Quarterly of the European Observatory on Health Systems and Policies

EUROHEALTH

incorporating Euro Observer

RESEARCH • DEBATE • POLICY • NEWS

European Health Forum Gastein 2015

› Securing health in Europe: balancing priorities, sharing responsibilities

- Securing health in all EU policies
- Affordability of new medicines
- Innovative approaches for mental illness
- Securing the health workforce
- The power of patients
- The power of the International Health Regulations
- Strengthening primary care
- Enhancing public health preparedness
- Czech Republic: financial stability
- Luxembourg: key reforms and challenges
- The Netherlands: long-term care reform

:: Special Issue ::

Volume 21 | Number 3 | 2015

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

EUROHEALTH

Quarterly of the
European Observatory on Health Systems and Policies
Eurostation (Office 07C020)
Place Victor Horta/Victor Hortaplein, 40/10
1060 Brussels, Belgium
T: +32 2 524 9240
F: +32 2 525 0936
Email: info@obs.euro.who.int
http://www.healthobservatory.eu

SENIOR EDITORIAL TEAM
Sherry Merkur: +44 20 7955 6194 s.m.merkur@lse.ac.uk
Anna Maresso: a.maresso@lse.ac.uk
David McDaid: +44 20 7955 6381 d.mcdaid@lse.ac.uk

EDITORIAL ADVISOR
Willy Palm: wpa@obs.euro.who.int

FOUNDING EDITOR
Elias Mossialos: e.a.mossialos@lse.ac.uk

LSE Health, London School of Economics
and Political Science
Houghton Street, London WC2A 2AE, United Kingdom
T: +44 20 7955 6840
F: +44 20 7955 6803
http://www2.lse.ac.uk/LSEHealthAndSocialCare/aboutUs/LSEHealth/home.aspx

DESIGN EDITOR
Steve Still: steve.still@gmail.com

PRODUCTION MANAGER
Jonathan North: jonathan.north@lshtm.ac.uk

SUBSCRIPTIONS MANAGER
Caroline White: caroline.white@lshtm.ac.uk

Article Submission Guidelines
Available at: http://tinyurl.com/eurohealth

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.

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, Norway, Slovenia, Sweden, the United Kingdom and the Veneto Region of Italy, the European Commission, 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

Eurohealth is available online http://www.euro.who.int/en/who-we-are/partners/observatory/eurohealth and in hard-copy format.
Sign up to receive our e-bulletin and to be alerted when new editions of *Eurohealth* go live on our website:
http://www.euro.who.int/en/home/projects/observatory/publications/e-bulletins
To subscribe to receive hard copies of *Eurohealth*, please send your request and contact details to: bookorder@obs.euro.who.int

If you want to be alerted when a new publication goes online, please sign up to the ***Observatory e-bulletin:***
http://www.lse.ac.uk/lsehealthandsocialcare/publications/eurohealth/eurohealth.aspx

Back issues of *Eurohealth* are available at: http://www.euro.who.int/en/who-we-are/partners/observatory/eurohealth

CONTENTS

Eurohealth Observer

Eurohealth International

Eurohealth Systems and Policies

© Gasteinertal Tourismus

List of Contributors

Jan Alexa ◆ Ministry of Finance, Prague, Czech Republic

Christoph Aluttis ◆ WHO Regional Office for Europe, Copenhagen, Denmark

Hanne Bak Pedersen ◆ WHO Regional Office for Europe, Copenhagen, Denmark

Nicola Bedlington ◆ European Patients' Forum, Brussel, Belgium

Françoise Berthet ◆ Ministry of Health, Luxembourg

Helmut Brand ◆ Department of International Health, Maastricht University; European Health Forum Gastein

Anne Calteux ◆ Ministry of Health, Luxembourg

Massimo Ciotti ◆ European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden

Karl Ekdahl ◆ European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden

Irene A. Glinos ◆ European Observatory on Health Systems and Policies, Brussels, Belgium

Thomas Hofmann ◆ WHO Regional Office for Europe, Copenhagen, Denmark

Michael Hübel ◆ DG Health & Food Safety, European Commission, Brussels, Belgium

Barbara Kerstiëns ◆ DG for Research and Innovation, European Commission, Brussels, Belgium

Hans Kluge ◆ WHO Regional Office for Europe, Copenhagen, Denmark

Katarina Krepelkova ◆ DG for Research and Innovation, European Commission, Brussels, Belgium

Madelon Kroneman ◆ The Netherlands Institute for Health Services Research (NIVEL), Utrecht, The Netherlands

Kevin McCarthy ◆ DG for International Development & Cooperation, European Commission, Brussels, Belgium

David McDaid ◆ LSE Health & Social Care, The London School of Economics & Political Science, UK

Martin McKee ◆ The London School of Hygiene and Tropical Medicine; European Observatory on Health Systems and Policies, UK; European Public Health Association

Ellen Nolte ◆ European Observatory on Health Systems and Policies, London, UK

Govin Permanand ◆ WHO Regional Office for Europe, Copenhagen, Denmark

Zinta Podniece ◆ DG for Employment, Social Affairs and Inclusion, European Commission, Brussels, Belgium

Bernd Rechel ◆ European Observatory on Health Systems and Policies; The London School of Hygiene and Tropical Medicine, UK

Lukáš Rečka ◆ Charles University, Prague, Czech Republic

Jane Robertson ◆ The University of Newcastle, Australia; WHO Regional Office for Europe, Copenhagen, Denmark

Guénaël Rodier ◆ WHO Regional Office for Europe, Copenhagen, Denmark

Anne Spranger ◆ Berlin University of Technology, Germany

continued ...

CONTENTS

Eurohealth Monitor

Jonathan E. Suk ◆ European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden

Marianne Takki ◆ DG for Health & Food Safety, European Commission, Brussels, Belgium

Ann Uustalu ◆ DG for Research and Innovation, European Commission, Brussels, Belgium

Thomas Van Cangh ◆ European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden

Ewout van Ginneken ◆ Berlin University of Technology, Germany

Jana Votápková ◆ Faculty of Social Sciences at Charles University, Prague; Ministry of Health, Czech Republic

Matthias Wismar ◆ European Observatory on Health Systems and Policies, Brussels, Belgium

Featuring viewpoints on securing health in Europe from:

Sabine Oberhauser: Federal Minister of Health, Austria

Lydia Mutsch: Minister of Health and Minister for Equal Opportunities, Luxembourg

Vytenis Andriukaitis: European Union (EU) Commissioner for Health and Food Safety

Zsuzsanna Jakab: Regional Director of the World Health Organization (WHO) Regional Office for Europe

Ilona Kickbusch: Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva

Richard Bergström: Director General of the European Federation of Pharmaceutical Industries and Associations (EFPIA)

GUEST EDITORIAL

An Agenda for Securing Health in Europe

A year and a half after the last European elections, the state of the European Union (EU) is a puzzling one. In the North and South we saw national elections with a swing to Euroscepticism.

On the EU's Eastern border there is an armed conflict. In the South the consequences of the financial crisis still dominate the news and a humanitarian crisis in the Mediterranean is taking place. In the West there are problems in transatlantic cooperation, such as spying (NSA) and the negotiations of a free trade agreement (TTIP). And one country (the United Kingdom) is even going for a referendum on EU membership. The prediction that EU-sceptic members of national parliaments are a greater threat to the idea of European integration than the ones in the EU Parliament has proven correct, as ruling parties are forced to become more Eurosceptic to avoid losing even more voters. At a time in which we need "more Europe" instead of "less Europe" to secure health, these are worrisome developments.

"More" in this context does not mean that Member States have to delegate more competences to Europe. It is about a common understanding that only increased cooperation (and solidarity), which is already codified in the treaty, will secure the level of health (and wealth) that we have reached and will make further developments possible.

Why do we need "more Europe"? Let us have a look at six examples:

Migration

The humanitarian crisis in the Mediterranean, with several hundred thousand refugees, cannot be solved by a single Member State alone: neither in hosting all the refugees nor in tackling the reasons why they leave their countries. European solidarity in handling this problem is clearly needed. And there is time pressure as the push factors are high. Five countries taking care of 75% of all asylum seekers shows the uneven distribution. If we cannot develop together solutions for a "Mare Europaeum" we will not be able to solve other serious problems. This is a litmus test for European cooperation.

Innovation

New innovative products and technologies in the health sector put pressure on Member States regarding how to finance them and how to assure equal access at the same time. In addition, the disease burden is often distributed unevenly: e.g. the countries with the highest Hepatitis C burden in Europe, for which there is now an expensive treatment available, are those with the lowest GDP.

Pandemic control

The next Pandemic will come – we have to learn from the Ebola experience regarding the management of outbreaks and the response within and between international organisations, as well as how to better position ourselves in globalisation.

Data

We live in a data-economy in which individual data are the new currency. Thus, in Europe we cannot afford to have scattered regionalism in Data Protection laws any longer. E- and m-health applications can only show their full potential if we find European solutions.

Demographic change

The demographic change in Europe is a long-term problem and a "political marathon" but is often pushed aside by more hot topics. Europe will definitely become a continent of less, older and more diverse people. We live longer, have a low fertility rate and will see more migration of people and changes in the workforce. This will lead to higher and, more importantly, different needs and demands in health and care.

The economic rise of other countries

By 2050, no individual European country will be part of the G7/G8 any longer. This is important as these meetings gain importance in international diplomacy – and health issues show up on the agenda. The first one to be discussed was antimicrobial resistance this year. The major challenge of this development is how to secure our social standards in this changing economic environment.

How can we achieve "more Europe"? There are different ways that can help to secure health and to demonstrate, at the same time, the clear benefit of the EU to its citizens.

- ***Consolidating the fiscal union***
  Triggered by the financial crisis, measures have already been taken for a closer fiscal union to prevent another such crisis in the future. Additionally, the European Semester issues Country Specific Recommendations for Health as the percentage spent on health is not a negligible amount in national budgets. The Recommendations' content varies and countries beyond those still facing a financial crisis receive them. Austria, for example, was challenged regarding primary care services. Through this kind of health system performance assessment, the EU becomes (in)directly involved in the monitoring of the management of health services in the Member States.

- ***Deepened cooperation between the Member States***
  Increased cooperation is either steered by the Commission or by the Member States themselves. We already see this happening in the development of approaches to European health technology assessment as a basis for the national and, perhaps later, European adoption of technologies – as we have seen for pharmaceuticals through the creation of the European Medicines Agency twenty(!) years ago; or in the fact that most Member States have signed up for the joint procurement initiative for vaccines and will take part in the upcoming discussions to expand this to pharmaceuticals to make more use of economies of scale.

- ***Making full use of existing European regulations***
  At the moment, European Member States have not exploited the full potential of existing regulations in health, such as the "cross-border" directive. They allow for a much deepened cooperation as shown in current examples in rare diseases. And they need to be used to make improvements beyond only health services. Health information can benefit too, as comparable data on quality and the costs of health systems are needed for health systems' performance assessment.

- ***Applying the cross-cutting nature of Health in All Policies (HiAP)***
  The EU has in a way already codified HiAP in the health mandate and has been pushing this concept for years. An obvious area for its application is demographic change and especially cooperation with social services. However, the potential of HiAP has not been exploited to its full extent. Health is too often kept in silos and administrative hurdles make it difficult to cooperate. But without HiAP, it will be difficult to secure health in an interconnected world. A clear roadmap would help to make things happen.

- ***Effective cooperation with international organisations***
  This is already ongoing in some areas, such as health information in cooperation with the WHO and OECD. But we should exploit the full potential of it as duplication of work is still happening too often and we will not be able to afford this in the long run. Furthermore, the European neighbourhood policy can benefit from WHO's mandate in a wider definition of Europe that would support EU actions. As the EU is often a payer in this cooperation it should emphasise value for money to secure efficiency.

- ***Good Governance models for (a social) Europe***
  We will have to discuss not only the model of "Intergovernmental Agreements" that have been used to combat the financial crisis versus the "Community Method" of the EU. There are already statements from inside the Commission regarding upwards social convergences with minimal standards expressed in benchmarks. Even a basic health care basket seems to be on the table again due to the experiences of the financial crisis. These are promising concepts on how to tackle the existing inequalities in health.

- ***Supporting the new drivers of European integration***
  In the past, the motors of European integration have been France and Germany. In the future, small European Member States will take up this role as they benefit most from the achievements of the EU. In health care, we already see this tendency in the above-mentioned joint procurement initiatives. Even the idea of BeNeLux gets a fresh start as Belgium and the Netherlands, together with Luxembourg, discuss negotiating prices for pharmaceuticals together.

- ***Europe is about the Europeans***
  As life is getting more complex and demanding we have to empower the Citizen to become a true "Citoyen" who is capable of being actively involved in decision making, not only in health care, but in all areas such as the data economy. And participatory processes are not only on the health agenda. We see them also in the data economy with concepts of Health Data Cooperatives in which the citizen is the owner of the data.

The European Health Forum Gastein is already mirroring most of the above-mentioned topics in its 2015 programme. It provides not only a place for open discussion, but also a forum for the development of new ideas that help to solve European health-related problems.

Helumt Brand
President, European Health Forum Gastein

Cite this as: *Eurohealth* 2015; 21(3).

COMMENTARY

SECURING HEALTH IN EUROPE: SETTING PRIORITIES, SHARING RESPONSIBILITY

By: Martin McKee and Bernd Rechel

Summary: The idea of Europe has been severely tested in the past year. The crisis facing the Greek economy has challenged the political basis of the single currency. The migrant crisis, with its major consequences for southern Europe, has placed the Schengen Agreement under strain. These experiences highlight the need for Europe's political leaders to reflect on the resilience of our shared values, our commitment to solidarity, and our ability to secure health for all in Europe.

Keywords: *Europe, Solidarity, Shared Responsibility, Economic Crisis, Health Impacts*

Martin McKee is Professor of European Health Policy at The London School of Hygiene and Tropical Medicine, Research Director at the European Observatory on Health Systems and Policies, United Kingdom and President, of the European Public Health Association; **Bernd Rechel** is Researcher at the European Observatory on Health Systems and Policies and Honorary Senior Lecturer at The London School of Hygiene and Tropical Medicine, United Kingdom. Email: Martin.McKee@lshtm.ac.uk

Bringing Europe and its citizens together

The people of Europe are linked in many different ways. Some of those links involve what might be termed "hardware", going deep in the earth, such as the tunnel under the English Channel linking France and the United Kingdom or those under the Alps, joining Austria, France, Italy, and Switzerland, or into the air, such as the bridges that cross Europe's mighty rivers, the Rhine and the Danube. A few combine both, such as the elaborate structure that now links Copenhagen with Malmo. Others involve "software", such as the computerised systems that guide planes across European airspace or allow Europe's citizens to communicate effortlessly across borders using their mobile phones. In these myriad ways, engineers have fostered the idea of Europe as an integrated whole, and not merely the sum of individual countries, thus echoing the theme of the 2014 European Health Forum Gastein, on the vision of Europe.

Those engineers who create these links are judged on many different criteria, whether it be their ability to drive shafts deep into the highest mountains or under the sea and meet in the middle, the aesthetic beauty of a bridge or the volume of traffic it can support, or the ease with which the computer programme can be used by those lacking complex technical skills. However, one of the most important of these criteria is resilience, another theme of an earlier European Health Forum, this time in 2013, and a topic now attracting growing interest from health researchers and policy makers.[1] How well do the structures or systems cope when exposed to a severe shock? If they fail, there can be profound implications for health, whether it be the collapse of a bridge, a mid-air collision, or the inability of the mobile phone system to cope with the increased call volume in an emergency. Health professionals will wish to know that there are mechanisms in place to reduce, as far as can reasonably be achieved, the risk of failure.

Engineers put enormous effort into ensuring that their creations can withstand almost anything imaginable. Take perhaps the most iconic of all Europe's bridges, that in the divided city of Mostar, a city whose very name is derived from the presence of the "stari most", as the old bridge is known in many of the languages spoken in the territory that was once Yugoslavia. Even though he lacked modern materials, and using techniques still not fully understood, the 16th century Ottoman architect Mimar Hayruddin was able to create a structure of beauty and strength, only succumbing finally to sustained shelling by 20th century tanks. Fortunately, the bridge has now been reconstructed, taking its place once again as an iconic structure.[2] More recently, the engineers who created the Great Belt, linking different parts of Denmark with Sweden have created a structure that combines aesthetic appeal with resilience, both to the effects of Baltic tidal movements and even, on the 3rd March 2005, to a collision by a merchant ship which interrupted traffic for less than five hours.

Testing times for the vision

Strong, secure bridges are thus a means of bringing the people of Europe together. However, they represent much more than assemblies of metal and concrete. They exemplify vision. The vision that people and places can be joined together, both geographically and cognitively. This second meaning was not lost on those charged with creating another system linking the people of Europe, the single currency. For them it was natural that bridges from across Europe should adorn euro notes of all denominations. The euro is, just like a bridge or a piece of software, a means to an end and, specifically, a means to bring the people of Europe, or at least those living and working in the Eurozone, together.

By most of the conventional criteria, the euro has been a success, eliminating both the uncertainty and cost of currency transactions by those trading across borders, and facilitating trade that brought many benefits, especially to the traditional manufacturing areas of Northern Europe. The rising prosperity has provided the means to invest in health-promoting policies. Yet, as is now clear, the architects of the euro never subjected it to the stress tests that they would have applied if they had been designing the bridges that feature in their designs. When the first severe shock came, the system was shaken to its roots.

The causes of the global financial crisis are now well understood.[3] The global financial corporations engaged in reckless lending and, when interest rates rose, they made massive losses. The prevailing doctrine of privatisation of profit but socialisation of risk required that governments bail them out, which they did, contributing several trillion euro. The one exception, Iceland, which refused to bail out its banks, instead prosecuting some of the bankers whose actions precipitated the crisis, faced action under anti-terrorist legislation from countries normally regarded as its allies. Partly to make up the shortfall, European governments imposed, or in some cases were forced to impose, severe austerity. There is a widespread consensus among leading academic economists that this made things worse, with recovery delayed much longer than in earlier severe recessions.[4] [5]

Yet, ultimately, most of the worst affected countries did come through, albeit with many casualties along the way, including several thousand additional suicides.[6] The one country that has not so far achieved any recovery is Greece. As we write this commentary in mid July 2015, no-one can tell how events will unfold. What is clear is that the Greek people are suffering grievously, with rising suicides,[7] outbreaks of infectious disease, and shortages of essential medicines.[8] It is also recognised by independent observers, and now also by the International Monetary Fund, that Greek debt is unsustainable and it will either have to be written off, as happened with German debt in the 1950s and Polish debt in the 1990s, or the country will default. Whatever happens, its creditors will lose. They are not alone. Many Greek people have lost, their livelihoods, their homes, and in too many cases their health or even their lives. Yet perhaps the greatest loss has been a belief in the idea of Europe, a people with many nationalities, many and no religious faiths, and speaking many languages, all joined together in solidarity. Individually and collectively, Europe's governments have simply failed to step up to the mark and find a solution. It is too easy to forget that the architects of the European Union, such as Schuman and Adenauer, were driven by an earlier failure.

The challenges of staying together

The Greek referendum in July 2015 was quite explicitly not about Europe or the euro, despite being portrayed this way by some politicians. However, there is another referendum coming up that is explicitly about Europe and, specifically, whether the United Kingdom wishes to remain a member of the European Union. It is already apparent that a narrative, pitting unelected European officials against the democratic will of the Greek people, will be exploited gleefully by those supporting exit from the European Union, with consequences that seem no easier to predict than was the case with the Greek referendum. There seems little doubt that the people of Scotland, Wales and Northern Ireland do recognise the many benefits of being part of the European Union, but many in England may not, which some fear may lead to the break-up of the United Kingdom, raising questions about the resilience of both Europe and some of its Member States.

Yet Euroscepticism is not confined to England and, while it is important not to exaggerate their support, political parties with an explicit anti-European agenda have attracted increasing adherents in many countries, including Finland, France, Denmark and Hungary.[9] One by one, the political and economic bridges are being placed under stress, with concerns that some may even collapse. Evidence of a political willingness to share responsibility seems to be receding rapidly.

The need for united action

It is, however, important to recognise that Europe's bridges are not solely internal. The European Neighbourhood Policy creates another set of bridges, linking countries to the East and South. These bridges have also been coming under strain, in this case from rapidly increasing numbers of migrants, many fleeing conflict in countries such as Mali, Syria, Iraq and Afghanistan. These events provide many examples of Europeans securing health and sharing responsibility. They include Antonis Deligiorgis, an off-duty Greek soldier pictured widely in the media pulling a young Eritrean woman from the sea of Rhodes,[10] and the Italian and Maltese sailors and coastguards risking their lives to rescue young children drowning as their overcrowded boats capsize. Yet, as with the financial crisis, it has also exposed Europe's lack of resilience, with some countries struggling to absorb migrants and others unwilling to share responsibility.[11] Nowhere was this more obvious than in the sea off Libya. While many European, and other, governments, joined enthusiastically in the military action to overthrow President Gadhafi, they were less willing to join together to tackle the consequences of the political vacuum that resulted, which allowed people smuggling to become established on an industrial scale. The Italian Navy, in the front line, committed substantial resources to Operation Mare Nostrum, rescuing thousands from a possible watery grave. Yet it soon became clear that the task was on a scale far beyond the resources of a single country. The European Union eventually came to its aid, with Operation Triton, but deploying many fewer ships and aircraft. As Amnesty International noted, this is "a face-saving not a life-saving operation".[12]

Developments in the Mediterranean have, in turn, placed a major strain on another of the main elements of the European vision, the Schengen Agreement. A week before the European Union initiated celebrations of twenty years of passport-free travel, France temporarily reintroduced border controls to prevent migrants who had arrived in Italy from travelling north, causing the Italian Prime Minister to threaten to issue them with temporary Schengen visas. As a European Union official is reported as noting: "it's not looking good".[13]

Securing health and sharing responsibility

These two examples, the financial crisis and mass migration, provide examples of how Europe has been called upon to secure health, set priorities, and share responsibilities but questions are being raised about whether it has failed. Worryingly, there are many other challenges on the horizon. Some are only possibilities, such as pandemic illnesses, with little evidence that the lessons of failures in the Ebola epidemic have yet been learned.[14] Some are certainties, like the consequences of falling birth rates, and thus future labour supply, and rising numbers of old people, many with multiple complex illnesses.[15] Others are not inevitable, but are extremely likely unless concerted action is taken soon, including the severe health effects of climate change and the growth of antimicrobial resistance.[16]

Previously, at the European Health Forum Gastein, Europe's leading thinkers, policy-makers and practitioners have sought to instil a vision of Europe based on solidarity, shared values, and the need for resilience, both in health systems and beyond. Recent events suggest strongly that these messages have not been taken up sufficiently in the corridors of power, whether at national or European levels, despite the clearly stated commitments of governments to "Health in all policies".[17] The 2015 Forum offers an opportunity for the European health community to issue a powerful wake-up call to Europe's leaders, reminding them of their responsibilities to "secure health in Europe, set priorities, and share responsibility".

References

[1] Glonti K, Gordeev VS, Goryakin Y, et al. A systematic review on health resilience to economic crises. *PloS One* 2015;10(4):e0123117.

[2] Petrovic J. *The old bridge of Mostar and increasing respect for cultural property in armed conflict*. Leiden/Boston: Martinus Nijhoff Publishers, 2013.

[3] McKee M, Karanikolos M, Belcher P, et al. Austerity: a failed experiment on the people of Europe. *Clinical Medicine* 2012;12(4):346–50.

[4] Krugman PR. *End this depression now!* 1st ed. New York: W.W. Norton & Co., 2012.

[5] Stiglitz J. Austerity – Europe's man-made disaster. *Social Europe Journal* 2012;8.

[6] Reeves A, McKee M, Stuckler D. Economic suicides in the Great Recession in Europe and North America. *British Journal of Psychiatry* 2014;205(3):246–7.

[7] Rachiotis G, Stuckler D, McKee M, et al. What has happened to suicides during the Greek economic crisis? Findings from an ecological study of suicides and their determinants (2003–2012). *BMJ open* 2015;5(3):e007295.

[8] Kentikelenis A, Karanikolos M, Reeves A, et al. Greece's health crisis: from austerity to denialism. *The Lancet* 2014;383(9918):748–53.

[9] FitzGibbon J. Euroscepticism and the 2014 European Parliamentary Elections. *L'Europe en Formation* 2015;373(3):29–44.

[10] Smith H. Migrant boat crisis: the story of the Greek hero on the beach. *The Guardian* 2015. Available at: http://www.theguardian.com/world/2015/apr/25/migrant-boat-crisis-the-sergeant-who-did-his-duty-towards-people-struggling-for-their-lives

[11] Razum O, Bozorgmehr K. Disgrace at EU's external borders. *International Journal of Public Health* 2015;60(5):515–6.

[12] Amnesty International. *Europe's response: "Face-saving not a life-saving operation"*, 2015. Available at: https://www.amnesty.org/en/latest/news/2015/04/face-saving-not-a-lifesaving-operation/

[13] Traynor I. Italy threatens to give Schengen visas to migrants as EU ministers meet. *The Guardian* 2015. Available at: http://www.theguardian.com/world/2015/jun/15/italy-threatens-to-give-schengen-visas-to-migrants-as-eu-dispute-deepens

[14] World Health Organization. *Report of the Ebola Interim Assessment Panel*. Geneva: WHO, 2015.

[15] Rechel B, Grundy E, Robine JM, et al. Ageing in the European Union. *The Lancet* 2013;381(9874):1312–22.

[16] Davies SC, Grant J, Catchpole M. *The drugs don't work: a global threat*. Penguin, 2013.

[17] Ståhl T, Wismar M, Ollila E, et al. *Health in all policies: Prospects and potentials*. Helsinki: Finnish Ministry of Social Affairs and Health, 2006.

VOICES FROM EUROPE

Eurohealth asked some of the leading figures representing different stakeholders gathering at the EHFG for their reflections on this year's central theme "Securing health in Europe: balancing priorities, sharing responsibilities". Here are their views and ideas on the health dimensions of humanitarian crises and the value of solidarity for European health systems.

Sabine Oberhauser: Federal Minister of Health, Austria

Lydia Mutsch: Minister of Health and Minister for Equal Opportunities, Luxembourg

Vytenis Andriukaitis: European Union (EU) Commissioner for Health and Food Safety

Zsuzsanna Jakab: Regional Director of the World Health Organization (WHO) Regional Office for Europe

Ilona Kickbusch: Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva

Richard Bergström: Director General of the European Federation of Pharmaceutical Industries and Associations (EFPIA)

Q: Recent events such as the Ebola crisis, the refugee crisis in the Mediterranean, as well as the continuing financial crisis in Greece, have led to humanitarian crises in which the EU and its Member States have been called to action. How do you evaluate the way the health dimension was addressed in one of these cases? How do you think it will affect more generally our policies and priorities to securing health for the population?

A: Highlighting that in her annual summer interview, the German Chancellor Angela Merkel stated that the refugee crisis was a much larger challenge than the Greek financial crisis – and that she considers it to be one of the key issues that Europe will have to resolve, **Ilona Kickbusch, Director of the Global Health Programme at the Graduate Institute of International and Development Studies**, Geneva, starts off these reflections with the idea that: *"Europe is faced with redefining its role in the world: the health and security of European citizens can no longer be ensured without decisive European political action–at home and abroad."* **Zsuzsanna Jakab, Regional Director of the WHO Regional Office for Europe** echoes these sentiments from a policy perspective when she emphasises the way that crisis situations have further challenged the way we understand public health in a globalised, interdependent world: *"Recent political, social and economic developments show the need for policies and priorities that go beyond an emergency response, including enhancement of health system capacity and establishment of response mechanisms involving health and non-health actors. Our work is very much based on this approach. Establishing a cross-sectoral dialogue on public health is essential to mainstream the health dimension of any crisis or emergency. WHO European Member States, supported by the WHO Regional Office for Europe, have adopted and are actively implementing the WHO European Health 2020 policy framework, which focuses on that. One of its major goals is to strengthen countries' capacity to respond to these and many other public health issues and challenges pushing Health-in-all Policies and creating coordination mechanisms for appropriate health responses".*

For Sabine Oberhauser, Federal Minister of Health, Austria international health crises can trigger change and improvements in EU health security responses: *"The Ebola crisis, for instance, showed us that rapid intervention is of vital importance. Evaluating the way the Ebola crisis was addressed by the EU and its Member States, I see potential for improvement. We need enhanced and better structured coordination at a global level, especially with the WHO. The appointment of a permanent "EU Ebola Coordinator" under the responsibility of DG SANTÉ could contribute to this need. We also should think about the creation of a health fund financed from the largest EU budget* *lines."* **Vytenis Andriukaitis, EU Commissioner for Health and Food Safety**, agrees that the Ebola crisis, in particular, provides opportunities for learning and improving response strategies, by all countries: *"The Ebola outbreak in West Africa is unprecedented – it is the largest and most complex Ebola epidemic on record. The EU has been very active in the response to Ebola. We have appointed an EU Ebola coordinator … and the EU has mobilised more than €1.8 billion to assist the affected countries. However it is quite clear that the difficulty to contain the outbreak also lies within the overall weakness of the health systems in those countries. All over the globe evaluation processes are now ongoing to see how we can be better prepared for similar events in the future. This refers to the support for affected countries but we are also looking at the lessons learned for public health globally and in the EU."* And despite the obvious challenges and hardships, **EFPIA Director-General, Richard Bergström**, also seeks out the prospects for learning from crises, in this case the global economic crisis: *"We are slowly recovering from a period of financial hardship. Health systems were not shielded from savings and now we are seeing the negative impact on public health. There must be learnings for the inevitable next time of austerity. Savings on health care carry a very negative "multiplier" effect (to use the language of the economists), leading to poorer patient outcomes, increased costs per patient, as well as direct social and economic costs."*

Above all, ensuring that the health dimension of humanitarian crises is not neglected, is of paramount importance, explains **Lydia Mutsch, Minister of Health and Minister for Equal Opportunities, Luxembourg:** *"The Ebola epidemic, the refugee tragedies in the Mediterranean and the financial crisis in Greece are most striking illustrations of what we all know but what is never stressed enough: health is our most important capital. The health dimension is all but too often neglected when decisions are taken. The importance of strong and resilient health care systems should not be neglected. Preparedness and response capacities of the EU need to be reinforced so as to put its Member States in a position to react swiftly and efficiently to future outbreaks. These concerns will be addressed during the Luxembourg Presidency by a ministerial conference allowing all concerned stakeholders to reflect on the lessons learned from the Ebola crisis. The results of the conference will feed into Council conclusions."* This objective is also seen as fundamental by **Zsuzsanna Jakab**: *"To tackle the root-causes of these crisis situations we need action across government and society: we must reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality."* But while these are widely shared goals within the health policy community, **Minister Oberhauser** reminds us that political commitment is also required if such objectives are not to be undermined: *"As to the question of how humanitarian crises will affect our policies and priorities to safeguard the health of the population more generally, I am convinced that this strongly depends on our political will as a worldwide community of nations. Unfortunately, the financial crisis has led to the questioning of the welfare state – including public health care systems – by certain interest groups and political leaders. Considering the current political climate, even maintaining the existing level of social security – including access to public health care – requires major efforts."*

Q: Solidarity has been one of the foundations for ensuring social security to European citizens. Solidarity between Member States has also been considered as one of the fundamental principles for European integration. Do you think it is time to give this a new meaning or dimension in health, i.e. solidarity between citizens in Europe and with citizens outside Europe? How could this be achieved in terms of access to health care and what would be the specific responsibility of your country/organisation/sector in this?

There is consensus that strengthening solidarity is the right focus. For **Commissioner Andriukaitis**, solidarity is central to Europe's health systems: *"Health policy is at the heart of the social model in the EU Member States. Our health care systems are based on solidarity. We are working hard to maintain these systems efficiently, effectively and able to respond to the evolving needs of EU citizens… [For example], the Cross-border health care Directive which is about to bring a major change in the functioning of health systems in the EU. I believe that in the long run the complete and fair transposition of this directive will deliver real, tangible benefits to the EU citizens through greater co-operation and collaboration."* **Minister Mutsch** echoes these views: *"Every citizen, even the most marginalised, should benefit from the right to equal access to high quality health care. Solidarity and universal health care coverage are an essential pillar of our health care systems; they are the foundation of our social security. The milestone Council conclusions on common values and principles adopted in 2006 rightly stressed that 'health systems are a central part of Europe's high levels of social protection and make a major contribution to social cohesion and social justice'. Our citizens attach great importance to the highest possible levels of human health. We must make sure it is really a given."* **Zsuzsanna Jakab** adds: *"Global solidarity is also at the heart of the world's response to various crises and emergencies. New developments in these areas bring new meaning or dimension to solidarity in health."* Elaborating on this theme, **Minister Oberhauser** also points to the challenges involved: *"The Union should always act on the basis of the principle of solidarity – also with regard to third countries in need. However, as long as Member States are still suffering severely from the aftermath of the economic crisis and as long as they are subject to austerity measures, it will be difficult to reach a common EU-wide consensus on a change in the kind of solidarity in health at a global level we are currently practicing. But exactly this change has to be our common future goal. We are all part of the same world and therefore solidarity should not stop at the EU borders."* Despite these challenges, **Ilona Kickbusch** reminds us of the obligations underpinning the value of solidarity: *"Humanitarian action will need to be strengthened as people sleep in the streets of Kos, Traiskirchen or Berlin but it will not be sufficient. The interdependence of countries is becoming ever more obvious and Europe cannot live up to its values if it tries to turn into a fortress."*

Turning to practical implementation, **Zsuzsanna Jakab** points out that: *"In the WHO European Region, this new dimension of solidarity is reflected in the WHO European policy framework for health and well-being Health 2020, which builds on the governments' solidarity commitments. It puts solidarity, equity, social justice and human rights principles at the forefront when supporting countries in improving governance for health through whole-of-government, intersectoral or other participatory approaches"*. Access to health care is definitely one way to operationalise a commitment to solidarity. Providing a very specific example **Richard Bergström** points to access to pharmaceuticals: *"In the area I know best, pharmaceuticals, I think most payers would agree that in many cases there are systems and processes in place that mean money is spent wisely; high-volume use of off-patent medicines at low, sustainable prices and innovative medicines at appropriate volumes and prices."* Broadening the focus, **Zsuzsanna Jakab** highlights that: *"In public health, one of the most powerful concepts in support of solidarity is the concept of universal health coverage. It aims at improving health and reducing inequalities at the same time"* while **Ilona Kickbusch** expands on this universality to include refugees fleeing conflict zones abroad: *"The humanitarian crisis has not yet turned into a major health crisis because many of the refugees are middle class and well educated, others are young and immunised – even though many of them require treatment on arrival after what they have endured. Their access to European health services will need to be ensured. European medical and nursing associations, as well as public health professionals, will need to give any help they can in the short term – but they will also need to propose long term solutions for equitable access."*

Q: Any final thoughts on what should be guiding principles to overcome current and future health crises and stand stronger in securing the health of the population?

A: Sabine Oberhauser: *"Medical care and access to health care are fundamental rights. It is our common responsibility to not only maintain the existing level of public health care, but to also contribute to the improvement of the aforementioned, not only at a national level, but also within the EU and worldwide. Furthermore, it is paramount that we guarantee the financing of our health care systems on a solidarity basis, i.e. the healthy pay for the treatment of sick people. As a social democrat and Austrian health minister I will indeed make every effort to achieve this."*

Lydia Mutsch: *"Well-organised coordination and cooperation between all the concerned actors, public authorities, international and national organisations, civil society, academic sector and private stakeholders is vital to the success of a comprehensive approach [to public health]."*

Vytenis Andriukaitis: *"Diseases and their causes do not respect national borders, therefore global health issues can only be addressed collectively. The fact is, for health or other policies, that we are, in fact, bound by a "collective self-interest". We are involved in global problems for which we need a concerted global effort to devise global solutions."*

Zsuzsanna Jakab: *"The Millennium Development Goals and the post-2015 agenda underpin the values of solidarity and equity. At WHO, we dedicate all our work to promoting it. This makes me proud to work for the Organization and contributes to my optimism about the future – with the international spirit of solidarity, any ambitious global public health goals can be attained."*

Ilona Kickbusch: *"European politicians will have to show political courage [in meeting the humanitarian crisis we are facing], new European legislation will need to be put in place and European countries will need to share the burden. EHFG will be a good place to set the parameters of what is necessary to ensure health as a human right."*

Richard Bergström: *"The challenge going forward, will be to manage a population that is living longer (a good thing!) and has rightly high expectations of health and social care systems. At the same time we need to make sure people have access to all the good things coming in the pipelines of the life science industry. The unprecedented challenges call for new solutions and new partnerships. We have to break down the silos – intellectual, political, structural and financial between different parts of the health and welfare system and with the innovation system. Many of the partnerships we have were forged in Gastein. Time for new ones. See you there!"*

SECURING HEALTH IN ALL EU POLICIES

By: Michael Hübel, Barbara Kerstiëns, Kevin McCarthy, Zinta Podniece and Marianne Takki

Summary: The European Commission addresses European public health concerns following the maxim that policies must be formed and implemented across different policy areas. This article presents some exemplary areas of action to illustrate what the European Union (EU) does to reach optimum collaboration across policy sectors. It outlines the ongoing European initiatives to establish a framework on health information and evidence, the EU's work on occupational safety and health, and its efforts to stimulate the health Research and Innovation (R&I) cycle. Furthermore, going beyond its outer border is the EU's work on development cooperation.

Keywords: *Health Systems, Health Information, Development Cooperation, Occupational Safety, Research and Innovation*

➤ #EHFG2015 Forum 4: Global health and health systems strengthening

➤ #EHFG2015 Forum 5: Health Information

Michael Hübel is Head of Unit Programme Management and Diseases, DG SANTE; **Barbara Kerstiëns** is Head of Sector Public Health, DG Research and Innovation; **Kevin McCarthy** works in the Health Sector of the unit responsible for Education, Health, Research and Culture, DG Development & Cooperation; **Zinta Podniece** is a Policy Analyst in Health, Safety and Hygiene at Work Unit, DG EMPL; **Marianne Takki** is Policy Co-ordinator in the Unit Health information and Scientific committees, DG SANTE, European Commission, Brussels, Belgium. Email: Michael.Huebel@ec.europa.eu

Introduction

Health systems and outcomes are affected by decisions across many policy fields – and health decisions have an impact on other policy fields. At European Union (EU) level, this is explicitly recognised by the Treaty which stipulates in Article 168 that 'A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities'. Working across policy silos towards common goals and objectives is a central working principle of the new Commission, which took office in 2014. At the 2015 European Health Forum Gastein, the interaction between health and other EU policies is explored in a series of sessions organised by different European Commission services. This article examines a number of these areas, and also looks at efforts to support and underpin health policy development and implementation by improving information and evidence.

European Union Health Information Initiative

Commission President Juncker stated in the mission letter to Commissioner Andriukaitis that one of the key health objectives of the Health and Food Safety Commission should be "developing expertise on performance assessments of health systems, drawing lessons from recent experience, and from EU-funded research projects to build up country-specific and cross-country knowledge that can inform policies".[1]

To meet these objectives, the European Commission is working towards a comprehensive and sustainable framework on health information and evidence. The availability of scientifically sound, comparable and high quality health information helps to identify the key challenges in health systems and in the field of public health in order to target scarce resources most effectively.

This initiative builds on past EU-level projects and activities on health data and information. Its key aim will be to improve EU and international cooperation on health information for the benefit of policy making and research.

The framework will comprise three layers of a health information system. First of all, the Commission is considering a more formalised system to define, develop and adopt EU-level health indicators. Such a system might review and replace the set of 88 European Core Health Indicators which have been developed since 1998.

> specific proposals for EU action

Although these indicators have been instrumental in the way EU health policies have been defined, they will need to be updated in order to meet today's challenges as set out in the mission letter to Commissioner Andriukaitis. We are today in a situation where on the one hand, new indicators are emerging by different players, and on the other, we lack information which would be essential to tackle pressing health issues against heavy financial constraints. Therefore, it is now the time to consider a coherent system which will allow for an improved, more transparent and legitimate process to define EU health indicators.

The second layer is about developing technical support for the creation of health information, including the development of health indicators. The Expert Group on Health Information (EGHI) which brings together EU Member States' representatives, the World Health Organization (WHO) and the Organisation for Economic Co-operation and Development (OECD), has set up a taskforce which will look at ways to develop sustainable technical support on health information. The creation of a European Research Infrastructure Consortium has been suggested as one possible option but other options are also being explored. In addition, the task force oversees a project, "Bridge-Health", which brings several existing and past health information projects together and is being funded under the EU health programme. Malta is chairing this taskforce.

The final layer of the health information initiative involves putting these elements into practice, such as establishing policy making tools and decision aids. The European Commission is developing country specific analysis and proposing EU action tailored to the needs of the Member States based on the available data on the key health indicators. The main objective will be to identify EU-level tools that can be used at the national as well as European level to address health challenges and to exchange experiences for pooling knowledge and expertise on different issues.

This exercise is not about ranking Member States in their performance but pooling their expertise and needs, as countries have different strengths and weaknesses. To ensure that the Member States are at the centre of this process, the Commission will consult every Member State on their own situation through the existing sectoral groups such as the EGHI, the Health Systems Performance Assessment Group and the Health Inequalities Group, to name a few.

The result of this exercise should be specific proposals for EU action, tailored to the needs of individual Member States. The information will be updated regularly and it will also form part of the future EU Health reporting which will provide new, more policy-relevant communication for the Member States and stakeholders on health issues.

This overall health information initiative is currently being developed by the European Commission in consultation with a number of interested parties such as the above mentioned EGHI. The European Health Forum Gastein 2015 will provide an opportunity for the stakeholders to hear more on this important initiative and to provide the Commission with feedback on today's needs for improving EU health information from the perspective of citizens and stakeholders.

The EU's work in health care worldwide

A healthy population and a health system that can deliver basic services to everyone are needed for any country to develop and grow. The EU works to strengthen countries' overall health care systems, globally, and promote research and development in health care.

Goals include:

- Reducing child mortality
- Improving maternal health
- Combating HIV/AIDS, malaria and other priority diseases

The EU has integrated these goals into its development policy and significantly contributed to the progress in achieving them. In 2010, in order to help accelerate progress, the European Commission decided to launch the Millennium Development Goal (MDG) Initiative for €1 billion; about a quarter of this is used for health-related goals.

2015 is a special year for development as the first ever European Year to focus on the EU's external action and Europe's role in the world. This year is a landmark year for international aid and development cooperation as the MDGs come to their conclusion. Based on these, the world will come together to agree on a new course of action and post-2015 development agenda. The EU believes that one overriding goal of the post-2015 development agenda should be to achieve universal health care, accessible to all, with accountability of governments and institutions. The biggest challenges remaining in many places are infectious diseases, reproductive health and rights, and under-nutrition, but chronic diseases are an increasing burden.

Europeans support health as a priority in development. In a recent Eurobarometer opinion poll 39% identified health as the most pressing challenge for the future of developing countries; moreover, 65% of respondents believe that access to medical care when needed is the most important element for leading a life in decent conditions.

Twenty percent of the 2014–2020 EU aid budget will be allocated to support human development and social inclusion, which includes health. The EU aims to strengthen national health systems in developing countries in a coordinated, comprehensive way so that basic health services are available to those in need, including the most vulnerable and marginalised parts of the population. In countries, where EU cooperation focuses on health, support is given to governments to help them achieve universal health coverage.

In addition to helping individual countries, the EU also supports global health initiatives, such as the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis, and the GAVI Vaccine Alliance, as well as UN organisations such as WHO.

The following figures give some indication of how EU aid contributes to fulfilling the three health-related MDGs:

1. Reducing child mortality:
Globally, major progress has been made in improving child survival. The under-five mortality rate has halved since 1990, dropping from 90 to 46 deaths per 1,000 live births in 2013. Moreover, greater absolute declines have been achieved among the poorest households than among the richest in all regions although substantial disparities remain: Sub-Saharan Africa and South Asia together account for four out of five under-five deaths globally. Despite these advances, the toll of under-five deaths is still unacceptable high with 6.3 million deaths among children under five years of age in 2013.[3]

EU action:

- at country level, the EU provided comprehensive health sector support to 39 countries in 2012 alone, with child health a key target.
- thanks to EU support at country level, 18.3 million children were vaccinated against measles between 2004 and 2012
- the EU is a major donor to the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance, the global alliance for vaccines and immunisation.

2. Improving maternal health:
Globally, the maternal mortality ratio dropped by 45% between 1990 and 2013.[4] In developing regions in 2012, half of pregnant women received the recommended four antenatal check-ups (coverage for four visits increased from 37% in 1990 to 52% in 2012) and two-third of deliveries were attended by skilled health personnel (increased from 56% in 1990 to 68% in 2012) but an estimated 40 million births were not attended to by any health professional. In 2013 alone, an estimated 289,000 women died from causes related to pregnancy and childbirth. The uptake of family planning increased from 52% to 63% between 1990 and 2012, but by the end of 2013 some 214 million women still had no control over family planning choices due to social and economic barriers.[5]

The EU's approach to improving maternal health is two-fold: it supports governments to develop and implement national health policies and strategies, and cooperates with other players – from non-governmental and other civil society organisations to UN agencies, such as the UN Population Fund (UNFPA) – to advocate for an approach to reproductive and maternal health rights in conformity with local legislation, so that women and girls can make informed choices.

EU action:

- over 7.5 million births were attended by skilled health personnel
- almost 17 million consultations on reproductive health took place
- more than 8,500 health centres and facilities have been built, renovated or furnished.

3. Combating HIV/AIDS, malaria and other diseases:
The number of deaths caused by AIDS, TB and malaria, six million each year at the beginning of the millennium, has decreased by 40%[4]; however, in 2012 globally 36% of people with advanced HIV infection did not have access to treatment.[6] In 2011, 1.4 million people died from TB, with Africa recording the highest per capita death rate.[7] Multidrug-resistant TB poses a major threat. Between 2000 and 2013, malaria mortality rates decreased by an estimated 47% worldwide (53% in the under-five age group) and by 54% in Africa. But in 2013 there were still about 198 million malaria cases and an estimated 584,000 malaria deaths of which 78% were children under five years of age mostly in Africa.[8]

> rapid transfer of knowledge and innovative solutions

The EU provides substantial financial resources to fight diseases through country programmes via the Global Fund to Fight AIDS, Tuberculosis and Malaria, and also through research programmes such as the European & Developing Countries Clinical Trials Partnership.

EU action:

- Since 2004, the EU has financed the distribution of 18 million insecticide-treated bed nets.
- Between 2010 and 2012 the EU financed antiretroviral combination therapy for more than 350,000 HIV patients.

Keeping workers healthy – EU action on Occupational Health and Safety

For decades, the EU has been active in the area of occupational safety and health (OSH) by adopting a comprehensive body of legislation and by putting in place a series of multi-annual action programmes and strategies. The recent EU Strategic Framework on health and safety at work[9] identifies for the period 2014–2020 the three key challenges and seven strategic objectives for improving OSH, together with actions and instruments to address and achieve them. In line with the *Europe 2020 Strategy,* it contributes to improving job quality, while improving the competitiveness and productivity of European companies. The three challenges are: 1) to improve the implementation of OSH legislation, particularly by helping micro and small enterprises; 2) to improve the prevention of work-related diseases; and 3) to take account of the ageing of the EU's workforce.

Concerning the last challenge, most EU citizens think that good health and safety practices are very important to help people work longer.[10] On the other hand, only three in ten workers say there are already measures to adapt their workplaces for older workers.[11] The new EU Strategic Framework proposes concrete actions to address this issue including awareness raising, sharing good practice information and tools, and promoting rehabilitation and reintegration measures. It also underlines that good health and safety has to be ensured throughout the working life, starting from the very first workday. In this respect, the ongoing European Parliament pilot project investigates OSH policies and initiatives taken in the context of older workers, as well as identifies tools available at EU, national, intermediaries and company level. The results of this project are also relevant for the next Healthy Workplaces Campaign 2016–2017.[12] The ageing population is a cross-cutting issue and therefore good collaboration across different policy areas, such as OSH, public health and research, is essential.

EU policy action and research for successful innovative models

Under *Horizon 2020*,[13] the Commission aims to stimulate the entire health Research & Innovation (R&I) cycle from bench to bedside and the rapid transfer of knowledge and innovative solutions into prevention, diagnosis, treatment modalities and health care in Europe and around the globe. It does so in order to support better health for all, to increase Europe's competitiveness, prosperity and wellbeing, and support global sustainable development. Its action is informed by the challenges faced: the ageing of the European population, an increasing burden of communicable and non-communicable disease and the continuing economic uncertainty. In combination, these challenges jeopardise the sustainability and equity of European health and care systems, and thus our health and wellbeing. The choice is also informed by the necessity to act at the European level, the opportunities presented by the state of the art (scientific, technological, societal, political), and by specific European R&I strengths.

In addition to delivering direct funding for research, the Commission also aims to leverage and align other global sources of funding. Working with stakeholders in this way firstly enables improvements in the co-ordination of European and global health R&I. Secondly, it results in outputs which contribute to the achievement of EU policies related to jobs and growth, development and public health, and a knowledge base which enables the further development of different health related policy areas.

References

[1] European Commission. Letter from Jean-Claude Juncker, President of the European Commission, to incoming Commissioner Andriukaitis for Health and Food Safety. Brussels, 1 November 2014. Available at: https://ec.europa.eu/commission/sites/cwt/files/commissioner_mission_letters/andriukaitis_en.pdf

[2] European Commission. Citizens' views ahead of the European Year for Development, Eurobarometer 82.1, 2014. Available at: http://ec.europa.eu/public_opinion/archives/ebs/ebs_421_fact_eu28hl_en.pdf

[3] UNICEF. *Committing to Child Survival: A Promise Renewed*. New York: UNICEF, 2004. Available at: http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/APR-2014-17Oct14-web_194.pdf

[4] United Nations. *The Millennium Development Goals Report 2014*. New York: United Nations, 2014. Available at: http://www.un.org/millenniumgoals/2014%20MDG%20report/MDG%202014%20English%20web.pdf

[5] Family Planning web site. Available at: http://progress.familyplanning2020.org/

[6] United Nations. *Report of the Secretary-General on the work of the Organization*. Sixty-ninth Session. New York: United Nations, 2014. Available at: http://www.unic.org.in/items/Publications_ReportOfTheSecretaryGeneralOnTheWorkOfTheOrganization2014.pdf

[7] European Commission. *EU announces €370 million of new support to fight AIDS, Tuberculosis and Malaria Brussels* (2 December 2013). Available at: http://europa.eu/rapid/press-release_IP-13-1189_en.htm

[8] World Health Organization. Factsheet on the World Malaria Report 2014 web site. Available at: http://www.who.int/malaria/media/world_malaria_report_2014/en/

[9] European Commission. Communication on an EU Strategic Framework on Health and Safety at Work 2014–2020. COM(2014) 332 final. Brussels: European Commission, 6 June 2014. Available at: http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52014DC0332&from=EN

[10] EU-OSHA. Opinion poll, 2012. Available at: https://osha.europa.eu/en/priority_groups/ageingworkers

[11] European Commission. Working Conditions, *Flash Eurobarometer 398*, 2014. Available at: http://ec.europa.eu/public_opinion/flash/fl_398_sum_en.pdf

[12] EU-OSHA. Healthy Workplaces Campaigns web site. Available at: https://osha.europa.eu/en/campaigns

[13] European Commission. HORIZON 2020: The EU Framework Programme for Research and Innovation web site. Available at: http://ec.europa.eu/programmes/horizon2020/en/area/health/ReportOfTheSecretaryGeneralOnTheWorkOfTheOrganization2014.pdf

CHALLENGES TO THE AFFORDABILITY OF NEW MEDICINES IN EUROPE:

THE CASE OF CANCER DRUGS

By: Jane Robertson, Hanne Bak Pedersen, Govin Permanand and Hans Kluge

Summary: Governments throughout Europe are facing difficulties in providing access to new and expensive medicines. Cancer medicines highlight some of these challenges, with an increasing burden of disease and high expectations of patients and their families for access to new treatments. Strategies such as reducing smoking, attention to lifestyle factors, vaccinations and treatment of some infections will help prevent some cancers. For other cancers, chemotherapy will be a key component of effective cancer treatment. This article identifies some of the issues and evidence that should inform debate on value-based pricing for cancer medicines to ensure fair, accessible and affordable cancer care.

Keywords: *Cancer Medicines, Value-based Pricing, Access, Affordability, Clinical Benefit*

➤ #EHFG2015 Forum 6:
Access to new medicines in Europe

Jane Robertson is a Senior Lecturer at the University of Newcastle, Newcastle, Australia and consultant to the WHO Regional Office for Europe; **Hanne Bak Pedersen** is Programme Manager for Health Technologies and Pharmaceuticals; **Govin Permanand** is Senior Health Policy Analyst; **Hans Kluge** is Director of the Division of Health Systems and Public Health, WHO Regional Office for Europe.
Email: hba@euro.who.int

Introduction

As highlighted in a recent World Health Organization (WHO) Europe report, governments are finding it increasingly difficult to afford the rising number of new medicines being introduced in Europe.[1] And while it is encouraging that new medicines are being developed, national health authorities have to be sure, when taking decisions on purchasing these products, that the price paid accords with the therapeutic benefits to be gained by using them. These issues of high medicine costs are most clearly illustrated with medicines for cancer, as both high-income and low and middle-income countries grapple with how to provide affordable cancer care.

The size of the challenge being faced globally is shown in the statistics, with 8.2 million people worldwide dying from cancer in 2012,[2] and annual numbers of new cancer cases projected to reach 21.4 million by 2030.[3] It is estimated that the health care costs of treating cancer in the European Union (EU) was €51.0 billion in 2009, equivalent to €102 per citizen.[4] There were substantial variations in spending across the 27 countries analysed in this study, ranging from €16 per person in Bulgaria to €184 per person in Luxembourg. While the per capita national income measured as gross domestic product (GDP) was the most important predictor of spending on cancer, countries with comparable national income invested in cancer health care to differing extents. The difficulties of providing cancer care will intensify with ageing populations, increased and longer survival, higher expectations of patients and the rising costs of therapy.[3]

Affordable treatments and access

On World Cancer Day in February 2015, several targets to be achieved by 2025 were identified: (i) health systems need to be strengthened to ensure sustained delivery of effective and people-centred-health cancer control programmes; (ii) improved access to accurate diagnosis, quality multi-modal treatment, rehabilitation and palliative care services, including the availability of affordable essential medicines and technologies; and (iii) universal availability of effective pain control and distress management services.[5] At the same time, EU funding under the *Horizon 2020* programme for research and innovation has been supporting research in developing new technologies to deliver targeted, personalised medicine*. These tensions between affordable treatments and good end-of-life care with innovation and technological developments underpin the current discussions on the provision of affordable and sustainable cancer services (**see Box 1**).

> one-third of cancers are preventable

Box 1

"Because access to new therapies is almost always a highly emotionally charged issue – especially in oncology, where life-and-death decisions are not uncommon and the current standard of care is unfortunately so poor for many cancers – the ability to limit costs or forgo marginally beneficial drugs inevitably becomes a complex discussion… Until we can engage in a rational debate about how best to balance cost against therapeutic efficacy… it may be impossible to avoid gross misallocation of precious drug-discovery resources".

Source: [6]

The WHO estimates that around one-third of cancers are preventable.[2] Reducing use of tobacco and environmental tobacco smoke, attention to physical activity, dietary factors and obesity, limiting harmful use of alcohol, and reducing exposure to carcinogenic chemicals, ionizing radiation and environmental pollution are important and cost-effective strategies to reduce the cancer burden. Vaccination, prevention and treatment of infection can reduce cancers associated with human papilloma virus, viral hepatitis and *Helicobacter pylori*. However, other cancers are less amenable to preventive strategies.

Emphasis should be placed on the early detection of the most treatable cancers, including a number of paediatric cancers, and ensuring access to curative treatments for them. These curative treatments are most clearly identified as essential cancer medicines. However, despite the considerable numbers of new oncology medicines brought to the market, and the pipeline of new drugs, there has been limited progress in improving the outcomes for many cancers. For these, the question is how to manage the difficult balance of meeting the expectations of patients and their families for access to new, often high-cost oncology medicines and the capacity of health systems to provide this cancer care. End-of-life care, reducing imaging use and reducing medicine prices are identified as important strategies for reducing total cancer care costs with least impact on patient outcomes.[3] Perceptions of the unsustainable growth in costs of cancer care have led other commentators to conclude that there is a need for priority-setting and assessment of cost-effectiveness as a core part of cancer systems.[7]

The high cost of medicines

IMS Health has reported that total global spending on oncology medicines for treatment and supportive care exceeded US $100 billion in 2014, with this spending concentrated in the United States and the five largest European countries, and accounting for almost two-thirds of the global market.[8] However, spending more on cancer care does not correlate directly with improved outcomes, with structural, organisational and cultural factors being equally important to delivering effective care.[7] Some have suggested that evidence-based medicine in high-income countries has mostly steered away from issues of payment, affordability and value-for-money.[7] It seems unlikely that in the face of criticism of unsustainable prices for cancers care that this situation can continue.

Reducing prices for cancer medicines requires some consideration of what is a just price for a cancer medicine. Just prices would maintain reasonable profits to pharmaceutical companies but remain fair, accessible and affordable to patients and to the health care system.[9] It has been suggested that currently the formula for pricing cancer medicines is based on the prices for the most recent similar drug on the market and to price the new one within 10% to 20% of that price (usually higher).[10] Others have suggested that institutional factors, including generous third-party coverage that insulate patients from the true costs of treatment, the desire of physicians and hospitals to use novel products, and a lack of therapeutic substitutes, also support the high prices of cancer medicines.[11]

Determining the true prices paid for cancer medicines in different countries in Europe is difficult. There is a lack of transparency in prices paid due to negotiated commercial-in-confidence arrangements with manufacturers, undisclosed rebates and various risk sharing arrangements. Purchasing and payment arrangements are often complex, involving public and private insurance agencies, direct purchase by hospitals, and regional or other sub-national funding schemes. These can give rise to different prices for a medicine even within the same country. Dedicated schemes for providing

---

* See http://ec.europa.eu/programmes/horizon2020/en/news/bring-revolution-personalised-medicine-cancer-treatment

access to expensive cancer medicines that are not available under usual funding mechanisms may be attractive to politicians and patient groups; however, there are opportunity costs of preferential consideration of cancer medicines. These opportunity costs are the often hidden costs of treatments for other clinical conditions that cannot be funded and other patients who are not treated.

> fair, accessible and affordable cancer care

Value-based pricing

The double burden of increasing costs of cancer care and the impacts of the global financial crisis on national health budgets have focused attention on the options for value-based pricing of cancer medicines. Some prioritisation based on evidence of treatment benefit seems inevitable and, indeed, appropriate to ensure the best value-for-money from national investments in health care. Health technology assessments (HTA) and cost-effectiveness analyses (CEA) have been used for some time to guide decisions on public funding of medicines in a number of European countries, including the United Kingdom (the National Institute for Health and Care Excellence, NICE), Germany (under the Pharmaceutical Restructuring Act, AMNOG) and Norway (through the Norwegian Knowledge Centre for the Health Services, NOKC). Even France, which was initially quite reluctant to use economic evaluation in the health care sector, introduced it as a part of its HTA process in 2013. However, the use of cost-effectiveness alone will not resolve the problems of unequal access to cancer medicines in different countries. Differences in mechanisms of reimbursement, and in the use of CEAs and the possible thresholds applied in decision-making can lead to differences in access to particular medicines. Particularly challenging are those medicines deemed not cost-effective in one setting but made available to patients in other settings.

Clinical benefit

There is an emerging debate on what might be a reasonable magnitude of clinical benefit from new cancer treatments, particularly those that will be funded from the public purse. Currently, regulatory agencies such as the US Food and Drug Administration and the European Medicines Agency (EMA) approve medicines for marketing based on evidence of clinical efficacy and safety without consideration of a minimum threshold for benefit. Approvals may be based on surrogate endpoints such as progression-free survival without formal evidence of any prolonged survival associated with the treatment.[11] Once approved by the EMA, national authorities must decide on which patients they should be used and paid for.[12]

The challenges of affordable cancer care have prompted the high-level engagement of clinicians and medical societies in discussions around the quantification of the clinical benefit associated with various cancer treatments and on measures to ensure the most cost-effective use of existing medicines and technologies; indeed, it is not the case that higher spending on cancer care delivers better outcomes.[13] The European Society of Medical Oncologists (ESMO) has recently published the ESMO Magnitude of Clinical Benefit Scale (ESMO-MCBS version that can be used to compare outcomes for treatments for solid cancers.[14] The assessment tools developed distinguish between treatments in the curative and palliative settings. For non-curative interventions, the tools assess a range of outcomes including survival, quality of life (QoL) and various surrogate outcomes for survival or QoL and treatment toxicity. The authors argue that "while a high ESMO-MCBS score does not automatically imply high value (that depends on the price), the scale can be utilised to frame such considerations and can help public policy-makers advance 'accountability for reasonableness' in resource allocation deliberations".[14]

As part of the US "Choosing Wisely" initiative, the American Society of Clinical Oncology (ASCO) has identified five practices or interventions that are costly, widely used and not supported by high-level clinical evidence as opportunities to improve cancer care and reduce costs.[15] These practices include not using cancer treatments for solid tumours in patients unlikely to get substantial benefit from the treatment, reduced use of imaging (PET, CT and radionuclide bone scans) in patients with early prostate and breast cancer at low risk of metastasis, and limiting the use of white cell stimulating factors for primary prevention of febrile neutropenia in patients with less than 20% risk of this complication.

The future

The economics debate on cancer often focuses on the costs of medicines, ignoring the impact of high-cost radiation technologies. Discussions around cancer care need to include an assessment of the most effective (and cost-effective) use of both new and existing diagnostic and treatment strategies. There are some important opportunities for formal collaboration across Europe with sharing of information on costs, cost-effectiveness and experiences with the use of new cancer drugs in practice. It will be increasingly important to follow-up patients to determine whether the projected clinical outcomes have been achieved; this may require more attention to national and cross-national registries of patients. These registries would need to be accessible to governments and researchers to allow critical review of the performance of new and existing treatment strategies in real-world clinical practice.

The effective management of scarce health care resources means there must be transparent frameworks and criteria for decision-making that include the formal assessment of the evidence of benefits and costs. The newly developed ESMO-MCBS tools are an important development in this regard. It is important to reflect on the current situation with a lack of transparency in pricing arrangements that give rise to different costs in different settings and different countries. Commercial-in-confidence arrangements may suit national interests. However, these favour the countries with most effective capacity to negotiate the best prices. There need to be realistic pricing models for the pharmaceutical industry that reflect a reasonable return on investment; at present it is often seen as pricing targeted at the country's ability to pay.

There is a critical need for dialogue with all the relevant stakeholders – the regulatory authorities who approve the new cancer medicines for marketing, the pharmaceutical manufacturers who legitimately seek an appropriate return on their investments in these new medicines, the clinicians who use the medicines in practice, the patients who seek the best possible care when confronted with a diagnosis of cancer and the community which ultimately must pay for these medicines and health care for cancer. Decision-making must be evidence-informed and reflect the values and preferences of the community. This will also include discussions on the appropriate balance between treatment interventions and high quality end-of-life palliative care.

Medicines for cancers are only one of the challenges of new high-cost medicines facing European health care systems. Others include hepatitis C (effective treatments but high cost), medicines for orphan diseases (high cost, evidence of benefit sometimes based on surrogate outcome measures) and biologic agents (how and where do biosimilars fit[1]). Constructive dialogue between all stakeholders, information sharing and pricing transparency will be important strategies in developing a European response to these challenges.

References

[1] WHO Europe. *Access to new medicines in Europe: technical review of policy initiatives and opportunities for collaboration and research*. Copenhagen, 2015. Available at: http://www.euro.who.int/en/health-topics/Health-systems/medicines/publications2/2015/access-to-new-medicines-in-europe-technical-review-of-policy-initiatives-and-opportunities-for-collaboration-and-research

[2] WHO Cancer. Available at: http://www.who.int/cancer/en/

[3] Kelly RJ, Smith TJ. Delivering maximum clinical benefit at an affordable price: engaging stakeholders in cancer care. *The Lancet Oncology* 2014;15:e112–8.

[4] Luengo-Fernandez R, Leal J, Gray A, Sullivan R. Economic burden of cancer across the European Union: a population-based cost analysis. *The Lancet Oncology* 2013;14:1165–74. DOI: http://dx.doi.org/10.1016/S1470-2045(13)70442-X

[5] Union for International Cancer Control (UICC). Press release for World Cancer Day, 2015.

[6] Fojo T, Mailankody S, Lo A. Unintended consequences of expensive cancer therapeutics – the pursuit of marginal indications and a me-too mentality that stifles innovation and creativity: The John Conley Lecture. *JAMA Otolaryngology Head Neck Surgery*. doi:10.1001/jamaoto.2014.1570.

[7] Chalkidou K, Marquez P, Dhillon PK, et al. Evidence-informed frameworks for cost-effective cancer care and prevention in low, middle and high-income countries. *The Lancet Oncology* 2014;15:e119–31.

[8] IMS HEALTH. Cancer Drug Innovation Surges As Cost Growth Moderates, 2014.

[9] Kantarjian H, Steensma D, Sanjuan JR, et al. High cancer drug prices in the United States: reasons and proposed solutions. *Journal of Oncology Practice* 2014;10:e208–11.

[10] Experts in Chronic Myeloid Leukemia. The price of drugs for chronic myeloid leukemia (CML) is a reflection of the unsustainable prices of cancer drugs: from the perspective of a large group of CML experts. *Blood* 2013;121:4439–42.

[11] Siddiqui M, Rajkumarb SV. The high cost of cancer drugs and what we can do about it. *Mayo Clinic Proceedings* 2012; 87(10):935–43. doi: 10.1016/j.mayocp.2012.07.007.

[12] Jönsson B, Wilking N. New cancer drugs in Sweden: Assessment, implementation and access. *Journal of Cancer Policy* 2014;2:45–62. doi:10.1016/j.jcpo.2014.01.003.

[13] Uyl-de Groot CA, de Vries EGE, Verweij J, Sullivan R. Dispelling the myths around cancer care delivery: It's not all about costs. *Journal of Cancer Policy* 2014;2:22–9. http://dx.doi.org/10.1016/j.jcpo.2014.01.001

[14] Cherny NI, Sullivan R, Dafni U, et al. A standardised, generic, validated approach to stratify the magnitude of clinical benefit that can be anticipated from anti-cancer therapies: The European Society for Medical Oncology Magnitude of Clinical Benefit Scale (ESMO-MCBS). *Annals of Oncology Advance Access*, 30 May 2015.

[15] Schnipper LE, Smith TJ, Raghavan D, et al. American Society of Clinical Oncology identifies five key opportunities to improve care and reduce costs: the top five list for oncology. *Journal of Clinical Oncology* 2014;30:1715–24. doi:10.1200/JCO.2012.42.8375.

INNOVATIVE SOLUTIONS FOR PREVENTING AND TREATING MENTAL ILLNESS

By: Ann Uustalu, Barbara Kerstiëns, Katarina Krepelkova and David McDaid

Summary: Recent years have seen significant initiatives at the European level to promote better psychological wellbeing, as well as to prevent and treat mental illness. Nevertheless, most people with mental health problems do not have sufficient contact with health and other services that can help meet their needs. This article highlights potential actions that could strengthen European research and foster innovation, focusing in particular on the role of new digital technologies and how they might help increase access to services and avoid some future costs. Lessons could be learned from longstanding experience in other countries, notably in Australia and the USA.

Keywords: *Mental Health, Research, Innovation, Digital Technology, Telemedicine*

➤ #EHFG2015 Workshop 3: Mental health

Ann Uustalu is Scientific Officer in the Public Health Sector; **Barbara Kerstiëns** is the Head of the Public Health Sector; **Katarina Krepelkova** is Scientific Officer in the Public Health Sector, European Commission, Directorate General Research and Innovation (DG RTD), Brussels, Belgium; **David McDaid** is Associate Professorial Research Fellow in Health Policy and Health Economics at the London School of Economics & Political Science, UK. Email: Ann.UUSTALU@ec.europa.eu

Introduction

Poor mental health, the consequences of which have not always been well understood and sometimes not seen as substantive health concerns, has steadily emerged from the shadows. It is now well accepted that mental disorders place a heavy burden on individuals and their families in Europe, with depression alone being the second most frequent reason for years lived with disability in the European Economic Area.[1] There are also considerable increased risks of physical health problems.[2] Poor mental health is either the leading or second most common cause for absence from work and premature retirement in most high income countries,[3] impacting on the productivity and competitiveness of the European workforce. The importance of protecting the psychological health and wellbeing of European Union (EU) citizens during times of economic crises has also come to the fore.[4]

Europe has reacted to this challenge. In 2008, the European Commission launched the *European Pact for Mental Health and Wellbeing*.[5] The Pact was supported by a series of consensus conferences and expert papers, emphasising the need to address mental health issues in an innovative way and through collaboration across sectors. A more recent development has been the participation of nearly all Member States in the *Joint Action for Mental Health and Wellbeing* launched in 2013 (see http://www.mentalhealthandwellbeing.eu/).

Despite these welcome policy developments, most people with mental health problems do not have sufficient contact with health and other services that can help meet their needs. This is not just a question of financial investment, although in some EU countries spending on mental health remains below 5% of public sector health expenditure.[6] It is also a question of how to design and implement mental health services that people with mental health problems actually want to use, as well as on how to meet the challenge of developing services to help promote and protect mental wellbeing in the whole population. Innovative approaches, delivered within and beyond the health sector will be critical to meeting these challenges. The potential benefits of effective, innovative actions will also stretch well beyond health systems and the European Commission continues to play an important role in developing the evidence base.

> Digital apps could help meet needs of service users

Research and innovation

The EU Research Framework Programme has invested in a number of projects that have sought to encourage innovation for better mental health, including the ROAMER (ROAdmap for MEntal health and well-being Research in Europe) project. This initiative, which brought together hundreds of mental health experts from across Europe, has set out recommendations on key potential areas to explore so as to advance mental health research in Europe.[7] It covered mental disorders named in the 2010 Global Burden of Disease study, with the exception of neurodegenerative disorders (Alzheimer's disease and other dementias). Six research priorities were highlighted (**see Box 1**). These research priorities emphasise the importance of strengthening existing data systems to look at the long term impacts of different actions, across the life-course, whilst recognising the importance of service user involvement in mental health research. The ROAMER project also highlighted the potential competitive advantage that Europe can have in mental health research, being able to evaluate interventions within very different health and social welfare systems across the EU.

Digital innovation

The ROAMER recommendations also place considerable emphasis on evaluating and exploiting the potential of new technological interventions, particularly digital technologies. These are already being developed in several European countries and include a wealth of Internet- or computer-enabled health and care tools on the market: web based treatments, applications for symptom monitoring and patient self-management, such as online programmes for the prevention of eating disorders, applications for early interventions in anxiety disorders, prevention of depression or substance abuse, and web-based cognitive behavioural therapy (CBT). In the EU Seventh Framework Programme, a number of ongoing research projects focus on innovations in prevention and treatment of mental illness, for example E-COMPARED (Internet-based depression treatment), IN-MINDD (promoting long term brain health and dementia deterrence) and MILESTONE (innovative transitional mental health care for children and adolescents).

These investments in telemedicine[*] and related innovations could help meet the needs of service users and potentially avoid some costs to health and social welfare systems. Seeing that the majority of Europeans use the Internet, and most of them do so daily, these e-health and m-health[†] applications could bring benefits for mental health, such as reaching individuals who may be unwilling to come into contact with face to face services, by offering anonymity and thus overcoming stigma and labelling. They may also help reduce waiting times for treatment and eliminate transportation barriers to services. Potential advantages of these approaches also include the opportunity to manage several conditions at the same time, as mental disorders often appear alongside other diseases (e.g. diabetes). New technologies can also be used for preventive purposes, such as the development of e-health tools to help reduce the risks of suicide.

Box 1: ROAMER priority areas

1. Research into mental disorder prevention, mental health promotion and interventions in children, adolescents and young adults
2. Focus on the development and causal mechanisms of mental health symptoms, syndromes and well-being across the lifespan (including older populations)
3. Developing and maintaining international and interdisciplinary research networks and shared databases
4. Developing and implementing better interventions using new scientific and technological advances
5. Reducing stigma, empowering service users and carers in decisions about mental health research
6. Health and social systems research that addresses quality of care and takes account of socio-cultural and socio-economic contexts and approaches.

Source: ROAMER consortium [7]

However, there are also concerns that the internet options and mobile applications may not be equally accessible and affordable to all, creating new inequalities. The appropriateness of the tools can also vary significantly with the digital health literacy and technical skills of the individual, not necessarily being equally useful to everyone.

All of these new tools need careful evaluation. Substantive research is ongoing to evaluate the efficacy of the various tools and to compare them with traditional approaches, or to find new

---

[*] Telemedicine – the use of telecommunication and information technologies in order to provide clinical health care at a distance. It helps eliminate distance barriers and can improve access to medical services that would often not be consistently available in distant rural communities. It is also used to save lives in critical care and emergency situations.

[†] M-health – mobile smartphone applications in the area of health and wellbeing.

combinations of e-tools and professional support. Much of this research (i.e. for prevention, self-help and some treatments) suggests that they can be effective for a wide range of mental health-related disorders. However, the effects may vary, depending on contexts, type and degree of mental health problems and availability of additional ‘offline’ mental health support. Evidence of online treatment of depression and anxiety disorders has, for example, shown that CBT is effective and well accepted by the participants,[8] but direct comparisons between Internet and face to face delivered therapies in trials have been limited.[9] Much less is known about both the effectiveness and acceptability of other applications of new technology. With greater attention being placed on personalised approaches to health care, the ROAMER group have, for instance, called for evaluation of the use of ‘real time’ psychometric feedback over the course of treatment (supported by modern software) to ‘personalise’ and adapt dosage and intensity of treatment to service users’ complexity and problem profile in order to promote better outcomes.

Evaluation is not just a question of determining the effectiveness of different tools, but also whether they are acceptable to service users. The uptake of information and communication technology solutions in many European countries is low, and many individuals who could benefit from online interventions are not able to access them. Questions on where the evidence base can be strengthened include knowing more about interest in and acceptability of the new tools to mental health service users and health care workers, as well as understanding how effective different tools are for different population groups – do they contribute to improvements in mental health and wellbeing?

Recognising the importance of uptake and implementation the ROAMER group, therefore called, in particular, for more robust evaluation not only of the effectiveness but also the acceptability of internet delivered psychological therapies. It is also important to strengthen the evidence base on the economic costs and benefits of these new tools. It is often assumed that online tools can help reach more individuals at a low cost, but there is still relatively little evidence yet on exactly how and for whom these tools may be cost-effective.

> Robust evaluation of effectiveness and acceptability

Quality assurance and implementation challenges

There are also structural, regulatory and quality assurance issues to consider. Perhaps most importantly, how do people with mental health needs identify, assess the quality and choose between different services that may be offered on the Internet? This may be highly problematic, as not all of these tools may come with sufficient professional support or guidance. A fundamental question, therefore, concerns the level of information that can or should be provided about the quality of these services. Currently, there is no system across Europe to validate such tools and to ensure their scientific quality. Moreover, users react differently to these new tools; some find them easy to adopt, while others are sceptical, perhaps having doubts about sharing sensitive data. Such ethical concerns must be taken very seriously, as people living with mental health needs are even more vulnerable. What safeguards can be put in place to encourage use of high quality services, and will service users be aware that safeguards may be very different if they make use of online services that are hosted outside of the EU?

There are also implementation challenges to be faced by health care systems. How do health care providers integrate effective new technological applications into existing health and care systems? Past experience of introducing new tools and care models into existing health and care systems show a large range of issues that must be addressed; be it related to planning and organising work, staff training to master tools and provide guidance to users, health insurance coverage and investment decisions. Additional issues arise when introducing new tools and models in mental health care. Mental health clinicians and nurses also need better tools to facilitate their work in mental health and to make it more efficient; such as new solutions to organise care and training, to gather patient data to help manage conditions, reduce the risk of relapse, and improve social inclusion (e.g. the Illness Management and Recovery (IMR) programme developed in the USA).[10] Implementation experience with such tools has shown the need for simple and practical solutions that can be rolled out without much need for adaptation or staff training.

We can also learn from those countries that already have evaluation experience of implementation. Australia has been a pioneer in this field, with new digital tools and care models for mental health first introduced more than 15 years ago. For instance, researchers at the National Institute for Mental Health Research in Australia have looked at many different tools for different client groups, both from a user and a health care system perspective, drawing important lessons for policy‡. It would be interesting if these pioneers could discuss and share their insights with us, and to see how these experiences could benefit Europe.

References

[1] Institute for Health Metrics and Evaluation. Global burden of disease website. Available at: http://www.healthdata.org/gbd

[2] McDaid D, Park A-L. Counting all the costs: the economic impact of co-morbidity. In Sartorius N, Holt R, Maj M (Eds) *Comorbidity of Mental and Physical Disorders* 2015;179;23–32.

[3] OECD. *Sick on the job? Myths and realities about mental health and work.* Paris: OECD Publishing, 2012.

[4] Wahlbeck K, McDaid D. Actions to alleviate the mental health impact of the economic crisis. *World Psychiatry* 2012;11(3):139–45.

[5] *European Pact for Mental Health and Wellbeing.* Brussels, European Commission, 2008. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf

[6] Dlouhy M. Mental health policy in Eastern Europe: a comparative analysis of seven mental health systems. *BMC Health Services Research* 2014;14:42.

---

‡ See http://nimhr.anu.edu.au/research/themes/e-health for a list of publications.

[7] ROAMER consortium. *A roadmap for mental health research in Europe. Final roadmap March 2015.* Barcelona: ROAMER consortium, 2015.

[8] Ebert D, Zarski A, Christensen H, et al. Internet and computer-based cognitive behavioural therapy for anxiety and depression in youth: a meta-analysis of randomised controlled outcome trials. *PLoS One* 2015;10(3):e0119895.

[9] van Ballegooijen W, Cuijpers P, van Straten A, et al. Adherence to internet-based and face-to-face cognitive behavioural therapy for depression: a meta-analysis. *PLoS One* 2014;9(7):e100674.

[10] Mueser K, Meyer P S, Penn D L, Clancy R, Clancy D, Salyers M. The Illness Management and Recovery Program: Rationale, Development, and Preliminary Findings. *Schizophrenia Bulletin* 2006;32(Suppl 1):S32–43.

SECURING THE HEALTH WORKFORCE

By: Matthias Wismar, Irene A. Glinos and Martin McKee

Summary: Many countries in Europe are striving to improve chronic care in primary health care settings. They are facing a growing burden of chronic diseases alongside an ageing health workforce. This challenge requires new models of chronic care and new skill-mixes. There is, however, not a single best model for skill-mix and skill-mixes vary widely across Europe. There are large difference between countries in how they configure their workforce, including general practitioners, specialists, nurses, dentists, pharmacists and the ever growing number of allied health professions. This is an opportunity for cross-country learning about good strategies and practices in reforming skill-mix.

Keywords: *Chronic Care, Health Workforce, Primary Health Care, Skill-mix, Performance*

➤ #EHFG2015 Lunch workshop 3:
Workforce skill-mix

Matthias Wismar is Senior Health Policy Analyst and **Irene A. Glinos** is Senior Researcher at the European Observatory on Health Systems and Policies, Brussels, Belgium; **Martin McKee** is Professor of European Health Policy at the London School of Hygiene and Tropical Medicine and Research Director at the European Observatory on Health Systems and Policies, London, United Kingdom. Email: mwi@obs.euro.who.int

The authors would like to acknowledge the invaluable input they have received from Ljubisa Stojanovic, Swiss Federal Office of Public Health.

A new Observatory study will begin shortly on skill-mix reforms in Europe, accompanied by extensive dissemination activities including policy dialogues and policy briefs.

Securing the health workforce

The numbers of ageing patients afflicted with chronic conditions and co-morbidities is constantly growing in Europe. Chronic conditions differ markedly from acute disease: the onset of chronic conditions will be gradual and often subtle, the duration is lengthy or indefinite, there are multiple causes and they may change over time, prognosis is frequently uncertain, there is no cure, uncertainty is pervasive, and patients and professionals have complementary knowledge and experiences.[1] As a consequence, patients with chronic diseases often require complex and costly health and social interventions, posing challenges to those who must deliver them.

The health workforce is also ageing. The average age of a nurse in 2010 in the United Kingdom was 42, an increase of nine years since 1987. Twenty-five per cent of all nurses, midwives and health visitors are now over 50 years of age.[2] In 2014, the average age of a German doctor in the ambulatory sector was 53 years.[3] These demographic changes have profound consequences for the supply of health professionals in Europe. According to a 2010 European Commission forecast, a health workforce crisis is looming in Europe by 2020 – with a shortage of two million health and social workers, with the greatest shortage among nurses.[4] Since that forecast, the situation has become even more uncertain. Countries have changed the training pipelines, recruitment policies, salary levels, pension entitlements, retirement age and income taxes during the financial and economic crisis, often with an impact on the health workforce.[5]

> health professionals changing traditional roles

Chronic care in primary care settings

Faced with these challenges countries are exploring ways to improve the performance of their health systems. One approach to do this is to strengthen chronic care in primary health care (PHC) settings as chronic diseases represent a particularly complex and expensive form of care. There are many definitions but most researchers would agree that the well-established ‘four Cs’ cover essential aspects of PHC. These are:

- the point of first *contact* for all new needs;
- *continuous care* over time that is person-centred rather than disease-focused;
- *comprehensive* care provided for all needs that are common in the population; and
- *coordination* of care for common needs and those that are sufficiently uncommon or demanding to require specialised services.[6]

Countries making changes to PHC start from very different positions. To give just a few examples, Estonia moved from an inherited Soviet-style model that was hospital-centred and specialist-led, where the role of general practitioners (GPs) was very limited.[7] Slovenia also had an inheritance, this time from the Socialist Federal Republic of Yugoslavia, which had created a network of ‘health centres’, but by 1991 general practice had long been declining in status compared to other specialties.[8] Austria is in the process of implementing major primary care reform, moving from a system of free choice of GPs and specialists and a hospital sector which has an important role in general outpatient care that is accessible during non-office hours, weekends and holidays.[9]

Many of these changes involve health professionals changing traditional roles, in particular the division of tasks between doctors and nurses. This varies greatly, as can be seen from the ratios of doctors and nurses, which can be considered as a proxy measure for skill-mix (**see Figure 1**). Greece has 2.8 times more medical doctors per 100,000 population than Poland. Switzerland has 3.8 times more nurses per 100,000 population than Bulgaria. And the lowest doctor/nurse ratio is reported for Bulgaria with 1.1 (when excluding Liechtenstein), while the highest is reported for Ireland with 4.5.

A note of caution has to be raised here. The data are incomplete and despite improvements in recent years there are still some questions regarding the accuracy of the data. For the analysis of skill-mix it needs to be noted that **Figure 1** is useful in representing professions but much weaker with regard to skills. For example, the medical skills of prescribing nurses do not come to the forefront in these data. This means some medical skills may be hidden in the nursing column. Vice versa, the small number of nurses in Bulgaria, Cyprus Latvia and Spain poses the question of whether medical doctors in those countries are performing tasks that are considered to be nursing tasks in other countries.

These variations in skill-mix in Europe provide a lot of input when searching for new and innovative skill-mix models. They are helpful in terms of cross-country learning and establishing benchmarks. However, some of the more extreme differences visible in **Figure 1** are probably detrimental for patient care. It is implausible that all the skill-mix formulas represented in the figure work equally well. On the contrary, some of the skill-mixes shown are suspiciously unbalanced and are unlikely to produce good value for money. Poor outcomes and a waste of resources are much more likely in some of the countries, prompting skill-mix comparisons and potential for reform.

Strategies for closing skill gaps

PHC reforms aim to improve access to the first contact point and to improve continuity, comprehensiveness, and coordination of services. Introducing new models of PHC may require new skill-mixes. Sometimes, these skills are just not available or not available in the numbers needed, resulting in large skill-gaps and eventually in poor health system performance. In other situations, the skills are there, in principle, but regulation of practice or payment mechanisms do not allow an effective combination of the available skills. To close these skill-gaps and to facilitate the combination of different skills, countries have employed a host of strategies.

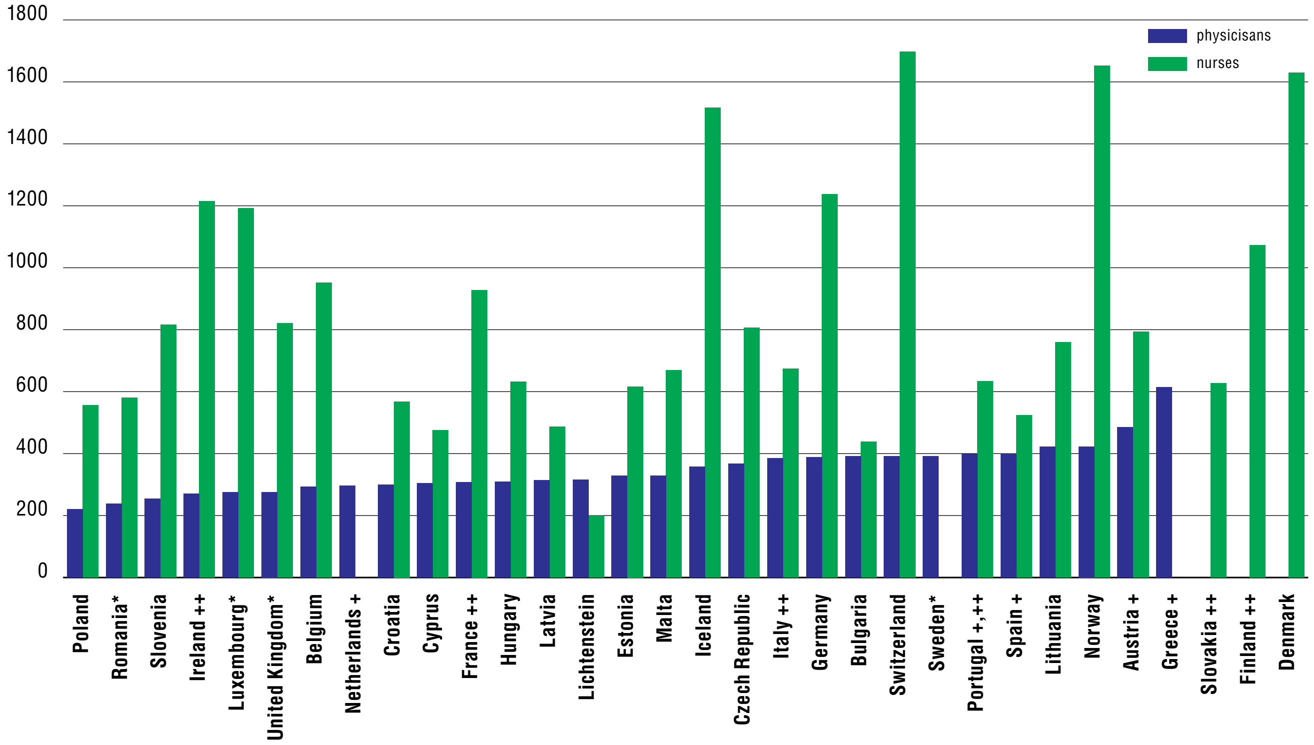
Denmark, England, France and Germany, like many other countries, are trying to *empower patients and peers* through patient self-management of chronic diseases.[11] In these instances, patients can learn a comprehensive set of new skills, for example how to: deal with problems such as frustration, fatigue, pain and isolation; undertake appropriate exercise for maintaining and improving strength, flexibility, and endurance; use medicines appropriately; communicate effectively with family, friends, and health professionals; understand good nutrition; make decisions and evaluate new treatments.[12]

Shifting service provision towards *the community* requires new skill-mixes encompassing health and social services facilitated by a strong coordinating function. Useful examples are coming from psychiatric care, end-of-life care, and the coordination of medical and social services within nursing homes. To this end, countries have scaled up health and social care at the community level to build up the skills necessary for health care delivery.

Some countries have tried to close skill-gaps by *strengthening medical capacity* in the primary care settings. Slovenia introduced ‘model practices’ in family medicine in 2011 to strengthen PHC through employing in each practice an additional 0.5 full-time equivalent qualified nurse to unburden doctors for nursing tasks. Ten countries in Europe have legislated, or are in the process of legislating, nurse practitioners to free up the medical capacity of GPs for more complex treatments. Germany, Estonia and Slovenia are providing examples of retraining and/or re-licensing GPs, doctors of internal medicine, and other specialties for PHC practice.

Improving *mulit-disciplinarity*, by scaling up the number of allied health

Figure 1: Medical doctors and nurses per 100,000 population, free-mobility zone, 2012



Source: [10]

Note: All data are EUROSTAT 2012 except * 2011, + HFA-DB doctors, ++ HFA-DB nurses. Doctor data for United Kingdom and Ireland are estimates.

professionals and professionals in long-term and social care, represents a further strategy. There are also countries, like the Netherlands, that provide for training in PHC settings, or interdisciplinary training.

> variations in skill-mix between countries

Another strategy is to improve skill-mix through the use of *information and communication technology (ICT).* This can help improve the continuity and coordination of health care. Denmark, Estonia, Norway, the Netherlands and Croatia employ various systems, including electronic health records, patient information systems, hospital information systems, GP information systems, national electronic registers and electronic prescriptions.[13]

Many attempts have been made to *improve coordination* directly. For example the setting of the French/Belgium 'maison medical' provides the seamless linking of different skills and professions and allows coordination on the spot. Health care centres in Sweden and Finland or the (re)established multidisciplinary ambulatory medical treatment centres in Germany provide similar settings. Some countries have tried to improve their skill-mix through the use of 'navigators' or case managers performed by GPs, nurses, practice managers or sickness fund personnel. There are also regional provider coordination platforms, i.e. in the Netherlands.

There are models and innovations from all over Europe, even though some of them might be incremental, regional, sectoral and too early to fully judge. While these examples are valuable, they remain unsystematic and a real overview or mapping of initiatives and approaches remains missing. In fact, a synthesis of innovative skill-mix examples in PHC settings is long overdue.

However, any enthusiasm for change needs to be cautious. Many of these skill-gaps turn out to be difficult to close and are persistent. Adjusting the skill-mix to PHC is complex, sometimes causing 'ripple effects' on regulation of practice, payment mechanisms, health profession education, employment and working conditions, and governance. All too often, these are barriers to adjusting the skill-mix to PHC reform. It will be of utmost importance to remove these barriers or rather transform them into enablers.

Conclusion

In Europe, demographic change is a driver for chronic care and PHC reforms. The ageing population and the looming workforce shortages provide little alternatives but to improve the performance of health systems. The skill-mix is clearly a critical factor in this equation. To support reforms aimed at adapting the skill-mix, we can build bridges between research and policy-making through a number of measures. These include:

- The variations in skill-mix between countries could be considered as a gold mine of policy options for policy-makers. And much of the gold hasn't been extracted as yet, calling for systematic mapping, comparison and analysis on how countries are developing their skill-mixes. This will need to cover both the ‘big-bang’ style reforms, but also the more incremental skill-mix changes that develop over a long period.

- We need to establish a common understanding that skill-mix should start with the patient (in the landscape of the future) and the appropriate models of chronic care and PHC. The distribution of skills across patients and peers, and health and social care professions, should come at the end of the process. However, all too often, our debates and reforms are starting from the wrong end, with the professions.
- The obvious and substantial variations in skill-mix between European countries are in need of performance measurement. Policy-makers need to know how good the skill-mix in their country is. Therefore, we need to understand to what extent variations in skill-mix result in variations in quality of care, job satisfaction, patient satisfaction and variations in the costs incurred. This is a large and complex scientific task and it will be essential that this research is combined with the research on PHC and chronic care.
- There is a treasure trove of successful implementation strategies which needs to be harnessed to inform policy-makers when developing skill-mix reform. This is practical knowledge that provides us with insights on the levers for change.

References

[1] Nolte E, Knai C. Introduction. In: Nolte E, Knai, Saltman R (eds.) *Assessing chronic disease management in European health systems*. Copenhagen: World Health Organization/European Observatory on Health Systems and Policies, 2014:1–7.

[2] Pike G, Barker G, Beveridge K, McIlroy R. *Who will care? Nurses in the later stages of their careers*. London: Royal College of Nursing, 2011. Available at: https://www.rcn.org.uk/__data/assets/pdf_file/0010/395380/004126.pdf

[3] Bundesärztekammer [Statistik der BÄK und der KBV]. Available at: http://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/Stat13Abb05.pdf

[4] Testori Coggi P. Foreword. In: Wismar M, Glinos IA, Dussault G, Figueras J (eds.) *Health Professional Mobility and Health Systems*. Copenhagen: World Health Organization/European Observatory on Health Systems and Policies, 2011.

[5] Dussault G, Buchan J. The economic crisis in the EU: impact on health workforce mobility. In: Buchan J, Wismar M, Glinos IA, Bremner J (eds.) *Health professional mobility in a changing Europe*. Copenhagen: World Health Organization/European Observatory on Health Systems and Policies, 2014:35–64.

[6] Starfield B. *Primary Care: Balancing Health Needs, Services, and Technology*. Oxford University Press, 1998.

[7] Kyratsis Y. Issues of governance in implementing complex policy innovations: Lessons from primary healthcare reforms in Estonia, and Bosnia & Herzegovina. In: Greer SL, Wismar M, Figueras J (eds.) *Strengthening health system governance*. European Observatory on Health Systems and Policies, forthcoming 2015.

[8] Health Systems and Policy Monitor – Slovenia. Available at: http://www.hspm.org/countries/slovenia25062012/livinghit.aspx?Section=1.3%20Political%20context&Type=Section

[9] Health Systems and Policy Monitor – Austria. Available at: http://www.hspm.org/countries/austria08012013/livinghit.aspx?Section=5.3%20Primary%20/%20ambulatory%20care&Type=Section

[10] EUROSTAT. Database. Brussels: European Commission.

[11] Nolte E, Knai C, McKee M. *Managing chronic conditions*. Copenhagen: World Health Organization/European Observatory on Health Systems and Policies, 2008.

[12] *Chronic Disease Self-Management Programme*. Patient Education, Stanford School of Medicine web site. Available at: http://patienteducation.stanford.edu/programs/cdsmp.html

[13] European Commission. Overview of the national laws on electronic health records in the EU Member States web site. Available at: http://ec.europa.eu/health/ehealth/projects/nationallaws_electronichealthrecords_en.htm

New HiT on Czech Republic

By: J Alexa, L Rečka, J Votápková, E van Ginneken, A Spranger, F Wittenbecher

Copenhagen: WHO Regional Office for Europe

Number of pages: 165, **ISSN:** 1817-6119

Available online at: http://www.euro.who.int/__data/assets/pdf_file/0005/280706/Czech-HiT.pdf?ua=1

The Czech population has near-universal coverage, a broad range of benefits in their statutory health insurance system, and they also enjoy a high degree of financial protection. Some important health indicators are above EU averages or even among the best in the world (such as infant mortality). On the other hand, a range of health-care utilisation rates, such as outpatient contacts and average length of stay in acute care hospitals, both of which are notably high, point to a substantial potential in the Czech Republic for efficiency gains and improved health outcomes. In addition, plentiful human resources, such as the relatively high number of physicians, show regional disparities, and the ageing profile of primary care physicians represents a potential human resources problem in the near future.

The Czech health system in its current form has faced constant financial problems since its establishment at the start of the 1990s, reflected in the solvency problems of the health insurance funds. This became acute again following the financial crisis as the health insurance funds depleted their reserves. Earlier attempts to increase the share of private expenditure in health-care services, e.g. by user fees, have been gradually reversed by later governments. This lack of political consensus poses an increasingly acute problem in the Czech health system as it results in several rather small changes each time a new political party comes into power, while the larger issues regarding sufficient resource mobilisation are not addressed.

Health Systems in Transition
Vol. 17 No. 1 2015

Czech Republic
Health system review

Jan Alexa • Lukáš Rečka
Jana Votápková • Ewout van Ginneken
Anne Spranger • Friedrich Wittenbecher

European Observatory on Health Systems and Policies

THE POWER OF PATIENTS

By: Nicola Bedlington

Summary: In May 2015, over 150 patient leaders, health professionals, NGO representatives, researchers and policy-makers gathered in Brussels to explore the role of patient empowerment in building high-quality equitable, sustainable health systems in Europe. This marked the official launch of a major campaign on patient empowerment by the European Patients' Forum (EPF), which works with the health community to take European discussions on this topic a crucial next step forward. The EPF is calling on EU decision-makers to adopt an EU strategy on patient empowerment, including an action plan on health literacy and high-quality information for patients on all aspects of their care.

Keywords: *Patients, Empowerment, Involvement, Health Literacy*

➤ #EHFG2015 Lunch workshop 4:
Empowerment in practice

To engage in the campaign, please visit: www.eu-patient.eu/campaign/PatientsprescribE/ or contact: policy@eu-patient.eu

Nicola Bedlington, Secretary General European Patients' Forum, Brussel, Belgium. Email: nicola.bedlington@eu-patient.eu

Introduction

Chronic diseases are seen as a sustainability challenge for European health systems. This is usually presented in terms of funding – our health systems cannot cope financially with chronic conditions and ageing populations. However, from a patient's perspective, the health systems are unable to cope well with chronic conditions because they do not meet patients' needs. Besides the financial aspects, problems are related to the way health care is delivered and services organised. Fragmentation of care is a major issue for patients, who often have to "fight the system" just to get the care they need.[1] [2]

Patients with chronic conditions are often referred to as the most under-used resource in the health system, while patient-centred care models have demonstrated better quality of care as well as potential long-term cost-efficiencies. Too many patients are still struggling to get the support they need to become equal partners in care. To make real progress, EPF believes patient empowerment needs to become a priority, starting with the development of an EU-wide strategy and action plan.

From disease-centred to patient-centred

Chronic disease requires a fundamental shift from a disease-centred to a patient- and family-centred approach. This implies the empowerment of patients and their involvement at every level in the health system to ensure effective self-management, well-integrated professional support, and active patient engagement in co-designing care services to better meet their needs.

Empowerment is a process through which patients increase their capacity to draw on their personal resources in order to live well with chronic conditions in their daily life, as well as navigate the health care environment.[3] Empowerment is not a simple process, nor is it necessarily linear. Patients can feel empowered in a certain context, and disempowered in another.

During the patient journey, patients' feeling of being empowered can change according to the people and structures that they come into contact with.

From passive to active players

In recent years, the patients' role in health care has transformed from passive recipients of health care services to active and responsible actors in their own health management and health care decision-making. This stems from patients' and citizens' own demand for more information on many aspects of health and health care and from their need to be empowered in order to take part in a shared decision-making process with health professionals. The empowerment approach aims to realise the vision of patients as "co-producers" of health and as integral actors in the health system. Many patients would like to take more responsibility for their own health and care, given the opportunities and support to do so. To achieve this, there is a need to support patients, inter-alia through high-quality information and health literacy, but also to equip health professionals with the necessary skills to work in partnership with patients.

Empowerment, essential to patients

Patient empowerment has been a topic close to EPF's heart since its establishment in 2003. The organisation's mission is to promote the development and implementation of policies, strategies and health care services that empower patients to be involved in the decision-making and management of their condition according to their preference, whilst raising awareness about their rights. EPF represents the interests of over 150 million patients across Europe.

In 2014, EPF took part in the mapping study *Empowering patients in the management of chronic diseases* (EMPATHiE).[4] The aim of this study, commissioned by the European Commission, was to achieve a better understanding of the concept of patient empowerment and to identify good practices, success factors and barriers across the European Union (EU). EPF led a specific piece of work exploring different scenarios for future European cooperation in this area.

EPF perceived from this work a very clear signal on the need and indeed the appetite for a European strategy on patient empowerment. The Forum knows that this is not uppermost on the political agenda, and its work over the next year will hopefully stimulate fresh commitment as well as fresh ideas on how to move forward.

From words to action

To take forward the outcomes of the EMPATHIE study in a concrete way, EPF launched a one-year campaign on patient empowerment in May 2015.[5] This is the first patient empowerment campaign launched at the European level by patients. The EPF wants to promote understanding of what patient empowerment means from the patient perspective among European political decision-makers and health stakeholders.

Ultimately, EPF calls on the European institutions to adopt an EU strategy on this topic relating to all aspects of health, from health promotion and prevention through to therapeutic options and self-management of chronic disease. Patients expect a strong commitment from EU decision-makers and health stakeholders to concrete activities to promote the empowerment and meaningful involvement of patients as equal and respected partners.

Launched on 20–21 May 2015 with a major conference in Brussels, the campaign will move up another gear in November. The Conference has taken the first steps towards formulating a powerful "Charter of Patient Empowerment" expressing a set of fundamental principles of patient empowerment in ten points. The work on the Charter will feed also into the drafting of a multi-stakeholder Roadmap to Patient Empowerment that will provide the basis for concrete actions to be taken by European policy-makers and stakeholders. In parallel, EPF is identifying good practices in patient empowerment and involvement for sharing and mutual learning.

Patients Prescribe

"Patients prescribe E^5 for sustainable health systems" is the tagline of the EPF campaign. It demonstrates that patients are active people who can, if supported and according to their individual capabilities and situation, make a difference for the sustainability of health care systems. The five "Es" of Empowerment stand for Education, Expertise, Equality, Experience, and Engagement.

E for Education

Although empowerment is much more than patient education, the right information and resources are fundamental tools for empowerment. To make genuinely informed decisions about their health and treatment, it is vital that patients can access all the relevant information needed to make those decisions, in an easily understandable format.[6] Health literacy is a key dimension of empowerment and encompasses not just accessing, comprehending and evaluating health information, but also relating the information to oneself and one's health, and transforming it into appropriate actions.[7]

Currently there is too little policy focus on health literacy and its vital role for health care. More generally, across the EU there is a lack of accessible, reliable and understandable health-related information that meets patients' needs, although core quality criteria have been defined at European level.[8]

E for Expertise

Patients living with chronic conditions are by necessity frequent users of health care services, and become experts in the management of their condition. Since patients are 'experts by experience', their perspective on chronic disease is unique: patients live with the condition every day, learn to manage it themselves with support from health care professionals, and learn to navigate the health system in order to get the right care.

Self-management is a key element of patient-centred care: in chronic conditions, the management of the condition is mostly handled by the patient at home and in the community, so in this sense patient already "self-manage". Self-management can be understood as a partnership between patients and the health care team. The team should support patients in living with their illness and in managing the conditions and their physical, psychological, emotional and social impacts. Through self-management support, patients can develop the confidence, self-efficacy and skills to take control of their daily life and attain the greatest possible quality of life.[9] This also helps to make the best use of all available resources by, for example, improving adherence, reducing hospitalisation and emergency visits, and improving health outcomes.[10] [11] [12] [13]

> Education, Expertise, Equality, Experience, and Engagement

Self-management, therefore, does not mean leaving the patient to cope on their own. It is a holistic approach providing the appropriate support and tools according to each person's individual needs and preferences.

E for Equality

The flip side of empowering and informing patients is the need for training and education of health professionals. Professionals need to be trained for better communication with patients, and for creating an enabling environment for dialogue, where the patient is an equal partner.

The patient's role may evolve and even fluctuate during the patient journey. At some points the patient may wish to simply follow the doctor's orders; whereas, at others s/he may wish to share the decision or even take control. Professionals need to develop the necessary skills and attitudes to adapt to the new patient role, shifting from a paternalistic medical culture to a collaborative culture.

E for Experience

Patient organisations are civil society NGOs that play an important role in the democratic process as proponents of patients' human rights. Patients act collectively through patient organisations to channel their experience into decision-making to ensure that all health-related policies and practices at EU, national and regional or local levels reflect patients' real-life needs, preferences and capabilities.

Although patient involvement is recognised as one of the shared operating principles of European health systems, there is still wide divergence across the EU in the recognition of patients as a legitimate stakeholder group and in the level of their collective involvement.

E for Engagement

Only the patient sees the whole journey. The patient experience is a crucial evaluation and learning resource to develop services that meet patients' real-life needs and preferences. This requires their involvement patients at every stage of the cycle, from planning and designing to implementation, evaluation and improvement.

Patient organisations can contribute to the future sustainability and high quality of health care systems, by participating in the development and (re-)design of services and in research into new and better treatments. To achieve this, patient organisations should be involved pro-actively in policy decision-making at all levels and be given appropriate support to fulfil their essential role.

From doing things TO patients to doing things better WITH patients

It is widely acknowledged that empowering patients is good for health care systems as it brings better health outcomes. Empowered patients take responsibility for their care in equal partnership with health professionals, take preventive measures, seek earlier diagnosis and adhere to treatment, which can reduce health care costs in the long run.[14] [15]

Patient empowerment is a key element of future high-quality, patient-centred health systems.

The slogan EPF has chosen for its campaign – Patients Prescribe – says it all: for the first time ever at EU level the patients drive a campaign on their empowerment. They are no longer passive, but are active, decisive, and assertive people, ready to play their rightful role at collective and individual level.

They call on EU decision-makers to develop an EU strategy on patient empowerment to achieve a real impact on the ground for the benefit of the 150 million patients with chronic disease whose interests EPF represents.

References

[1] EPF. *EU Reflection on Chronic Disease.* EPF consultation response, 10 May 2012. Available at: http://www.eu-patient.eu/globalassets/policy/chronic-disease/epf-chronic-diseases-consultation-response-2012.pdf

[2] EPF. *Innovation Partnership on Healthy and Active Ageing.* EPF Response to the Commission Public Consultation Integrated, 3 February 2011. Available at: http://www.eu-patient.eu/globalassets/policy/ageing/ageing-epf-response-integrated-final.pdf

[3] EPF. *EPF Background Brief: Patient Empowerment,* 15 May 2015. Available at: http://www.eu-patient.eu/globalassets/campaign-patient-empowerment/epf-briefing-paper—patient-empowerment.pdf

[4] EMPATHiE. Final Summary Report, 2014. Available at: http://ec.europa.eu/health/patient_safety/docs/empathie_frep_en.pdf

[5] EPF. Conference and Campaign Launch on Patient Empowerment web site. Available at: http://www.eu-patient.eu/Events/past-events-june-2015/conference-on-patient-empowerment/

[6] Stacey D, Légaré F, Col NF, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Systematic Reviews* 2014, Issue 1. Art. No.: CD001431. DOI: 10.1002/14651858.CD001431.pub4

[7] Kickbusch I, Pelikan JM, Apfel F, Tsouros AD. (eds) *Health literacy: The solid facts.* Copenhagen: World Health Organization, 2013. Available at: http://www.euro.who.int/__data/assets/pdf_file/0008/190655/e96854.pdf

[8] Conclusions and Recommendations of the High Level Pharmaceutical Forum, October 2008. Available at: http://ec.europa.eu/enterprise/sectors/healthcare/files/docs/pharmaforum_final_conclusions_en.pdf

[9] Coulter A, Entwistle VA, Eccles A, Ryan S, Shepperd S, Perera R. Personalised care planning for adults with chronic or long-term health conditions. *Cochrane Database of Systematic Reviews* 2015, Issue 3. Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2

[10] Stanford model, Chronic Disease Self-Management Program. Selected publications available at: http://patienteducation.stanford.edu/bibliog.html

[11] de Silva D. *Helping people help themselves: Evidence about supporting self-management.* London: The Health Foundation, 2010.

[12] Warsi A, Wang PS, LaValley MP, Avorn J, Solomon DH. Supporting people with long term conditions to self-care: a guide to developing a local strategy and good practice. London: Department of Health, 2006.

[13] Newman S, Steed L, Mulligan K. Self-management interventions for chronic illness. *The Lancet* 2004;23-29;364(9444):1523–37.

[14] Stone S. A Retrospective Evaluation of the Impact of the Planetree Patient Centered Model of Care Program on Inpatient Quality Outcomes. *Health Environments Research and Design Journal* 2008;1(4):55–69.

[15] *Health Literacy – part 2: evidence and case studies.* Somerset: World Health Communication Associates, 2010:20-22. Available at: www.whcaonline.org/uploads/publications/WHCAhealthLiteracy-28.3.2010.pdf

THE POWER OF THE INTERNATIONAL HEALTH REGULATIONS

By: Guénaël Rodier, Thomas Hofmann and Christoph Aluttis

Summary: In the wake of the Ebola virus disease outbreak, the international community's response has been scrutinised and criticised, also with a view on the effectiveness of the International Health Regulations (IHR) in preventing such tragedies. This article argues that the IHR remains the most valuable framework that the international community has at its disposal to coordinate the international response to large-scale outbreaks. The Ebola virus disease outbreak forms a window of opportunity to make IHR fully operational and well-functioning in order to prevent future tragedies.

Keywords: *International Health Regulations, Ebola, Health Security, Advancing IHR*

➤ #EHFG2015 Forum 8: Securing health. Importance of the implementation of the IHR

Guénaël Rodier is Director, Division of Communicable Diseases, Health Security and Environment; **Thomas Hofmann** is IHR Area Coordinator, Division of Communicable Diseases, Health Security & Environment; **Christoph Aluttis** is Technical Officer, Strategic partnerships and resource mobilisation, WHO Regional Office for Europe, Copenhagen, Denmark.
Email: HOF@euro.who.int

Introduction

Ten years ago, on 23 May 2005, the 58th World Health Assembly adopted the revised International Health Regulations, commonly referred to as IHR (2005). Two years later, the IHR (2005) entered into force, adopted by 194 countries. They required countries to put in place the capacity to detect, assess, notify, and respond to public health risks and potential or declared public health emergencies of international concern (**see Box 1** for an overview of obligations).[1] Against the backdrop of the SARS epidemic in 2003, these revisions were deemed critical to enhance global health security against public health risks stemming from infectious diseases, and chemical and radiological disasters.

The agreement among 194 World Health Organization (WHO) Member States (196 State Parties, with the addition of the Holy See and Liechtenstein) was widely regarded as a large success. The IHR has the authority of an international treaty and its 2005 revision was considered a major step towards higher global health security, as well as towards the acknowledgement of global interdependencies and mutual responsibilities. However, already at the time of signing, cautious voices emphasised that the IHR would only function as intended when fully used and implemented, and when national core public health capacities were fully in place and operational.

Eight years after the IHR entered into force, the Ebola virus disease outbreak occurred in West Africa. As of June 2015,

Box 1: Provisions laid out in the IHR (2005)

a) scope not limited to any specific disease or route of transmission, but covering "illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans" (Art. 1 on definition of "disease")

b) State Party obligations to develop certain minimum core public health capacities (Art. 5, 13 and Annex 1)

c) obligations on States Parties to notify WHO of events that may constitute a public health emergency of international concern, according to defined criteria (Art. 6, Annex 2)

d) authorisation for WHO to take into consideration unofficial reports of public health events and to obtain verification from States Parties concerning such events (Art. 9)

e) procedures for the determination by the WHO Director-General of a "public health emergency of international concern" (Art. 12)

f) protection of the human rights of persons and travellers (Art. 32) and

g) the establishment of National Focal Points and WHO Contact Points for urgent communications between States Parties and WHO (Art. 4).

Source: [1]

more than 27,000 cases were reported and more than 11,000 people have died from the disease. On 8 August 2014, WHO Director-General Margaret Chan declared the West Africa outbreak a Public Health Emergency of International Concern (PHEIC). Accordingly, and following WHO recommendations, all countries worldwide have strengthened their surveillance and preparedness to detect potential Ebola cases and prevent further international spread of the disease. On its side, WHO has engaged in its largest emergency response ever, with WHO presences in 77 field sites and more than 700 personnel (staff and consultants) across the three most affected countries.

> critical to enhance global health security

While the Ebola virus disease outbreak continues to be a PHEIC (as of June 2015), recent months have shown a dramatic decline of new infections. Even though the epidemic is not yet over, WHO and its partners, as well as other stakeholders have started to evaluate the overall epidemic response and to discuss the lessons learned and changes needed in order to better prepare for future disease outbreaks and other emergencies with health consequences. Throughout this process, critics have raised a series of questions about the effectiveness of WHO's and the international community's responses, and about the role and power of the IHR. How could the Ebola virus disease outbreak occur, with the IHR in place?

In the following section, we will discuss the IHR in the context of the Ebola virus disease outbreak, address the lessons learned, and put the debate in a European context to facilitate the discussion on what Europe should put on its agenda. We argue that the IHR remains the most valuable framework that the international community has at its disposal to coordinate the international response to large scale outbreaks.

Lessons learned from Ebola

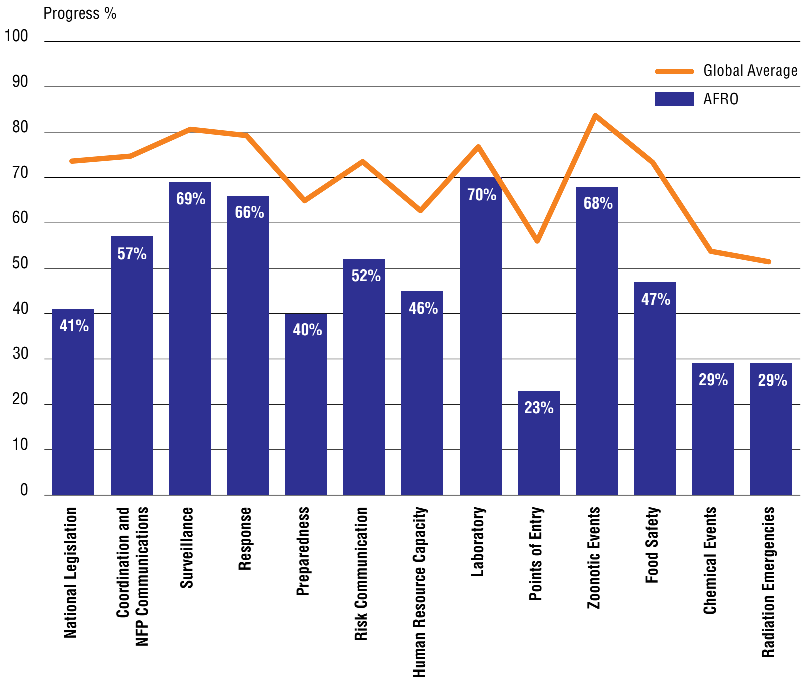
Ebola has been only the second real major test of the IHR since they entered into force. The general perception with regards to the first real major test – the A(H1N1) influenza epidemic of 2009–10 – was that the IHR actually worked fairly well.[2] So why did the IHR seem unable to prevent the initial Ebola outbreak from turning into a large regional outbreak? Apart from the fact that the three most affected countries had very specific features and history, there are underlying issues, which should be looked at more closely.

It has been commonly overlooked that in 2014, the same year that the Ebola virus disease outbreak occurred, the extended deadline for countries to fully implement the provisions of the IHR (2005) had silently passed. Initially, the target for full IHR implementation was set to June 2012. But in 2012, 118 countries asked for a two-year extension. In 2014, 81 countries had requested another two-year extension. Failure to implement the provisions laid out in the IHR was often attributed to the fact that many states simply lacked the resources and infrastructures to ensure that their national health systems could provide the surveillance and response capacities to meet the IHR's functional criteria. Correspondingly, WHO's 2013 summary of state parties' self-assessed status of the IHR showed that for the African continent, core capacity areas were not well-developed (**see Figure 1**).

While there is large variation across countries, it implies that many countries were ill-equipped to control outbreaks at the source at the onset of the Ebola virus disease outbreak. Failure to prevent Ebola from spreading was therefore not necessarily a systemic failure of the IHR framework itself, but rather a failure to follow the provisions that were laid out. Along these line, the WHO Ebola Interim Assessment Panel concluded in 2015 that: *"the Ebola outbreak might have looked very different, had the same political will and resources* [that were spent in responding to the outbreak] *been applied to support IHR implementation over the past five years."*[4] In other words: had the IHR been used and implemented to their full extent, the Ebola virus disease outbreak would have likely been detected and contained much quicker. But to date, no additional financing has been put in place and no proper accountability mechanisms have been created to accelerate the use of the IHR.

The experience with the Ebola virus disease outbreak has taught us an important lesson about the IHR as they currently operate. According to

Figure 1: Regional Average Attribute Scores from the WHO African Region



Source: [3]

Halabi,[5] they *"do not effectively commit the international community to building core IHR capacities in resource poor countries to manage international public health emergencies"*. In other words, strengthening respective health systems' infrastructures for IHR implementation is currently impossible to achieve for low income countries, without respective international assistance.

The 'IHR Review Committee on Second Extensions for establishing national public health capacities and on IHR implementation', convened by WHO in 2014 furthermore concluded that additional impediments to IHR implementation included: insufficient authority and capacity of National IHR Focal Points; the focus on IHR deadline extensions rather than on an expansion of capacities; and the perception that "implementation" is a rigid, legal process with less emphasis on operational implications and learning from experience. "Implementation of the IHR should now advance beyond simple "implementation checklists" to a more action-oriented approach to periodic evaluation of functional capacities."[5]

The power of the IHR

Despite current criticism, the IHR have not lost their power or appeal. To date, they remain the only comprehensive framework that provides an appropriate base for global health security from infectious disease threats and other biological, chemical or radiological threats. Its unique advantages are substantial for the following reasons:

Firstly, it is universal in scope, with 196 State Parties having adopted the revised IHR (2005). It is therefore a politically legitimate instrument, respecting the sovereignty of countries while acknowledging the increasing mutual dependencies and responsibilities.[6]

Secondly, the IHR provide a well-developed risk-based framework to all parties that recognises the different nature of various threats and the measures needed to address them, including a pronounced need for proportionality, as to not overly restrict travel and trade in a globalised world, as per IHR article 2 on its purpose and scope ("avoid unnecessary interference with international traffic and trade").[6]

Thirdly, its recognition of interdependencies between sovereign countries with respect to both threats to public health and the respective capacities of those countries to manage those threats allow the IHR (2005) to call strongly for solidarity among countries. In a hyper-connected world, global health security is only as strong as its weakest link and failure to strengthen that link through global cooperation can have implications for the whole chain.

The IHR (2005) agenda in Europe

While public fears speculated that Ebola could spread to the WHO European Region on a large scale, it ultimately did not materialise, and those cases that were imported to countries of the European Region were contained well. Subsequently, throughout the outbreak, the risk for the European Region of acquiring the disease was estimated to be very low.[7]

> IHR call strongly for solidarity among countries

Nevertheless, this is no reason to become complacent in Europe. In 2014 alone, 42 public health events with serious potential international consequences were recorded by the WHO Events Management System. Recent examples include the Balkan floods in May 2014 that had devastating consequences in Bosnia and Herzegovina, Croatia and Serbia, especially increasing the risk of vector-borne diseases; another example includes imported cases of Middle East respiratory syndrome (MERS) coronavirus infection cases in Austria, Germany, the Netherlands and Turkey in 2014.

While European Member States usually indicate comparatively high levels of capacities, this shows that also for the seemingly well-prepared European Region, strengthening the IHR framework remains highly important. Respective challenges in the Region are mostly focused on non-capacity building issues, such as building awareness, training people in specific IHR relevant areas, and ensuring that the IHR remain operational and sustainable. In this regard the European Region is entering a new phase of working with the IHR, shifting the focus from using the IHR as a capacity development framework towards a tool that informs epidemic intelligence on a day-to-day basis. The WHO Regional Office for Europe has been playing a crucial role in providing respective support to Member States in achieving this. Through its country offices, it has been the primary source of support for many countries, supporting country level IHR implementation, as well as monitoring performance against respective indicators.

In addition, the EU Decision on Serious Cross-Border Threats to Health, which was adopted early in 2013, reconfirms the importance of the IHR and also created opportunities and raised attention among EU Member States for health security.

Advancing the IHR (2005) agenda

WHO is the world's only agency with a mandate to act on global health matters. Under its auspices, the creation of the IHR has been a consensual and globally accepted mechanism to prevent the spread of infectious diseases and to prepare for emergencies with health consequences. And once fully implemented and utilised properly, the IHR remain to be an extraordinarily valuable framework for rapid information sharing and coordination of international response. However, to achieve global health security through the IHR, we need to make sure that the IHR are enabled to do what they are supposed to do.

Article 44 of the IHR calls for solidarity between countries in detecting and responding to health threats. Global health security can only be achieved by such solidarity among countries. In light of recognising their mutual vulnerabilities and responsibilities, high-income countries need to support the creation of core capacities in the poorest countries, in accordance with Article 44 of the IHR. Without such support, many developing states will continue to struggle to implement the IHR and to strengthen their capacities.

Furthermore, Member States need to work towards proper implementation of the IHR and fulfilling its reporting and information sharing requirements. During the Ebola virus disease outbreak, some Member States were hesitant to report cases for fear of restrictions being put on them, while others waited too long to provide medical assistance and were too eager in their response to impose travel and trade restrictions. Learning the appropriate response to the respective threat will be a major challenge in the years to come.

During the 9th European Union Development Day in June 2015, WHO Director-General, Dr Margaret Chan said in her opening remarks that the *"Ebola outbreak has been a wake-up call for the international community, and that never in the future, the international community, national Governments and local authorities should not be fully equipped to respond to such threats"*.[8] Since the IHR have been agreed upon at the World Health Assembly ten years ago, now is the time to act and to fully utilise the full power of the IHR. The emergence of the SARS outbreak in 2003 changed the political mood and allowed for the IHR to be pushed onto the highest political agenda. Currently, the Ebola virus disease outbreak forms another window of opportunity, not to push for another IHR revision process, but to make the IHR fully operational and well-functioning in order to prevent future tragedies. Given the current low rate of implementation of the IHR, it is highly likely that another disease can cause another large outbreak in the future. The international community therefore needs to learn the lessons from Ebola now and translate these into specific actions so that the world can prevent outbreaks and prepare for pandemics.

References

[1] World Health Organization. *International Health Regulations (2005)*. Second Edition. Geneva: WHO, 2008. Available at: http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf?ua=1

[2] Wilson K, Brownstein JS, Fidler DP. Strengthening the International Health Regulations: lessons from the H1N1 pandemic. *Health Policy and Planning* 2010;25:505–9. doi:10.1093/heapol/czq026

[3] World Health Organization. Summary of States Parties 2013 report on IHR Core Capacity Implementation. *Regional Profiles*. Geneva: WHO, 2014. Available at: http://apps.who.int/iris/bitstream/10665/145084/1/WHO_HSE_GCR_2014.10_eng.pdf

[4] World Health Assembly. Report of the Ebola Interim Assessment Panel, 2015. Available at: http://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1

[5] Halabi S. The International Health Regulations after Ebola. JREG Notice and Comment. A blog from the Yale Journal of Regulation, 2015. Available at: http://www.yalejreg.com/blog/the-international-health-regulations-after-ebola-by-sam-halabi

[6] World Health Organization. *Implementation of the International Health Regulations (2005): report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation,* 2015. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf

[7] World Health Organization. Risk of Ebola spreading in Europe is very low: statement by Zsuzsanna Jakab, WHO Regional Director for Europe, 2014. Available at: http://www.euro.who.int/en/health-topics/emergencies/ebola-outbreak-2014/news/news/2014/10/risk-of-ebola-spreading-in-europe-is-very-low-statement-by-zsuzsanna-jakab,-who-regional-director-for-europe

[8] World Health Organization. News: Health a Priority for European Development Days, 2015. Available at: http://www.euro.who.int/en/about-us/partners/news/news/2015/06/health-a-priority-for-european-development-days

STRENGTHENING PRIMARY HEALTH CARE: MOVING FROM EXPERIMENTS TO ROUTINE PRACTICE

By: Ellen Nolte

Summary: There is growing recognition among policy makers and practitioners alike that strong primary care systems that enhance continuity of care and coordination can be effective to meet the needs of people with complex problems. However, translating this recognition into concrete policies is proving difficult for a number of reasons related to health system organisation, governance and financing. Some levers for effecting change have been identified, including providing the regulatory context to enable innovation; adequate resources and incentive systems to encourage co-ordination among providers; striking a balance between centrally defined requirements and local autonomy in implementation; involving key stakeholders; and learning from experience.

Keywords: *Primary Care, Health Systems, Continuity of Care, Care Coordination, Innovation*

➤ #EHFG2015 Forum 3: Implementation of comprehensive Primary Care

Ellen Nolte is Hub Coordinator at the European Observatory on Health Systems and Policies, London. School of Hygiene and Tropical Medicine and London School of Economics and Political Science, UK. Email: e.nolte@lse.ac.uk

Introduction

There is a wide range of international policy documents describing the importance of primary care and its core role in ensuring that health services are centred around people's needs and expectations.[1] Primary care is believed to be central to high-performing health care systems, with available evidence linking the strength of a country's primary care system to improved health outcomes such as reduced premature mortality[2] and lower death rates from certain conditions such as cardiovascular and respiratory disease, along with lower levels of unnecessary hospitalisations.[3] Although countries with strong primary care do not necessarily have cheaper health systems, at least relative to national income,[3] the overall evidence suggests that the financing, organisation and delivery of primary care seem to have an important impact on population health.[4]

Countries vary widely in the way they conceptualise and implement primary care, and although uncertainties remain about costs and effectiveness, reform efforts in many countries have emphasised strengthening this sector so as to make health systems more responsive to the changing needs of an ageing population that is characterised by a rising burden of multiple chronic and long-term conditions. Emerging empirical evidence supports the intuitive belief that enhanced continuity of care and coordination, which are considered to form core components of strong primary care systems,[3] can be effective to meet the needs of people with complex problems.[5] [6]

The growing recognition of this evidence is causing many countries to explore new approaches to health care delivery to enhance care coordination and so better support patients with long-standing care needs. We have previously shown how high-income countries in Europe and elsewhere vary in their attempts to do so, although our recent survey of responses to the rising burden of chronic disease in twelve European countries identified some common trends (**see Box 1**).[7]

Box 1: Approaches to enhancing care coordination in European countries

The majority of approaches that were and are being implemented by countries tend to focus on populations with defined conditions, which are typically targeted by means of structured disease management to enhance coordination. There is wide variation in the nature and scope of approaches; commonly, the general practitioner (GP) or family physician acts as 'care coordinator'.

There is a trend towards introducing nurse-led approaches in primary care and while this has remained challenging in countries where primary care is traditionally provided by doctors in solo-practice with few support staff, even in these settings there are now moves towards enhanced functions of nurses in care coordination.

Approaches that seek to reduce barriers between sectors are less common and many of the observed approaches tended to be implemented within existing organisational and governance structures. Such (limited) approaches may still be effective in enhancing coordination, through for example, the use of structured referral pathways, but structural barriers between sectors remain, potentially impeding further progress in advancing service delivery.

The implementation of approaches frequently involves the use of financial incentives in the form of additional funding such as start-up funding to support infrastructural development or financial incentives, typically targeted at individual providers or physicians.

Many approaches are being implemented in selected geographical regions and so may potentially limit access to defined population groups. The majority of approaches provide some form of patient self-management support, although the level and scope of support offered varies. The use of clinical information systems to strengthen coordination tends to be the least developed strategy in most settings.

Source: [8]

Barriers to change

While policy-makers in European health systems have recognised the challenge, and acknowledge both the fiscal and social importance of more effectively addressing the requirements associated with chronic and long-term conditions, they often have had considerable difficulty translating this recognition into effective policy programmes.[8] There are several reasons for these 'translational' difficulties, but the core challenge is that strategies that would address these complexities sit at policy intersections between different sub-systems involving public health, health care and social care, and the wider regulatory framework within which these are embedded. Strengthening primary care and community services, and optimising their interface with secondary care tend to be at the core, but this can be difficult to achieve against the background of complex set of interests and priorities of those involved in the delivery and financing of care services.[8] These are likely to differ at the different tiers of the system, from the primary process of patient care and the organisational context, to the financing and policy context at system level, each with distinct rationales and perspectives concerning the delivery of health care.[9] Even where innovative approaches addressing the various objectives may be possible, the likelihood of their successful implementation will be determined, to a considerable extent, by the specific political, economic and cultural context within which they are being introduced.

These challenges are not new and, indeed, common to any change involving different actors, rationales and levels in a given health system. However, as Boerma and Rico have noted, changes in primary care are particularly challenging to achieve given the specifics of the sector (for example, small and numerous units of provision or the disciplines and professions involved). They highlighted the need to draw on a range of policy instruments and to involve the range of actors at the different levels, including government, funders and professionals.[10]

Effecting change in primary care

Some reflections are provided here on a few of the levers that have been suggested to effect change in primary care towards the development and implementation of service delivery models away from the traditional model of fragmented care to one where the service user's journey is better coordinated. Drawing on Boerma and Rico,[10] our recent work on approaches to chronic care,[7] [8] and the wider literature on the implementation of innovations, we propose a set of core requirements that would need to be put in place to enable this transition, and which can be seen to act at the different levels in the system. Each of these points is discussed in turn.

Provide the (regulatory) context to enable innovation

The policy context within which services are being designed and delivered will be crucial to encourage innovation.[8] Those with oversight of the system, whether they are central government, regional authorities, insurance funds or provider networks, often working together, must provide adequate and sufficient political support for change to ensure that the necessary actions are taken to reconfigure organisational structures, remove barriers to change and invest in education and training of the workforce to ensure appropriate skill mix, and information technology. High level political support will be particularly important in relation to adequate resourcing as coordination means bringing together different funding streams, different levels of decision-making, and different entitlements, among other things.[10] The central level can introduce mechanisms to help overcome these challenges through, for example, introducing single budgets. They must also ensure that change is comprehensive, consistent and contextually appropriate. The literature suggests that where an innovation is adapted to the local context, it is more likely to be successfully implemented.[11]

> Payment systems must encourage coordination

Provide for adequate resourcing and create incentive systems that encourage coordination among providers and sectors

There is a need to ensure that payment systems encourage rather than discourage coordination, with particular attention to be paid to changes in health services which appear likely to fragment care, such as payment based on activity or the introduction of competition among service providers. Countries are increasingly experimenting with new forms of payment, such as the introduction of 'bundled payment schemes' for a defined package of chronic care in the Netherlands.[12] Such schemes recognise that payment systems, which encourage multiple providers with different incentives, are unlikely to provide well-coordinated care.[4] Countries are also increasingly using pay-for-performance schemes in primary care, incentivising chronic and coordinated care in particular, although the evidence of its benefits remains limited, unless it is used as part of other quality improvement initiatives.[13] At the same time, a country-wide pay-for-performance scheme (the Quality and Outcomes Framework) in the United Kingdom has been associated with rapid and universal adoption of electronic records by GPs and GP practices employed more staff, especially nurses and administrative staff, with nurses increasingly providing proactive care for major chronic diseases within their GP practices.[14]

Balance 'top-down' and 'bottom-up' and deliver consistent messages

There is a need to strike a balance, in a given country context, between centrally defined requirements and local autonomy.[8] Actors operating at the different levels of the health system are faced with different pressures and consequent priorities that are not necessarily compatible or may even be contradictory.[9] There are particular challenges for organisations that arise from policies initiated by health care reformers on the one hand and established ways of delivery, on the other, which are likely to result in a gap between policy intent and actual implementation. We have observed such tensions in our review of reform experiences in a number of countries, highlighting the need to create a policy environment that provides the means for those who are asked to implement change to acquire the actual capacity and competence to do so to be critical for success.[7]

Involve key stakeholders

Evidence suggests that involving key stakeholders affected by the innovation at an early stage and encompassing all levels is likely to strengthen the success of implementation.[11] A critical role is to be played by professionals, who exert a large degree of control in health care organisations, such as primary care practices and hospitals. Failure to engage them in the reform process is likely to hamper sustainable change. The professions also play a crucial role in recognising and promoting new roles through supporting professional development.[10] This will be particular important in systems where primary care or general practice have traditionally had a low status. The reasons for this are likely to be multifactorial and related in part to income, but also the way teaching is organised and delivered. Strengthening the status of general practice within medical schools is one way of approaching this challenge, if general practice or primary care is seen to form the 'hub' for better coordination.

Learn from experience

There is a need to systematically assess existing inefficiencies in health service delivery and disincentives for the service user or the provider to receive or deliver the highest quality care (such as access or cost) to inform change. There is also a need to use existing evidence to better understand how specific local conditions influence the outcomes of a given approach to inform implementation. In other words, what are the structural, organisational and cultural prerequisites for success? It cannot be assumed that a given approach that works in one setting, where there may already be consensus of the value of multidisciplinary working, will work in another.

References

[1] World Health Organization. *The world health report 2008: primary health care now more than ever.* Geneva: World Health Organization, 2008.

[2] Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970–1998. *Health Services Research* 2003;38:831–65.

[3] Kringos D, Boerma W, van der Zee J, Groenewegen P. Europe's strong primary care systems are linked to better population health but also to higher health spending. *Health Affairs* 2013; 32:686–94.

[4] Roland M, Nolte E. The future shape of primary care. *British Journal of General Practice* 2014;64:63–4.

[5] Powell Davies G, Williams A, Larsen K, Perkins D, Roland M, Harris M. Coordinating primary care: an analysis of the outcomes of a systematic review. *The Medical Journal of Australia* 2008;188:S65–8.

[6] Health Quality Ontario. Continuity of care to optimize chronic disease management in the community setting: an evidence-based analysis. *Ontario Health Technology Assessment Series* 2013;13(6):1–41.

[7] Nolte E, Knai C, Saltman R (eds.) *Assessing chronic disease management in European health systems. Concepts and approaches.* Copenhagen: World Health Organization, 2014 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies).

[8] Nolte E, McKee M (eds.) *Caring for people with chronic conditions. A health system perspective.* Maidenhead: Open University Press/McGraw Hill Education, 2008.

[9] Plochg T, Klazinga N. Community-based integrated care: myth or must? *International Journal for Quality in Health Care* 2002;14:91–101.

[10] Boerma WGW, Rico A. Changing conditions for structural reform in primary care. In: Saltman RB, Rico A, Boerma WGW (eds.) *Primary care in the driver's seat? Organizational reform in European primary care.* Maidenhead: Open University Press, 2006: 50–67.

[11] Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Quarterly* 2004;82:581–629.

[12] Elissen AMJ, Duimel-Peeters IGP, Spreeuwenberg C, Vrijhoef HMJ, Nolte E. The Netherlands. In: Nolte E, Knai C (eds.) *Assessing chronic disease management in European health systems. Country reports.* Copenhagen: World Health Organization, 2015 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies): 99–110.

[13] Roland M. Pay for performance: not a magic bullet. *Annals of Internal Medicine* 2012;157:912–3.

[14] Nolte E, Brereton L, Knai C, Roland M. England. In: Nolte E, Knai C (eds.) *Assessing chronic disease management in European health systems.* Country reports. Copenhagen: World Health Organization, 2015 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies): 27–36.

ENHANCING PUBLIC HEALTH PREPAREDNESS: TOWARDS AN INTEGRATED PROCESS

By: **Jonathan E. Suk, Thomas Van Cangh, Massimo Ciotti** and **Karl Ekdahl**

Summary: Investments in public health preparedness can mitigate the human and economic costs of disease outbreaks. Preparedness is an iterative process of quality improvement through which public health seeks to optimise the anticipation of, response to, and recovery from health threats. Integrating preparedness processes into routine public health activities is essential to ensure the sustainability of preparedness measures. Developing means to efficiently prepare for a wide range of health threats and to coordinate across sectors and national borders will be important priorities in the coming years.

Keywords: *Emergency Preparedness, Public Health, Infectious Disease, Epidemics, Ebola*

Introduction

It is accepted among global development communities that disaster preparedness not only saves lives but is also a sound investment. The United Nations Development Programme's (UNDP) "Act Now, Save Later" campaign[1] is based on the premise that each dollar spent in preparedness saves seven dollars in emergency response.

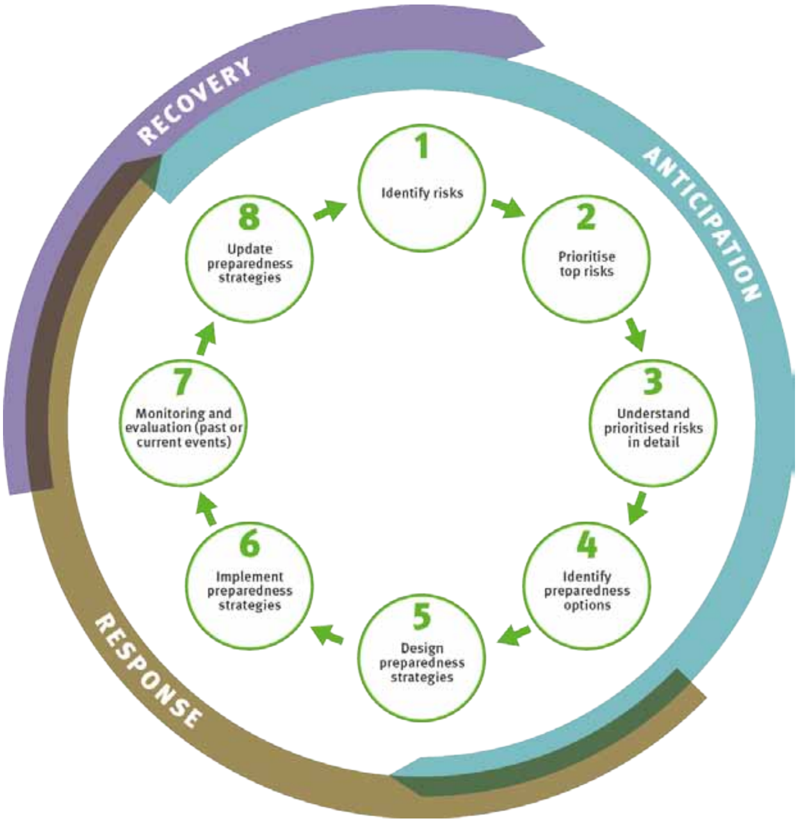
In a highly interconnected world in which many key global risks are also drivers of infectious disease (e.g. climate change, terrorism, deforestation, intensified trade and agriculture), it is the case that outbreaks with a cross-border element are increasingly likely.[2] As well as the immediate health impact, such outbreaks can also incur significant costs. Following the SARS outbreak in 2003, it was estimated that the costs to the world economy were a staggering US$40 billion,[3] which led to the conclusion that *"there is a strong economic case for direct intervention in improving public health … where there are inadequate expenditures in public health and insufficient investments in research into disease prevention."*

Ten years later, there have been two major influenza scares (H5N1 avian influenza and the 2009 H1N1 pandemic), countless

➤ #EHFG2015 Lunch workshop 1:
Health threats response

Jonathan E. Suk is Expert, Emerging Threats & Preparedness, **Thomas Van Cangh** is Expert, Public Health Preparedness, **Massimo Ciotti** is Deputy Head of Unit, Public Health Capacity and Communication, and Head of Section, Country Preparedness Support, **Karl Ekdahl** is Head of Unit, Public Health Capacity and Communication, European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden. Email: Jonathan.Suk@ecdc.europa.eu

Figure 1: The preparedness process



Source: [7]

other outbreaks, and the 2014 outbreak of Ebola in West Africa. The latter in particular has demonstrated that there continue to be significant gaps in the global preparedness for infectious disease risks.[4] There have been nearly 30,000 cases and over 11,000 deaths since the onset of the epidemic. In addition, West Africa regional economic losses for 2014–2017 are estimated at an average of US$3.6 billion per year. Ebola has also led to an increased risk of poverty, heightened food security challenges, the disruption of national childhood vaccination campaigns, and negative impacts on the overall social fabric in Guinea, Liberia and Sierra Leone.[5]

As global attention to the Ebola outbreak gradually waned, in May 2015 a traveller to South Korea from Saudi Arabia triggered an outbreak of Middle East respiratory syndrome (MERS-CoV). This offered further evidence that global interconnectedness can lead to disease outbreaks anywhere and that all countries, rich and poor, are potentially susceptible (although to varying degrees). Public health preparedness has subsequently emerged as an important priority, which means that it is time to move beyond the mantra that better preparedness will lead to better global health security. In order to make the case for further investments in preparedness, it is necessary to clarify what, exactly, is meant by “preparedness”, and what activities will be required in coming years to ensure that preparedness is sustainably strengthened.

Public health preparedness: a process of improvement

The United Nations Office for Disaster Risk Reduction (UNISDR) usefully defines preparedness as *“the knowledge and capacities developed by governments, professional response and recovery organisations, communities and individuals to effectively anticipate, respond to, and recover from, the impacts of likely, imminent or current hazard events or conditions.”* [6]

Implicit in this definition is that knowledge and capacities must exist, and that they must be operationalised and harnessed so as to ensure that activities during the anticipation, response, and recovery phases are conducted as efficiently as possible. In this sense, public health emergency preparedness can be seen as a process of quality improvement (**see Figure 1**). The types of activities relevant to a preparedness process are related to the preparedness phases of anticipation, response, and recovery. In an ideal world, each of the phases of the cycle are iteratively enhanced and effectively integrated into the routine activities of public health institutions. The processes established to ensure that this occurs are arguably as important as the technical activities, for without robust processes the sustainability of preparedness initiatives may be jeopardised. In the following sections, we will focus on the areas for improvement that can be identified at various phases of the preparedness cycle (**see Figure 1**).

Anticipation: Identifying, prioritising, and understanding risks

Early warning is a critical component of preparedness activities. Organisations such as the European Centre for Disease Prevention and Control (ECDC) routinely conduct epidemic intelligence and horizon-scanning activities to identify emerging threats. Innovative new approaches that leverage tools such as Geographic Information Systems (GIS) are being developed that may increase the ability to anticipate the evolution of risks, such as by linking epidemiologic data with data from other sectors. Examples include modelling the impact of environmental changes on certain vector-borne diseases,[8] or using airline transportation data to assess the risks of disease importation.[9] There is great potential for further researching and developing such approaches, and for integrating them into epidemic intelligence activities.

With multiple emerging disease risks often on the horizon, prioritisation efforts may be helpful so as to inform preparedness planning and to ensure that precious resources, both human and financial, are wisely allocated. One approach for doing so is to utilise methodologies such as multi-criteria decision analysis to solicit multidisciplinary opinion and, it is hoped, enhance strategic decision-making.[10] ECDC is currently in the process of adapting such a methodology and has observed that the process of "risk ranking" may be as useful as the outputs, for it can bring together stakeholders that rarely meet with one another.

Prioritised risks may become the focus of more detailed investigations and studies, as might risks that quickly arise and demand immediate attention. In both cases, detailed threat assessments often become the cornerstone for subsequent preparedness and response measures. Considering threats from the perspective of vulnerabilities, and conducting multidisciplinary threat assessments are preferable, because preparedness strategies are often implemented in complex settings. To give one example, an important impediment to the Ebola response has been the highly varying local ideas of what the virus is, where it comes from, and how it can be stopped. These ideas are in turn affected by varying sociopolitical contexts, and thus a comprehensive understanding of the threat would also consider perspectives from the social sciences in addition to, for example, virology, epidemiology and clinical medicine.

Response: Identifying, designing, and implementing preparedness strategies
Preparedness and response strategies must be designed according to the temporal and geographic scale of the threat, and they must consider the resources available and the context in which they will be implemented. One of the key current challenges is to understand the extent to which preparedness measures can be "generic". In other words, it is increasingly argued that preparedness measures should be "all-hazard", which could lead to efficiency gains, but it is unclear to what extent "generic" preparedness measures can actually account for a wide range of threats. A commonly cited rule of thumb is that 80% of preparedness measures are common across threats. While it is indeed likely that many preparedness processes and capacities are generic, this assumption is worthy of further research. Technically speaking, it is perhaps more likely that classes of infectious diseases can be prepared for similarly, such as mosquito-borne diseases or respiratory diseases, but even then it would not be prudent to assume that the measures in place for one disease would necessarily be relevant for another.

One thing that is clear is that preparedness strategies need to consider the activities of multiple sectors, which means that the health sector will increasingly need to reach out to other relevant partners when developing, testing, and implementing plans. Examples of sectors can include transport and aviation, energy, water treatment, environment, and civil protection.

Similarly, an increasingly important consideration is the cross-border dimension of infectious disease risks. Preparedness measures in one country could affect or need to be conducted in another country (e.g. road closures, trade embargoes, airport screening measures, contact-tracing). Thus, there is a need for coordination of preparedness measures across jurisdictions, and for the exchange of information about risks and the efficacy of specific preparedness measures. In the European Union, Decision 1082/2013/EU on serious cross-border threats came into effect in November 2013. It provides an integrated European framework for the different preparedness phases described in this article and aims to ensure a consistent European response across multiple types of hazards (biological, chemical, environmental).

Recovery: monitoring, evaluating, and updating preparedness strategies
The recovery phase demands many important types of measures, such as transitioning attention and resources back towards routine public health activities. It is also an opportunity to reflect upon the extent to which preparedness measures had achieved their goals. Reviews of past incidents such as H1N1 have tended to focus on concrete "lessons learned" or on specific pharmaceutical interventions (such as stockpiling of countermeasures), but they do not typically address issues such as health system capacities.[11] A similar issue exists with the ways in which tools or simulation exercises seek to evaluate the status of preparedness.[12] They tend to focus on structure- or process-indicators, but do not often capture the degree to which preparedness actually contributes to an efficient response to public health emergencies. In addition, ensuring that lessons learned from exercises and real emergencies are transferable and translated into actual improvements in daily practice remains a challenge.[13]

Ensuring that formal knowledge and capacities are in place is surely important, but is that enough? Other pertinent questions could include: what capacities and knowledge is essential, and what is not? How will personnel and protocols function in practice during highly stressful emergencies? How can health systems be made more resilient? How do we really know when we are prepared for a given threat – or for an unknown one?

The road ahead: strengthening preparedness in Europe and abroad

It has been posited here that preparedness is usefully viewed as a strategic process; one which seeks to optimise the anticipation of, response to, and recovery from major risks. Although knowledge and capacities are crucial components, preparedness activities and processes need to be embedded in the routine activities of public health organisations in order to ensure that future responses to infectious disease outbreaks will be optimised. This should also help to strengthen the resilience of "routine" public health activities, because the most effective health services and system during an emergency are the ones used during peacetime.

In the coming years, ECDC, in collaboration with the European Commission and partners such as the World Health Organization (WHO), will pursue a programme of work that includes: research into threat anticipation and prioritisation; approaches for optimising multi-sector and cross-border collaboration; the essentials for monitoring and evaluation; and, more generally, the integration of preparedness processes into core public health business. Investments in such work, it is hoped, will help to mitigate the human and economic costs of future disease outbreaks.

References

[1] #ActNow – Save Later web site. Available at: http://www.undp.org/content/undp/en/home/ourwork/get_involved/ActNow.html

[2] Suk JE, Van Cangh T, Beaute J, et al. The interconnected and cross-border nature of risks posed by infectious diseases. *Global Health Action* 2014;7:25287.

[3] Lee J-W, McKibbin W. Estimating the global economic costs of SARS. In S. Knobler, A, Mahmoud et al. (Eds.) *Learning from SARS: Preparing for the Next Disease Outbreak: Workshop Summary.* Washington, D.C: Institute of Medicine Forum on Microbial Threats, 2004.

[4] Heymann DL, Chen L, Takemi K, et al. Global health security: the wider lessons from the west African Ebola virus disease epidemic. *The Lancet* 2015;385(9980):1884–1901.

[5] United Nations Development Group, West and Central Africa. *Socio-economic impact of Ebola Virus Disease in West African countries.* New York: United Nations Development Programme, 2015.

[6] United Nations Office for Disaster Risk Reduction. Geneva: Switzerland, 2014. Available at: http://www.unisdr.org/we/inform/terminology#letter-p

[7] ECDC. With inspiration from Kunreuther, Michel-Kerjan and Useem. *Corporate Strategies for Managing Catastrophic Risks in the S&P 500: Linking Intuitive and Deliberative Thinking.* Interim Report. The Wharton School, University of Pennsylvania, 2013.

[8] Semenza JC, Sudre B, Oni T. et al. Linking environmental drivers to infectious diseases: the European Environment and Epidemiology Network. PLoS Neglected Tropical Diseases 2013;7(7):e2323.

[9] Semenza JC, Sudre B, Miniota J, et al. International Dispersal of Dengue through Air Travel: Importation Risk for Europe. *PLoS Neglected Tropical Diseases* 2014;8(12):e3278.

[10] ECDC. *Best practices in ranking emerging infectious disease threats.* Stockholm: ECDC, 2015.

[11] Drake TL, Chalabi Z, Coker R. Cost-effectiveness analysis of pandemic influenza preparedness: what's missing? *Bulletin of the World Health Organization* 2012;90(12):940–1.

[12] CDC. National Health Security Preparedness Index. Atlanta: CDC, 2014. Available at: http://www.nhspi.org/the-index/

[13] Piltch-Loeb R, Kraemer JD, Nelson C, Stoto MA. A public health emergency preparedness critical incident registry. *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 2014;12(3):132–43.

Promoting Health, Preventing Disease: The economic case

Edited by: David McDaid, Franco Sassi and Sherry Merkur

Maidenhead: Open University Press, 2015

Number of pages: 368, **ISBN:** 9780335262267

Executive summary for download at: http://www.euro.who.int/__data/assets/pdf_file/0006/283695/Promoting-Health-Preventing-Disease-Economic-Case-Executive-Summary.pdf?ua=1

Available for purchase at: http://www.mheducation.co.uk/9780335262267-emea-promoting-health-preventing-disease-the-economic-case

This book provides an economic perspective on health promotion and chronic disease prevention, and gives a rationale for assessing the economic case for action. It provides a comprehensive review of the evidence base in support of a broad range of public health interventions, addressing not only their effectiveness in improving population health, but also their implementation costs, impacts on health expenditures and wider economic consequences.

An economic perspective is about more than counting the costs associated with poor health. It is about understanding how economic incentives can influence healthy lifestyle choices in the population. The book provides tools for developing effective and efficient policy strategies and addressing trade-offs between the goals of improving population health, while being mindful of the need to tackle inequalities in health outcomes across individuals and populations.

The book:

- practically illustrates methods and measures of cost and outcome used in the evaluation of interventions
- covers specific risk factor areas including tobacco smoking, alcohol, unhealthy diets, physical inactivity, poor mental health and harmful environmental factors
- considers cross-cutting themes including key implementation issues, health inequalities, and the merits of early life interventions.

The book is designed for health policy makers and all those working or studying in the areas of public health, health research, medicine or health economics.

FINANCIAL SUSTAINABILITY OF THE CZECH HEALTH SYSTEM:

IS HISTORY REPEATING ITSELF?

By: Anne Spranger, Jana Votápková, Jan Alexa, Lukáš Rečka and Ewout van Ginneken

Summary: The Czech health system has performed relatively well with low out-of-pocket payments, a broad benefit basket, plentiful human resources, and good results for some important health indicators. However, the recent global financial crisis once again highlighted the financial vulnerability of the current system, reflected among other things, by the return of solvency problems among health insurance funds. Yet no consensus exists among political parties on financial reform. Rather, reforms are limited to several small changes every time a new political party comes into power, while the larger issues regarding sufficient resource mobilisation are not addressed.

Keywords: *Czech Health System, Human Resources, Physical Resources, Economic Crisis, Financial Sustainability*

Anne Spranger is a researcher at the Berlin University of Technology, Germany; **Jana Votápková** is a PhD candidate at the Faculty of Social Sciences at Charles University and an analyst at the Ministry of Health, Czech Republic; **Jan Alexa** is an analyst at the Ministry of Finance, Czech Republic; **Lukáš Rečka** is an analyst at the Environment Centre of Charles University, Czech Republic; **Ewout van Ginneken** is senior researcher at the Berlin University of Technology, Germany. Email: anne.spranger@tu-berlin.de

Introduction

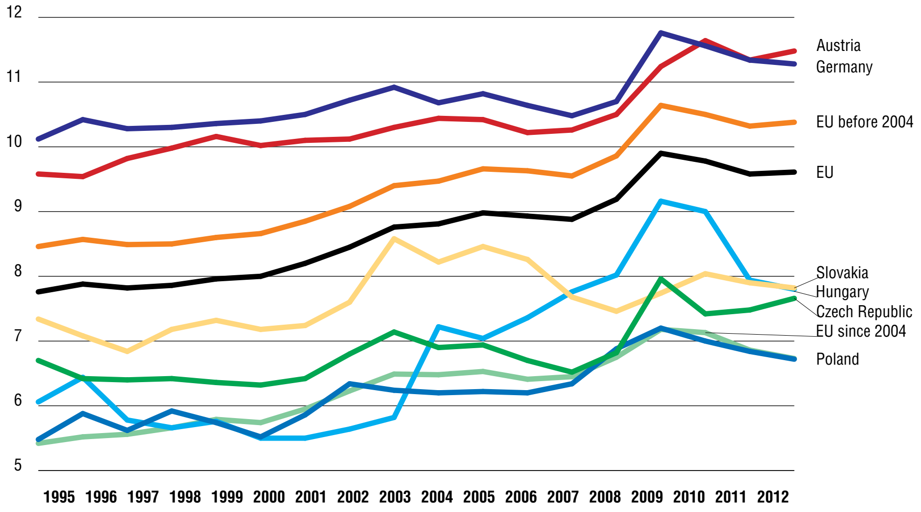
The Czech Republic has good health outcomes: life expectancy at birth is increasing, having reached 75.1 years for men and 81.3 years for women in 2012; these are well above the average for the EU-13, but still below the EU-15 average. The population has virtually universal coverage and a broad range of benefits, and some important health indicators are better than the EU averages (for example, mortality due to asthma) or even among the best in the world (such as infant mortality).[1] And an overall declining trend of amenable, as well as preventable, mortality in the Czech Republic reflects continuous efforts in modernising and improving the health system.[2]

On the other hand, mortality rates for diseases of the circulatory system and malignant neoplasms are above the EU-28 average. Furthermore, the 2008 global financial crisis had a substantial impact on the Czech economy and consequently on revenues in the health system. With the return of solvency problems for the country's health insurance funds, a ghost from the recent past has re-entered Czech politics with full force.[3] This article assesses the Czech health system and its recent reforms and sustainability challenges.

The SHI system provides good coverage

The Czech Republic has a system of statutory health insurance (SHI) based on compulsory membership of a health insurance fund, of which there were seven in 2014. The funds are quasi-public, self-governing bodies that act as payers and purchasers of care. The core health

Figure 1: Trends in health expenditure as a share (%) of GDP in selected countries, 1995 to latest available year



Source: [1]

Notes: GDP: Gross domestic product; EU: European Union.

legislation of the Czech Republic was adopted in the 1990s and has changed only marginally since then. The fourteen regional authorities (kraje) and the health insurance funds play an important role in ensuring the accessibility of health care, the former by registering health-care providers, the latter by contracting them. Czech residents may freely choose their health insurance fund and health-care providers. The health insurance funds must accept all applicants; risk selection is not permitted.

> cost-saving emergency measures

Population coverage is virtually universal, and the range and depth of benefits available to insured individuals are broad; in principle insured individuals are entitled to any medical treatment aiming to maintain or improve their health status, though in practice there is a range of limitations. The SHI system is financed through compulsory, wage-based contributions and through state contributions on behalf of economically inactive people, such as children and the unemployed. A risk-adjustment formula based on age, gender and ex-post compensation of 80% of costs above a set limit is used to redistribute resources between the health insurance funds.

A history of underspending

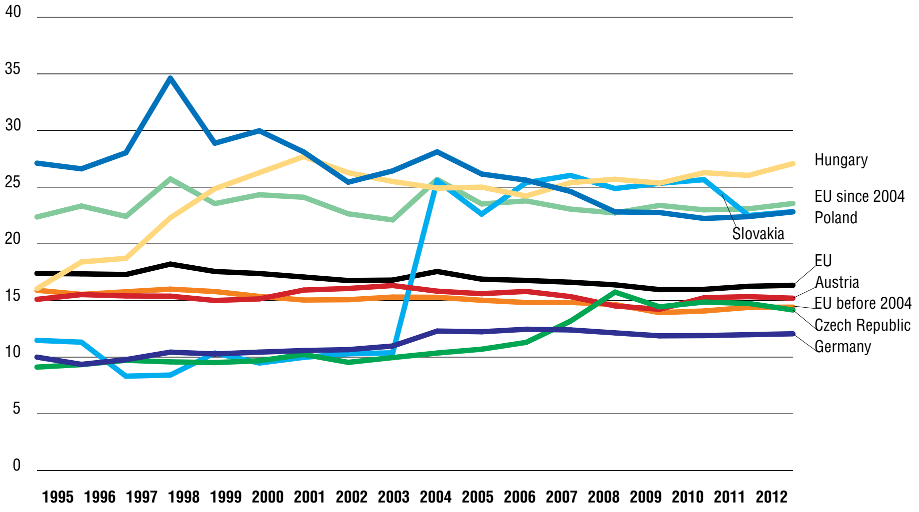
Following a rapid increase in the early 1990s, total health expenditure in the Czech Republic as a share of gross domestic product (GDP) has remained relatively low (7.7%) compared to the EU average of 9.6% in 2012 (**see Figure 1**). Health expenditure as a share of GDP rose temporarily following the financial crisis because of the fall in GDP, but fell back due to restrictions in expenditure. Health expenditure from public sources as a share of total health expenditure remains relatively high at just under 85% (the EU average is 75.9%), with the balance made up through out-of-pocket (OOP) expenditures (private insurance plays only a marginal role) (**see Figure 2**).[1] However, the current health system as a whole has had constant financial problems since its establishment at the start of the 1990s, reflected in the health insurance funds' solvency problems. Although insurance funds had built up reserves towards the end of the last decade, following the financial crisis the largest insurance fund (Všeobecná zdravotní pojišťovna České republiky; VZP) – which additionally suffers from an inadequate risk adjustment and a relatively bad risk profile of their enrolees – required a €62 million loan, which was partially repaid in December 2014. It is hoped that a new risk adjustment model, that not only includes age and gender but also pharmaceutical cost groups as risk adjusters, will improve the situation.

Many of the recent reforms of the Czech health system have attempted to address the chronic financial instability that has marked the system since the early 1990s.[4] The global economic crisis since 2008 has only further aggravated the need for reforms. Due to rising unemployment rates, SHI contributions increasingly have been funded by the state and health insurance funds have faced stagnating financial resources. Thus, the most recent reform activities, to a large extent, consisted of various cost-saving emergency measures, including attempts to increase the share of private expenditure on health care services and reforms in reimbursement mechanisms.

Infrastructure challenges

The Czech Republic has an extensive public health network responsible for a range of services, including epidemiological surveillance, immunisation logistics, quality analyses for consumer and industrial products, and monitoring the impact of environmental factors on health status. Approximately 95% of primary care services are provided by physicians working in private practice, usually as sole practitioners. Patients register with a primary care physician of their choice, but can switch to a new one every three months without restriction. Primary care physicians do not play a true gatekeeping role; patients are free to obtain care directly from a specialist and frequently do so; on average about eleven times per year (2011), far above the EU average of seven in the same year, and only surpassed by Hungary (11.8).[1] Secondary care services in the Czech Republic are offered by a range of providers, including private practice specialists, health centres, polyclinics, hospitals and specialised inpatient facilities. Almost all pharmacies in the Czech Republic are run as private enterprises, and at the time of writing

Figure 2: OOP payments as a share of total health expenditure, 1995 to latest available year, in selected countries



Source: [1]

there is a trend towards the establishment of pharmacy chains, especially in urban areas.[5]

> increasing need for financial reform

During the 1990s, changes made to the structure of inpatient facilities in the Czech Republic were driven primarily by an excessive number of beds in acute care and an insufficient number of beds in long-term care. In the past two decades, the number of acute beds decreased continuously while the number of long-term beds increased, though at 470 acute care hospital beds, the Czech Republic is still well above the EU average of 385 per 100 000 population in 2011.[1] Furthermore, the lack of capacity in the social care system is a bottleneck for the hospital system. Since 2007, over €480 million from EU Structural Funds were invested to improve ageing-related resources, in addition to national efforts. However, many psychiatric institutions, long-term care and nursing facilities for older people are out-dated and in need of modernisation.

Plenty but ageing health professionals

By European standards, the number of physicians in the Czech Republic is relatively high, with 3.6 physicians per 1000 population in 2011 (the EU average is 3.5),[1] though the ageing profile of primary care physicians represents a potential human resource problem in the near future.[5] At the end of 2012, the average age of physicians was 48.1 years (48.9 years for men, 47.5 years for women). The Czech physician population has been ageing, with 26.6% of physicians aged between 50 and 59 years and 21.1% of physicians aged 60 or above in 2012.[6] The nurse-to-population ratio is slightly above the average for the EU (8.5 per 1000, as compared to 8.4 per 1000 for the EU as a whole) and has increased slightly since 2009.[1] Although the total number of human resources allocated to health care in the Czech Republic are high from a European perspective, it should be noted that the physician (and dentist)-to-population ratio varies considerably between the country's fourteen regions (with the capital Praha having considerably more health personnel than the Středočeský and Pardubický regions).

Political deadlock remains

The Czech population values and takes pride in its health system – and rightly so, as several indicators show. However, there is increasing need for financial reform in order to tackle various sustainability challenges. These not only include the recurring solvency problems among health insurance funds, but also the ageing physical resources, restructuring of beds, lack of social care, and ageing workforce, especially in primary care. The main political parties are aware of this necessity and they each propose different solutions. On the left of the political spectrum, more centralisation with fewer or possibly only one health insurance fund is favoured; whereas a more market-oriented approach with increased competition is preferred on the right side of the political spectrum. While both ideological approaches have advantages and disadvantages, the lack of consensus in itself poses an increasingly acute problem. Thus far, disaccord has resulted in several small changes (e.g. with user fees) every time a new political party comes into power, while the larger issues, regarding sufficient resource mobilisation, have not been addressed.

References

[1] WHO Regional Office for Europe. European Health for All database (HFA-DB) [online database]. Copenhagen: WHO Regional Office for Europe, accessed 4 September 2014. Available at: http://data.euro.who.int/hfadb/

[2] Nolte E, McKee M, Evans D, Karanikolos M. Saving lives? The contribution of health care to population health. In: Figueras J, McKee M (eds). *Health systems, health, wealth and societal well-being*. Maidenhead, UK: Open University Press, 2012:101–24.

[3] Alexa J, Rečka L, Votapkova J, van Ginneken E, Spranger A, Wittenbecher F. *Czech Republic: Health System Review. Health Systems in Transition* 2015; 17(1).

[4] Bryndová L, Pavlokova K, Roubal T, Rokosova M, Gaskins M, van Ginneken E. *Czech Republic: Health system review. Health Systems in Transition* 2009;11(1).

[5] ÚZIS. *Zdravotnická ročenka České republiky* 2012 [Czech Health Statistics Yearbook 2012]. Prague: Institute of Health Information and Statistics of the Czech Republic, 2013. Available at: http://www.uzis.cz/en/publications/czech-health-statistics-yearbook-2012

[6] Czech Statistical Office. *Aggregate data on the Czech Republic*, 2013. Available at: http://www.czso.cz/csu/redakce.nsf/i/souhrnna_data_o_ceske_republice

KEY REFORMS AND CHALLENGES FOR THE LUXEMBOURG HEALTH SYSTEM

By: Anne Spranger, Anne Calteux, Françoise Berthet and Ewout van Ginneken

Summary: Luxembourg has the highest per capita health spending in the WHO Europe Region and the highest share of patients seeking care abroad in the European Union (EU) in 2012. Major reforms in 2008 and 2010 aimed at cost-containment and increasing quality by establishing a single health insurance fund which includes maternity benefits and long-term care insurance. Furthermore, the strengthening of patients' rights and the development of a national e-health infrastructure has only recently occurred as the latter is only in its pilot stage and is not fully developed. This article gives an overview of this relatively little known health system in light of the Luxembourg Presidency of the Council of the EU.

Keywords: *Luxembourg, EU Presidency, Cross-border, Health Care Directive*

Introduction

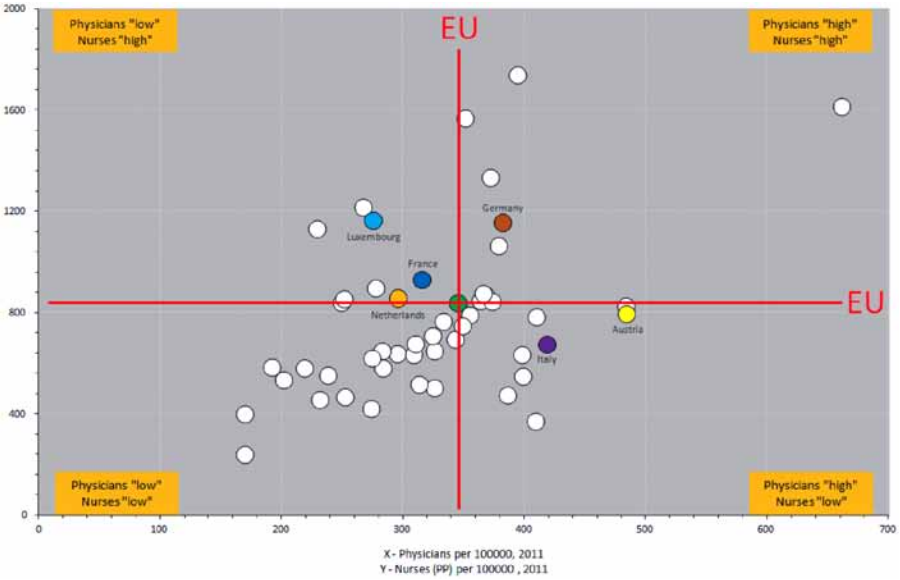
The current Luxembourg Presidency of the EU has put the spotlight on the relatively little known health system in Luxembourg. This is long overdue, especially since Luxembourg is facing unique challenges of which some, perhaps in magnified form, reflect typical EU health policy challenges in many countries.

First, Luxembourg has the highest per capita health spending in the WHO Europe Region; at US$PPP (Purchasing Power Parity) 6341 it is almost twice as high as the EU-28 average of US$PPP 3346 in 2012. However, in terms of health spending as a percentage of Gross Domestic Product (GDP), expenditures in Luxembourg (6.9% of GDP) are below those of neighbouring countries and the EU-28 average (9.6% of GDP in 2012[3]). This is mainly the result of the extraordinary performance of the Luxembourg economy. Second, several indicators demonstrate significant scope for efficiency gains in the delivery system. Third, Luxembourg is lacking capacity to train health personnel and is facing shortages in some specialty care, which also necessitates a generous policy towards receiving care abroad.

After large reforms in 2008 and 2010 overhauled some key organisational features, the Bettel-government is expected to continue with its reform agenda, for instance, with regard to hospital financing. This article gives an overview, key reforms, and the challenges facing the Luxembourg health system.

Anne Spranger is a researcher at the Berlin University of Technology, Germany; **Anne Calteux** is Senior Counsellor at the Ministry of Health, Luxembourg, in charge of EU Coordination; **Françoise Berthet** is head of the division for curative medicine, Health Directorate, Ministry of Health, Luxembourg; **Ewout van Ginneken** is senior researcher at the Berlin University of Technology, Germany. Email: anne.spranger@tu-berlin.de

Figure 1: Number of physicians and nurses per 100,000 population in the EU-28, 2011 or latest available year



Source: [3]

A key role for government

Regulatory responsibilities for the health system are split between the Ministry of Health and the Ministry of Social Security. Both Ministries cooperate closely and share responsibility for the organisation, legislation and financing of the health system. This includes implementing health policy, ensuring that health is considered in all aspects of policy, and coordinating actors and activities in the system. The Ministry of Health plans and organises the delivery of care, authorises large hospital investments, and directly co-finances public health programmes. The Ministry of Social Security develops social policy and legislation, and oversees the compulsory health, accident and long-term care insurance schemes. The Ministry of the Family is responsible for licensing and inspecting long-term care facilities.

The health, maternity and long-term care insurance schemes are managed by the National Health Fund (*Caisse nationale de santé;* CNS). CNS was created in 2008 by merging three existing sickness funds and is now the single payer fund for health and maternity benefits and long-term care insurance. In April 2015, it covered 773 060 insured individuals (67% were residents and 32.9% were non-residents commuting to Luxembourg) and offers a standardised benefit basket.[2] [3]

According to government plans, the basket of services covered must increasingly be based on the effectiveness, quality and economic efficiency of diagnostic and therapeutic interventions. When it was created, it was envisaged that CNS would play a stronger role in cost-containment by pooling resources better and through stronger purchasing. This strategic goal was further emphasised under the health reform law in 2010 (entitled “Promoting quality and efficiency”), which equipped CNS with a standardised accounting system for hospital services and a new e-health infrastructure, which also aimed to improve the quality of health care.[4]

Predominantly publicly funded, low OOPs

The overall budget of the health insurance system is determined annually by CNS for the following year based on multiannual expenditure forecasts. The financing of health insurance is based on a system of contributions from the working population, employers and state budget transfers. While the state contributes 40% of health insurance funding, the remaining 60% is equally shared between the insured population, and employers. The same system of shared contributions is applied to the long-term care insurance scheme. The private share of health expenditure, mostly out-of-pocket (OOP) payments and voluntary health insurance (VHI), saw an increase from 9.1% in 2008 to 15.5% in 2012, driven, in particular, by government cost-containment reforms in 2010, which introduced more cost-sharing. Most of the OOP payments by households are for cost-sharing for services provided under the national health, long-term care and accident insurance schemes (68.2% in 2012). It should be noted that approximately 56% of the resident population has complementary insurance for cost sharing services (CMCM), and therefore receive an additional payment above the base reimbursement rate set by CNS for certain hospital care and other specified treatments (dental care and eye disease). Representing about 30% of private expenditure, co-payments covering accommodation and meal costs in long-stay, residential facilities are a significant element of private household expenditure.

> “pooling resources better and stronger purchasing

Low on doctors, high on nurses

In the non-hospital sector, providers practise without direct supervision and are reimbursed using the tariffs and conditions laid down in the medical procedure frameworks and in the negotiated contracts between professional groups and CNS. In general, CNS negotiates agreements with professional groups in almost all fields of health care services. Once an agreement is reached, providers licensed to practice in Luxembourg are obliged to adhere to the tariffs and reimbursement rules of CNS, which are generally fee-for-service (FFS). The Ministry of Health does not act as an active purchaser in the ambulatory sector. Every applicant meeting the conditions for a licence is free to open a practice and be automatically contracted by the health insurance scheme and therefore remunerated.

The health system has a proportionally lower than average numbers of physicians, while the numbers of nurses are relatively high. In 2011, there were 2.8 practising doctors per 1000 inhabitants in Luxembourg (**see Figure 1**). This is below the EU-28 average of 3.5 (2011) and lower than in the neighbouring countries, Belgium, France and Germany. In 2012, 29.6% of all practicing doctors were general practitioners (GPs). Most doctors work as self-employed medical practitioners, with most specialists dividing their time between their private practice and hospital work. In general, GPs work in private consulting practices; while specialists are based in hospitals (although they are not salaried employees of these institutions) and also consult from their private practices.

Table 1: Hospital indicators in Luxembourg and selected countries, 2011

	Bed occupancy rates in acute care hospitals (%)	Beds in acute care hospitals per 100,000 population	ALOS for acute care hospitals
Austria	85.5	544.7	6.6
France	75	353	5.1
Germany	79	530.8	7.9
The Netherlands	48.6	333.9	5.8
Luxembourg	71.5	396°	7.3
EU 15	76.6*	345*	6.5

Source: [1]

Notes: * indicates 2010 data, ° national data for 2012.

Lack of training in some areas

The comparatively low number of physicians may be explained by the fact that several health professions, such as medicine, dentistry and pharmacy, cannot be trained in Luxembourg. Tertiary education is not available for medical graduates (except for post-graduate training in general medicine), dentists, veterinarians, pharmacists, physiotherapists and speech therapists. This results in a dependency on foreign-trained health professionals and complicates sustainable health workforce planning. However, it is possible to obtain professional qualifications in nursing, midwifery, care work and social assistance in Luxembourg.

Weak gatekeeping

In Luxembourg, there is no referral system to medical specialists, meaning that patients are free to choose to visit any GP without registration and face no obstacles to directly visiting medical specialists. Unsurprisingly, according to the PHAMEU monitor Luxembourg was among the few EU-15 Member States with a “weak” primary care system, together with Ireland and Austria,[5] contrasted by “strong” primary care in neighbouring countries. In 2011, Luxembourg had 6.6 outpatient contacts per person, which is below the EU-28 average and neighbouring countries (France 6.8, Belgium 7.4, and Germany 9.7).

High percentage of care provided abroad

As some specialised care is not readily available within Luxembourg, a generous policy on seeking treatment abroad is in place. Referrals to institutions for complex treatments and diagnostic procedures, for which an adequate quality of care cannot be guaranteed in Luxembourg, require prior approval by CNS. This approval has to be granted if the treatment cannot be carried out without undue delay in Luxembourg, and if the treatment is categorised as essential and not available in the country. In 2012, costs for care abroad amounted to €363 million for CNS, representing 19.1% of total costs of the health-maternity benefit scheme. This share has been fairly stable in the last few years ranging between 18% in 2010 and reaching an all-time high of 19.4% in 2014. Furthermore, a total of 17 545 cases have received care abroad (with Germany being the lead destination with 58%, followed by Belgium with 25% of referred cases), representing 16% of all patients. This is the highest percentage of all EU Member States seeking care abroad, followed by Italy (12%) and Hungary (10%), far above the EU-28 average of 4% (2013).[4] [6]

Room for efficiency improvements in hospitals

In the hospital sector, services are financed on the basis of a global budget as established by CNS based on the Hospital Act of 1998. A dedicated hospital plan must address the health needs of the country, as identified by national survey data, while ensuring that hospitals function efficiently and stay within the budget. The latest hospital plan (2009) applies to thirteen hospitals, both public and private.

The number of hospital beds has gradually reduced since 2004, with acute care beds falling steadily from 5 in 2004 to 3.9 per 1000 inhabitants in 2012, and are now close to the EU average. The average length of stay (ALOS) in acute hospital care has stabilised in Luxembourg to 7.5 days, well above the EU average of 6.4 in 2011 (**see Table 1**). This is partly explained by missing incentives for hospitals to reduce ALOS as they are financed from global hospital budgets. In addition, physicians are paid on a FFS basis and thus earn more by treating more. The bed occupancy rates in acute care hospitals have stabilised at a relatively low level of 71%. This is well below the average in all neighbouring countries and the EU average (76.6%) in 2011. All in all, these indicators seem to suggest room for efficiency improvements in hospital care. Recognising this, the government is looking for the most appropriate way of introducing a diagnosis-related group (DRG)-based hospital financing scheme, which in theory should incentivise hospitals to become more efficient and reduce individual over-utilisation of hospital services.

A future with e-health and empowered patients

Luxembourg has invested considerable effort in strengthening its e-health capacities, e.g. by establishing an e-health agency and introducing the Shared Health Record (*Dossier de Soins Partagé, DSP*). DSP was adopted in 2015. Currently in its pilot phase, it applies mostly to patients with chronic diseases before being extended to all insured individuals. It contains patient health information that is meaningful for promoting safety, continuity of care, coordination of care and efficient use of health care services. Patients can access their DSP online and authorised health providers automatically receive key medical data if needed.

> “no referral system to medical specialists

Furthermore, patient empowerment was strengthened by a new law in 2014 that gave patients the right to receive all available information about their health status and diagnosis, as well as an examination plan and treatment options to make an informed choice. In line with the European cross-border care directive of 2011, patients are now able to access probable treatment costs and options in Luxembourg and abroad via the newly established patient information service which is operated by CNS for questions relating to costs and by the newly established Health Mediator for questions on treatment options available within the country. A robust hospital information system, collecting data on in-patient services, their quality, safety and performance, is currently being built, which should make this information available to patients in the future and enable informed planning of hospital facilities. Both reforms will strengthen Luxembourg’s aim to have personalised medicine high on the political agenda.

Good health outcomes, but at high costs

Luxembourg had the highest per capita health spending among European countries in 2012 but the country seems to get a return on this investment. The indicators of life expectancy and infant mortality are among the best in Europe, although risk factor burden as high obesity and overweight level is reason for some concern. The population enjoys good access to a broad range of health services with relatively little cost sharing. This is reflected in a low level of unmet need compared to other countries (Eurostat 2015). Furthermore, Luxembourgers have access to an above EU average level of acute beds, staffed with one of the highest proportions of nurses among EU countries. Only the number of doctors ranges below the EU average. Despite constant population growth, mainly driven by immigration (from 363 450 inhabitants in 1980 to 537 039 in 2013), population size remains limited, meaning that certain tertiary specialties are not available in Luxembourg. In these cases however, Luxembourg employs a generous policy to allow patients to receive care abroad.

Health system gains can mostly be made by improving efficiency. For example, more can be done with the proper use of Health Technology Assessment (HTA) to rationalise the benefit basket, especially for coverage of pharmaceuticals. A stronger gatekeeping function and expansion of competences in primary care could also prevent unnecessary and expensive specialist visits. Furthermore, hospitals have a high ALOS combined with low occupancy rates, which may reflect inefficient use of these resources. Some of the planned future reforms, particularly the set up of a robust health information system on hospital services will allow hospital performance evaluation. Efficiency gains could follow the introduction of DRGs and greater use of HTA, but careful implementation will be required.

References

[1] WHO Regional Office for Europe. *Health for All Database*, 2015. Available at: http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db

[2] CNS. *Annual Report* 2013. Luxembourg: CNS, 2013. CNS. Rapport annuel 2013. Luxembourg, 2014. Available at: http://cns.lu/files/publications/CNS_Rapp_2013_NET_.pdf

[3] CNS. Financial situation of the maternity benefit insurance scheme- presentation *Internal Document*. Luxembourg: Ministry of Social Security. CNS. Comptes annuels et bilan de clôture de l’année 2014 de l’assurance maladie-maternité. Luxembourg, 2015. Available at: http://cns.lu/files/publications/DECOMPTE_AM_2014.pdf

[4] Inspection Général de la sécurité social. *Rapport 2013 sur la sécurité sociale* [Annual Report 2013 of the social security system]. Ministry of Social Security, Luxembourg, 2015. Available at: http://www.mss.public.lu/publications/rapport_general/rg2013/rg_2013.pdf

[5] Kringos D, Boerma W, Bourgueil et al. The strength of primary care in Europe: An international comparative study. *British Journal of General Practice* 2013;742.

[6] European Commission Directorate General for Health and Consumers (SANCO), 2015. Special Eurobarometer 425 “Patients’ rights in cross-border healthcare in the European Union”. Available at: http://ec.europa.eu/public_opinion/archives/ebs/ebs_425_sum_en.pdf

LONG-TERM CARE REFORM IN THE NETHERLANDS: TOO LARGE TO HANDLE?

By: Ewout van Ginneken and Madelon Kroneman

Summary: To ensure the affordability, accessibility and quality of long-term care in the future, the Exceptional Medical Expenses Act (AWBZ) underwent major reform in 2015, aiming to save costs and keep people self-sufficient for as long as possible. Most forms of non-residential care were transferred to the municipalities and added to the Social Support Act and Youth Act, while insurers were made responsible for home nursing. Residential long-term care will be available under the new Long Term Care Act, which will replace the AWBZ. So far, implementation has been rocky, leading to several problems, including late payments and shortfalls in provision.

Keywords: *Long-term Care Reform, Residential Care, Home Care, The Netherlands*

Ewout van Ginneken is senior researcher at Berlin University of Technology, Germany; **Madelon Kroneman** is senior researcher at The Netherlands Institute for Health Services Research (NIVEL), The Netherlands. Email: ewout.vanginneken@tu-berlin.de

Introduction

The Dutch long-term care (LTC) system, governed since 1968 by the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten, AWBZ*) is enormous. With expenditure amounting to €27.8 billion in 2014, it is about two-thirds the size of the curative insurance scheme (€40.1 billion in 2014).[1] Almost one in twenty residents in the Netherlands are recipients. It is a single-payer programme, administered by care offices set up by regionally dominant insurers, and covers residential care and home care, mainly for older people (about 75% are over 65 years), patients with psychiatric disorders, and people with learning, sensory, or disability conditions. Until recently, individuals receiving LTC could choose between benefits in-kind or a personal care budget (20% of recipients chose the latter in 2010). The cost of this scheme has been steadily rising, with the majority funded from payroll contributions (12.7% with a maximum of about €4220 per year in 2014).

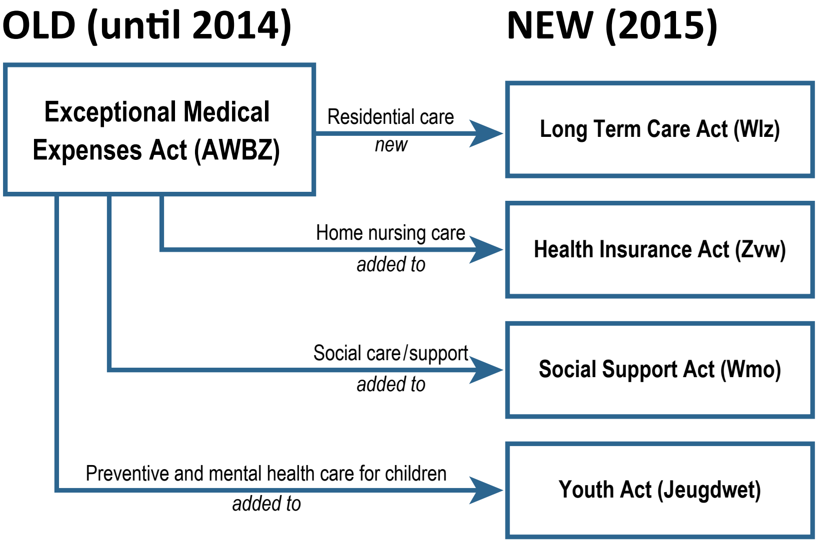
For a long time, the government has sought to control costs in LTC, a situation that is expected to worsen as the population ages. Since 2012, for example, the personal budget was drastically restricted in terms of eligibility and entitlements after strong increases in the number of new budget holders led to large spending increases.[2] Concerns about spending on LTC have remained and have now culminated in a major reform that will change the financing structures but will also, in many cases, affect how people receive their care.

The 2015 long-term care reform

The old LTC scheme (AWBZ) will be integrated into three existing laws and one new law (**see Figure 1**). First, if living at home is no longer possible, residential

LTC will be available under the new Long Term Care Act (*Wet langdurige zorg, Wlz*). Second, insurers will be made responsible for home nursing (which includes personal care), which is now part of the Health Insurance Act (*Zorgverzekeringswet, Zvw*). Third, most forms of non-residential care (the social care part) will be transferred to the municipalities and added to the Social Support Act (*Wet maatschappelijke ondersteuning, Wmo*). Fourth, preventive and mental health care for children will be transferred to the completely revised Youth Act (*Jeugdwet*). The overall goals of this reform are to: (1) save costs, and thus keep LTC affordable, starting with €500 million in 2015, reaching savings of €3.5 billion annually in 2018; (2) keep people self-sufficient for as long as possible – also given the high Dutch institutionalisation rate; and (3) improve quality and coordination of care.

Figure 1: Changes in long-term care



Source: Authors' own

Residential care: the all-new Long Term Care Act

A new Long Term Care Act (*Wlz*) will replace the Exceptional Medical Expenses Act (*AWBZ*) as the main scheme for LTC but with a much lower contribution rate (9.65% with a maximum of €3241 per year in 2015). It will nevertheless absorb by far the largest share of the funding previously allocated to the old Act. Clients who, due to their limitations (functionally or mentally), are in need of permanent supervision have access to 24-hour inpatient care. Eligibility will be based upon a needs assessment. Eligible people who nevertheless would prefer to stay at home can apply for a personal budget. Previously, budget holders could manage their own budget, but following concerns about fraud, a government body, the Social Insurance Bank (*Sociale Verzekerings Bank, SVB*), now manages the budget on behalf of budget holders. In the future, care covered by the Wlz may also become the responsibility of health insurers.[3] If that happens, the Dutch single-payer system for LTC would be fully abolished.

Home nursing care (including personal care): the Health Insurance Act

Home nursing is now included under the Health Insurance Act, i.e. the curative care insurance scheme. With this shift, home nursing is moved closer to other types of primary care, such as general practitioner care. Health insurers become responsible for the whole medical domain, from home nursing care to specialist hospital care. Ideally, this would foster a better integration of care. District nurses will play a key role in keeping people in their homes. They will visit home nursing recipients and assess whether it is possible to be more self-reliant. These nurses combine their medical tasks with improving the cohesion between prevention, care, wellbeing and housing. In addition, the Health Insurance Act will now cover the first three years of inpatient mental care, before the Wlz takes over. Previously, it covered only the first year.

> provision-based approach

Social care: the Social Support Act 2015

The objective of the Social Support Act is that municipalities will support citizens to participate in society. This includes, for instance, home help, transport facilities and house adjustments. According to the national government, municipalities will be better able to provide tailored solutions and to promote informal care than the previous nationally organised system. Municipalities first explore the opportunities for applicants to take care of themselves, with the help of their social network. If these are considered insufficient, publicly-funded support will become available. Interestingly, municipalities are free to organise tailor-made support for their citizens, which could lead to different solutions among municipalities. Thus, the rights-based approach of the AWBZ will be replaced with a provision-based approach. For example, municipalities may choose to substitute professional care with other solutions, such as care provided by neighbours or volunteers, whereas in the previous situation, people, if eligible, had a right to professional home care. Since municipalities are closer to their citizens and in a better position to assess their needs, they are expected to organise the care more efficiently by, among other things, appealing more strongly to self-reliance. Therefore, the state budget for non-residential LTC will be lowered.[3] The amended Social Support Act (Wmo 2015) was approved by Parliament in April 2014.

Long-term youth care: the Youth Act

The fully revised Youth Act, which came into effect in January 2015, makes municipalities responsible for care services targeted at parenting problems, developmental problems, mental health problems and disorders for all people under 18 years and their parents. Only those who are expected to depend on 24-hour supervision after they reach the age of 18 will receive care under the Wlz. The Youth Act intends to improve coordination of care by combining all care (except somatic care) into one Act and by making one organisation, the municipality, responsible. Municipalities should install care and advice teams to reach this goal. In practice, a family experiencing problems will be assigned a care coordinator to ensure easy access to services. Municipalities receive financial compensation for these activities from the government via the Municipality Fund, a general taxation based fund that provides for the largest share of the municipality's income (about 90%), but this compensation is not earmarked. Thus, if municipalities decide to spend more or less than the intended amount, they are free to do so.

> implementation has led to a great deal of debate

Impact of the reform

In the run up to the reforms, many stakeholders voiced important concerns often relating to the short time provided to adequately prepare because uncertainties in the new legislation persisted well into 2014. Patient associations worried that patients who were ineligible for residential care could not stay at home because of a lack of adequately adapted housing.[4] The associations also feared the lack of coordination in provision, which in the new situation, is split across separate institutional arrangements. Another concern was the position of informal carers and that the new arrangements would make informal care an obligation.[5] Health insurers were more positive about the reform, but they feared not being ready for its implementation as their financial systems were not yet adapted.[6] The association of LTC providers was positive about the reform, but also feared that 2015 was too early and voiced concerns that it was unclear who was entitled to care.

People who were already living in a residential home, but who do not meet the new, stricter entitlements, fall under transitional provision arrangements. This provision allows this group of individuals to keep their entitlements for Wlz-care for the rest of their lives. There are fears, however, that those who need a lot of care but do not meet the new criteria for Wlz-care, will not be able to organise their care themselves. Furthermore, the closure of residential homes is considered worrisome, because they also provide care to people living in the neighbourhood in the form of meals or day care.[7] Municipalities felt that the new Social Support Act provided an opportunity for a broad and cohesive support package for citizens, but were concerned about a lack of funding and instruments to stimulate the self-reliance of citizens. The cooperation with health insurers and home nurses was another source of concern.[8]

Half a year after the reform came into effect, it is clear that the implementation has been far from smooth. Many of the concerns and fears voiced in 2014 have become a reality. There has been continued heated political debate and media coverage. A newly published report by the Netherlands Court of Audit (*Algemene Rekenkamer*) called the expected savings unrealistic.[1] Problems were reported with late payments to providers, made by the SVB on behalf of budget holders, putting both the provider and the patients into difficulty. The SVB was not ready to fulfil this task, mostly due to inadequate staffing levels, computer system problems and increased numbers of applications for a budget. The Secretary of State, who first denied the problems, finally had to apologise to parliament for the chaos and his political future is in peril. The Ministry of Health will now allocate more funds to the personal budgets than originally planned.

Another problem is finding home help (help with household chores under the Wmo), which has been the subject of a major funding cut. The government has set a savings target of 34% on the budget.[9] Municipalities reacted in different ways: some abolished the provision of home help completely, some decreased the number of hours provided and some decided to keep the existing level of provision at the expense of other spending items in the municipal budget. To mitigate the negative effects, a transitional measure was agreed in which municipalities can temporarily apply for a higher budget for social support. Many recipients of social support (about 3000 in June 2015) have filed complaints with the municipalities[10] and in some cases, people have sued their municipality. One court ruling stated that municipalities are not allowed to cut into home help provision without an in-depth investigation of the situation of the recipient.

Conclusion

With many countries dealing with ageing populations and exploring ways to have affordable LTC arrangements in place, the Dutch reforms are likely to receive a great deal of attention in the near future. In the short term, it seems that the ability to find quick solutions to immediate problems, which is reminiscent of the first years after the country's major health insurance reform in 2006, will be tested. The difference with that reform, however, is that in 2006 only the payment system changed, not the provision of care. In the 2015 LTC reform, new institutions (municipalities and health insurers) have to organise types of care for which they lack previous experience and expertise. Providers of home care and youth care that had contracts with a limited number of payers, now have to negotiate with a much larger number of health insurers and municipalities, each with their own targets, budget limitations and financing systems. Moreover, the SVB, which is now responsible for paying on behalf of people with a personal budget, has shown how complex this is, as they clearly were not ready to cope with this task. It is also not yet clear to what extent municipalities will succeed in fostering informal care, since they cannot oblige people to provide it. However, in their decision to provide professional care, they can take informal care into account.

If the new system of provision is not adequately organised and funded, the repercussions for population health and health infrastructure can become enormous. A systematic evaluation of the implementation is not yet available. However, the extensive media coverage suggests that implementation has led to a great deal of debate. Since the reform affects a vulnerable group of people, it can only be hoped that most of these issues will be resolved soon and that further social unrest will be avoided.

References

1 Algemene Rekenkamer. *Regionale verschillen in de zorg, mogelijke verklaringen voor zorggebruik van ouderen en chronisch zieken*. [Regional differences in care, possible explanations for the use of care of elderly and chronically ill people] *Den Haag*, 2015. Available at: www.rekenkamer.nl/Publicaties/Onderzoeksrapporten/Introducties/2015/06/Regionale_verschillen_in_langdurige_zorg

2 van Ginneken E, Groenewegen PP, McKee M. Personal healthcare budgets: what can England learn from the Netherlands? *BMJ* 2012;344:e1383. doi:10.1136/bmj.e1383

3 Minister van Volksgezondheid, Welzijn en Sport. *Hervorming van de langdurige ondersteuning en zorg* [Reform of long term support and care]. Ministry of Health, 23–04–2013. Available at: www.rijksoverheid.nl/documenten-en-publicaties/publicaties/2013/04/25/hervorming-van-de-langdurige-ondersteuning-en-zorg.html

4 NPCF. *Grote zorgen om nieuwe wet* [Large concerns about the new act], 2014. Available at: www.npcf.nl/index.php?option=com_aiportfolio&view=article&Itemid=2&id=63:AWBZ/Overheveling%20langdurige%20zorg&standpunten=12&year=2013&standpunt=5393

5 NPCF. *Zorgen over gevolgen voor gebruikers langdurige zorg en fasering plannen* [Concerns about the consequences for clients of long-term care and the speed of transition]. Available at: www.npcf.nl/index.php?option=com_aiportfolio&view=article&Itemid=2&id=63:AWBZ/Overheveling%20langdurige%20zorg&standpunten=12&year=2013&standpunt=5113

6 Zorgverzekeraars Nederland. *Dossier AWBZ. In het kort*. [Dossier AWBZ. In short], 2014. Available at: www.zn.nl/beleidsthemas/overzicht-dossiers/dossier/?attributeId=5704723d-0e6f-4276-b68c-4dd1303bbaa9&attributeTitle=AWBZ#section=tabs-1

7 Actiz. *Wet langdurige zorg: te snel, te smal en te dichtgeregeld* [Long term Care Act: too fast, too limited, too much regulation], 10–04–2014. Available at: www.actiz.nl/nieuwsberichten/website/nieuws/2014/wet-langdurige-zorg-te-snel-te-smal-en-te-dichtgeregeld

8 Vereniging van Nederlandse Gemeenten. Brief Tweede Kamer betreffende Wetsbehandeling Wmo 2015 [Letter to the house of parliament concerning the treatment of the Social Support Act 2015], 16–04–2014. Available at: www.vng.nl/files/vng/brieven/2014/20140416_brief-parlement_wetsbehandeling-wmo-_2015.pdf

9 Secretary of State of the Ministry of Health. *Memorie van Toelichting inzake het voorstel van wet, houdende regels inzake de gemeentelijke ondersteuning op het gebied van zelfredzaamheid, participatie, beschermd wonen en opvang (Wet maatschappelijke ondersteuning 2015)* [Explanatory memorandum with regard to the proposed Act for municipal social support (Social Support Act 2015)], 2014. Available at: www.rijksoverheid.nl/bestanden/documenten-en-publicaties/kamerstukken/2014/01/14/memorie-van-toelichting-van-wet-maatschappelijke-ondersteuning-2015/memorie-van-toelichting-van-wet-maatschappelijke-ondersteuning-2015.pdf

10 De Koster, Y. *Hausse aan bewaarschriften schoonmaakhulp* [Lots of complaints filed against decisions on home help], 17–06–2015. Available at: www.binnenlandsbestuur.nl/sociaal/nieuws/hausse-aan-bezwaarschriften-schoonmaakhulp.9479815.lynkx

New Policy Brief: How can countries address the efficiency and equity implications of health professional mobility in Europe? Adapting policies in the context of the WHO Code of Practice and EU freedom of movement

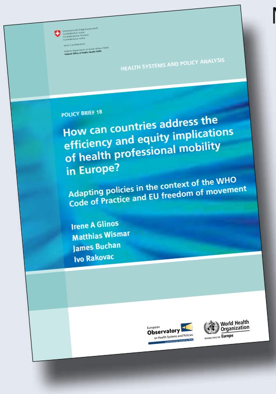
By: I A Glinos, M Wismar, J Buchan

Copenhagen: European Observatory on Health Systems and Policies, 2015

Policy Brief 18

Freely available for download at:
http://www.healthobservartory.eu

The health workforce is a key factor for the performance of health systems. But many countries are facing shortages, mal-distribution and skill-mismatches of health professionals. This brief analyses the impact of the European Union's (EU) free movement of health professionals for destination countries, source countries and the EU as a whole. It also presents the policy tools decision-makers can use to mitigate the negative and encourage the positive effects of professional mobility. The authors build on the WHO Global Code of Practice on the International Recruitment of Health Personnel that was adopted in 2010. Based on an analysis of the consequences of free mobility for equity and efficiency, they review the options for Member States to improve health workforce sustainability and for managing professional mobility. They also explore what the EU can do to address the consequences and opportunities of free mobility.



The policy brief was presented jointly with the WHO report entitled "Making Progress on Health Workforce Sustainability?: The WHO Code in the Context of the European Region" at the 65th session of the WHO Regional Committee for Europe, September 2015 in Vilnius, Lithuania.

NEW PUBLICATIONS

Economic crisis, health systems and health in Europe: impact and implications for policy

By: S Thomson, J Figueras, T Evetovits, M Jowett, P Mladovsky, A Maresso, J Cylus, M Karanikolos and H Kluge

Copenhagen: Open University Press

Number of pages: xxv + 200; **ISBN:** 978 03 352 64 001

Available for purchase at: http://www.mheducation.co.uk/9780335264001-emea-economic-crisis-health-systems-and-health-in-europe-impact-and-implications-for-policy

Economic shocks pose a threat to health and health system performance by increasing people's need for health care and making access to care more difficult – a situation compounded by cuts in public spending on health and other social services. But these negative effects can be avoided by timely public policy action. While important public policy levers lie outside the health sector, in the hands of those responsible for fiscal policy and social protection, the health system response is critical.

This book looks at how health systems in Europe reacted to pressure created by the financial and economic crisis that began in 2008. Drawing on the experience of over 45 countries, the authors:

- analyse health system responses to the crisis in three policy areas: public funding for the health system; health coverage; and health service planning, purchasing and delivery
- assess the impact of these responses on health systems and population health
- identify policies most likely to sustain the performance of health systems facing financial pressure
- explore the political economy of implementing reforms in a crisis.

The book is essential reading for anyone who wants to understand the choices available to policy-makers – and the implications of failing to protect population health or sustain health system performance – in the face of economic and other forms of shock.

Contents: Ch 1 Making sense of health system responses to economic crisis; Ch 2 Implications for household financial security, government resources and health expenditure; Ch 3 Changes to public funding; Ch 4 Changes to health coverage; Ch 5 Changes to health service planning, purchasing and delivery; Ch 6 The health effects of the crisis; Ch 7 Lessons for policy.

Economic crisis, health systems and health in Europe: country experience

Edited by: A Maresso, P Mladovsky, S Thomson, A Sagan, M Karanikolos, E Richardson, J Cylus, T Evetovits, M Jowett, J and H Kluge

Copenhagen: World Health Organization 2015, Observatory Studies Series No. 41

Number of pages: xxxi + 517; **ISBN:** 9789289050340

Freely available for download at: http://www.euro.who.int/__data/assets/pdf_file/0010/279820/Web-economic-crisis-health-systems-and-health-web.pdf?ua=1

The financial and economic crisis has had a visible but varied impact on many health systems in Europe, eliciting a wide range of responses from governments faced with increased financial and other pressures. This book maps health system responses by country, providing a detailed analysis of policy changes in nine countries and shorter overviews of policy responses in 47 countries. It draws on a large study involving over one hundred health system experts and academic researchers across Europe.

Focusing on policy responses in three areas – public funding of the health system, health coverage and health service planning, purchasing and delivery – this book gives policymakers, researchers and others valuable, systematic information about national contexts of particular interest to them, ranging from countries operating under the fiscal and structural conditions of international bailout agreements to those that, while less severely affected by the crisis, still have had to operate in a climate of diminished public sector spending since 2008.

Along with a companion volume that analyses the impact of the crisis across countries, this book is part of a wider initiative to monitor the effects of the crisis on health systems and health, to identify those policies most likely to sustain the performance of health systems facing fiscal pressure and to gain insight into the political economy of implementing reforms in a crisis.

Contents: Part I: Country case study chapters on the impact of the health system and health in Belgium, Estonia, France, Greece, Ireland, Latvia, Lithuania, the Netherlands and Portugal.
Part II: Country profiles of health system responses to the crisis.

NEWS

International

Priorities of the Luxembourg Presidency

Having taken over from Latvia in holding the Presidency of the Council of the European Union, Luxembourg's stated priorities for its six month term include a deeper focus on public health, focusing on patients and innovation. The priorities foresee quicker access to "safe and high quality medical devices", personalised medicines, greater action on dementia, learning from the Ebola epidemic and ensuring the protection of European citizens in case of a nuclear or radiological emergency. Health promotion is also addressed through a greater emphasis on (childhood) physical activity and coordination with the World Anti-Doping Agency.

More information on the Presidency at: http://tinyurl.com/o6wtrwb

WHO European Region has lowest global breastfeeding rates

WHO recommends that breastfeeding be initiated within the first hour of birth and be exclusive for six months, with the introduction of complementary food after six months and continued breastfeeding up until two years or beyond. However, new research published in the journal *Public Health Nutrition,* led by Professor Ayse Tulay Bagci Bosi from Hacettepe University in Ankara, concludes that many countries in the Region are far from complying with this WHO recommendation.

In 2006–2012, only 25% of infants in the WHO European Region were exclusively breastfed for the first six months. This compares with 43% in the WHO South-East Asia Region. Only 21 countries had data on breastfeeding rates at six months. Even though the rate of early initiation of breastfeeding is very high in some countries, exclusive breastfeeding rates drop rapidly between 4 and 6 months of age. Data show that, on average, just 13% of infants are exclusively breastfed during the first 6 months, although rates vary substantially across the Region from just 0.7% and 1.0% in Greece and the UK to 43.9% and 49.3% in Hungary and Slovakia.

Poverty, difficulty in accessing health services, social marginalisation, obesity, workplace policies and marketing of breast-milk substitutes are just some of the reasons for low breastfeeding rates and inequality in the Region. Mothers with low socioeconomic status are up to ten times less likely to begin breastfeeding, and this tendency is transmitted through generations. The latest issue of *EntreNous* – the European Magazine for Sexual and Reproductive Health is devoted to birth in Europe. It includes an article from the WHO Collaborating Centre for Global Nutrition and Health, Metropolitan University College, Copenhagen, on how breastfeeding initiation at birth can reduce health inequalities.

Entre Nous is available at: http://tinyurl.com/nsv75wj

The open access article Breastfeeding practices and policies in WHO European Region Member States is available at: http://tinyurl.com/nw7l53m

European Health Insurance Card: carried by more than 200 million

Almost 206 million Europeans have the European Health Insurance Card (EHIC), according to figures available for 2014. This represents nearly 40% of the total population in reporting Member States. There are six million more cards than in 2013 (+4%).

More information on EHIC at: http://tinyurl.com/q2v89kz

Country News

Serbia: SEEHN meeting held

Ministers from ten countries in the South-Eastern Europe Health Network (SEEHN) met in Belgrade on 22–23 June 2015. Jointly organised by Dr Zlatibor Lončar, Minister of Health of the Republic of Serbia and current President of SEEHN, and Dr Zsuzsanna Jakab, WHO Regional Director for Europe, the meeting concluded with agreement on joint regional and national actions towards securing universal health coverage. In addition to promoting an equitable Europe free of impoverishing health expenditures, the Belgrade Statement, endorsed by the ministers, also commits the countries to promote and scale up political commitment to implementing the European Health Strategy, Health 2020, and agree on more specific regional actions to strengthen human resources for health and coordinate cross-border support in public health emergencies.

Read the Belgrade Statement at: http://tinyurl.com/nwx9k5o

Germany: Restricting refugee access to health care increases costs

Germany is one of a number of European Union countries that restrict initial access to health care for asylum-seekers and refugees (A&R). Under the 1993 Asylum-Seekers' Benefits Act (Asylbewerberleistungsgesetz, AsylbLG) access is limited to emergency medical care, treatment for acute and painful conditions, care during pregnancy and childbirth, vaccinations and other "necessary preventive measures". Additional care may be granted upon formal request if deemed to be "essential" to preserve health. New analysis published in the journal *PLoS One* by Kayvan Bozorgmehr from Heidelberg University and Oliver Razum from Bielefeld University looked at health-related costs for A&R in Germany between 1994 and 2013. It found that annual per capita expenditure for A&R with restricted access was 40% higher (€376) than for A&R with full access to services. The authors conclude that rather than saving money restricting access to health services has increased costs, even after accounting for higher levels of need. Excess and potentially avoidable expenditure was estimated to account for 22% of all health expenditures for A&R in this twenty year period.

The paper is available at: http://tinyurl.com/oy75ax2

Additional materials supplied by:
EuroHealthNet Office
67 rue de la Loi, B-1040 Brussels
Tel: + 32 2 235 03 20
Fax: + 32 2 235 03 39
Email: r.rollet@eurohealthnet.eu

European Health Forum

Gastein