about the current scope and implementation of care pathways across Europe, and their potential to support Cross-Border Care. We collected 163 responses (25% response rate) in our survey on care pathways from countries across the world. Of the 39 countries represented, 19 were European, with the highest proportion of respondents (30%) from the United Kingdom. The survey uncovered variability in the use of evidence-based guidelines, a continued reliance on giving patients information rather than investing in self-management training, and reported challenges of evaluating the effectiveness of care pathways against a range of indicators.[3]

We sought to understand commonalities and variations in the management of three specific conditions or procedures: type 2 diabetes (to represent long-term conditions in patients living abroad), acute myocardial infarction (to represent a tourist requiring emergency care) and hip arthroplasty (to represent elective Cross-Border Care). Of 338 responses from clinicians in 14 European countries, 91% of study participants reported using care pathways but only half reported employing national clinical guidelines and one-third referred to local clinical guidelines. The majority of respondents had treated foreign nationals but lacked guidance on Cross-Border Care.

Cross-Border Care collaborations

We also looked at four case studies of well-established Cross-Border Care collaborations in order to elucidate the success factors of the existing cross-border agreements. A study of French mothers going to Belgium to deliver their babies highlighted high levels of satisfaction and perceived quality of care despite evidence of poor communication and collaboration between providers.[4]

However, a survey of orthopaedic patients choosing treatment in Hungary pointed to the importance of clear communication along the care continuum and useful discharge summaries in supporting patient satisfaction and perceived quality of care. A study of the long-standing health care collaboration between Malta and the United Kingdom attributes success in delivering highly specialised care to the collaboration's longevity and personal relationships between health professionals, communication and data sharing, a shared care approach and well-established patient support systems.[5] A study of patients seeking dialysis services in the Veneto Region in Italy attributed the strengths of the service to coordination of care prior to going abroad and the use of patients' pre-existing care plans.[6] However, some challenges remain, mainly revolving around accessibility, language and communication barriers.

Continuity of care

Finally, we explored potential issues that could impact on continuity of care by analysing the experience of over 17,000 patients in Germany who had obtained services abroad. These data were drawn from the Europa Survey 2012 in collaboration with Techniker Krankenkasse (TK), one of the major sickness funds in Germany, and the Technical University of Berlin. Preliminary analyses find that 37% of respondents reported requiring follow-up treatment, which was in most cases planned and carried out by a German physician. Communication between the treating physician abroad and the patient's physician in Germany was relatively rare and this was usually achieved through the patients themselves. However, only a few respondents reported that they would have wished for more exchange. Interestingly, the majority of respondents indicated that the language of communication was German, although this was clearly related to the country the services were obtained in. Very few of the respondents who were prescribed medications encountered difficulties, and these were mostly attributable to different products and only rarely to the prescriptions themselves.

Conclusion

Analysed together, the various components of this study identify potential strategies for improving a patient's journey to receive Cross-Border Care, including measures to improve follow-up and address cultural, language and related factors, making care pathways mutually compatible, and harmonising hospital discharge summaries.

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THE ROLE OF DISCHARGE SUMMARIES IN IMPROVING CONTINUITY OF CARE ACROSS BORDERS

By: Cécile Knai, Katharine Footman, Ketevan Glonti and Emily Warren on behalf of the Work Package 3 Team for the Evaluating Care Across Borders (ECAB) Project

Summary: Discharge from hospital is an important time for ensuring continuity of care for patients receiving health care abroad. As there is no official guidance standardising discharge summaries in the European Union, wide variations exist in their national management. A systematic literature review on discharge summary content and an exploratory analysis of existing discharge summary guidance reveal wide variations in the categories of information used, and some important categories for continuity of patient care are not well represented. A set of discharge summary categories is suggested that could comprise the minimal data requirements for a harmonised European discharge summary.

Keywords: *Discharge Summaries, Cross-Border Care, Continuity of Care, Hospital Discharge, Communication*

Importance for patients

Discharge from hospital can be a challenging time for patients.[1] Much has been written on improving discharge planning and practices as a result of the deficits identified in transferring information between hospital and primary care providers.[1-4] The discharge summary is particularly important for patients who have received care abroad and are thus potentially more vulnerable. Whilst the estimated number of patients crossing borders for care is relatively small, the importance of clear directives for both the patient and the family practitioner or specialist will be essential if patients are already outside of their home country (on holiday or in retirement), living in a border region, sent for specialist treatment

Cécile Knai is a Lecturer and **Katharine Footman**, **Ketevan Glonti** and **Emily Warren** are Research Assistants at the European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, United Kingdom. Email: cecile.knai@lshtm.ac.uk

abroad, or seeking more rapid access to treatment in another European Union (EU) country.

Earlier studies, most notably the EU funded 'MARQUIS' project (2004–2007), which focused on health care quality in Europe, called for a standardised European discharge summary.[5] Another, more recent EU funded project, HANDOVER (2008–2011), found many problems with the discharge process within countries, attributed to an inward focus of hospital care providers, an unwillingness to collaborate, and a low priority placed on the provision of comprehensive discharge summaries. The project found that the amount and quality of information provided to patients, family members, and primary care providers was often insufficient.[3,4]

Wide variation across Europe

Building on the existing evidence, we sought insights into discharge summary content within EU countries and explored the scope for a harmonised European discharge summary. We developed a conceptual model of the journey from the home country to the host country and back (**see Figure 1** in our article on disease management across borders in this issue), highlighting the importance of discharge planning and harmonised discharge content to support communication and continuity of care.

To the best of our knowledge, no official guidance on standardised discharge summaries exists within the EU. We identified wide variations in the management of hospital discharge summaries across countries, with countries proposing national standards (e.g. Poland and Lithuania), or others suggesting minimum data requirements (e.g. Spain and Scotland), a standard form for all electronic discharge summaries (e.g. Denmark), a set of national standard headings for the structure and content of clinical records including discharge summaries (e.g. England) and hospital accreditation bodies defining standards (e.g. Finland).

When comparing guidance for discharge summaries provided by seven EU Member States, we found agreement on a core set of categories, including provider and admission details, clinical information, diagnosis, treatments and procedures, medications information, discharge details and follow-up. However, when comparing actual discharge summary templates from 15 countries, we found wide variations in the categories of information used, and particular categories relevant to the continuity of patient care do not seem well represented.[6]

Our findings from this exercise were reflected in a systematic review of 25 studies from eight European countries.[6] A total of 31 discharge summary content categories were identified in 21 papers, the most frequent being diagnosis, procedures, tests, treatment received, medications prescribed at discharge, and follow-up. Other than the content analysis, the most frequently discussed issues in these papers were the reduction of medication errors at discharge and the tendency towards (and challenges inherent to) electronic communication of discharge information.

Towards harmonised discharge summaries

Our research on discharge summaries in Europe suggests that a number of discharge summary categories could comprise the minimal data requirements for harmonised discharge summaries across Europe (**see Box 1**). In addition, several categories that might be particularly relevant to supporting continuity of care in a Cross-Border Care scenario include social and psychosocial support for the patient, support for the carer, contact details for close relatives, and patient and carer concerns/information given to the patient. Information in discharge summaries is potentially critical when questions or clarifications arise with respect to treatment and follow-up.

Additionally, the use of internationally recognised diagnostic and procedure classifications would bring many benefits, not only in relation to Cross-Border Care, but also in research and evaluation. Yet it was striking how infrequently the diagnosis was coded. There is an ongoing need for an internationally accepted system of procedure coding to replace the myriad of national systems.

Box 1: Recommended data for harmonised discharge summaries

- Patient details (name, date of birth);
- Hospital details (including ward and department);
- Specialist details (name, contact details, preferably phone/e-mail);
- Primary health care professional details (name, practice);
- Admission details (date, mode, presenting complaint);
- Clinical information;
- Diagnoses (using ICD codes);
- Operations, treatments, procedures;
- Medication information (using international non-proprietary names);
- Discharge information (date, reason, discharge diagnosis, person signing the discharge summary); and
- Follow-up/future management.

Source: Authors.

Conclusion

There is relatively little relevant research on discharge summaries, despite the importance of communication across the primary-secondary care interface and the speed with which electronic communication is advancing. More research on a broader scale is needed to assess practices on hospital discharge summary management within Europe and to explore the similarities and differences in content and practice.

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CROSS-BORDER RECOGNITION OF MEDICINES PRESCRIPTIONS: RESULTS FROM A MYSTERY SHOPPING EXPERIMENT

By: Rita Baeten and Lorena San Miguel

Summary: According to the Directive on the application of patients' rights in cross-border health care, medicines legally prescribed in a Member State should be dispensed by pharmacists in other Member States in which the medicinal product is authorised. We explored potential challenges from a public health perspective, which could arise when this provision is implemented. Our research included a mystery shopping experiment in which we presented prescriptions prescribed in other European Union countries in pharmacies. We conclude that, overall, the provisions on mutual recognition of medical prescriptions in the Directive do safeguard patient safety. Yet, clear information and guidelines for pharmacists and prescribers on the legal framework are indispensable to ensure effective implementation.

Keywords: *Cross-Border Care, Medical Prescriptions, Mutual Recognition, Directive on Patients' Rights*

Rita Baeten is Senior Policy Analyst at the European Social Observatory (OSE), Brussels, Belgium and **Lorena San Miguel** is an Expert in Economic Analysis at the Belgian Health Care Knowledge Centre (KCE) and former Researcher at the OSE. Email: baeten@ose.be

Mutual recognition of prescriptions

The European Union (EU) Directive on the application of patients' rights in cross-border health care,[1] provides that medicinal products legally prescribed in a Member State should be dispensed by pharmacists in other Member States in which the medicinal product is authorised (Article 11). (See also the article on 'Cross-border Health care: common rules on medical prescriptions when travelling to another EU country' in this issue). Restrictions on the recognition of individual prescriptions are prohibited unless limited to what is necessary to

safeguard human health or based on legitimate and justified doubts about the authenticity, content or comprehensibility of an individual prescription. Medicinal products containing narcotic and psychotropic substances and products likely, if incorrectly used, to present a substantial risk of medicinal abuse, to lead to addiction or be misused for illegal purposes, are excluded from this mutual recognition.[2] In an implementing act, the Commission ruled that Member States have to ensure that prescriptions which are issued upon the request of a patient who intends to use them in another Member State, should contain a minimum set of elements, including professional qualifications and contact details of the prescriber. Additionally, aside from some exceptions, these types of prescriptions should be written using international non-proprietary names (INN).[3] The Directive had to be transposed into national law by 25 October 2013.

Our research aimed to identify potential challenges from a public health perspective that could arise when this provision is implemented; in particular, a prescribed product may not be dispensed to a patient who needs it; an inappropriate product could be dispensed or inappropriate instructions may be given at the time of dispensing and finally, a product may be dispensed and further consumed or sold based on a false prescription.

The methodology used included a review of national legislation regarding prescribing and dispensing, stakeholder interviews and a mystery shopping experiment to capture pharmacists' reactions when confronted with cross-border prescriptions.

Ensuring cross border access to medicinal products

Between October 2011 and February 2012, 192 Belgian or Finnish prescriptions were presented in pharmacies in five other Member States (Belgium, Finland, Germany, Spain and the United Kingdom) in order to assess whether pharmacists would dispense the prescribed product and to identify factors that influence such decisions.[4] Over half of pharmacists were willing to dispense, yet willingness varied greatly depending on the country where prescriptions were presented, with pharmacists in Finland (33% of the prescriptions) and the United Kingdom (29%) being less willing to dispense than in Belgium (67%), Germany (79%), and Spain (67%). The main reasons given by pharmacists in Finland and the United Kingdom not to dispense was a belief that their national laws barred them from dispensing foreign prescriptions. However, there is no such legal restriction in the United Kingdom, while Finnish prescribers in 2012 were constrained in relation to non-Nordic prescriptions.* This finding suggests that having an enforceable law in place is not sufficient to change dispensers' behaviour; clear guidelines on how pharmacists should respond to EU prescriptions are necessary.

Reasons for not dispensing in the remaining countries were primarily linked to the impossibility of identifying the correct product when pharmacists were presented with prescriptions using country-specific brand names. This obstacle appears to be key to dispensing. In most countries, prescribing by brand is still common practice. Furthermore, generic substitution is forbidden for private prescriptions in three of the five countries analysed (Belgium, Germany and the United Kingdom), which makes the dispensation of an equivalent product illegal.

Our legal analysis revealed that there are differences in the information requested for a prescription to be valid in the different countries. As a result, pharmacists may consider prescriptions coming from another Member State to be 'incomplete'. Our interviews revealed that pharmacists are more likely to dispense against an incomplete prescription in emergency cases or if the product was for the treatment of a chronic condition and presented no potential risks for the health of the patient.[5] This reflects the findings of the experiment, where no prescription was refused due to a lack of information that was legally required in the country of dispensing. Nevertheless, having a minimum list of elements included in cross-border prescriptions (as defined by the Commission) would avoid refusals to dispense on the grounds of insufficient information.

Avoiding confusion

Although in our experiment the right molecule was dispensed in all cases (brands and pack sizes sometimes differed from the prescribed ones), the potential for dispensing the wrong product, primarily due to pharmacists' inability to recognise its commercial name, or to read and understand the instructions on the prescription form, should be taken seriously. The Commission's decision to limit the mutual recognition of prescriptions as a general rule to products that have been prescribed by their INN, should enable pharmacists to recognise the right product.

Avoiding fraud or abuse

Products that could reasonably lead to inappropriate, illegal or commercial use are excluded from the mutual recognition of prescriptions. This limits the risk of dispensing against a false prescription. To reduce the risk of fraud further it is necessary to facilitate the authentication of both the prescriber and the prescription. Although during the experiment, the verification of the authenticity of the prescription or the prescriber did not appear to play an important role in the decision on whether or not to dispense a product; we should recognise that our scenarios were for common conditions with few risks. Thus, our results should not be generalised to more complex cases in which the safety of the patient could be put at risk. Tools used nationally/locally to this end, such as prescriber codes, stamps and signatures would not help in the validation of foreign prescriptions, since codes are only valid within the specific national territories. The obligation in the Commission's implementing act to insert contact details, in particular a phone number of the prescriber in EU-wide prescriptions, could enable pharmacists to both verify the authenticity of the prescriber, and ask for further information in case of doubt.

* At the time of the research (2012) Finland had not yet transposed the Directive into national legislation.

Conclusion

Overall, the provisions on medical prescriptions in the Directive do safeguard patient safety. Yet, clear information and guidelines for pharmacists and prescribers on the legal framework are indispensable to ensure effective implementation.

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WHAT INFORMATION DO PATIENTS WANT WHEN CHOOSING A HOSPITAL AT HOME OR ABROAD? A CASE STUDY FROM GERMANY

By: Michela Tinelli, Zlatko Nikoloski and Dimitra Panteli

Summary: The European Union (EU) is keen to promote patients' rights, and to ensure that an informed choice is pursued when seeking health care in EU Member States. The 2011 Directive on the application of patients' rights in cross-border health care is aimed at supporting the achievement of these goals. This article investigates German patients' experience regarding their access and use of quality information when choosing hospital care in their own country and abroad. The findings could be used to inform the implementation of the Directive and the provision of quality information to patients, via the establishment of National Contact Points.

Keywords: *Cross-Border Care, Patients' Rights, Patients' Choice, Hospital Care, Quality Information*

Introduction

Ensuring patients have access to quality information is crucial to help them make informed choices, not only when they are in their home country, but also before going abroad for health care. One of the key objectives of the European Union's (EU) 2011 Directive on the application of patients' rights in cross-border healthcare is to make sure that people have clear information on their rights to Cross-Border Care and relevant knowledge on quality and safety standards enforced in the country of interest, as well as specific medical, organisational and financial aspects of the health care services and the treatment options on offer.[1] Such information should be provided by so-called National Contact Points (NCPs) which are to be established in all Member States (MS). This case study investigated what type of information German patients accessed and what source they used when choosing a hospital for their care. Two scenarios were compared, one examining patients seeking care in their own country

Michela Tinelli is Research Fellow and **Zlatko Nikoloski** is Research Officer at LSE Health and Social Care, The London School of Economics and Political Science, London, United Kingdom. **Dimitra Panteli** is Research Fellow at the Department of Health Care Management, Berlin University of Technology, Germany.
Email: m.tinelli@lse.ac.uk

Table 1: Sources and types of information sought by patients when seeking hospital care at home and abroad

	Scenario 1 Hospital care in their home country (Making Choice in Health Care Survey; percentage of responses)	Scenario 2 Planned Hospital care abroad (The Europa-Survey 2012; percentage of responses)
Source of information		
Media (Newspaper/Internet/Television)	12/20/5	3/19/n.a.
Personal (Friends/Family/Neighbours)	21/20/3	18
Health care providers	74	40
Health insurers (TK customer service/TK hotline)	n.a.	62/42
Type of information		
Health-related Professional qualifications Risk of treatment/Rates of infection. Quality of medical care/Hospital performance	 65 57 47	 41 3 38
Organisational-related (How to contact the health care provider/Location/ Language staff)	65/50/n.a.	n.a./n.a./7
Financial-related (Savings, Coverage of costs by insurer, Reimbursement modalities)	n.a.	7/42/49

Source: Authors. Note: n.a = not available as the survey did not collect this particular information.

and one investigating patients planning to receive care in another MS. Two separate patient surveys conducted in Germany in late 2012 were used for this purpose.

Scenario 1 – Patients seeking care in their own country

The *Making Choice in Health Care Survey* collected data from a series of EU countries, including Germany.[2,3] A total of 128 German patients from two General Practitioner (GP) practices completed the survey whilst waiting for their consultation. They were asked about their personal experience of accessing information when choosing hospital care. Key findings are summarised in Table 1. Patients used different sources of information when making a decision on their hospital care, be it media (i.e. newspaper, internet or television), personal contacts (i.e. friends, family, or neighbours) or health care providers. The latter were reported as the preferred source of information compared with the others (health care professionals (74%), personal (3–21%), and media (5–12%)) for care received in Germany.

Patients were also interested in a variety of topics regarding their care, including health-related information such as quality standards (e.g. hospital performance or professional qualifications), safety (e.g. risk of treatment and infection rates) and organisation-related information (e.g. how to contact the health care provider and its location). Health-related and organisational-related information were equally important when making choices on hospital care (e.g. "professional qualifications" and "how to contact the health care providers" accounted for 65% of the responses).

Scenario 2 – Patients planning their care abroad

The Europa-Survey 2012 was designed by the *Techniker Krankenkasse* (TK) sickness fund in collaboration with the *Berlin University of Technology* to collect information from the 45,000 insured individuals who obtained services abroad and had them processed by the fund in 2010.[3] Of the 17,543 respondents, about 19% (3,307/17,543) reported having received planned care abroad, and 11% (1,888/17,543) indicated that they used cross-border services on a regular basis. The majority of those receiving planned care at a hospital abroad (mainly seeking care for musculoskeletal conditions, renal failure (dialysis), or cancer) were keen to access guidance on their rights to Cross-Border Care (59%; **see Table 1**). They reported that health care professionals were used as sources of information more frequently than personal contacts or media (health care professionals (49%), personal (18%), media (22%)). Most respondents used services provided by the health insurer as a source of information before seeking hospital care abroad (62% contacted TK customer service;* 42% contacted the TK hotline†).

Information related to health (e.g. hospital performance (38%) and professional qualifications (41%)) and financial issues (e.g. coverage of costs by insurers (42%) and reimbursement modalities (49%)) was sought more frequently by patients compared with organisation-related information, in particular "language of staff" (7%).

Scenarios 1 and 2

For both patients seeking care in their own country (Scenario 1) and planning care abroad (Scenario 2) health care professionals were reported as a preferred source of information compared with personal contacts or media. When looking

* Local contact points for those insured by the TK; they can be contacted by phone or visited by appointment.

† 24/7 hotline providing information on TK services free for national calls; however, it can also be reached from outside Germany.

at the type of information accessed, health-related and organisation-related information were valued by resident patients, whilst patients seeking care abroad valued information related to health and financial issues (**see Table 1**).

Results from the German case study showed that patients do value the support received by health care providers and health care insurers when making choices about health care, and want to access clear information about their rights to Cross-Border Care when planning to obtain care abroad. On the basis of the German case study more effort should be made to help patients seeking treatment in another MS to make contact with the health care providers from the MS of treatment, and to inform the referring health care providers in their home country about the potential health care opportunities of patients when they go abroad. According to the Directive, health insurers from the MS of treatment are not expected to provide information to patients coming from other MS, although evidence suggests that they do so for their own patients when the latter seek care abroad. In addition, whether health care providers in the MS of treatment are already used to sharing quality information with resident patients may have an impact when supporting patients to make informed choices about health care available in another MS.

Conclusion

Despite differences in the survey instruments adopted to describe the two separate scenarios, it is confirmed that both resident and cross-border patients want to be informed on multiple health-related aspects of care, most of them equally important between the two groups. Surprisingly, patients seem to be more worried about the risk of treatment and infection rates when receiving care in their home country than when seeking care abroad. As expected, patients going abroad are more likely to seek information on financial issues from their health insurer, whilst patients looking for hospital treatment domestically, in principle, should already have this information. The detailed results of the case study could inform possible challenges and opportunities when setting up NCPs in MSs.

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INTRA-EUROPEAN RETIREMENT MIGRANTS' ACCESS TO STATE-FUNDED LONG-TERM CARE AND HEALTH ENTITLEMENTS

By: Stephanie Kumpunen and Lisa Trigg

Summary: The rights of 'Intra-European retirement migrants' (IRMs) to long-term care and health benefits in their 'home' and 'host' countries are complex. We compared characteristics of entitlements and access to them by interviewing 31 public sector employees in four case study sites across England (2), France (1) and Italy (1). Qualitative analyses uncovered variation in eligibility for seemingly similar benefits, and different understandings of access rights among interviewees. Overall, we recommend increased procedural consistency and for IRMs to develop understandings of national and regional differences before migrating.

Keywords: *Intra-European Retirement Migrants, Health Care, Long-Term Care, Benefits, Entitlements*

Introduction

When older people move between European Member States (MS), they are faced with the complex challenge of negotiating their rights to health and long-term care (LTC), often in both their 'home' and 'host' countries. The rights of 'intra-European retirement migrants' (IRMs) can be spread across numerous jurisdictions and interpreted by a range of regional and local public sector employees. This often leads to significant case-by-case variation, especially in regions with small numbers of IRMs and few formal processes.[1]

One of the causes of the complex landscape is residency restrictions. Unlike workers, who have no mobility restrictions, older people of pensionable age only have the right to live in any MS "if they have comprehensive health insurance cover in the host country and sufficient income (from any source) to live without needing income support"[2], or until they have gained permanent residency after five years of continuous residence. MS have the freedom to develop national legislation defining availability and characteristics of benefits and entitlements (e.g. eligibility, duration), resulting in differences that are sometimes only understood by IRMs post-relocation. Furthermore, regional and local governments – to whom health and LTC funding and organisation are often devolved – frequently have a remit to interpret laws and create their own policies regarding what types of care are provided

Stephanie Kumpunen is a Research Officer and **Lisa Trigg** is a Research Fellow at LSE Health, The London School of Economics and Political Science, United Kingdom.
Email: s.kumpunen@lse.ac.uk

Acknowledgement: The authors would like to thank **Emilie Courtin**, **Konstantina Davaki** and **Michela Tinelli** for their contributions to the study.

in the area and to whom. Therefore, even if legally resident in a MS with comprehensive health insurance, IRMs may only be eligible for certain types of services and may receive varying levels of public support, depending on both the MS and region to which they have moved.

We interviewed 31 local public sector employees (e.g. social workers and health professionals), across four geographical regions in England, France and Italy* to investigate how characteristics of benefits and entitlements, and processes of provision differed across sites. We defined IRMs as people who had grown old in their host countries, or who were already older when they emigrated, either to re-join family, for lifestyle reasons or to return to their 'home' country. The benefits and entitlements examined were health care services (primary and secondary care); LTC services for persons who are dependent on help with basic activities of daily living over an extended period of time;[3] and cash benefits (means-tested allowances for the disabled/dependent).

System-level differences

The health and LTC systems varied significantly across study sites. France operates a social insurance-funded health system and statutory supplementary health insurance is required to cover co-payments, whereas in England and Italy, most health care is free at the point of service via a tax-funded national health service.[4] In terms of LTC, all three countries have high private expenditure, high use of informal care, and no discrete funding scheme. LTC spending† and cash benefit allowances are lower overall in Italy (even allowing for regional differences) than in England and France.[5] Interview participants described Italy as highly regionalised with independent legislation and budgets, France as regionally organised, but with less local discretion, and England as highly-localised.

Available benefits and entitlements

The benefits and entitlements described by participants were broadly similar across countries, and included universal benefits (for support, transport, etc.), social assistance, and in-kind care (day care, care homes, etc.), but eligibility differed. Some of the most notable differences are highlighted in **Box 1**.

Access to benefits and entitlements

Almost all interviewees in England and Italy said that there were few restrictions to accessing health and LTC. Requirements included formal registration in the municipality in Italy and proof of residence (via a utility bill, for example) in England. Many of these participants (some acknowledging that they had only one or two IRM cases per year) even suggested that means-tested social assistance was available to all, which according to European Union (EU) law is not permitted within the first five years of residence for pensioners. Overall, there was confusion as to how long it took to become a permanent resident, the impact of dual nationalities, and whether these factors changed access to services. However, most English and Italian participants said that IRMs who did not meet eligibility criteria were always cared for in some capacity through local/municipal budgets (although sometimes at a "lower priority") and were not asked to leave the region or country.

In France, efforts were also made to support IRMs who did not fulfil eligibility criteria, such as registering in the local area, having a pension, and purchasing health insurance. Frontline staff often had IRMs representing up to 25% of their case loads and were familiar with potential solutions to a lack of eligibility criteria, such as older people becoming legal dependents of their children or claiming survivor's pensions from spouses. However, if no options were available, IRMs did not have access to services and were advised to return to their home country.

Box 1: Differences in benefits and entitlements

- National cash benefits for the 'cared for' person were available on a needs-based scale for people aged 65+ and 60+ in England and France, respectively (while also accounting for means); however, flat rate benefits were only available to people (of any age) assessed as '100% disabled' in Italy;
- Benefits for carers were provided through national bodies in England and France, but at the regional level in Italy;
- Eligibility and co-payments for in-kind care (e.g. day centres, care homes) in Italy are based on a family's income, in France on an individual or couple's income, and in England on an individual's income only; and
- In Italy there is a legal framework within care plans for older people to be cared for by family (and assisted by trained staff), but not in the other two countries.

Source: Authors.

More consistency needed

One of the conclusions of this project is that EU Directives (which to date have excluded LTC) and national legislation can affect IRMs' access to care, but regional or local autonomy dictates the availability of most benefits (based on legislation and budgets). The knowledge and experience of public sector employees can have significant influence over how much state support is provided within the first five years of residency. These findings highlight the need for IRMs to have an understanding of national legislation and local services before migrating. They also suggest a need for better procedural consistency and knowledge of IRMs' rights to equalise treatment of IRMs regardless of where they choose to reside and who they speak to during the process.

* Two local authorities in England, one department in France, one province in Italy.

† As a share of Gross Domestic Product (GDP) corrected for the population share 65+.

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RISK COMMUNICATION FOR CROSS BORDER HEALTH THREATS: INFECTIOUS DISEASES AND ANTI-MICROBIAL RESISTANCE

By: Petra Dickmann, Sam Keeping, Katharina Wittgens, Naheed Jivraj, Andrea Schmidt, Nora Doering, Sergio Ariño-Blasco and Joan Gil

Summary: The threat posed by anti-microbial resistant pathogens, especially in the context of health care associated infections, has taken on an increasingly pan-European dimension thanks to greater population mobility and provision of cross-border health care. Risk communication involves informing patients, health care workers and the wider public about health risks and helps to encourage risk-compensating behaviours. This article examines risk communication with regards to Methicillin-resistant Staphylococcus aureus (MRSA) in a number of different European countries, and discusses how lessons from the past can be used to improve future approaches to communicating risk.

Keywords: *MRSA, Anti-Microbial Resistance, Risk Communication, Health Care Associated Infections*

Petra Dickmann is Research Fellow and **Sam Keeping**, **Naheed Jivraj** and **Katharina Wittgens** are Researchers at LSE Health, The London School of Economics and Political Science, United Kingdom; **Andrea Schmidt** is a Researcher at the European Centre for Social Welfare Policy and Research, Vienna, Austria; **Nora Doering** is a Researcher at the University of Maastricht, The Netherlands; **Sergio Ariño-Blasco** is Clinical Researcher and **Joan Gil** is Professor at the Department of Economic Theory and the Centre d'Anàlisi Econòmica i de les Polítiques Socials (CAEPS), University of Barcelona, Spain. Email: p.dickmann@lse.ac.uk

Introduction

Anti-microbial resistance (AMR) and health care associated infections (HCAIs) are high on the health policy agendas across Europe. The European Centre for Disease Prevention and Control (ECDC) has placed the "Antimicrobial Resistance and Healthcare-associated Infections Programme" among its top priorities for the future,[1] while the Chief Medical Officer in England recently described the threat posed by AMR as "catastrophic" and on a par with international terrorism.[2] The recently adopted European Directive on the application of patients' rights in cross-border health care facilitates

European citizens' access to health care in Member States other than their own. However, with these opportunities come increased risks of cross-border health threats such as AMR.

Risk communication encompasses all measures that contribute to perceptions of the risk associated with certain practices. It is an important component of infection control measures, as accurate assessment of risk can have a large impact on appropriate risk-compensating behaviours (e.g. frequent hand washing).[3] Recent research has highlighted a number of areas which are key to understanding effective risk communication, such as the nature and quality of information provided,[4] patients' and the general public's perceived information needs[5] and the role of the media.[6]

Study framework and findings

A framework of key elements of MRSA infection control policy was developed and applied to five European Union (EU) countries (Austria, Germany, Netherlands, Spain, United Kingdom) in order to find out how chosen approaches differed between and within countries. Our assumption was that infection control practices are implicit messages that can either reinforce or refute explicit risk communication measures and consequently can impact on the public perception of the risk posed by MRSA.

Strategies aimed at limiting the impact of MRSA were found to vary significantly between the countries. Only The Netherlands has a proactive "search and destroy" strategy involving screening of all patients and staff for carriage as well as symptomatic infection with MRSA. In hospitals, all patients are subject to a risk assessment, with those deemed at high-risk placed in pre-cautionary isolation until testing can confirm the absence of carriage or infection. The United Kingdom screens a select number of high-risk cohorts (e.g. Accident and Emergency admissions) and since 2009 all elective admissions. The other three countries have a reactive risk-based approach recommending that only patients that are likely to be colonised are tested. Despite themselves being an important vector for transmission, health care workers are only regularly screened in The Netherlands. The reporting of MRSA is voluntary in Austria and Spain, whereas Germany and the United Kingdom have mandatory reporting for MRSA bacteraemia, the most advanced stage of MRSA. Only The Netherlands has mandatory reporting of screening results down to the level of carriage. The quality of the data across countries is therefore variable, and thus it is difficult to offer solid scientific evidence for the risk communication of MRSA.

While all countries in our study have a legal obligation to implement measures to assure basic levels of hygiene, implementation is not rigorously enforced. Only The Netherlands has controlled implementation. It appears that current approaches to MRSA control do not adequately reflect the risks associated with infection. Misconceptions about the role that patients, staff and the general public can play in spreading the disease highlight the importance of consistent application of infection control measures. It is also apparent that there is a need for greater attention to be paid to effective service organisation and hospital/care facility architecture, as well as policies which encourage the rational use of antibiotics.

Risk communication

In order to further examine the minutiae of risk communication of MRSA, we analysed data on helpdesk interactions pertinent to MRSA from a public health authority that hosts one of the biggest MRSA networks in Germany. After applying pre-determined eligibility criteria, data on 501 helpdesk interactions from between 2010 and 2012 were coded, with descriptive statistics generated for different classes of questions and also their trigger, grouped by caller type. The main finding from the study was that both health care professionals and private individuals regularly contacted the helpdesk to request information which was already available from various other public sources, suggesting this information is either insufficient or not being routinely accessed. Private individuals commonly required further explanations on the management of MRSA. They reported receiving incorrect or confusing information, or none at all, from health care professionals. This highlights the need for improved risk communication measures during patient discharge and transfer between services and levels of health care.

In another case study, we conducted interviews with a number of key stakeholders (journalists, public health officials and hospital representatives) regarding the strengths and weaknesses of risk communication surrounding MRSA that has been delivered in the United Kingdom over the past decade. Having clean hands, being "bare below elbows" and the presence of alcohol gel dispensers were the main goals for commentators, with MRSA appearing to become a catalyst for a broader discussion around quality of care. The complex reasons for the increase of MRSA prevalence were thus narrowed down to hygiene issues and developed into a control mechanism for staff: patients were asked to check whether their nurse or doctor was bare below the elbow and whether they had washed their hands before dealing with them. Interviewees felt that the public was one of the key drivers of the MRSA discourse; without the fervent public interest, media coverage around MRSA could not have been sustained. Major barriers to effective risk communication were seen in a reactive communication policy. Journalists felt the need to communicate critical findings; however, a lack of access to first-hand information restricted them in this endeavour. A more proactive and transparent communication policy was seen by all as key to more balanced reporting of future health events.

Conclusion

Risk communication is focused on individual infection control measures. This narrow focus is congruous with the limited approach used in risk-based screening and surveillance. This results in obscuring the broader role that all patients, health care workers and members of the public play in spreading disease. The variability of recommendations within, and across, countries may be further contributing to these misperceptions. Having consistent European guidelines could improve infection control through encouraging effective risk compensating behaviour. Risk communication is not only about providing explicit scientific information

on a health-related topic; implicit messages such as the way health care providers implement and apply infection control measures is another consideration.

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HOSPITALS AND BORDERS: SEVEN CASE-STUDIES ON CROSS-BORDER COLLABORATION

By: Irene A. Glinos

Summary: While the EU Directive on the application of patients' rights in cross-border health care deals mainly with patient mobility, Article 10 promotes cross-border cooperation for the provision of health care in border-regions. As key providers of health care, this places hospitals at the centre of attention. Yet, little evidence is available on why hospitals engage in cross-border collaboration. A new book composed of seven in-depth case-studies provides new evidence on health care actors' motivations for engaging in cross-border collaboration, the beneficiaries of these activities, the role of the European Union in promoting cross-border collaboration, and the policy implications as the Directive is being implemented by Member States.

Keywords: *Hospitals, Border Regions, Collaboration, Motivations, Patients*

Introduction

Cross-border collaboration in the field of health care is not new but as of 25 October 2013, a legally binding text promotes it. Article 10 of the EU Directive on the application of patients' rights in cross-border health care calls upon Member States (MS) to "facilitate cooperation in cross-border health care provision at regional and local level" (Article 10.2) and upon the European Commission (EC) to "encourage Member States, particularly neighbouring countries, to conclude agreements" and "to cooperate in cross-border health care provision in border regions" (Article 10.3).

Given that patient mobility in border-regions concerns mostly secondary care[1] the Directive places hospitals and their interactions across borders at the centre of attention, and raises new questions.

As they implement the Directive, MS need to consider under which circumstances cross-border collaboration is likely to work, and what implications it might have for health systems. For the EC questions of whether and how cross-border collaboration can be promoted are equally relevant. It is against this background that a study on hospital collaboration in border-regions has been conducted.[2]

Irene A. Glinos is a Researcher at the European Observatory on Health Systems and Policies, Brussels, Belgium. Email: igl@obs.euro.who.int

Box 1: In-depth case studies on collaboration in border-regions

- Austria–Germany, between hospitals in Braunau and Simbach
- Belgium–France, involving the hospital at Dinant and French health care actors
- Germany–Denmark, between the hospital at Flensburg and Danish health authorities
- Finland–Norway, covering hospitals in Finnmark and Lapland
- The Netherlands–Germany, between Maastricht and Aachen University Hospitals
- Romania–Bulgaria, between hospitals in Călăraşi and Silistra
- Spain–France, between Catalan and French health care actors to build Cerdanya Hospital.

Source: Author.

Box 2: Prerequisites to initiating and maintaining cross-border collaboration in health care

- *An objective, local need for cross-border collaboration:* this activates and motivates partners and justifies collaboration to external actors. The need usually stems from patients who require access to care locally, or in some case, that of border-region hospitals seeking health professionals to fill vacancies. If the need changes or disappears, the rationale for collaboration may do so too.
- *Committed individuals:* collaboration is unlikely to take off without the involvement of "militants" who believe in the cause, push collaboration forward, invest time/ effort, and take risks. If frontrunners leave, collaboration is less likely to continue.
- *Shared interests among partners:* while partners inevitably have different and varied interests, these must not be conflicting. If interests clash, collaboration can quickly transform into competition. Where interests change, partners re-assess their involvement in collaboration.
- *Support from external actors:* this can be passive, meaning that actors do not obstruct collaboration, or active. Active support usually stems from three sources: the community and stakeholders affected by cross-border collaboration (such as local doctors), public authorities that are not partners in the collaboration, and funding institutions.
- *A suitable governance structure:* this should be as simple as possible within the particularities of the border region and the purpose of the collaboration. Whether partners choose a relational, contractual or ownership-based approach to governance, it has to suit the institutions, rules and interests of the health systems involved.

Source: Author.

Objectives of the study

Article 10 of the Directive and earlier studies[3-5] assume that cross-border collaboration in health care is desirable. This study takes a different approach: by critically exploring why collaboration takes place and whom it benefits, the aim is to expand the scope of analysis to focus on three aspects in particular: the underlying incentives, stakeholder motivations, and needs driving hospital collaboration; the means (i.e. governance formulas, resources and EU-sponsorship) which collaborating actors use; and the interaction between collaboration and its surroundings (i.e. the border-region context, health system context, and political context).

Methods and country coverage

The study is based on in-depth qualitative case-studies. Primary data were collected through stakeholder interviews. Each case-study zooms in on one case of collaboration to bring out how collaboration works, its context, stakeholder behaviour and motivations, the beneficiaries, and the role of the European Union (EU). **Box 1** lists the seven cases of collaboration included in the study.

Observations

A selection of key findings is presented below:

Cross-border collaboration is not easy. Of the seven cases of collaboration, one has been terminated, three are in doubt, two are at an early or transitory phase, and one is working smoothly. While collaboration can bring benefits, it is vulnerable to the changing needs and priorities of health systems as authorities tend to prioritise domestic solutions to service provision. This makes the duration of cross-border arrangements unpredictable.

Patients sometimes benefit, but partners always benefit. While most cross-border initiatives serve to improve patient access to care, what drives collaboration are the advantages it brings to stakeholders: providers extend their catchment areas or recruit health professionals to expand service capacity, while purchasers use foreign facilities to overcome domestic capacity constraints.

Border-regions are anchored in domestic health systems. Cross-border collaboration is complicated because collaborating partners are bound by the rules of their health systems. As these rarely coincide, partners need derogations and permissions from competent authorities, or to invent solutions. Moreover, stakeholders react to domestic incentives and constraints, even when these are played out locally.

Cross-border collaboration is neither constant nor standard. Collaboration adapts to circumstances and suffers when these are unfavourable (**see Box 2**). Second, while collaboration has its use and purpose, the bulk of health care will

continue to be provided and consumed nationally. Cross-border collaboration may not be a rarity in Europe, but it is the exception rather than the rule.

The role of the EU is ambiguous. Collaborating partners can make use of the EU in three ways: as a branding to boost the legitimacy of their project; to obtain financial support; or by using EU legislation which facilitates collaboration. On the other hand, the EU did not play any direct role in three of the case-studies while in some cases, partners expressed disappointment that it had not done more to support collaboration.

Conclusion

It is questionable whether cross-border collaboration can be encouraged given its complexity and context-dependence. If the prerequisites for collaboration (**see Box 2**) are not in place, no amount of funding or official support can, for example, foster the need for cross-border collaboration, shared interests between partners or dedication among individuals. Where the prerequisites are in place and collaboration initiated, external encouragement can probably help cement existing practices or contribute to the funding of infrastructure. In general, policy-makers have few tools and few reasons for trying to encourage cross-border collaboration where it has not already taken root and proved its worth. This suggests that the impact of Article 10 of the Directive may be limited.

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New HiT on Estonia

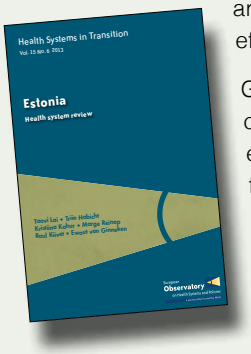
By: T Lai, T Habicht, K Kahur, M Reinap, R Kiivet and E van Ginneken

Number of pages: 196; **ISSN:** 1817-6127 Vol. 15 No. 6

This analysis of the Estonian health system reviews recent developments in organisation and governance, health financing, health-care provision, health reforms and health system performance.

Without doubt, the main issue has been the 2008 financial crisis. Although Estonia has managed the downturn quite successfully and overall satisfaction with the system remains high, it is hard to predict the longer-term effects of the austerity package that was imposed in the country. The latter included some cuts in benefits and prices, increased cost sharing for certain services, extended waiting times, and a reduction in specialised care. In terms of health outcomes, important progress was made in life expectancy, which is nearing the European Union (EU) average, and infant mortality. Improvements are necessary in smoking and alcohol consumption, which are linked to the majority of avoidable diseases.

Although the health behaviour of the population is improving, large disparities between groups exist and obesity rates, particularly among young people, are increasing. In health care, the burden of out-of-pocket payments is still distributed towards vulnerable groups. Furthermore, the number of hospitals, hospital beds and average length of stay has decreased to the EU average level, yet bed occupancy rates are still below EU averages and efficiency advances could be made.



Going forwards, a number of pre-crisis challenges remain. These include ensuring sustainability of health care financing, guaranteeing a sufficient level of human resources, prioritising patient-centred health care, integrating health and social care services, implementing intersectoral action to promote healthy behaviour, safeguarding access to health care for lower socioeconomic groups, and, lastly, improving evaluation and monitoring tools across the health system.

CROSS-BORDER POTENTIAL OF TELEMEDICINE SOLUTIONS

By: Ain Aaviksoo and Priit Kruus

Summary: Telemedicine is expected to improve quality of life in home settings, while enabling timely medical intervention. Similarly, cross-border care arrangements could improve quality and patient experience of health care services and also drive innovation. Yet, there are only a few cross-border telemedicine solutions that link professionals directly to patients. The EU-funded international DREAMING project piloted services in six countries using telemedicine to support the independent living of older people with chronic diseases. Analysis shows that the service could benefit from centrally organised monitoring and data-management subject to developing sustainable payment models and a legal framework for data security and liability issues.

Keywords: *Telemedicine, Cross-Border Care, Telemonitoring, Health Care*

Project on telemedicine across borders

The DREAMING (elDeRly-friEndly Alarm handling and MonitorING) project piloted services using information and communication technology to support the independent living of older people with three chronic diseases: diabetes, chronic obstructive pulmonary disease (COPD) and heart failure.[1] Semi-structured interviews with project participants were carried out to evaluate their experience with the pilot and qualitative analysis was used to address mainly evaluative and strategic questions. A conceptual framework developed by Saliba et al.[2] was used for the data analysis.

The project involved thirteen private and public organisations from seven different European Union (EU) countries (Italy, Belgium, Denmark, Germany, Estonia, Spain, Sweden)* to conduct a multi-centre randomised controlled trial. Cooperation between hospitals and municipalities was the main vehicle for project implementation but in Estonia one hospital took the leading role. The technological solution consisted of three components:

a) a monitoring and alarm handling system that included a health monitoring subsystem, an environmental monitoring subsystem, and a mobile alarm and localisation subsystem;

b) a data management tool to collect, organise, analyse and store data collected by the subsystems;

c) video conferencing technology.

Potential for cross-border service

In addition to a locally provided, useful home-monitoring telemedicine service we were also interested in the potential to move from loose project-based collaboration to the formal cross-border provision of a monitoring service

* Pilots occurred only in six countries.

Ain Aaviksoo is a lecturer at the Institute of Clinical Medicine, Tallinn University of Technology and researcher at the Health Policy Programme, Praxis Center for Policy Studies, Tallinn, Estonia; **Priit Kruus** is an analyst at the Health Policy Programme, Praxis Center for Policy Studies.
Email: ain.aaviksoo@eesti.ee

facilitated by intelligent software. Although home monitoring is a local service by nature and the need for culturally and logistically close contact with some health professionals remains, the technology is transferable. Thus, monitoring and data-management could be organised centrally, which allows for the improvement of decision-support algorithms using a richer data-pool. A recent systematic review[2] identified factors that hinder or support cross-border telemedicine implementation: legal, sustainability, cultural and contextual factors.

Legal factors

Legal considerations in the context of provision of cross-border telemedicine are crucial to ensure trustworthiness and quality of the service. The interview statements reveal that a medical doctor should decide the final diagnosis and treatment on the basis of the information provided by the monitoring data and algorithm (i.e. this function should not be delegated to a technological solution). Thus, liability should also lie with the doctor, whether the service is provided in a single country or across borders. Since specific provisions for doctors providing services via telemedicine solutions to patients in other countries are not stipulated in EU legislation,[3] prior agreements addressing the liability issue have to be made for cross-border service provision. In this respect, EU regulation on cross-border health care provision should consider liability issues in telemonitoring. Patient data is moved across borders and thus requires patients' informed consent to data sharing and storage. Data security concerns were felt to be relevant especially where legal clarity was lacking at national level.

Sustainability factors

The financial sustainability of telemedicine remains a critical issue, regardless of the rapid decline in the cost of technology over the last few years. While start-up costs for setting up the technical infrastructure for data transfer are considerably low, costs for technical maintenance exist; however, these are outweighed by personnel and management costs. For example, estimates from Estonia reveal that costs for technology and its maintenance accounted for around 30% of the project budget, while personnel and management costs absorbed 70%.

In general, telemonitoring was integrated into the everyday practice of the service provider involved in the pilot. However, challenges remained due to the limited involvement of staff members in the project as well as non-integration of the IT (Information Technology) platform into national health information systems. In addition, integration into national health systems in terms of reimbursement continues to be a challenge, particularly when the telemonitoring service includes elements of health and social care that rely on different financing mechanisms. Currently, such mechanisms do not provide incentives to enable patients to live at home, but reward health care providers for curative service provision, such as hospital stays. Thus, a rethinking of reimbursement and the financing of telemedicine is necessary in order to deploy telemedicine on a larger scale.

Cultural, language and contextual factors

In addition to the challenges of liability and sustainability, it was acknowledged that working across countries with different languages needed to be addressed through common standards, definitions and guidelines. Equally, cultural differences arising from different working methods, patterns of communication and perception of privacy across countries need to be addressed.

Trust and acceptance between health professionals and in relation to patients was pursued through training of health professionals and running support schemes for patients in order to overcome resistance to change and fear of technology. Moreover, infrastructure has to be suitable for the given service and user preferences, which means adequate and forward-looking planning of investments, as the cost of technology is dropping fast.

Conclusion

The review by Saliba et al.[2] identified that most cross-border telemedicine services link professionals, but only a few link professionals directly to patients. It also revealed that the main motivation for developing cross-border telemedicine is to compensate for the lack of specialist health care workers, improve access to care in low-middle income countries and enable cost containment in high income countries.

The internationally piloted telemonitoring service described here responded to a need for such services in local health care systems. In Estonia, the participating hospital had a large ambulatory patient base, but significant space constraints in acute care, creating an incentive to find alternative means to service the high number of patients. This could be achieved by timely medical intervention and keeping patients in home settings. Whether it be space constraints, lack of health professionals or more efficient use of resources, these are quite universal factors and indicate that there might be potential for moving from loose project-based collaboration to formal cross-border service provision with this type of service.

Issues of liability, clinical governance, patient consent and data security were seen by the service providers participating in the pilot programme as important barriers where no national or EU-wide guidance on telemedicine services existed, and therefore special agreements between providers are requested to facilitate implementation. Financial sustainability was highlighted as a critical issue for long-term service provision in cases of small-scale collaborations while low levels of integration into national health information and reimbursement systems also caused problems, particularly for larger scale and longer-term service provision.

Overall, the respondents claimed that since current health systems are organised mainly to cure and not to prevent ill-health, a paradigm shift would contribute to the enhanced provision of cross-border telemonitoring services. Nevertheless, preconditions for cross-border telemedicine are the development of sustainable payment models and a legal framework for data security and liability issues.

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CROSS-BORDER DENTAL CARE BETWEEN AUSTRIA AND HUNGARY

By: Juliane Winkelmann, Maria M. Hofmarcher, Eszter Kovacs, and Gabor Szocska

Summary: Cross-border movement for dental care between Austria and Hungary has been widespread for several decades. Austrians seek dental care in Hungary particularly for affordable and timely prosthetic treatments that are not covered by Austrian health insurance. This article analyses key drivers of cross-border dental care, including patients' motivations and regulatory provisions, and addresses the implications for safety and quality of care. Results suggest that safety of cross-border dental care may be enhanced through (1) informed choices over treatment options, (2) continuous follow-up care and (3) enhanced transparency and exchange of information between providers across countries.

Keywords: *Dental Tourism, Cross-Border Care, Prosthetic Treatments, Quality Assurance, Patient Safety*

Juliane Winkelmann is a Researcher at and **Maria M. Hofmarcher** is Head of, the Health and Care Department, European Centre for Social Welfare Policy and Research, Vienna, Austria; **Eszter Kovacs** is Assistant Professor at, and **Gabor Szocska** is Scientific Leader of, the Evaluating Care Across Borders (ECAB) project at the Health Services Management Training Centre, Semmelweis University, Budapest, Hungary. Email: winkelmann@euro.centre.org

Acknowledgment: The authors are grateful to **Gabriele Schmied** and **Leslie Tarver** who contributed to an earlier version of this article.

Hungary and dental tourism in Europe

Hungary has been recognised as a main destination country for dental treatment in Europe, attracting patients from bordering and non-bordering countries.[1] In particular, cross-border movement for dental care between Austria and Hungary has occurred for several decades. Austrian patients seek dental treatment in Hungary particularly for affordable prosthetic treatments which are largely uncovered by statutory health insurance in Austria.

Hungary's widely known prominence in dental care provision in Europe must be understood in the context of the privatisation process of dental care beginning in 1995. The introduction of fee-for-service payments, in combination with subsidies to cover fixed costs, led to a significantly decreased budget for publicly financed dental care.[2] As a consequence, dental practices and laboratories were separated and often privatised. This privatisation process and emergence of new private providers was enhanced by foreign patients from Germany and Austria seeking dental treatment in Hungary, especially in the Austrian-Hungarian border region. Due to reliable service provision and the good cost-quality ratio, dental care tourism to Hungary started to expand. In the last

decade, increasing prices in Western Europe, low-cost airlines and improved dental care made Western Hungary and Budapest the main destinations for dental tourists from all over Europe.[3] This trend was reinforced by Hungary's accession to the European Union (EU), the introduction of the European Health Insurance card in 2004, and finally the EU Directive on the application of patients' rights in cross-border health care (2011/24/EU).

Dental Cross-Border Care between Austria and Hungary

The case study on cross-border dental care between Austria and Hungary undertaken within the Evaluating Care Across Borders (ECAB) project sought to examine the scale and nature of cross-border dental care between the two countries, its underlying drivers, the regulatory context and implications for patient safety and quality of care. Cross-border dental care between Austria and Hungary is unique as strong cultural-historical ties between the two countries and geographical proximity have led to a specialisation of dental services for German-speaking patients. Furthermore, dental care offered by Hungarian doctors is often packaged with the help of agencies providing all-inclusive-services for clients, especially in the border region.[4] A Hungarian and an Austrian ECAB team conducted this research which used multiple methods, including data collection from health insurers on existing regulatory reimbursement provisions of cross-border dental treatments in Austria. In addition, qualitative interviews with Austrian patients (11) and dentists (10), Hungarian regulators and professional bodies (10) and a survey of Hungarian dentists (273) were conducted.

Better value for money? Key findings

Estimates of the scope of dental tourism between Austria and Hungary in 2006 range from 70,434 to 160,000 patients.[5-6] Our survey undertaken with Hungarian dentists reveals that Austria represents the second largest source of foreign patients in Hungarian dental practices after German patients. The broad range of these figures results from a lack of official numbers on Austrian patients receiving dental care in Hungary due to the fact that most of the dental services are paid out-of pocket.[7] The large majority of Austrian patients travel to Hungary for fixed prosthetic treatments (e.g. bridges, implants, and crowns) that are not covered by statutory health insurance in Austria. For defined medical reasons, only removable and necessary dentures are partially refunded by health insurance. The limited coverage of state-of-the art dental treatment is thus the main reason for Austrians travelling to Hungary where implants are provided at up to half of the prices charged in Austria. Importantly, treatment quality in Hungary has become comparable with Austrian standards. Hungarian dentistry is known for well-trained dentists who provide high quality care using state-of-the-art technologies. The regulatory framework on professional standards is continuously developed and supervised, resulting from adherence to European-level protocols and standards in order to ensure patient safety and quality.

The findings show that the main motive of patients seeking dental treatment in Hungary is the better value for money they receive for prosthetic treatments. In general, individuals travelling to Hungary for dental care (1) received recommendations from relatives and friends, (2) appreciate the all-inclusive services offered by agencies or dental offices and (3) were reached by targeted marketing by Hungarian dentists. Austrian patients are mostly satisfied with the treatment they receive in Hungary, in particular with the price and quality of services and the strong customer service orientation. However, Austrian dentists observe quality gaps in the treatments even though they also confirm the excellent technical service that Hungarian dentists provide.

Despite significant quality improvements in Hungary over the last decade, Austrian dentists remain critical towards dental services provided in Hungary as they observe complications and long-term damage resulting from a lack of follow-up care, as most interventions are made during a defined period of time, often a week, and follow-up care is mostly not provided by the same dentist due to distance. While patients usually prioritise affordability and fast treatments, dentists noted that most patients are not aware that fixed dentures require treatment over longer periods. The observations of Austrian dentists may be biased as they only treat patients with complications resulting from care received in Hungary. Nevertheless, with rising patient mobility to Hungary, Austrian dentists increasingly face competition on services and prices offered in Hungary and which are openly advertised in Austrian newspapers and websites.

Patient safety and continuity of care

In light of our findings, the movement of patients between Austria and Hungary for dental treatment raises new questions on the quality and safety of Cross-Border Care in the EU. The results suggest that cross-border dental care has many benefits for patients but also may come with a number of risks. To decrease the level of risk, patient safety should be enhanced by enabling them to make informed choices about treatments and to be involved in risk management (e.g. information on the duration of treatment). In particular, patients should be provided with specific information* on the risks inherent in Cross-Border Care (i.e. difficult access to follow-up care, and compliance). On the provider side, regulation is needed to ensure (1) obligatory and continuous follow-up care, (2) monitoring of patient flows and (3) an enhanced flow of information between care providers across countries.

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CROSS-BORDER HEALTH CARE: COMMON RULES ON MEDICAL PRESCRIPTIONS

WHEN TRAVELLING TO ANOTHER EU COUNTRY

By: Dirk Van den Steen

Summary: A new Commission Implementing Directive lays down measures to facilitate the recognition of medical prescriptions issued in another Member State. Until recently, around half of cross-border prescriptions were not dispensed. This poses problems, particularly for chronic disease patients, rare disease patients and patients living in border regions. A common set of descriptive elements in cross-border prescriptions has been defined to help dispensers (pharmacists) identify prescribers, patients and prescribed products. This set of elements is expected to increase the dispensing rate for cross-border prescriptions from 50% to 70%.

Keywords: *Cross-Border Health Care, Patient Mobility, Medical Prescriptions, Implementing Directive, Impact Assessment*

Dirk Van den Steen is team leader at the European Commission, Healthcare Systems Unit, DG SANCO, Brussels, Belgium. Email: dirk.van-den-steen@ec.europa.eu

Note: This article expresses the personal views of the author, and does not represent the official position of the European Commission.

Introduction

October 25th, 2013 marked the day by when Member States (MS) should have transposed the Directive on the application of Patients' Rights in Cross-Border Healthcare[1] (hereafter "the Directive") into national legislation. This was also the transposition date for the Implementing Directive laying down measures to facilitate the recognition of medical prescriptions issued in another MS,[2] hereafter (the "Implementing Directive").

The purpose of this Implementing Directive is to lay down measures to facilitate the recognition of medical prescriptions issued in another MS as described in Article 11 of the Directive. The Implementing Directive contains

Table 1: Non-exhaustive list of elements to be included in cross-border prescriptions

Element	Facilitates
Surname(s)	Identification of the patient
First name(s) (written out in full, i.e. no initials)	
Date of Birth	
Issue date	Authentication of the prescription
Surname(s)	Identification of the prescribing health professional
First name(s) (written out in full, i.e. no initials)	
Professional qualification	
Details for direct contact (email and telephone or fax, the latter both with international prefix)	
Work address (including the name of the relevant Member State)	
Signature (written or digital, depending on the medium chosen for issuing the prescription)	
"Common name"* as defined by Article 1 of Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community code relating to medicinal products for human use	Identification of the prescribed product, where applicable
The brand name if: (a) the prescribed product is a biological medicinal product, as defined in point 3.2.1.1.(b) of Annex I (Part I) to Directive 2001/83; or (b) the prescribing health professional deems it medically necessary; in that case the prescription shall shortly state the reasons justifying the use of the brand name	
Pharmaceutical formulation (tablet, solution, etc.)	
Quantity	
Strength, as defined in Article 1 of Directive 2001/83/EC	
Dosage regimen	

Source: Annex to Implementing Directive.[2] Note: * "Common Name" in practice means the INN, except for product groups such as vaccines that have not been assigned an INN.

a non-exhaustive list of elements to be included in prescriptions further to a request of a patient who intends to use them in another MS (hereafter "cross-border prescriptions").

Un-dispensed cross-border prescriptions

The principle of mutual recognition of medical prescriptions derives directly from the Treaty on the Functioning of the European Union (TFEU). Under European Union (EU) rules on freedom to provide services, MS should recognise medical prescriptions issued by medical doctors from other MS. Thus, this principle clearly predates the Directive. Nevertheless, there was evidence that the real-life application of this principle to cross-border prescriptions was suboptimal.

Further research on the recognition of cross-border prescriptions was carried out in a study by Matrix.[3] This study included a survey completed by nearly 1,000 pharmacists across seven MS (Denmark, Germany, Greece, France, Netherlands, Poland and the United Kingdom) sharing their views on dealing with foreign prescriptions for eight pathologies (asthma, chronic obstructive pulmonary disorder, depression, diabetes, epilepsy, hypertension, ischemic heart disease and osteoarthritis/rheumatoid arthritis). In all, the pharmacists scored 7,440 hypothetical prescriptions.

The findings from Matrix suggest that 55% of patients would have faced difficulties in getting prescribed products dispensed in another country. The key challenges are the verification of the prescriber (such as a doctor), possibly exacerbated in handwritten prescriptions and unfamiliarity with the language, and missing information. The availability of (substitute) products was mentioned as a problem less often. The latter is a problem that, of course, is not related to actual recognition of the prescription, while problems related to language or handwriting cannot be not tackled by an Implementing Directive either.

More recent research by San Miguel et al[4] involved a "mystery shopping exercise" whereby 192 Belgian or Finnish prescriptions were presented in pharmacies in five other MS. Overall, 108 prescriptions (56%) were dispensed. Results showed important differences depending on the country of the pharmacist. Moreover, for a given active substance, prescriptions written by International Nonproprietary Name (INN) stood a higher probability of being dispensed compared to prescriptions by brand name (see also the case study article in this issue's Observer section).

Therefore, evidence from both these studies indicated that about half of patients did not have their cross-border prescriptions dispensed.

Common elements in prescriptions

A very first "long-list" of possible cross-border prescription elements was based on the outcome of a study by NIVEL in 2011.[5] In this study prescribers and dispensers across the EU were requested to score relevant prescription items to facilitate the recognition of cross-border prescriptions on the following main dimensions: "patient identification", "prescriber identification" and "product identification" and "other information". This exercise yielded two, largely overlapping, item sets: 23 items for medicinal products and 20 items for medical devices.

In a next stage, the European Commission consulted stakeholders to see how the recognition of cross-border prescriptions could be improved,[6] presenting (among others) the NIVEL 2011 "long list". In parallel, formal discussions with MS delegated experts started. Finally, following a favourable MS vote in the Committee on Cross-Border Health Care on 28 November 2012, a list of elements to be included in cross-border prescriptions was adopted (**see Table 1**).

This list introduces a common set of descriptive elements to help identify prescribers, patients and prescribed products. In accordance with findings on obstacles to the recognition of cross-border prescriptions, the "common name" for medicinal products must always be included. The list does not, however, deal with the appearance, format or language of the prescription. In addition, further elements, in line with local practices, can be added by prescribers. Finally, Article 11 of the Directive clearly states that the recognition of cross-border prescriptions shall not affect national rules governing prescribing and dispensing, including generic or other substitution, provided that those rules are compatible with Union law.

Type of Prescriptions

The list of common elements is limited to cross-border prescriptions requested by the patient, not prescriptions used within a country (unless a MS so chooses). National Contact Points, established under the Directive will inform patients on the right to travel with a cross-border prescription when visiting other MS, as well as the minimum list of elements that it should contain.

Cross-border prescriptions also include prescriptions for medical devices for which the same non-exhaustive list must be used. However, elements to identify the prescribed product must only appear on the prescription "where applicable" (for instance medical devices do not have common names as medicinal products do). Also, the application of the list is not restricted to only those products that are covered by public health care payers.

A final point to note is that MS maintain the right to subject certain types of medicinal products to a special medical prescription, as stated in Article 11, paragraph 5 of the Directive. For instance, this is related to the possible abuse of narcotic substances.

Expected Impacts

An Impact Assessment accompanying the Implementing Directive, conducted by the European Commission,[7] found that the number of cross-border prescriptions is estimated to be low, around 2.3 million per year – which translates to between 0.02% and 0.04% of all prescriptions in the EU. Nevertheless, for specific groups of patients, improving the recognition of cross-border prescriptions would make an important difference. This includes patients with chronic diseases wishing to travel to another country, for patients living in border regions or smaller MS for whom filling out a cross-border prescription is a necessity and for patients with a rare disease, where the best expertise can often be found across a border.

Furthermore, the Impact Assessment found that the use of the non-exhaustive list may help increase dispensing rates for cross-border prescriptions by some 20 percentage points to around 70% by addressing issues in the identification of the prescriber and by further completing "missing data" from the perspective of a cross-border dispenser (pharmacist). As patients would avoid having to visit a local doctor this way, at an average cost of €34 for a doctor visit in the EU, some €7 (20% of the average cost) would be saved per cross-border prescription for patients and public health care payers.

In case a MS opts to have a "separate cross-border prescription form", the general principle of mutual recognition of prescriptions shall continue to apply for "regular" prescriptions presented to a foreign dispenser. However, the cost analysis in the Impact Assessment found that it is advisable for MS to integrate the non-exhaustive list in all prescription forms and not to restrict it to a separate "cross-border" form. Based on the findings of the NIVEL report[5] it should be assumed that MS would prefer in the long run to incorporate the non-exhaustive list in their existing prescriptions. Consequently, this scenario is considered realistic only for a transitional phase.

The Commission Impact Assessment recommends evaluating the real-life impact of the Implementing Directive as soon as dispensers are sufficiently familiar with the non-exhaustive list. This is likely to mean conducting an evaluation a few years after the measures are brought in.

Conclusion

The Implementing Directive is expected to remove real-life obstacles for the recognition of cross-border prescriptions – for example, through the inclusion of the INN in prescriptions. However, it is also clear that certain obstacles will remain in place, such as those related to the language of the prescription and to local rules on substitution. By and large, the dispensing rate for cross-border prescriptions in the EU is expected to improve from 50% to 70%. A timely evaluation of the real-life impact of the Implementing Directive is recommended.

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EUROPEAN PUBLIC HEALTH STRATEGIES: STATE OF PLAY

By: Paula Franklin

Summary: Europe has two supranational public health strategies – the World Health Organization's *Health 2020* and the European Commission's *Together for Health*. Both of these major initiatives have adopted a multi-stakeholder approach and are aiming for inter-sectoral governance. This article provides a snapshot of the current state of play with the strategies, discussing their stakeholder involvement, the acknowledgement of Health in All Policies (HiAP) approach, and the impact of the current economic situation in Europe on public health.

Keywords: *European Public Health Policy, Stakeholders, DG SANCO, WHO Europe, Health in All Policies (HiAP)*

Introduction

Currently, there are two major health strategies for Europe: the World Health Organization (WHO) Regional Office for Europe's *Health 2020* with the accompanying *European Action Plan (EAP) for Strengthening Public Health Capacities and Services* endorsed by the 53 member states in September 2012, and the European Commission (EC) Directorate General for Health and Consumers (DG SANCO)'s *Together for Health* (adopted in 2007) with a recently added policy document, *Investing in Health*. Both of these frameworks emphasise the importance of inter-sectoral governance[1] and acknowledge the present context of austerity and financial instability. The forming of these multi-stakeholder policies provides an interesting perspective on the Health in All Policies (HiAP) approach in practice and enables a critical evaluation of challenges that officials face when constructing health policies for Europe. This article offers a snapshot of the state of play in European health strategies based on a study of stakeholder participation in the forming of European public health strategies (by WHO Regional Office for Europe and EC), which includes policy documents analysis, interviews with European Union (EU) public health stakeholders (n=20) and WHO Regional Office for Europe officials (n=3), and observational data from EC, non-governmental organisations (NGOs), and think tank events held in Brussels between 2012 and 2014.

Governance approach within the Strategies

McKee et al.[2] point to a weakness in the EU's competence in the field of international public health when compared to specialist actors such as the WHO, but note that their public health activities have been successful when EU institutions have been "relatively open to contributions from all stakeholders, rather than subject to

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The Editors invite readers' responses and other articles on EU Health Policy, particularly as 2014 will be a special year, with European parliamentary elections and the appointment of a new Commission.

Paula Franklin is Research Fellow at the Centre for Public Policy and Health, Wolfson Research Institute for Health and Wellbeing, School for Medicine, Pharmacy and Health, Durham University, United Kingdom. Email: paula.franklin@durham.ac.uk

lobbying from only certain stakeholders". Previously, DG SANCO has emphasised stakeholder participation in policy-making from the beginning. For example, in forming the current strategy, it embarked on an extensive stakeholder consultation process, including an impact assessment and open consultation of stakeholders. The WHO Regional Office for Europe, on the other hand, has traditionally drafted documents and strategies to an advanced stage in-house before seeking stakeholder views.

However, the tables seem to have turned; the WHO actively engaged stakeholders in the development of its new *Health 2020* policy framework and strategy and accompanying EAP which is a main pillar of its implementation. It is presently seeking to work with those countries on the implementation of the strategy and plan. These documents have been developed through a participatory process with Member States and a wide variety of other interested parties across the European Region. Meanwhile, DG SANCO has decided not to form a new Health Strategy to replace *Together for Health* (initially envisioned to cover the period 2008–2013) but to continue with the existing one. There will, therefore, be no further stakeholder involvement in the framework; instead, DG SANCO presented in February 2013 a Staff Working Document *Investing in Health* as an "extension" to the current strategy.[3] This policy document addresses in particular the Member States.[4] Whereas it seems that the WHO is becoming more open to stakeholders, at the same time it seems that these interested parties have had a decreasing role in the EC strategy. This situation implies a shift in the governance approaches adopted by each institution respectively.

The steps to form a post-2013 EC Health Strategy by DG SANCO have included a plan for the Strategy Unit to "revise" the current strategy with an opinion from the EU Health Policy Forum (EUHPF)*. In addition, a major conference, Open Health Forum, was to have been organised in April 2013 with the theme 'the future of EU health policy'. The results would then have been fed into the revised strategy. This conference, which is supposed to take place bi-annually but last convened in 2010, has a purpose beyond simply disseminating and sharing information. As Brand and Michelsen[5] note, a conference can also be "an opportunity to revitalise public health services and to motivate for action in the fields of prevention and health promotion". In the event, neither the revision nor the conference has taken place. The availability of information regarding the revision of the health strategy has been scarce, and lack of transparency of the proceedings was criticised by the stakeholders interviewed for the study between October 2012 and March 2013.

At the very time when DG SANCO has internalised its decision-making, WHO Europe engaged in a two-year consultation process with Member States, NGOs, and their European Health Policy Forum. The content and the structure of the *Health 2020* Strategy was discussed at "numerous events", and "a written consultation process on a draft of *Health 2020*" involved "countries, international organisations, the Healthy Cities Network, the Regions for Health Network, non-governmental organisations, professional associations and other stakeholders".[6] The aim has been to engage stakeholders in the policy-making process from the very beginning so that the participants feel the framework is relevant for them and will be ready to implement the policy.

Thus, Europe is in a situation of having two health strategies that have both engaged in broad stakeholder consultations at different times in their creation (EC 2004–2007 and WHO 2010–2012). These strategies are related in that they include consultations with many of the same stakeholders. Although they occupy different positions within Europe–the EC has more political power, and the possibility to form legally binding policies, while the WHO can only adopt an advisory role and engage Member States in implementation on a voluntary basis – it is worth noting that the Member States have formally endorsed *Health 2020* and the EAP and have committed themselves to the implementation process, including an agreement to report on progress after three years. Moreover, since *Health 2020* has evolved in collaboration with the stakeholders, it should incentivise Member States to act while enabling them to own the document.

Health in All Policies (HiAP) approach and intersectoral governance

One of the key challenges for the effective governance of EC public health has been the fragmented nature of the policy field, with many relevant policies located outside DG SANCO. This situation requires strong collaboration between Directorates†. "The public health community" in Brussels, as defined by the research participants, is vocal about the need for strong leadership in the EC. Since the decision-making power in matters related to health rests with DG SANCO, the stakeholders expect the Directorate to balance out diverse views and the competing agendas of different stakeholder groups. Furthermore, the EC is committed to the Health in All Policies (HiAP) approach that was officially endorsed during the Finnish Presidency in 2006,[7] and is one of the key principles of the health strategy.[8]

The community is keen on reaching out from the field of health. This is evident in the work many NGOs conduct in the spirit of HiAP; while several stakeholder groups tend to focus on a particular aspect of health policy, which is relevant for their actions rather than on the holistic view, they seek out partners with a broad scope within the EC and the industry. The DGs mentioned as relevant for public health stakeholders–not-for profit and for-profit organisations–include Enterprise, Environment, Employment, Education, Agriculture and Connect. Also, the EU Health Policy Forum's response to *Investing in Health* document emphasises that the EC's approach should "be complemented by a HiAP approach". Evidently, this situation offers an ideal opportunity for DG SANCO to strengthen such an approach and lead the development of a more structured network of relevant stakeholders – both internal and external. While the broader civil society

* The EU Health Policy Forum gathers twice per year, bringing together 52 umbrella organisations representing European stakeholders in the fields of public health and health care.

† The Commission coordinates cross-sectoral groups and aims for cooperation across policies that are relevant for public health. See: http://ec.europa.eu/health/health_policies/coordination/index_en.htm

stakeholder engagement has been on-hold, this spring has seen the first meetings of the newly appointed DG SANCO public health Scientific Committees (Newly Identified Health Risks, Environmental Risks, and Consumer Safety) that mainly liaise with policy and research DGs. This indicates that intersectoral governance for HiAP through a technocratic approach is well under way.

The WHO has seized the opportunity to support its Member States to "facilitate dialogue and collaboration" between health and non-health actors throughout the implementation process of *Health 2020* via EAP.[9] As the WHO covers the entire spectrum of health systems and services, and has a wider remit for health and its determinants than the EC, it is vital that the HiAP approach lies at the heart of its strategy. For *Health 2020*, WHO undertook an intense 18 months of consultations with relevant stakeholders throughout Europe, including international organisations such as the EC (six Directorates), the Organisation for Economic Cooperation and Development, and the World Bank; major public health NGOs; and all Member State governments. Underpinning *Health 2020* is a whole-of-government and whole-of-society approach. This necessitated a wide engagement with organised structures.

Impact of the current economic situation

The decision of the EC to continue with the current strategy and to introduce the *Investing in Health* document supports the view that well-governed public health activities are important for economic recovery and stability.[10,6] In addition, the document is in line with *Europe 2020,* the EU's 10-year growth strategy, in its approach towards health as an investment. However, from a public health viewpoint, there is a generic caveat in the approach; the document has adopted a relatively narrow definition of health with key themes including an ageing population, health technology innovation and health care workforce. Also, the EUHPF in its response to *Investing in Health* noted that there needs to be a proper balance between biomedical and public health research, and a similar situation is observed in the recently announced EC Research Agenda, Horizon 2020.[11]

WHO's *Health 2020* ties the discussion about economic recovery and development to health inequalities, noting how "effective interventions require a policy environment that overcomes sectoral boundaries and enables integrated programmes". The EC *Investing in Health* document also acknowledges the social gradient in health, concluding: "The avoidable morbidity and mortality underlying health inequalities represent a waste of human capital that must be reduced". While the economic crisis puts a different spin on communicating the health policy agenda to budget holders, "wicked issues"[12] such as alcohol consumption, obesity and tobacco control which litter the public health field are by definition complex and require implementation of the HiAP approach. The implementation of the Health for Growth Programme 2014–2020 (EC) and WHO's European Action Plan will reveal how successful the proposed policy and practice changes have been.

Conclusion

This article has critically examined the current situation with DG SANCO's Health Strategy and WHO Europe's *Health 2020* from a public health stakeholder viewpoint. Two issues have been discussed within each framework: the governance approach, and the role of public health in the current financial climate prevailing in Europe. First, both major strategies for Europe emphasise inter-sectoral governance and a dialogue with diverse stakeholder groups. However, currently, the EC stakeholder influence is decreasing. WHO, on the other hand, has more of an advisory role in European public health issues, but has an up-to-date multi-stakeholder strategy with Member State commitment at its disposal. Second, public health is located within a broader health system, which in a situation of financial instability may suffer as a whole. In response to this, supranational policy-makers within the main institutions (EC and WHO) have taken a stand on the importance of health investment for the functioning of societies. Both current health strategies for Europe perceive health to be a value in itself, but also as an invaluable component of a well-functioning economic system.

Finally, the two strategies occupy different positions in Europe and have different ways of operating. The public health community perceives the EC Strategy as essential for defending the place health occupies in the wider EU agenda. Thus, the document plays a pivotal political role in helping DG SANCO to form and argue their case on behalf of public health stakeholders. The WHO policy framework and strategy, on the other hand, is intended to be a tool for the use of Member States as they think appropriate. While the governance process of the implementation is coordinated by the WHO, it will be the stakeholders themselves who ultimately determine whether and how the policy is adopted and with what effect. The success of the ambitious *Health 2020* policy framework will rely heavily on political will and WHO's ability to "navigate" the complex processes of implementation.[13]

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PROMOTING ORAL HEALTH: A CENT OF PREVENTION COSTS LESS THAN A EURO OF CURE

By: Beatrice Pipitone and Kenneth Eaton

Summary: Despite significant improvements in the oral health of Europeans since 1980, a number of problems remain pertaining to inequalities and worsening epidemiological trends. Current demographic and economic trends, with more people retaining their teeth into old age and drastic cuts in state support for patients in some countries, are also threatening to damage some of the progress which has been achieved. The state of oral health in Europe has recently been reviewed by the Platform for Better Oral Health in Europe. This article summarises the Platform's review and provides recommendations on areas where improvement is most needed in order to achieve successful prevention of oral diseases.

Keywords: *Oral Health Promotion, Platform for Better Oral Health in Europe, Common Risk Factors, Oral Care of Older People*

The Platform for Better Oral Health in Europe is a joint initiative of the Association for Dental Education in Europe (ADEE), the Council of European Chief Dental Officers (CECDO), the European Association of Dental Public Health (EADPH) and the International Dental Health Foundation (IDHF). Its work is supported by the Wrigley Oral Healthcare Program and GlaxoSmithKline Consumer Healthcare.

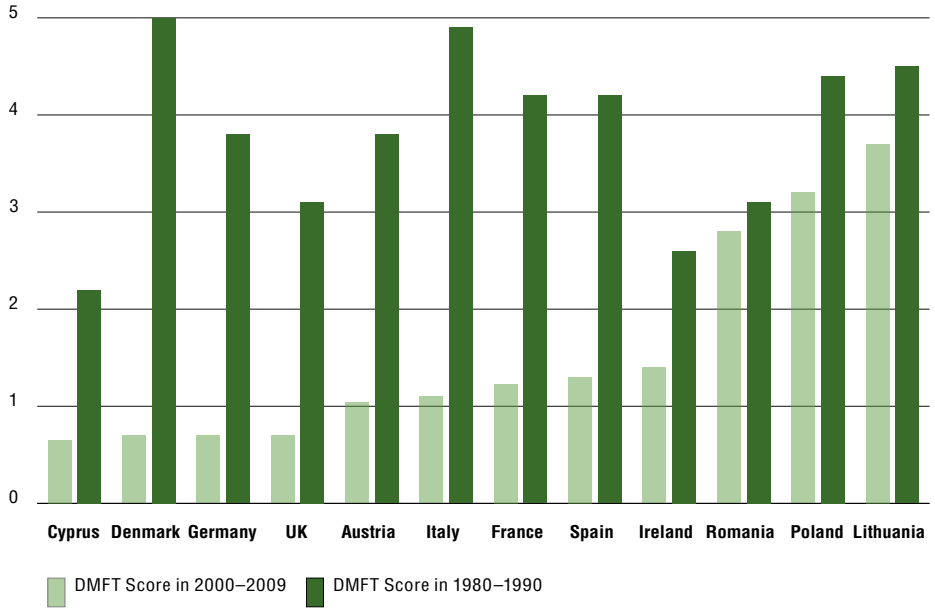
Beatrice Pipitone was formally the Secretary for and **Kenneth Eaton** is the Chairman of the Platform for Better Oral Health in Europe. Email: secretariat@betteroralhealthplatform.eu

The teeth of the matter

Oral health is essential for the general health and well-being of individuals. Oral diseases, including dental caries (tooth decay), periodontal (gum) diseases and oral cancer, have a significant impact in terms of pain, suffering, impairment of function and reduced quality of life.[1] Furthermore, gum diseases have been associated with a range of chronic non-communicable diseases such as diabetes, rheumatoid arthritis, adverse pregnancy outcomes and coronary heart disease. To a large extent, oral diseases are preventable. Yet, when they occur, they can be among the most expensive to treat. It has been estimated that governments in the European Union (EU) will spend nearly €95 billion on oral health in 2020 if current trends persist.[2]

In the last thirty years, there has been a major improvement in the prevalence of dental caries in children and adults and a decline in the percentage of people with no natural teeth in Europe (**see Figure 1**). These successes are presumed to be mainly due to improved living conditions,

Figure 1: Changes in mean national Decayed Missing Filled Teeth (DMFT) scores for 12 years old from profiled Member States between the 1980 and the first decade of 2000



Source: Reference 2.

the widespread use of fluoride toothpaste, changed dietary patterns and to some extent improved oral hygiene practices. They are the result of successful preventative strategies implemented by some western and northern European countries over the past three decades. One of the greatest successes has been in Denmark where the mean number of Decayed Missing Filled Teeth (DMFT) for 12 year olds has decreased from five in 1980 to 0.7 in 2008 despite relatively low spending on oral health (less than 0.4% of Gross National Product (GNP) in 2010). This has been achieved through a targeted and proactive approach delivering free preventative care and education to children up to the age of 18 in local clinics.[3]

Nevertheless, oral health remains a concern which must be addressed with appropriate policies. Significant oral health inequalities persist in Europe in relation to socio-economic status, age, gender and health status. Furthermore, epidemiological trends indicate an increase in the prevalence of gum disease and oral cancer in Europe. Dental caries still remains a problem for those from socio-economically deprived groups and in Eastern European countries. A rapid glance at mean national DMFT scores for 12 year olds shows a wide range of results, with 0.7 in the UK (2008–09), Denmark (2008) and Germany (2005) compared to 3.1 in 2001 in Bulgaria, 3.7 in Lithuania (2005) and 3.2 in Poland (2003). However, it should be borne in mind that methodologies to collect data diverge to the extent that a meaningful comparison is hazardous.[4] In children from low socio-economic backgrounds, the prevalence of caries is higher and there is more untreated disease.[2] Tooth pain and poor oral health may lead to learning difficulties at school and missed days at work for parents. Challenges are also high for those with special needs, such as older and disabled people. In France, it has been reported that 30–40% of people living in residential homes need dental treatment and that one out of three individuals with physical or learning disabilities has at least one untreated cavity.[5]

It has been suggested that over 50% of the European population suffers from some form of periodontitis and over 10% have severe disease, with prevalence increasing to 70–85% of the population aged 60–65. There is a perception that gum health is deteriorating in Europe, in relation to an increase in the prevalence of diabetes.[2] In addition, trends in oral cancer are showing a gender and age shift, with prevalence increasing overall and disproportionately in women and young adults, perhaps in part due to higher rates of smoking and oral cancer related to human papillomavirus (HPV) infections. Mortality rates continue to increase.[2]

Adding to these persistent problems, the current demographic and economic context is creating new challenges. The demographic transition towards an ageing society and the greater number of people retaining some of their teeth into old age creates new treatment needs whilst cuts in state support for patients to access affordable prevention and care in some EU Member States, such as Romania and Ireland, are threatening to damage the progress achieved in the past. In Ireland, the dental association has reported the consequences i.e. reduction in patient attendance, increase in patients presenting with pain, untreated decay and gum disease, increased referrals to hospitals and poorer levels of oral health.[6]

Oral health: a worthwhile investment

Against this background, adequate action should be taken to prevent oral diseases. To avoid negative health consequences in the coming years, it will be necessary to coordinate efforts across Europe, to identify cost-effective preventative health interventions and to dedicate resources to their implementation. Research shows that oral diseases are largely preventable and that oral health is influenced by a range of risk factors, including poor diet, poor oral hygiene, heavy alcohol consumption and misuse, tobacco consumption and age, which oral diseases share with other chronic non-communicable diseases.[2]

Prevention and early treatment substantially reduce the overall costs to the State and the individual. Several studies have shown that treatment of gum diseases results in a 10–12% lower medical cost for patients with diabetes.[6] There is also strong evidence that the benefits of preventing tooth decay exceed the costs of treatment, as savings in dental expenditure have demonstrated in Denmark and Sweden.[2] Thus, the evidence available points to the fact that investing in oral disease prevention is a worthwhile investment in relation to general health budgets and morbidity reduction.

A place for prevention

European policymakers should consider oral health as an integral part of general health and aim to reduce exposure to key risk factors for chronic and oral diseases. The promotion of healthy lifestyles and dietary choices can be achieved through a range of measures, including regulation, addressing the availability and marketing of potentially harmful products such as tobacco, public information and individualised support. For instance, initiatives promoting smoking cessation play an essential role in tackling the upstream causes of oral cancer. Yet, in many European countries, oral health is not fully integrated into generic health promotion programmes and healthy ageing policies.

Furthermore, many dental practitioners feel that patients still do not know about routine oral hygiene practices and do not follow preventive advice. Dedicated public awareness campaigns and school-based prevention programmes could promote healthy behaviours and could make citizens more aware, from an early age, of daily oral hygiene practices, including proper brushing using fluoride-containing toothpaste, inter-dental cleaning, taking care of teeth when on the move with the use of sugar-free chewing gum and regular attendance for dental check-ups.

To tackle inequalities in oral health, the challenges of specific categories of the population with special needs, such as older and disabled people, must also be addressed. Carers for older people, at home and in institutions, as well as those for orphan children and those with special needs, need to be trained on how to routinely provide daily oral hygiene and care. At-risk groups for oral cancer, such as smokers and heavy drinkers, should also be targeted with specific interventions to encourage attendance for dental examinations with a view to increasing early diagnosis and intervention.

Many preventative initiatives already exist at local, regional and national level but good practices are not shared in a systematic manner and replicated. For instance, various initiatives have been tested to improve oral hygiene among older people: e.g. oral hygiene training for carers in residential homes in France. Community-based interventions to prevent tooth decay or oral cancer in other at-risk groups have also demonstrated promising results: in a low socio-economic area in Malmö (Sweden), an oral health promotion programme targeting immigrant families with pre-schoolers (delivery of parent education, tooth-brushing instruction, diet advice and the prescription of a free daily 0.25 mg tablet of fluoride to children) has shown some success in preventing tooth decay.[2] A pilot programme using mass media to encourage attendance by at-risk groups for free dental examinations in Hungary has also allowed the identification of a significant number of individuals with premalignant lesions, as well as the diagnosis of early cases of oral cancer.[7] Finally, programmes involving primary school-aged children in disadvantaged areas of Germany and Ireland have also shown the benefits of using peers to teach younger children about oral health. A decrease in sugary snacking occurred, as well as an increase in knowledge among the children at these schools compared to children attending the control schools.[2]

Greater European coordination

There is an important role for Europe to play to share good practices and integrate oral health in the chronic disease agenda and in healthy ageing policies. Guidance based on a systematic assessment of the benefits of preventative interventions and educational campaigns could help national policymakers make the right choices. For instance, the UK Department of Health has produced an evidence-based toolkit for the prevention of dental caries, periodontal diseases and oral cancer by primary care dental teams. The French Haute Autorité de Santé (HAS) issues the same type of guidance for dental practitioners. A systematic review of such guidance tools, their effectiveness and their content would allow good practices to emerge at EU level. Good practices could be assessed and shared on an online portal, such as the Canadian Best Practices Portal.[8]

Finally, there is room for improving oral health data in Europe, particularly as reliable epidemiological data on gum disease are missing in several European countries. A permanent European oral health data collection network, based on agreed and common methodologies and timelines for reporting and involving European and national authorities in charge of collecting data, could help to inform policies.

The Platform for Better Oral Health in Europe is working to achieve all these aims and has recently published a consultation document which sets out targets to improve oral health policy and the prevention of oral diseases by 2020.[9] Readers of this article are invited to download the recent report on the State of Oral Health in Europe and to respond to the consultation via www.oralhealthplatform.eu

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REDUCING WASTE IN HEALTH AND LONG-TERM CARE IN THE NETHERLANDS

By: Fred Lafeber and Patrick Jeurissen

Summary: The Dutch government tries to involve the population in its struggle to contain the rising costs of health care. Among its efforts is a special virtual reporting point to report 'waste'. Between late May and August 2013, 16,000 questionnaires were filled in at the virtual reporting point. Results highlight that waste seems to occur in all aspects of care. However, in acute care waste seems predominantly related to volume and the level of pricing, whereas in long-term care more waste seems to be connected to management expenses and the administrative complexity of the system. There are some indications that in The Netherlands comparatively more waste is tied to volume than in the United States where waste with respect to pricing and administrative complexity is more prevalent.

Keywords: *Reducing Waste, Health Care, Long-Term Care, The Netherlands*

Introduction

European countries are struggling to curb rising health expenditures. However, since health care services are so highly valued, many countries find it hard to openly reduce entitlements or increase the level of co-payments. Research by the European Observatory on Health Systems and Policies echoes this view, at least for those countries that are at the centre of the storms of the fiscal crisis.[1] Keeping in mind the potential effects of more restrictive global budgets on things such as longer waiting lists, measures to directly address waste garner greater attention. Tackling waste also fits in with broader policy agendas in health, such as creating sustainable health systems and related to this, increasing the overall efficiency of health system functioning.

Indeed, Berwick and Hackbarth[2] claim that reducing waste is the largest and smartest opportunity for developing an affordable health system. They distinguish six categories of waste: 1) health care delivery failures; 2) failures of coordination (e.g. fragmented care); 3) overutilisation; 4) administrative complexity; 5) pricing failures; and 6) fraud and abuse. The authors estimate that between 21% and 47% of all US health care costs are being 'wasted'. In a recent study, former Dutch health care minister Ab Klink estimates that a combined strategy of reducing overutilisation, increasing integrated care and stimulating shared-decision making can add-up to annual savings of €8 billion in The Netherlands – almost 20% of the total budget for acute care.[3]

Fred Lafeber is project leader for waste in long-term care and **Patrick Jeurissen** is chief of the strategy group at the Ministry of Health, Welfare and Sport, the Netherlands.
Email: fn.lafeber@minvws.nl

The combination of pressures of the current austerity agenda and a broadly-felt perception that there is much waste in Dutch health care helped to encourage the Ministry of Health, Welfare and Sport to establish a virtual reporting point where patients, professionals and citizens could report cases of waste in Dutch health and long-term care. To our knowledge, no other similar initiative for addressing waste exists in other European countries.

Reporting point

In May 2013, an online questionnaire was designed by experts from the Ministry in collaboration with external consultants and tested by a professional market research agency. On the Waste-in-Care website (www.verspillingindezorg.nl) people could report anonymously on any waste they had encountered in the health care system. The questionnaire consisted of both open-ended and closed questions (**see Box 1**). Publicity for the website was undertaken via an announcement on the central government website and by the Minister directly in a consumer advice programme on television (which led to an explosion of reports in the first month). Between 25 May and 1 August 2013, 16,403 people filled in the survey at the virtual online reporting portal. More women (60%) than men reported, an outcome that is to be expected, as it is known that women are overrepresented both in the group of health care service users and in the health care workforce. There was also a high response from people aged 46–65 (55%). Most people who filled in the questionnaire were patients (42%) or caregivers (26%), although in long-term care the majority of people reporting were caregivers.

The amount of open non-structured answers (**see Box 1**) made it necessary to codify the answers, which was done by a team at the Ministry using a framework that is somewhat similar to Berwick and Hackbarth's categories (**see Table 1**). Codifying types of waste was further automated with the help of selected key words.

Box 1: Structure and examples of online portal questions

The questionnaire was structured as follows:

1. *What type of waste do you want to report?* Four categories were offered:

a) organisational waste

b) waste in the delivery of services

c) waste regarding prescription medicines

d) waste regarding medical devices

People could also fill in the option: 'Other (please specify)'.

For the four closed-question categories, people were asked to fill in a further specification of the type of waste plus the option for an open answer. For example for organisational waste people could select 'too much paperwork', 'bad procurement', 'limited use of ICT' etc.

2. *Who is causing the waste (for example doctor, pharmacist, specialist, government, insurer etc)?*

3. *Where does the waste occur (for example hospital, at home, institution etc)?*

4. *How do you think this waste can be addressed?*

The closed answers were dependent on the answer for Question 1. For example, for 'organisation' people could fill in 'better procurement', 'quality management', 'improve cooperation', 'more control' and the option 'Other (please specify)'.

Source: Authors.

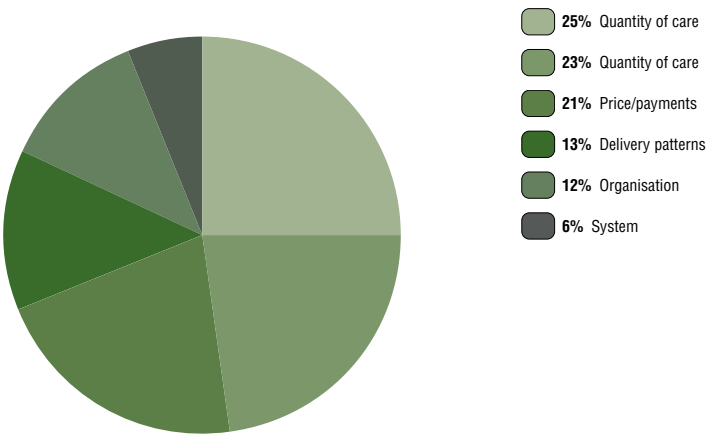
Table 1: Main waste categories and specific subcategories

Main category of waste	Subcategory of waste	Corresponding item in Berwick and Hackbarth (2012)
Quantity of care	Overutilisation, transition to other care settings, underutilisation	Overutilisation
Use of care	No re-use of devices, used too long, patient does not follow prescriptions	–
Price/payments	Too expensive, inaccurate billing (upcoding, fraud) too many amenities	Pricing failures Fraud
Delivery patterns	Care coordination, information failures, bad collaboration, quality problems, wrong diagnosis	Health care delivery failures and failures in care coordination
Organisation/administration	Unnecessary management, bad office management, too much bureaucracy	Administrative complexity
System	Abuse of personal budgets*, wrong incentives in laws and legislation, too extensive benefit package	–

Source: Compiled by the authors.

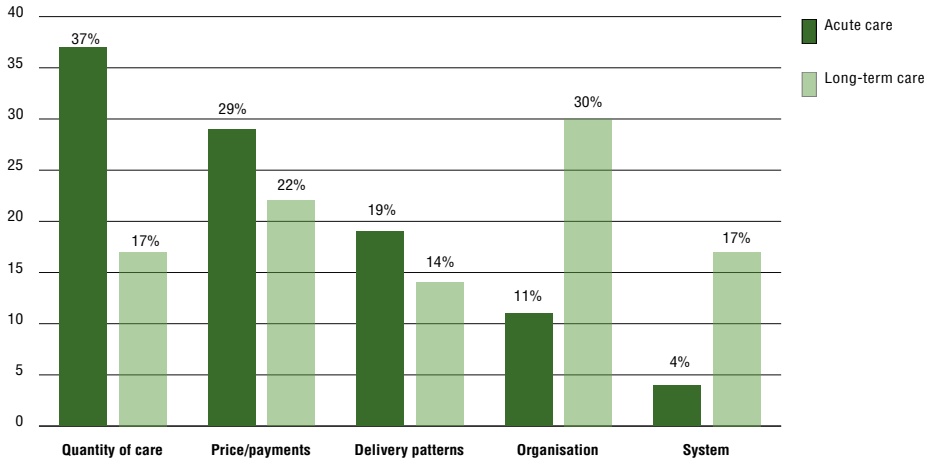
Notes: * Recently the government introduced steps to restrict eligibility for personal budgets. While many people reported on abuse with personal budgets in the online questionnaire, some were of the opinion that waste could be addressed by using personal budgets more often, as it is cheaper than care provided in kind.

Figure 1: Waste by main category



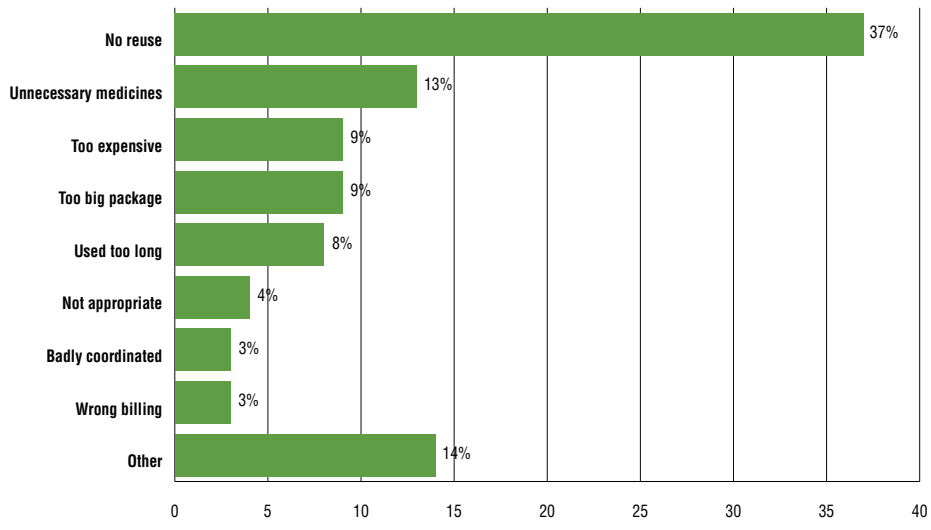
Source: Compiled by the authors.

Figure 2: Main categories of waste in acute and long-term care, excluding medicines and medical devices



Source: Compiled by the authors

Figure 3: Waste of medicines by subcategory



Source: Compiled by the authors

As explained in **Box 1**, people were asked where they thought that waste had occurred. Based on their answers we could distinguish between acute care, long-term care and other locations (health insurer, various health care related agencies). If people mentioned that the waste occurred in more than one place (e.g. at the pharmacy and in a nursing home) the waste was registered under both categories. Although we did not generate a randomised sample, people could decide for themselves whether or not to fill in the questionnaire and thus the sample might be somewhat biased towards those suffering from health issues. However, due to the large size of this sample we feel that the results do illustrate some general opinions among the population on waste in health care.

> 16,403 people filled in the survey

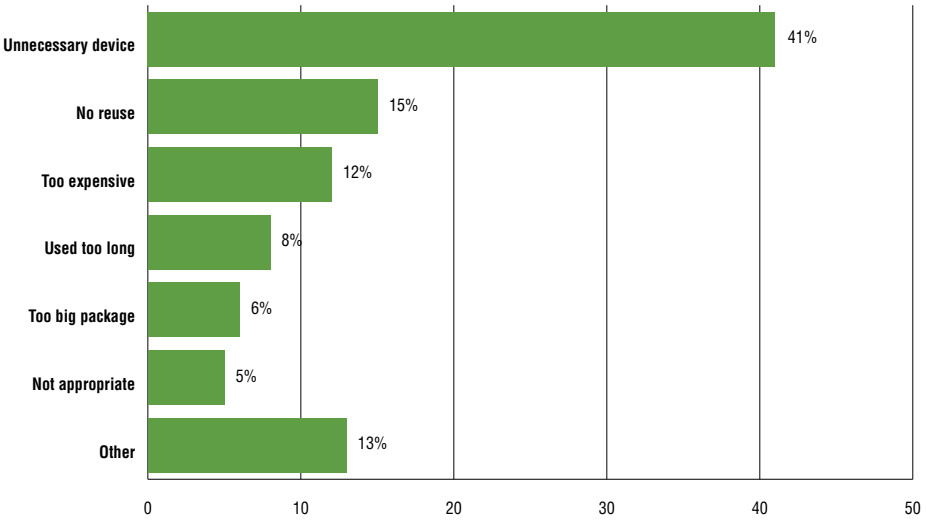
Results

From all the completed answers we could conclude that 55% of the reported waste was related to acute care; 18% to long-term care; and 21% to other sources or sectors (6% could not be categorised). In both acute and long-term care, pharmaceuticals and medical devices generated almost half of all waste reports. Overall, 31% of reports were related to medicines and 11% to medical devices. This might be due to the fact that these categories were highly visible on the opening screen of the survey.

If we focus on the different types of waste (**see Figure 1**), the main conclusion seems to be that substantial amounts of waste occur in all main categories. Waste in the quantity of care, as well as in the use of delivered care, are the most dominant (together totalling 48%), but there are also many cases of waste reported in pricing, organisation, and the delivery of care.

Figure 2 gives the breakdown of the main areas for waste within acute care and long-term care. We have excluded the reports on medicines and medical devices

Figure 4: Waste of medical devices by subcategory



Source: Compiled by the authors

Table 2: Comparison of waste distribution in the Berwick and Hackbarth study and The Netherlands

	Berwick & Hackbarth study) %	Reports in our survey %
Quantity	21%	48%
Price	34%	21%
Delivery/system	18%	19%
Organisation/Administration	27%	12%

Source: Compiled by the authors.

because of their large numbers (and included the remaining 'use of care' in the quantity category). Consequently, we can see that in acute care comparatively large amounts of waste seem to be tied to the volume of care: people reported many cases of overutilisation, unnecessary and duplicate care. Inconvenience with pricing seems to be a key issue in both acute and long-term care. People reported that care is too expensive, that bills are not justified or correct and that hospitals or nursing homes do not use the right coding during reimbursement procedures. In long-term care there were a relatively large number of reports on organisational waste in institutions. This includes administrative procedures, office management, waste of food, water and energy and too much management.

Figures 3 and 4 show the specific waste subcategories for medicines and medical devices. For medicines, the main issue seems to be a lack of use and reuse. For various reasons, people receiving medicines do not always use them or prescriptions are not always collected from the pharmacy. However, there are also many reports on medicines that are too expensive as well as unnecessary. Regarding medical devices, 41% of people reported that devices had been given without a clear need. In addition, there are also examples of the non-transferability of devices across care settings (e.g. from home care to nursing home or from one municipality to another).

The costs of waste

Results from the virtual reporting point cannot be translated into monetary amounts. However, as a thought experiment, we compared the distribution of the actual number of reports that we received with the distribution of costs estimated by Berwick and Hackbarth. To increase the level of comparability we had to combine certain categories (**see Table 1**).

The results are presented in **Table 2** and have a highly tentative character. However, they insinuate that in the United States more waste may take place in pricing (due to pricing failures/too high prices) and administrative complexity, a result that fits with existing literature.[4] In The Netherlands, the volume of acute care seems to be a main issue. This fits with some results of the Survey of Health, Ageing and Retirement in Europe (SHARE) surveys that show that the number of physician visits seem to have increased more in The Netherlands compared to certain other countries in Europe, perhaps indicating an increase in overutilisation and more prescriptions.[5] Universal coverage for health care, the broad benefit package, low copayments and the extensive public long-term care system in The Netherlands are factors that may all contribute to more overuse .

Conclusion

Further research is needed to quantify the costs of waste in The Netherlands and to enable more in-depth comparison with other European countries and the United States. As next steps, the results of the online reporting point will be used to initiate various actions to address waste in 2014–2016 in curative care, long-term care, and for medicines and medical devices.

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IS **SPAIN'S NHS** EVOLVING TO A HIGH-PERFORMING **CHRONIC CARE** HEALTH SYSTEM?

By: Manuel García-Goñi, Cristina Hernández-Quevedo, Roberto Nuño-Solinís and Francesco Paolucci

Summary: Most health systems in developed countries have been designed to 'cure' acute episodes rather than to 'manage' chronic conditions. New models of chronic care provision have been developed to respond to the changing burden of disease and there is already considerable practical experience in terms of policies and pilot studies focused on testing their feasibility. Applying a framework that identifies and analyses ten key prerequisites to achieving high performing chronic care-based health care systems, we find that the design of the Spanish NHS already meets some of these pre-requisites. However, other features are still in their early stages of development or are being applied only in limited geographical and clinical contexts.

Keywords: *Chronic Care, Spain, Integrated Care, Health Management*

Introduction

Increasing health care expenditure is a matter of concern in many countries, particularly in relation to the underlying drivers that include ageing, medical innovation, and changes in the burden of disease, such as the growing prevalence of chronic diseases.[1] In this context, however, it is notable that most health care systems in developed countries have been designed to 'cure' acute episodes, rather than to 'manage' chronic conditions, and therefore they are not suitably or efficiently organised to respond to the changing needs and preferences of users, in particular, those with multiple chronic conditions.

Chronicity and multi-pathology

Currently, chronic diseases are a major public health problem that impacts negatively on the population's health. Furthermore, the magnitude of the challenge is clear considering the high costs associated with the provision of health care to chronic patients under the current model of provision: 78% of total health expenditure in the USA[2] and 70% in Spain.[3] With an ageing population, Spain too has been following the international trend, with rising numbers of chronic patients over the last decade (currently more than 15 million people). In addition, in Spain there has been a decrease in mortality rates associated with chronic illnesses, such as diabetes, chronic respiratory illnesses, cancer,

Manuel García-Goñi is Lecturer at the Universidad Complutense de Madrid, Spain; **Cristina Hernández-Quevedo** is Technical Officer at the European Observatory on Health Systems and Policies, LSE Health, London, UK; **Roberto Nuño-Solinís** is Director of O+Berri, Basque Institute for Healthcare Innovation, Bilbao, Spain; **Francesco Paolucci** is Reader at the University of Northumbria, Newcastle, UK, and Fellow at the Australian National University, Canberra, Australia.
Email: mggoni@ccee.ucm.es

cerebrovascular diseases and acute myocardial infarction, with patients living longer with their diseases.[4]

Managing chronic care

As most health care provision and expenditure is taken up by chronic patients and more specifically by patients with multiple chronic conditions, health systems need to be oriented and integrated in such a way to provide efficient care to this patient group. New models of chronic care provision have been developed to respond to the changing burden of disease and there is already considerable practical experience in several different countries showing the advantages but also the difficulties associated with their implementation. The most notable example is the Chronic Care Model that focuses on elements of a health system that are important for chronic disease management, in particular, self-management support, decision support, clinical information systems and delivery system design, as well as community linkages and the broader organisation of the health system.[5] Another popular model is the Kaiser Permanente Pyramid that highlights the different needs of different levels of a population and the benefits of targeting the health interventions accordingly.[6]

Despite these examples and several other models inspired by them, there is a need, from a health policy perspective, to identify which elements of a health system contribute to a better response to the challenge of chronic disease. Ham[7] presents a framework that identifies and analyses the ten key characteristics of a high-performing chronic care system and provides practical guidance to policy makers and health care leaders on the most promising strategies for improving the provision of chronic care (**see Box 1**).

Box 1: Ten characteristics of a high-performing chronic care system

(1) Ensuring universal coverage

(2) Provision of care that is free at the point of use

(3) Delivery system should focus on the prevention of ill health

(4) Priority is given to patients to self-manage their conditions with support from carers and families

(5) Priority is given to primary health care

(6) Population management is emphasised through the use of tools to stratify people with chronic diseases according to their risk and offering support commensurate with this risk

(7) Care should be integrated to enable primary health care teams to access specialist advice and support when needed

(8) The need to exploit the potential benefits of information technology in improving chronic care

(9) Care is effectively coordinated

(10) Link these nine characteristics into a coherent whole as part of a strategic approach to change

Source: Reference 7.

The Spanish example

Assessing the Spanish National Health Service (NHS) according to Ham's model, we found that universal coverage is guaranteed, aiming to provide equal access to basic health care services according to need. At the point of use, under the Spanish NHS there are no co-payments in primary care (except for pharmaceutical prescriptions), specialist care, or hospital inpatient care. However, the economic crisis has led the Spanish government to impose some constraints on access to care by illegal immigrants that might be in conflict with the principle of universality; moreover, these measures may increase future total health expenditures through the increased use of hospital Accident & Emergency services.[8]

Nevertheless, a range of new preventative strategies have been adopted nationally in the last few years. For example, Spain introduced legislation in 2010 to regulate the smoking of tobacco in public places. There is also an increasing concern regarding the prevalence of obesity, in particular, child obesity. In response, more recent legislation on Food Safety and Nutrition, introduced in 2011, regulates the marketing and points of sale for certain products in schools.

Under the Spanish NHS, there are a growing number of initiatives in several Spanish Regions similar to the UK NHS's Expert Patient Programme, reinforcing the role of chronic patients in self-managing their conditions with support from carers and families. In addition, primary care is recognised internationally as one of the strengths of the Spanish NHS.[9] Primary care teams are assigned to defined population groups, and work with established electronic health information systems, putting them in a good position to develop active population management strategies. GPs act as gatekeepers, being the first point of contact, except in the case of emergencies, and patients have free access to 24-hour primary health care emergency centres as well as hospital emergency departments.

Stratification of patients by risk has been piloted in Spain. Indeed, there is relevant experience at regional level, in particular– for example, in the Basque Country (nearly 2.2 million inhabitants)- and the design of corresponding interventions.[10] Other pilot studies for specific populations include those conducted by the *Serveis de Salut Integrats Baix Empordà* (Integrated health care services Baix Empordà) in Catalonia, which has developed stratification and resource allocation analysis.[11]

Integrated care, both in its organisational and clinical approaches, is an area of huge current interest in Spain with a

range of initiatives such as Integrated Care Organisations (in some places called *Gerencias Únicas,* meaning single management structures), and the development of local integrated care pathways for several key chronic diseases. Furthermore, Spain has been improving its health IT (Information Technology) for the last ten years. By 2007, 97% of all consultations in primary care centres were supported by electronic health records, and 64% of centres had tools to support online patient referrals. In the next phase, an integrated electronic health record system is being developed throughout Spain using both centralised and decentralised platforms, to promote the exchange of information across levels of care and regional boundaries.[9]

Finally, there have been pilot studies exploring the coordination of health care and social care, which are both often required in chronic patients, especially among older people. Coordination between these types of care is particularly hindered by the diversity of institutions involved. In many regions in Spain, long term and social care for older people and the disabled falls outside the remit of the health authorities, making its coordination and integration with health care providers even more difficult. In 2006, Spain approved a Dependency Act (Act 39/2006, of 14th December) with the aim of providing support for informal caregivers and families that provide care to dependents. Although best practices are more common in small primary care or integrated care providers, the visibility of hospital-led innovative approaches for managing frail elderly people with multiple conditions in hospitals (such as the Virgen del Rocío Hospital in Andalusia, the Doce de Octubre Hospital in Madrid and the Donostia Hospital in the Basque Country), has been a key factor in influencing policymakers. In these examples, a specific role – the "assigned specialist" – was created, who provides health care for complex chronic patients in coordination with family physicians and other staff (nurses, cases managers, etc.). Early evaluations have shown their success, particularly in reducing hospital admissions and emergency department attendances.[12]

Some conclusions

Considering the Spanish NHS's current situation, it is possible to identify a transition towards a high-performing health system based on chronic care, with the NHS already meeting some of the pre-requisites outlined in **Box 1**.[13] However, other features are still in their early stages of development or are being applied only in limited geographical and clinical contexts. Several other aspects remain to be developed, such as changes to the delivery model and placing greater emphasis on prevention and self-management by patients of their conditions. Although the coordination of care is facilitated by GPs' gatekeeper function, there is considerable margin for improvement, especially in the case of patients with complex clinical and social needs.

> "growing number of initiatives in several Regions

Other health systems have initiatives favouring continuity within primary care, such as introducing pathway coordinators or special payments to GPs to act as coordinators of care for specific groups of chronically ill patients, and these should be evaluated in the Spanish context. Roles such as case management, for example, are not yet widely developed. Finally, a strategic approach to help achieve better chronic care at the national level is still lacking, although pioneering regions such as the Basque Country have already designed and are currently implementing their own regional strategies.

Given the recent evidence and trends, it is expected that the ongoing development of a chronic care strategy by the Spanish NHS will significantly transform its current health care delivery model in the next few years. However, policies responding to the current economic crisis also have resulted in reductions in health expenditures, as well as the introduction of some further co-payments, making access to some types of care more difficult for specific individuals. Although it is too early to know, this search for short-term savings might compromise longer-term efficiency and equity. Therefore, the current economic context poses a new challenge for the development of a more efficient chronic care system and for assuring that the pillars and virtues of the NHS are not compromised.

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SCALING UP E-HEALTH IN CATALONIA

By: Anna Kotzeva, Oriol Fuertes and Cristina Adroher

Summary: Innovation in health care through the application of Information and Communication Technologies (ICT) offers a broad range of opportunities. Although numerous pilots and research studies investigating new ICT-enabled services have reported positive results and user satisfaction, most of these initiatives never reach large-scale implementation. Here we describe a strategic framework developed in Catalonia to support the evidence-based decision-making process necessary to mainstream and consolidate a new eHealth service into the public health care system.

Keywords: *Health Care System, Public Policy, Evidence-Based Health Care, ICT-Enabled Services, Mainstreaming eHealth*

Introduction

There is growing recognition that in an increasingly digital world, spurred by technological advances and cultural changes, the health care sector must integrate ICT in order to meet stringent economic challenges and growing demand for more and better care[1]. Today, eHealth solutions are changing health care delivery, and they are and will continue to be at the core of responsive and resilient health care systems.

Similarly to other European health care systems, the health care system in the Catalan Autonomous Community in Spain (which is a tax-financed system with a €9bn budget) is undergoing a profound transformation, aimed at capturing efficiency gains while maintaining high quality services.[2] Properly integrated and well-functioning electronic health record (EHR) and ePrescription are necessary tools for this transformation. However, these are not sufficient. ICT-enabled health innovation in Catalonia is driven by both market forces (e.g. medical devices, pharmaceutical and ICT industries) and the health care system itself (e.g. health care providers, insurers, research and European Union funding programmes, etc). New eHealth advancements are constantly introduced into the Catalan health system with disparate results. Specifically, more than 175 ICT-related pilots were initiated over the last five years. Some ended up being implemented throughout the health care system, but a large proportion were discontinued after the pilot phase due to a variety of reasons that can determine the potential for system level extension and consolidation of new services (**see Table 1**).

In this context, and with the objective of maximising the potential of eHealth investments and bridge the existing gap between research evidence and actual implementation of best practices, the Catalan Ministry of Health promoted the

Anna Kotzeva is a Research Associate, and Oriol Fuertes and Cristina Adroher are Advisors to the CEO, at the Agency for Health Quality and Assessment of Catalonia (AQuAS), Barcelona, Spain. Email: akotzeva@gencat.cat

Table 1: Challenges in scaling-up innovative eHealth services

Service adequacy	Implementation success
Responds to questions such as …	*Responds to questions such as …*
• Is this innovation required in our health care system?	• Are the correct infrastructures and incentives in place?
• Is it cost-effective?	• Is there enough understanding and conviction around the new development?
• Is it interoperable with the current ICT system?	• Are the required new skills in place?
• Is it transferable to the rest of the health care system?	• Is a comprehensive monitoring process in place?

Source: Authors.

development of a framework for scaling-up eHealth services to the whole Catalan health care system.

Framework for scaling-up eHealth in Catalonia

The process involves two main phases: (1) Pilot study – when the degree of service adequacy is assessed and, (2) Mainstream service – when implementation success is assessed and consolidated (**see Figure 1**).

Phase 1: Pilot study – "Degree of service adequacy"

The key objective of this phase is to assess the potential and degree of adequacy for further scaling-up of a particular eHealth service. Three key steps are followed:

Step 1: Scanning and identification of existing innovative ICT-enabled services in the Catalan health care area. Health innovation pilots that are currently being implemented are registered at the Observatory of Innovation in Health Care Management in Catalonia and are classified and characterised via an open-collaboration platform developed by CIMIT*. This information is fully accessible to all stakeholders, including citizens. The main objectives of this initiative are (1) to promote knowledge transfer and exchange of best practices among health care provides; (2) to recognise and disseminate the value of the contributions achieved by innovative stakeholders within the health care system and, (3) to enable decision-makers to identify successful innovations that are aligned to current health policies and have potential for system-level implementation. Innovative health services selected at this stage are assessed further.

Step 2: Comprehensive assessment of the impact of the eHealth service. The Agency for Health Quality and Assessment of Catalonia (AQuAS)† uses the Model for Assessment of Telemedicine (MAST)[3] to assess the impact of the new service, its adequacy and readiness to be deployed at system-level. This model was chosen due to its multidisciplinary, rigorous and transparent approach to evaluation.

The process starts with some *preceding considerations* to determine assessment relevance and timeliness. First, the purpose of the eHealth service, its place in the care continuum and its comparator have to be clearly defined. Second, some key issues should be investigated early, such as the degree of development and maturity of the technology used, the appropriateness of the number of patients participating and the duration of the testing period. Third, the regulatory legislation and the reimbursement conditions in place have to be described at this stage, as potential barriers for further implementation and scaling-up.

Once the preceding evaluation is positive, a *multidisciplinary assessment* of the following dimensions is undertaken: clinical effectiveness and safety; economic impact; organisational impact; professionals' and users' perspective; and socio-cultural and ethical implications. A fundamental aspect of the model is the special attention it pays to both the *generalisability and transferability* of the results from one setting to another. Considering legal, organisational and cultural barriers and assessing the project's potential to overcome them is a keystone of the model.

> a multidisciplinary assessment is undertaken

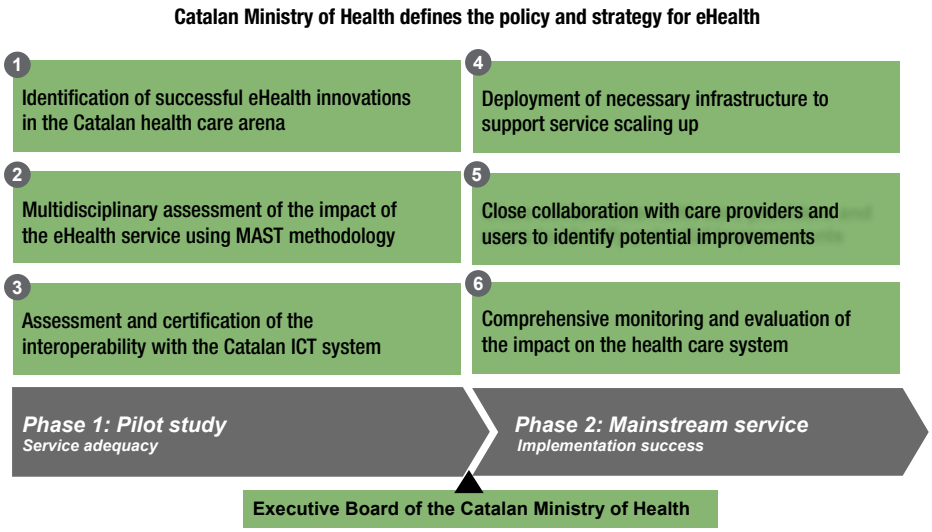
On the basis of the assessment of the aspects above-mentioned, a recommendation on the appropriateness of future scale-up of the particular eHealth service is issued. In order to ease the identification and dissemination of best practices, pilots are rated accordingly in the open-collaboration platform.

Step 3: Assessment and certification of interoperability with the Catalan ICT system. The Office of Standards and Interoperability has the objective to define and implement technical, syntactic and semantic standards to ensure the interoperability of the Catalan health care sector. To conduct the assessment of the interoperability of a certain system, the Office identifies the actors involved and the use of case scenarios where information exchange takes place. In each case, it identifies the syntactic standards (using mainly HL7) and semantic standards (using mainly HL7-cda, Snomed ct, ICD code and Loinc) as checks against the requirements in the system.

* The Center for Integration of Medicine and Innovative Technology (CIMIT) is a not-for-profit organisation, originally from Boston, United States. Its mission is to accelerate the health care innovation cycle by facilitating collaboration among clinicians, health care managers, technologists, engineers and entrepreneurs through the development and implementation of novel products, services and procedures to improve patient care.

† The Agency for Health Quality and Assessment of Catalonia (AQuAS) is a public entity of the Catalan Health System. AQuAS´s role is to generate scientific and relevant knowledge for all agents operating within the Catalan Health System, to inform decision-making processes and to contribute to the improvement of its quality, safety and sustainability.

Figure 1: Framework for scaling-up ICT-enabled health services in Catalonia



Source: Authors.

The conclusions derived from the multidisciplinary assessment and the interoperability analysis are synthesised by AQuAS, which issues a recommendation to the Executive Board of the Catalan Ministry of Health. If the service is rated "adequate for scale-up", the second phase takes place.

Phase 2: Mainstream service – "Degree of implementation success"

Once the pilot has been positively assessed, it is time to get the implementation process right. Managing change implies a broad range of actions, from defining new incentives and allocating human resources to communicating and engaging with key professionals, and building new skills. All this is what the second phase comprises. Getting implementation right and monitoring its progress towards its desired impact will determine how well the new health care service will be consolidated within the system. Again, three fundamental steps are followed:

Step 4: Planning and development of necessary infrastructure to support scale-up. The ICT Services Centre, a key division of AQuAS that ensures proper functioning of all large-scale ICT services (EHR, ePrescription, Personal Health Folder, etc), gets involved early in planning the infrastructure and technical support services that are needed for the implementation of the eHealth service. The ICT Services Centre will ultimately be responsible for the new service's adequate integration with existing health ICT systems and its future sustainability. This is a crucial step in guaranteeing successful scale-up and mainstreaming of the eHealth service as it ensures access and availability 24 hours a day, 365 days a year.

Step 5: Collaboration with health care providers and users to identify potential improvements of the eHealth service. At this stage, the Catalan Health Service (public insurer) coordinates closely with the network of care providers and users to ensure correct and homogeneous application of the new eHealth service and to identify potential improvements. This is considered fundamental as continuous functional and operational adjustments are sought in all ICT developments. Successful scale-up is positively correlated with an adequate service usage and thus, providers are engaged to identify specific improvements.

Four critical elements come into play during this stage: (1) building a common understanding with providers of the advantages of the new mainstreamed service; (2) identifying and sharing with providers the required changes in the processes at a micro, meso and macro level; (3) defining the economic incentives included in the overall payment system; and (4) building new skills for involved stakeholders that are required to ensure proper deployment. Continuous and positive feed back is reinforced during the whole process.

Step 6: Comprehensive monitoring and evaluation of the impact on the health care system.

In parallel, a detailed plan to monitor and evaluate the impact of the new eHealth service[4] is designed and coordinated by AQuAS. It registers implementation progress and results, and aids in securing long-term support and investment. Comprehensive impact assessment is typically an effort performed by various parties. A *governance model* is set-up to align these required collective efforts.

An effective monitoring and evaluation plan is built around a *set of meaningful indicators,* the measurement of which provides insight into the adoption, use and results that the eHealth service is delivering. These indicators include the perspectives of all relevant stakeholders (patients, health care providers, health care managers and administrators, health and medical researchers). Furthermore, baseline and target measures are defined for each indicator. Evaluating indicators against targets occurs at regular intervals.

Process, structure and outcome results (as quality measures) are regularly reported to the Catalan Ministry of Health and communicated to all relevant stakeholders in order to assess service sustainability and the need for changes and/or improvements. This ensures proper implementation throughout the whole system.

Case study: the *Renewing Health* project

Among the first eHealth solutions to be assessed under the described framework is the *Renewing Health* project (2010–2013)[5] which aims to deploy and assess the impact of innovative telemedicine and telemonitoring services for the management of patients with chronic conditions. Catalonia participates in the project, together with eight other European

regions. The project is partially funded under the European Union's ICT Policy Support Programme (ICT PSP) as part of the Competitiveness and Innovation Framework Program and is one of the largest in this area to date.

Renewing Health provides ICT-based integrated service solutions which are designed to support patient empowerment while reducing face-to-face visits and hospitalisations and increasing service user satisfaction. The organisational model created is intended to ensure a safe, seamless and efficient pathway for patients with chronic conditions in their journey through the health care system.

In Catalonia, the project is carried out in eight hospitals with different profiles and includes 380 Chronic Obstructive Pulmonary Disease (COPD) patients. The tested service is designed as a short-term follow up of COPD patients discharged from hospital after disease exacerbation. The frequency and intensity of the telemonitoring is tailored to each patient's clinical complexity and is coordinated by a specialised respiratory nurse.

The impact assessment of the service follows a holistic approach and is based on MAST methodology. The results of the project are expected in early 2014 and will provide valuable information for the planning and redesign of future health care delivery in Europe, as well as providing recommendations on the interoperability and deployment of large-scale telemedicine solutions.

Evaluation, knowledge transfer and dissemination are all key aspects of the project. However, a fundamental part of the value will come from assessing the adequacy of the tested service in the Catalan context and getting the scale-up process right. This is as true for *Renewing Health,* as it is for all other pilots and innovative projects currently being implemented in the Catalan health care system.

Value added

The described framework for scaling-up eHealth promotes and facilitates identification of best practices with potential for mainstreaming when they are still in pilot phase. Additionally, it provides guidance on how to implement meaningful health care innovations at system-level, leading to evidence-based redesign and improvement of the health care system in a sustainable manner. One of the fundamental assets of this framework is that it can be transferred and replicated in other health care systems around the globe with similar challenges.

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New HiT on Armenia

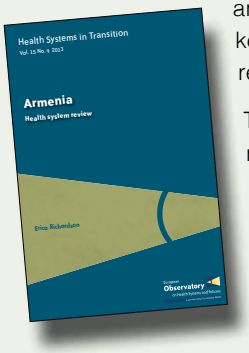
By: E Richardson

Number of pages: 99; **ISSN:** 1817-6127 Vol. 15 No. 4

This analysis of the Armenian health system reviews the developments in organisation and governance, health financing, health care provision, health reforms and health system performance since 2006.

Armenia inherited a Semashko-style health system on independence from the Soviet Union in 1991. Initial severe economic and sociopolitical difficulties during the 1990s affected population health, though strong economic growth from 2000 benefited the population's health. Nevertheless, the Armenian health system remains unduly tilted towards inpatient care concentrated in the capital city, despite overall reductions in hospital beds and concerted efforts to reform primary care provision.

Changes in health system financing since independence have been more profound, as out-of-pocket (OOP) payments now account for over half of total health expenditure. This reduces access to essential services for the poorest households – particularly for inpatient care and pharmaceuticals – and many households face catastrophic health expenditure. Improving health system performance and financial equity are therefore the key challenges for health system reform.



The scaling up of some successful recent programmes for maternal and child health may offer solutions, but require sustained financial resources that will be challenging in the context of financial austerity and the low base of public financing.

PROVISION OF DENTAL SERVICES TO MIGRANTS IN CYPRUS

By: Despena Andrioti, Christos Rodias, Efi Vrioni and George Charalambous

Summary: The present study examined access in 2009 to public dental services at Larnaca Hospital by migrants entitled to free health care. Demographic characteristics, type and costs of treatment received were analysed. The results suggest that migrants are aware of the availability of dental services and that women have better oral health than men. Given that the cost of these services is rather high, public dental care services should be reorganised through the implementation of best practice guidelines, taking into account migrants' cultural and socio-economic characteristics.

Keywords: *Cyprus, Dental Services, Migrant Health, Access, Gender*

Introduction

Through the years, Cyprus has traditionally been a country that exports migrants. However, in recent years, following accession to the European Union (EU), it has accepted a large number of citizens from other EU countries as a result of freedom of movement regulations. There has also been a significant inflow of illegal migrants into the island, especially in those areas of the island that are not under the effective control of the Republic of Cyprus.

In 2009 there were 128,200 foreign nationals in Cyprus, equating to 16.1% of the population:[1] 78,200 were EU citizens, while the remaining 50,000 came from other countries, most notably the Philippines, Russia, Sri Lanka and Vietnam. Migrant workers who do not possess high professional qualification levels tend to be employed largely in unskilled manual labour. They enjoy full health care coverage equal to that of Cypriot citizens with the same levels of income. Specifically, services are provided free of charge by the State to all whose incomes are roughly no more than €15,000 per annum (Medical Card A).[2] Most migrants who come from outside the EU, as well as some from EU states, hold the A card because they are employed in jobs with low salaries.

Although these migrants are entitled to free health services, their health status, as well as access and efficiency in their use of health care services has not been extensively studied. Given that almost the whole population needs dental care,[3] it is of interest to examine the state of migrant oral health and the type of dental interventions that they use. Poor oral health affects our general well being; in addition to pain, individuals may experience nutrition problems as they cannot chew properly. The policy for dental care, as formulated by the Ministry of Health, aims to promote the oral health of all citizens through the preservation of natural teeth until very old age, as well as

Despena Andrioti is Visiting Senior Lecturer, **Christos Rodias** and **Efi Vrioni** are MSc Health Management scholars and **George Charalambous** is Co-ordinator of the MSc in Health Management, at Frederick University, Cyprus. Email: dandrioti@gmail.com

Table 1: Number of dental treatments received by migrants at Larnaca Hospital Dental Service in 2009

Age	0–4	5–14	15–44	45–64	65–74	75+	Total
Men	16	121	230	275	154	15	811
Women	23	173	307	286	114	7	910
Total	**39**	**294**	**537**	**561**	**268**	**22**	**1721**

Source: Dental Services Record, Larnaca Hospital, 2010

Table 2: Types of treatment received by migrants at Larnaca Hospital Dental Service in 2009

Type of Treatment	Men	Women	Total
Examination	54	42	96
Endodontic Treatment (aponeurosis)	46	69	115
Extraction	182	118	300
Composite Resin	110	121	231
Amalgam	125	147	272
Fuji	135	208	343
Temporary Filling (ZnO)	114	108	222
Teeth Cleaning	40	75	125
X-ray	5	22	27
Total	**811**	**910**	**1721**

Source: Dental Services Record, Larnaca Hospital, 2010.

improving the quality of services provided to citizens irrespective of geographical, economic and social status.

It should be noted that, traditionally, Cypriots are used to visiting dentists in private practice.[4] The use of public dental services by the general population increased between 2006 and 2008 by 3%, while visits by migrants holding Medical card A accounted for 10% of total visits.[4] Moreover, the 2008 Health Interview Survey reported that 46.1% of the population had made use of public dental services in the previous year.[5]

This article therefore looks at the use of dental services by migrants in receipt of Medical Card A, in relation to their gender, age, type of treatment received and cost, with a view to considering the implications for any potential reorganisation of services to better meet needs through more preventive activities and other cost effective services. It draws on patient medical record data on the use of different types of service in the Larnaca district of the Republic of Cyprus in 2009. It should be noted that the services provided by public dental clinics are mainly therapeutic and not about aesthetic restoration. Therefore, fixed prosthodontics (bridges, crowns), orthodontics, implants, as well as aesthetic dentistry are not offered.

Results

Table 1 indicates that 1,721 dental treatments were received by migrants at Larnaca Hospital's Dental Service in 2009 (**see Table 1**): 811 treatments were administered to men and 910 to women. Table 2 provides a breakdown of theses types of treatment, with the most common treatments being tooth extractions and permanent/temporary fillings. Men had more extractions and women more fillings. The costs of each type of treatment are shown in Table 3 with total costs for all treatments in the year coming to €62,953.

Discussion

We have noted that the 2008 Health Interview Survey reported that 46.1% of the population received dental services from the public sector in the previous year. At Larnaca Hospital, in 2009 1,721 public dental service treatments were administered to migrants, holding Medical Card A. It is estimated that this is equivalent to approximately 10% of total services received by Cypriot citizens in the same hospital in 2009.

As Table 1 indicates, 910 treatments were performed on women compared to 811 on men while 1,098 treatments (63.8%) of all treatments were received by individuals of working age (15–64 years). This corresponds with the findings of studies that show that the majority of migrants are of working age.[6]

We have noted that the majority of therapeutic services were for dental restoration (filling) – either restoration with composite resin, amalgam, fuji (a type of cement used for permanent fillings) or temporary filling (ZnO). This was followed by extractions, which accounted for 17% of treatments. (**see Table 2**). As expected, the large number of extractions (300 of 1,721 treatments) suggests that the oral health of migrants was very poor.[7] Various studies of dental services show that the

Table 3: Mean and total costs per type of treatment at Larnaca Hospital Dental Service for migrants holding Medical Card A in 2009

Treatment	Number of Treatments	Price in Euros (€)	Total (€)
Examination	96	15.62	1,500
Endodontic Treatment (aponeurosis)	115	93.74	10,780
Extraction	300	31.24	9,372
Composite Resin filling	231	46.87	10,827
Amalgam filling	272	31.24	8,497
Fuji filling	243	31.24	10,715
Temporary filling (ZnO)	222	31.24	6,935
Teeth Cleaning	125	31.24	3,905
X-ray	27	15.62	422
Total	**1,721**	**36.45**	**62,953**

Source: Dental Services Record, Larnaca Hospital, 2010.

comparable rate of extractions for Greek Cypriots is around 5%. The comparison by gender shows that women's oral health is better than that of men, mainly in terms of a lower rate of teeth extraction (13.5% of treatments in women, compared with 22% of treatments in men) (**see Table 2**).

Migrants who live and work in the Republic of Cyprus are aware of their entitlements to health services and make fairly frequent use of this right, resulting in the consumption of a large amount of treatments. However, even when dental care is free, utilisation depends on the level of education, gender, age,[8] individual behaviour patterns, as well as cultural factors and language barriers. Fear of dentists and previous experiences of pain can also have an adverse impact on access to dental care.[9,10] Generally, the teeth of those who visited the public dental services at Larnaca hospital were in a bad condition, since 20% of treatments were for extractions while, as expected, the use of prevention services was low.

Furthermore, we have noted that the total costs of dental treatment for migrants at Larnaca hospital in 2009 were €62,953 or €36.45 per treatment (**see Table 3**). Even though the Ministry of Health in 2010 noted that lower prices were set in the public sector, costs have increased by 20% since 2004. Extrapolating these costs for migrant dental care to the 10% of EU citizens that hold Medical Card A, a rough estimate of the total costs of state funded dental care costs in 2009 would be more than €2 million.

Conclusion

In general, the integration of migrants into Cypriot society must aim at their participation in all social and public activities, the protection of their economic, social, political and cultural rights, as well as fighting against racism and discrimination. Good health, along with employment and housing, are important factors for better integration in society. The offer of free health services is a big step towards integration. However, taking into account the financial difficulty of the country, it would be wise to re-examine the various provisions so that resources can be used more effectively. As far as dental care is concerned, a reorganisation would be of benefit, with services specifically targeted at migrants through the implementation of best practice guidelines, so that services become more efficient and cost effective.

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NEW PUBLICATIONS

Hospitals and borders. Seven case studies on cross-border collaboration and health system interactions

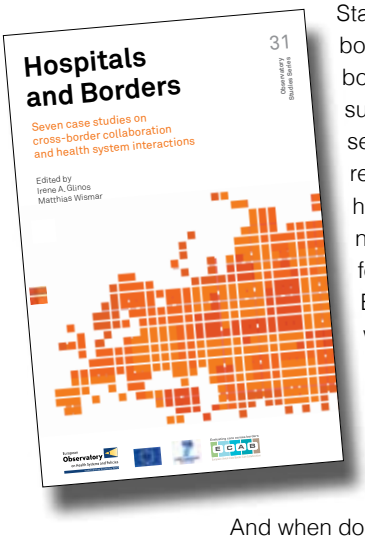
Edited by: Irene A. Glinos and Matthias Wismar

Observatory Studies Series No. 31, 2013

Number of pages: xii + 179; ISBN: 9789289000536

Available at: http://www.euro.who.int/__data/assets/pdf_file/0019/233515/e96935.pdf

The European Union (EU) Directive on the application of patients' rights in cross-border health care explicitly calls for Member States to cooperate in cross-border health care provision in border regions. Given that most such collaboration involves secondary care, the new legal requirement means that hospitals that are close to national frontiers will be the focus of significant attention. But how do hospitals interact with each other and with other health care actors across borders? Why does cross-border collaboration take place? Who actually benefits from it? And when does it work?



The study is original in offering qualitative and analytical scientific evidence on aspects of cross-border collaboration involving hospitals in 11 countries (Austria, Belgium, Bulgaria, Denmark, Finland, France, Germany, The Netherlands, Norway, Romania and Spain). Questions on feasibility, desirability and implementation are at the core of the analysis.

Contents:

Acknowledgements; Ch 1. Hospitals and borders: an introduction to cross-border collaboration; Ch 2. Hospital collaboration in border regions: observations and conclusions; Ch 3. Regional restructuring and European involvement: the ups and downs of the Braunau–Simbach hospital collaboration; Ch 4. Strategic positioning and creative solutions: French patient flows to hospitals and polyclinics in the Belgian Ardennes; Ch 5. Radiotherapy across the border: treating Danish patients in Flensburg Malteser hospital; Ch 6. Official projects, grass-roots solutions: the Sami people using cross-border health services in the Teno River valley; Ch 7. Local roots, European dreams: evolution of the Maastricht–Aachen university hospital collaboration; Ch 8. Working across the Danube: Calarasi and Silistra hospitals sharing doctors; Ch 9. One hospital for the border region: building the new Cerdanya Hospital).

Federalism and Decentralization in European Health and Social Care

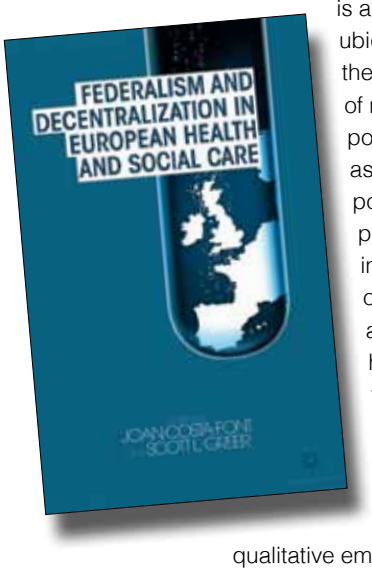
Edited by: J Costa-Font and S Greer

Pelgrave Macmillan, Basingstoke, UK, December 2012

Number of pages: 292

ISBNs: 0230285244, 9780230285248

This book integrates two disciplines – economics and political science – to map the past, present and future of the territorial allocation of authority in the decentralised big countries of Western Europe. By comparing different states, attention is drawn to the interesting similarities and differences that exist in the health and social care policies of varying countries in Europe. The result is an analysis that highlights the ubiquity of territorial politics and the necessarily territorial nature of many health and social care policies. By clarifying assumptions that economists, political scientists and practitioners have often introduced into their analyses of decentralisation and the allocation of authority in health, this book brings to the fore theoretical discussions from second generation fiscal federalism and new politics of the welfare state alongside both quantitative and qualitative empirical evidence of different European countries that differ widely in institutional design and historical inertias.



Contents:

Acknowledgements; Ch 1. Health system federalism and decentralization; what is it? Why does it happen? And what does it do?; Ch 2. Territory and Health: perspectives from economics and political science; Ch 3. The Italian *Servizio Nazionale Sanitario;* Ch 4. Decentralisation and the Spanish health system?; Ch 5. The rise and fall of territory in UK health politics; Ch 6. From centralisation to decentralisation, and back: Norwegian health care from a Nordic perspective; Ch 7. Decentralisation in health and social care in Poland?; Ch 8. Federalism in health and social care in Austria; Ch 9. Federalism and decentralisation in German health and social care policy; Ch 10. Politiques de santé: the territorial politics of French health policy; Ch 11. Devolution, nationalism and the limits of social solidarity: the federalisation of health policy in Belgium; Ch 12. Federalism in health and social care in Switzerland; Ch 13. Conclusions.

NEWS

International

European Union adopts Decision on serious cross-border threats to health

On 22 October, the European Union (EU) adopted a Decision to improve preparedness across the EU and strengthen the capacity to coordinate responses to health emergencies. This Decision entered into force on 6 November.

This new legislation is an important step forward in improving health security in the European Union and in protecting citizens from a wide range of health threats. It will help Member States prepare for and protect citizens against possible future pandemics and serious cross-border threats caused by communicable diseases, chemical, biological or environmental events.

It aims to strengthen preparedness planning capacity at EU level by re-enforcing co-ordination, as well as sharing best practices and information on national preparedness planning. It also provides risk assessment for threats that are not communicable diseases and for which no EU Agency is in charge. For the first time, the EU itself can trigger its pharmaceutical legislation to accelerate the provision of vaccines and medicines in the event of any health emergency, including pandemics. It also gives the Health Security Committee (HSC) a solid legal footing in co-ordinating preparedness. In case of crisis, the HSC is now able to decide quickly on the coordination of national responses, communication messages to the public and to health care professionals.

The new legislation is also expected to further enhance well established collaboration between the European Commission, the World Health Organization Regional Office for Europe (WHO/Europe), the European Centre for Disease Prevention and Control (ECDC) and other relevant EU agencies on health security. It is also expected to further enhance implementation of the 2005 International Health Regulations (IHR) in Europe.

Following the adoption of this legislation on 20–21 November 2013, WHO/Europe and ECDC held a joint meeting for 39 countries in Bratislava, Slovakia on generic and pandemic preparedness. It addressed the Decision and its implications in the context of European collaboration, implementation of IHR and strengthening of generic and pandemic preparedness.

More information at: http://ec.europa.eu/health/preparedness_response/docs/decision_serious_crossborder_threats_22102013_en.pdf

Analysis: inequalities in wellbeing rise in Europe during crisis

While life satisfaction increased marginally across the European Union between 2007 and 2011, happiness and optimism levels have fallen and perceived social exclusion has increased, indicating a decline in overall well-being in many European countries during the crisis. The European Foundation for the Improvement of Living and Working Condition's (Eurofound) new report assesses the impact of the crisis on the subjective well-being of Europeans, drawing policy-relevant findings from its third European Quality of Life Survey. It is the first in a series of reports which covers social inequalities, quality of society and public services and trends in quality of life in Europe over the past decade.

The report presents an innovative way of looking at inequalities in wellbeing; to measure the distribution of wellbeing within a country, differences in life satisfaction between the 20% with the highest life satisfaction and the 20% with the lowest life satisfaction in each country were computed. In addition, in each country it presents the average distance in life satisfaction between two individuals chosen at random. These analyses identify Bulgaria, Hungary, Slovakia, Cyprus, Romania, the UK and Austria as having particularly large differences in wellbeing inequality. The evidence suggests clear benefits from reducing income inequalities within a country. Rising inequality may be linked to declining wellbeing in the countries with higher levels of life satisfaction in 2007, despite rising average incomes. The report concludes that improving the situation of the least well-off is most likely to result in the largest gains in wellbeing.

The report is available at: http://www.eurofound.europa.eu/surveys/eqls/2011/secondaryanalysis.htm

Review of social determinants and the health divide in the WHO European Region

The final report of the *Review of Social Determinants and the Health Divide in the WHO European Region* was launched in London on 30 October 2013. The Review compiled evidence on the 53 countries of the WHO European Region and was undertaken by a cross-disciplinary consortium of Europe's leading experts led by University College London (UCL)'s Institute of Health Equity. The launch was supported by the UK's Department of Health. The conclusions and recommendations of the review informed the development of Health 2020, the new European policy framework for health and wellbeing – along with a companion study on governance for health in the 21st century.

The financial crisis threatens a public health emergency, and inaction will lead to a worsening of social, economic and health burdens.

The review identifies "best buy" priorities in 12 policy areas, covering action across the life-course; in wider society, based on social cohesion, protection and the right to health; in relation to economic, fiscal, environmental and other sectors; and in health systems.

More information on the report and launch event at: https://www.instituteofhealthequity.org/projects/who-european-review

Additional materials supplied by:
EuroHealthNet
6 Philippe Le Bon, Brussels.
Tel: + 32 2 235 03 20
Fax: + 32 2 235 03 39
Email: c.needle@eurohealthnet.eu

In Memoriam, Johan Calltorp

1947–2013

Johan Calltorp died suddenly in early September in Salt Lake City, Utah, where he was leading a group of Swedish health system decision-makers on a study tour of the quality assurance and integrated care methodology at Intermountain Health Care. This was his fourth visit to Intermountain, and on this trip Johan also put in place arrangements for a long-planned research project that would link Intermountain's highly respected patient care systems to the quality assurance work he had been doing at Jonkoping University in Sweden.

Johan had a long and distinguished career in the Swedish health care system as a researcher, a practitioner, a manager, an advisor, and, in recent years, as the main force behind the Swedish Forum for Health Policy. In his research, Johan had long been interested in quality assurance measures in health care systems, in the ethical and practical dimensions of priority setting programmes, and in transforming health care providers into learning organisations.

Shortly after graduating medical school, he was elected president of the Swedish young doctors association. During that period, he worked at the newly expanded National Board of Health and Welfare under Bror Rexed, its famed Director-General, and served as an editor of *Lakaretidningen*, the Swedish physician's journal. By the early 1990s, he had become interested in international comparative analysis, and in 1992 he hosted the first major conference on Swedish health policy in comparative perspective in Stockholm. Shortly thereafter, he served on the Swedish commission that developed a national approach to priority setting. In the 1990s Johan became Professor of Health Management at the Nordic School of Public Health in Gothenburg. Later in that decade, when four Swedish county councils in western Sweden merged into a new Regional county council, Johan became a senior manager in the new organisation, taking on the complex role of merging the new region's hospital activities as Director of Health Services. Subsequently, he developed and implemented the 2005 Swedish Care Guarantee program instituted by the Swedish Federation of Municipalities and counties (SKL). He also taught and conducted research on quality assurance issues at Jonkoping University, where he was instrumental in organizing the ongoing relationship between Jonkoping and the Boston-based Institute for Health Improvement.

Johan sat on a number of research boards in Sweden, and he also sat for a number of years on the Steering Committee of the European Observatory, representing SKL, which is one of the Observatory's two Swedish partners. Johan was often asked to participate in program evaluations for Schools of Public Health and other health-related institutions across Europe and beyond. Johan was a pioneer in the field of comparative health policy in Sweden. He was an articulate and knowledgeable voice in deliberations about health systems, drawing on international experience to inform the process of reform in the Swedish health care system. Through his widely varied experience, he brought rare insight into the forces that moved health systems, and he worked to bring that knowledge to bear on the day-to-day processes of patient care and service delivery. Johan was also influential in a number of European councils, and was respected in international health policy circles.

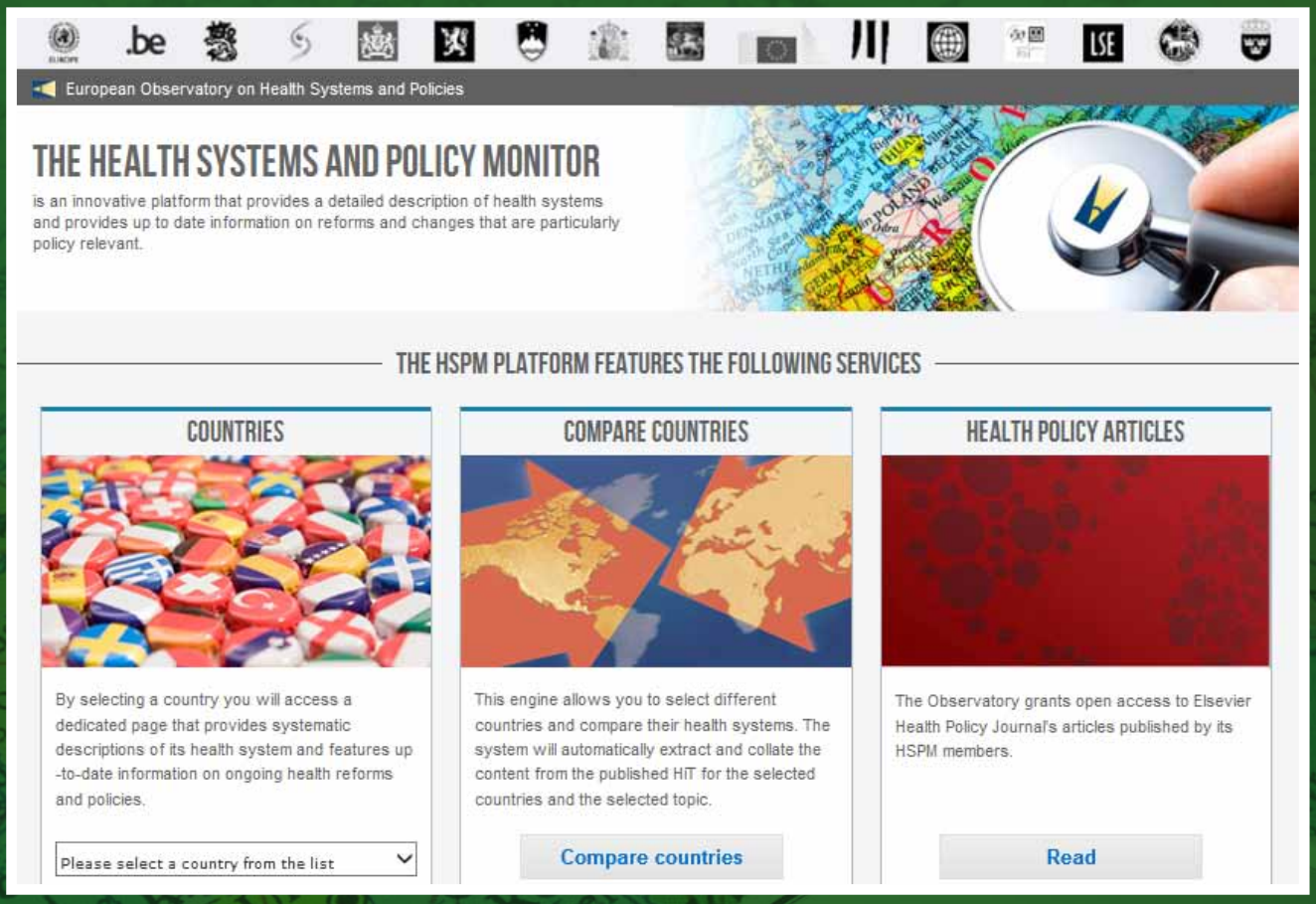
He will be missed.

Richard B. Saltman

Rollins School of Public Health, Emory University, USA.

New web platforms on health systems and financial crisis

www.healthobservatory.eu



The **Health Systems and Policy Monitor (HSPM)** is an innovative web platform that allows policy decision makers, practitioners and academics to follow and understand changes in national health systems across Europe and beyond. The HSPM platform

makes the Observatory's Health Systems in Transition (HiT) series accessible online and facilitates easy navigation through and between HiTs; provides up-to-date information about ongoing health system reforms and changes so that users can identify and understand shifts in policy; allows users to compare health systems information across countries.

www.hspm.org

The **Health and Financial Crisis Monitor (HFCM)** collates scientific evidence about the effects of the financial crisis on health and health systems across Europe, particularly in those countries most affected. The platform is intended to support and inform policy makers and those who advise them by identifying and organising publications, data and analysis on this subject. This web monitor is developed jointly by the Observatory and the Andalusian School of Public Health. It is also linked with a dedicated Twitter channel that also provides information on grey literature (press articles, opinion pieces) as well as on relevant events and activities.

www.hfcm.eu

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