Health Policy Developments 10
Sophia Schlette, Kerstin Blum, Reinhard Busse (eds.)

Health Policy Developments 10

Focus on Long-term Care, Sickness Funds as Payers and Players, Improving Quality of Care
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Foreword

Dear Reader,

We are pleased to present our Anniversary Edition, issue 10 of *Health Policy Developments*. For five years, this publication series has been reporting on the latest health policy developments in the 20 partner countries of the International Network Health Policy and Reform. Our aim is to provide you with a stimulating and useful overview of international health policy trends and good practice, and we appreciate your interest in our work.

To celebrate our anniversary, we are offering a new service. In addition to the list of reforms by country, this volume also contains a list organized by area of focus. There you’ll find a complete A to Z of all reforms detailed in our series of publications.

Volume 10 of *Health Policy Developments* again deals with a variety of health policy themes—from nursing care and new forms of care to quality assurance and prescription drug policy.

This time, the various effects of demographic change on health provision form a particular focus. Europe and Japan are currently in the middle of a far-reaching process of change, which is also taking place in countries with generally younger populations or greater levels of immigration. The growing proportion of older people in the overall population brings with it a range of challenges in terms of health policy.

Firstly, the need for long-term care increases in any society with an aging population. At the same time, the requirements in terms of quality of care also increase if care-intensive illnesses such as dementia, Alzheimer’s and Parkinson’s become more significant. The question of how to enable people to grow old with dignity—whether at home or in an institutional environ-
Coordinated care benefits everyone

GPS in the care labyrinth

Cancer—a disease of old age

ment—and also ensure sustainable funding is a cause of concern to many industrialized nations. Following the German approach, France is considering the introduction of long-term care insurance as the fifth pillar of social security insurance—a path already taken by Spain and Slovenia. Austria has opted for statutory regulation of 24-hour care, which will bring many nursing staff and assistants (mostly from Eastern European countries) and their Austrian employers out of the grey area of illegality. On the other hand, Japan and Israel (see Health Policy Developments 7/8, p. 141) are opting for specific health promotion measures for older people in order to stave off as long as possible, or even prevent altogether, the need for care.

Secondly, the growing incidence of chronic conditions and multimorbidity affecting our “graying” population has indirect effects on the care landscape. New forms of care aimed at improved care coordination are often the result of considerations on how to improve care for the chronically ill.

Aids to help navigate the often labyrinthine care system are immensely valuable, particularly for people with complex conditions. Various approaches have been developed in this area in the last few decades—from disease management programs and the more comprehensive chronic care model (which is currently being implemented by the Israeli health insurance company Maccabi) to the “medical home” model being tested in the United States. The medical home model, in particular, shows that reorganization of the care landscape can achieve improved quality of care for all patients and can also result in benefits for healthcare providers and payers.

Cancer is also becoming an increasing area of focus for the medical profession and public attention as the risk of cancer rises with increasing life expectancy. Aging is a fundamental factor for the development of cancer because of risk accumulation over the life course combined with the tendency for cellular repair mechanisms to be less effective as a person grows older. According to a health report issued by the German federal government, almost three-quarters of new cases of cancer in Germany occur in people over the age of 60.

As cancer becomes increasingly common, the battle against the disease is understandably an area of focus for health policy. The EU health ministers agreed in April 2008 on the need for a
joint EU action plan in the fight against cancer and called for a draft recommendation from the European Commission. In many countries, there are already very promising approaches at the national level for improving cancer prevention and the care of cancer patients. Japan, New Zealand and Australia have opted for a national action plan against cancer that links prevention with better coordination of care, specific continuous professional development of healthcare providers and patient information. In 2007, Denmark revised its 2001 Cancer Action Plan. Among other things, the new plan specifies that patients with suspected cancer should never have to wait longer than 48 hours for a diagnostic investigation.

The information sources for this book were, as always, the expert reports of the International Network Health Policy and Reform. This issue presents the results of the tenth half-yearly survey for the period May 2007–September 2007. Of the 79 reported reforms, we have selected 30 for the present publication.

Our special thanks go to Norbert Mappes-Niedieck and Phil Cain, authors and freelance journalists, for their help in preparing the first draft and to Ines Galla (Bertelsmann Stiftung) for her support in the editing and organizational management of this publication. Our thanks also go to all experts from partner institutions and their external co-authors:

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Commentators/Reviewers: Luca Crivelli and Mary Ries.

Any comments and ideas regarding Edition 10 of Health Policy Developments are more than welcome and can be addressed to the editors. We look forward to receiving your suggestions for improvements.

Sophia Schlette, Kerstin Blum, Reinhard Busse
Long-term care: Developing insurance solutions

Many countries have taken steps to prepare for the implications of their aging populations. A few, such as Germany, which made long-term care a fifth pillar of social insurance in 1995, were even considered pioneering. But few now think that measures like this came in time or went far enough.

By 2050, the number of over-65s will increase by 58 million in Europe, with the over-80s the most rapidly expanding age group among them (Sorenson 2007: 1). Despite the scale of the challenge, the proportion of gross domestic product that industrialized countries allocate to long-term care lies in a range between just 0.2 percent and 3 percent (see figures 1 and 2) (OECD 2005: 2).

The challenge posed by an aging population is not just one of raw numbers. It is expected to change the nature as well as the quantity of long-term care required. The pattern of illness and the associated care needs will inevitably change. For example, the number of people requiring long-term intensive care, including those with dementia, Alzheimer’s or Parkinson’s disease, is likely to grow particularly fast.

The demographic trend has drawn attention to other issues in long-term care which had in the past been largely ignored. Some might even say it has brought about a paradigm shift. It may seem absurd today that disabled people were cared for in facilities designed to meet the needs of acute patients, yet it was common practice for decades. Few trends appear as irreversible as the expansion of the number and scope of mobile care services. Home care has always been an important part of long-term care, mostly provided in informal arrangements. Increasingly, however, it is recognized to be a pillar of good, patient-oriented long-
Figure 1: Public and private expenditure on long-term care

![Bar chart showing public and private expenditure on long-term care for various countries.]

All data in percent of GDP

2005 data, for Australia and Japan 2004.


term care. Home care has become an important component of publicly funded long-term care (see fig. 2).

The system of long-term care insurance has been adopted by more and more countries. Japan and Luxembourg, for example, have developed similar schemes as Germany. In Austria, long-term care has been under state control since 1993 and has consequently developed into something organizationally and financially distinct from acute care. France is currently considering the merits of long-term care insurance (see report on France, p. 17), while Spain and Slovenia are in the process of introducing it.

Spain, a country with a state-funded health system, began to switch over to a long-term care insurance model in 2007. It will be for modifications to patients’ homes, the integration of inpatient and outpatient care, and pay for care-giving relatives. The central government will contribute a third of the cost, with the seventeen autonomous regions making up another third, and the last third paid by those receiving care. The introduction of long-
term care insurance comes in a number of phases, the first in 2007 and the last expected in 2015. The step-by-step approach was chosen to ease the financial burden on the insured and to allow for the parallel expansion of long-term care infrastructure (see *Health Policy Developments* 7/8, p. 102).

New compulsory insurance in Slovenia covers care at home and in institutions, as well as medical aid and the cost of modest home conversions, if the residents can still be cared for within their own four walls (see *Health Policy Developments* 9, p. 98). Adults aged between 20 and 64 years will also be given access to care. Previously, people often had to cover the cost of care themselves, unless they were able to obtain an old-age or disability pension. But places in nursing homes for this group remain scarce.

In Slovenia, 67,000 people currently receive care benefits, which is just 3.4 percent of the population of around 2 million. They are generally paid for by the local authorities or through health and pension insurance. A large portion of the cost, how-
ever, is covered by those who need the care: In the inpatient sector, the out-of-pocket share is over 40 percent.

The Slovenian government hopes that the new universal compulsory insurance will inject more money into the system and that this money can be used to expand specialist care facilities. In the last 20 years, the number of older people in the country has increased by 50 percent, and by 2020 this number will swell enormously as the baby-boomers reach retirement age. These dramatic figures led the government in Ljubljana to question the viability and fairness of the existing system.

The separation of long-term care from acute care and the introduction of a separate financing system come with a new set of problems. For the most part, these revolve around the question of how to make a meaningful distinction between long-term and acute care while at the same time ensuring sufficient coordination between the two.

The separation of acute from long-term care meant that new rules needed to be found to define which cases fitted into which category. But defining these rules presented the new sector with new challenges and contradictions. Putting people’s security at the center of long-term care inevitably leads to questions over the freedom of choice, power over one’s own destiny, individuality, and what it is to live a meaningful life (Kane/Kane 2001: 116). Providing a budget is not in itself a solution.

In the care systems in place in many countries, those in need receive payments that they can spend how they wish. The amount of the payment increases as the person is more dependent on care. In systems like these, any gain in independence entails a financial loss. Improvements in status—such as being able to eat or to wash oneself—lead to a worsening financial position, while the system completely ignores the effort required to learn or relearn such elementary skills.

There are some promising approaches, however. Higher levels of patient activity are increasingly recognized as the hallmarks of good long-term care. In Japan, expert groups formed to improve care of the elderly identified inactivity, among other things, as a major risk factor for disability and dependency. Physical training, nutritional counseling and group activities were added to the performance of long-term care insurance (see report from
Japan, p. 19). A similar course is also being followed by Maccabi, one of the sickness funds in Israel. It is following an ambitious pilot program which will train doctors in the special health needs of older people and will promote the benefits of physical and mental fitness (see Health Policy Developments 7/8, p. 141).

Germany, meanwhile, wants to provide financial incentives for inpatient care facilities to make care more active and to improve rehabilitation services. If a patient moves to a lower category, the nursing home will receive a one-time sum of €1,538 (see report on Germany, p. 23).

Internationally, insurance systems can be divided into (1) those which provide benefits in kind, (2) those which reimburse patients for their expenses and (3) those which provide monetary compensation if the insured event occurs. Some provide choice among several options. In the German system, for example, persons with a long-term need for ambulatory services have a choice between monetary benefits and benefits in kind.

Whether someone is cared for at home or in an institution is not the only possible criterion for distinguishing between those who receive a payment and those who receive benefits in kind. No matter where people live, some argue, the personal budget is the better solution for those with more modest needs, as it allows them to make their own decisions and to meet healthcare professionals as a customer. Those with greater needs are better off with direct coverage, because it means they do not have to make difficult decisions and, potentially, keeps them from being manipulated. The trend worldwide is toward more choice.

The German model of providing money for nursing care both at home and in institutions carries some explosive issues, as illustrated by the debate in neighboring Austria (see report on Austria, p. 29). At its highest levels, the payment provided for long-term care is the same as in Germany; just as in Germany, it covers only half of what is spent on 24-hour home care. But 80 percent of recipients in Austria receive long-term care at home (according to the Austrian Association of nursing care (OEGKV, November 2005) compared to just 60 percent of people relying on home care in Germany (Gleckman 2007: 3). The high percentage of home care usage in Austria is linked to an exploitation of nurses, often illegally employed people from Austria’s eastern neighbors.
All countries are ultimately faced with the problem of defining appropriate standards for long-term care. This is a particularly urgent need in Germany, where a proliferation of different kinds of care services is proving somewhat counterproductive. Old people in particular find it difficult to navigate the complex market. The current strategy is to create one-stop shops to help people find and coordinate the necessary services and to avoid cases in which five or more doctors or nursing teams provide services for patients in a single old person’s home.

An illustration of how the state can fail in its attempts to judge the quality of care facilities is provided by Israel (see report on Israel, p. 32). Here an attempt to tender for care services in the manner of the private sector led to a boycott by service providers. The Israeli government’s attempt to force through its ideas is likely to negatively affect patients more than anything.

Sources and further reading:
France: Elderly care a fifth pillar of social insurance

French President Nicolas Sarkozy wants to make the long-term care of frail elderly people a new pillar of the state social insurance system. But there is a quarrel over how to organize and pay for it.

Currently the French social security system has four pillars: insurance against the financial cost of disease and pregnancy; accident insurance against being injured or diseased at work; a family allowance for parents; and a pension for retirement and widowhood.

The government could choose one of two funding sources. One option is to raise the general social contribution rate, and so bring in another €750 million. Pensioners, who currently pay 6.6 percent of their income, would be asked to increase their contribution to 7.5 percent, the same percentage as the employed. Another option would be to extend a “solidarity and autonomy contribution” to those who make money by means other than wages, which could raise €1.5 billion.

In addition, the government wants to cut the co-payments made by people living in nursing homes. The national average is €1,500 a month and as much as €2,500 in Île de France. Development of complementary private insurance is considered. Currently, private insurance companies are not keen to insure the over-70s, while younger people show little inclination to acknowledge the possibility of frailty in old age and insure against it.

Driving the reforms are recent forecasts for the number of frail elderly people by 2040, with the number of people with neurodegenerative diseases such as Parkinson’s and Alzheimer’s diseases or people losing their physical independence expected to increase by 1 percent a year. Two reports in 2005 looking into the rising need for long-term care in old age came to alarming conclusions. Currently 0.94 percent of the gross domestic product...
(GDP) is spent to cover the long-term care needs of frail elderly. But this share is expected to increase by 3–4 percent a year, reaching 1.5 percent of GDP by 2025.

A report by the general accounting office (Hélène Gisserot) in 2007 concluded that over the next 20 years, an additional expenditure of between €250 and 430 million a year will be needed on long-term care.

On the plus side, several initiatives are already under way, recommended in “A Solidarity Plan—Old Age” (Plan Solidarité Grand Âge) in 2006. It provides several service development targets, including the number of nursing-home beds and the capacity to provide home care for the frail elderly and those with diseases such as Alzheimer’s.

Every year, 40,000 people will be recruited and trained to look after the elderly. And a “plan cerveau,” or “brain plan,” devotes money to research on neurodegenerative diseases.

Currently, finance for long-term care comes from three sources: the National Solidarity Fund for Autonomy (CNSA), local authorities, and the families of the people concerned. The CNSA, founded in 2004 (Debrand/Or 2005), gets its resources from health insurance and the proceeds of national Solidarity Day, an unpaid working day that all salaried workers have to take part in. The proceeds from the day of solidarity currently amount to around two billion Euro, while the share paid through health insurance is set annually.

Local authorities have expressed skepticism about Sarkozy’s idea of a fifth pillar. This is partly political, because most local authorities lean to the left while Sarkozy is on the right. But it is also a financial battle. While local government spent 129 percent more on long-term care between 2002 and 2006, the contribution of central government fell from 43 to 33 percent. The regional authorities are left spending more than 15 percent of their revenues on the care of the elderly.

Creating long-term care as a new pillar in the social security system would have a profound impact on its organization and management. Traditionally in social security funding, decisions are made by representatives of the employers and the employees. Currently, for long-term care, the national solidarity and autonomy fund—not as a social security branch—allocates money to local
authorities, who have great freedom in deciding how to use it. As the local authorities are major stakeholders in the planning of most of the long-term care services, they would hardly accept such a change. Therefore, the most acceptable compromise might be to define a fifth risk covered by public social insurance and maintain the national solidarity and autonomy fund, as this would not change the current balance of power.

Sources and further reading:


Japan: Rehabilitation of elderly care

The Japanese government took a series of steps to improve care of frail and elderly people: it raised subsidies for home care, improved access to services and created comprehensive care centers. More rehabilitation services are also going to be provided to help prolong people’s physical, mental and social functions.
Those wanting public assistance for long-term care need first to apply to their local authority. The local authority then asks the applicant’s GP for an assessment and sends a care manager to make another assessment and look at the suitability of the home situation. After this, applicants are assigned to one of three categories which determine the level of care they receive. Before the reform, the three categories and the services they received were the following:

- Those considered “at risk” received no actual care, but were given some assistance by the local government. They might, for example, have meals-on-wheels delivered.
- Those in support categories one to three were enrolled on an exercise and nutrition program intended to reduce the likelihood they would need care in the future.
- Those in care categories one to four received care matching their level of need, with each applicant having the choice between home or residential care.

In principle, this classification system has stayed the same. At the same time, it is no secret that costs have risen sharply over the last few years because more people than expected have been provided with care. This is why the system was reformed in 2005.

The reform was conceived between 2003 and 2005, while the country was still under Prime Minister Junichiro Koizumi, whose government was trying to reduce the budget deficit. The way health care was financed was changed, with a policy of decentralization giving the municipalities greater fiscal autonomy and encouragement for mergers between local authority units. The various strands of reform amounted to a strategy that sought to provide people with longer healthy lives. The motivations behind the reform combined both economic and health promotion goals.

In 2003, a research group formed by the Ministry of Health, Labor and Social Affairs found that physical and mental inactivity was a significant risk factor in the onset of disability and the need for long-term care. It therefore recommended screening for frailty, as well as concrete measures for rehabilitation.

This risk was especially apparent among people who were put into one of the lower categories of care while they were still able to be physically active. Before the reform, they had received the
necessary care, but their physical capabilities often went into decline. To rectify this, experts recommended that some of them should be downgraded to a lower category. This led to the transfer of 21.4 percent of people from the first care class to the highest support class. Understandably, some were unhappy and protested.

At the same time those “at risk” and those in the three support categories saw their service enhanced. Those reckoned to be at risk started to receive support from a program run by their local government. This includes courses to encourage an active old age through organized physical training and the formation of neighborhood support networks. In addition, local governments are required to regularly test those at risk for signs of increasing frailty to ensure they are moved to a higher category early. New coordination centers set up by local governments for each 6,000 senior residents will organize the services of several providers. Also household support for those at risk will now not be paid by the month but by the hour, so that it can be used more flexibly.

In the support categories, a new payment system should give providers greater incentives to offer a bigger range of services. Physical training, better nutrition, oral health and group activities will all be paid for in the future. Providers will also receive a payment according to results: If someone is moved to a lower category, the provider will receive a cash bonus.

The new strategy had been the subject of widespread debate in Japan. The positions varied between enthusiastic approval and outright rejection (see fig. 3).

The intense debate culminated in a resolution in the upper house of the Japanese Parliament, which made a number of amendments to the government’s original plans. MPs warned the government that it must ensure that no individuals should lose services they benefited from before the legislation. Representatives also urged the government to consider a more flexible payment system, more accurate identification of the needs of those affected, and measures to iron out regional differences in contribution rates, service delivery and eligibility criteria. And, finally, they also argued for the involvement of dentists and for linking the new services to health promotion. In June 2005, the new law was finally adopted, before coming into force in April the following year.
Figure 3: Positions on long-term care reform in Japan

![Diagram of positions and influences]

2. Professionals concerned, Democratic Party
3. Rehabilitative specialists
4. Social workers, Newspapers
5. Communist Party, Social Democratic Party
6. Care workers association


Sources and further reading:
Germany: Upgrading long-term care insurance

In October 2007, the German government introduced a draft law to reform the country’s long-term care system. Following parliamentary debate and consultation, legislation has come into force in July 2008.

The government’s main objective is to increase the uptake of home care and to improve care for people with mental illnesses as well the overall quality of care. The law increases the level of benefits, develops evidence-based care standards and brings in a system of regular quality inspections. More broadly, the government hopes it can increase the system’s responsiveness to patient wishes for an independent life in their own homes.

The background to the current proposal is the introduction of a mandatory, universal social long-term care insurance system in 1995. The system is financed equally through employer and employee contributions totaling 1.7 percent of gross income and is administered by the existing sickness funds, which provide both capped cash-benefits and services to the eligible population. With contribution rates unchanged since 1996, expenditures now exceed income.

In 2002, a law was passed which provided more funds to home care services, focused on those with dementia, Alzheimer’s and other mental diseases. The extra money was spent on improving home and short-term care services, on training volunteers and on informing patients better. In autumn 2003, the government established an expert committee made up of sickness funds, long-term care providers, patient representatives and academics which had the task of developing recommendations for long-term care improvement. In September 2005, it published its final conclusions, some of which have been taken up in the current proposals. In 2005, Christian Democrats and Social Democrats included re-
form of the long-term care system as one of the objectives of their coalition agreement.

By December 2007, almost 80 million people were covered either by social or private long-term care insurance, which came to the aid of 2.1 million beneficiaries, 1.4 million receiving home care benefits and 0.7 million receiving care in nursing homes (Federal Ministry of Health, 2007). The demand is set to increase: While 19 percent of the German population was over 65 years old in 2005, by 2050 this proportion is estimated to grow to over 30 percent (Federal Statistical Office, 2006). By 2040, the number of people expected to be beneficiaries of long-term care insurance is likely to rise to 3.4 million (von Schwanenfluegel, 2006).

One consequence of the static level of funding has been that the benefits people receive have not kept up with inflation. Also, there are those who have come to doubt the quality of the care being provided. The issue has been put into the spotlight by the August 2007 publication of the second report on the quality of long-term care by the Medical Review Board (MDS), the umbrella organization of sickness and long-term care funds. Despite overall improvement since 2003, the report found substantial shortcomings in the care provided to one nursing home resident in ten. Meanwhile, a systematic bias toward physical diseases and problems means the system has failed to recognize the needs of the growing number of people with mental diseases, such as dementia and Alzheimer’s disease. Many, therefore, think the law passed in 2002 was only a half measure.

The solution proposed in the new long-term care law is to increase contributions, with a greater share being allocated to home care compared to institutional care. Since July 2008, contribution rates have increased by 0.25 percentage points, from 1.7 percent to 1.95 percent. The increase, the government estimates, will lead to additional yearly long-term care expenditure of €2.2 billion in 2012. While earlier drafts of the reform bill aimed at a higher rate of increase to ensure financial sustainability, an increase to over 2 percent of wages was rejected on the grounds that it would be unpopular with voters. In an effort to foster competition, long-term care funds will be allowed to advertise private long-term insurance contracts to those they cover. As in private health insurance, funds for long-term care in old age will be transferable between insurers.
Those opting for home care will receive extra financial benefits and benefits in kind. These would be increased in stages until 2012, with home care benefits increased more quickly than institutional ones. From 2015 on, the law brings benefits into line with inflation every three years. Also, in recognition of the ongoing bias toward physical illness, benefits for the disabled and for patients with mental diseases, such as dementia or Alzheimer’s, will be increased by over 400 percent from the current level of €460 per year to €2,400 for patients with a high level of care needs (€1,200 per year for patients with lesser care needs). Moreover, eligibility for day care for the disabled and patients with mental diseases will be broadened.

The new law aims to remedy some shortcomings in care coordination by establishing local long-term care support centers, each serving a community of around 20,000 people. Their aim is to provide information on the available care services, facilities and providers, along with help for beneficiaries and their families with paperwork and decision-making. These are a genuinely innovative step, experts say.

Nevertheless, they were tagged as a new layer of bureaucracy by some Christian Democrats, opposition parties and care providers. They also raised some constitutional and contractual questions with regard to their administration and management as well as the necessary cooperation between private and public bodies. After long discussions between Social Democrats and Christian Democrats, the two coalition parties, the responsibility for implementing long-term care support centers was placed on the federal states. This puts an end to the idea advocated by Social Democratic Minister of Health Ulla Schmidt, of implementing about 4,000 long-term care support centers all over Germany. Federal states ruled by the Christian Democrats, the majority of whom oppose the idea of long-term care support centers, will not be obliged to install them. Where support centers are implemented, the federal government will support them with start-up financing of up to €50,000.

The centers will offer support ranging from information and advice to direct services—from meals-on-wheels, through help with activities of daily living, to full medical care. These “one-stop shops” will be run by the sickness and long-term care funds but,
ideally, all long-term care stakeholders will also be represented—private long-term care insurers, municipalities, social welfare bodies and local long-term care providers. These centers will also be where people could access case managers, known officially as “long-term care coordinators,” who will be responsible for organizing care. Sickness and long-term care funds, states and other stakeholders are supposed to work together to better integrate voluntary service providers, which are set to receive greater support through the creation of professional networks and training. In May 2008, Minister of Health Ulla Schmidt inaugurated the first pilot of a long-term care support center in Nuremberg.

The support centers are designed to make home care more attractive and more easily accessible, thus reducing demand for institutional care. But the case for home care is also to be strengthened by promoting assisted living for the elderly and apartment-sharing communities. One way of doing this is to allow beneficiaries to pool their resources and jointly employ caregivers. Meanwhile, anyone who cares for a family member and is employed by a business of 15 people or more is entitled to take six months leave of absence, with social insurance rather than the employer providing the income. This system also extends to acute cases, where employees will be allowed to take ten days leave. The idea was, predictably, opposed by employers, but it has also drawn criticism from other stakeholders who say that it does not solve the problem of financing care over the long term.

To help improve the quality of care, the law stipulates that all those involved in long-term care—long-term care funds, providers, social welfare bodies, local authorities, self-help groups, professional organizations and independent experts—jointly develop mandatory care standards. Care institutions will be measured against these standards every three years, with the results published in a form understandable by the general public. Care institutions are also to be rewarded for improving the health status of their residents. For each resident who improves to such a degree that the care level can be downgraded, the nursing home will receive a one-time bonus of €1,536.

Sickness funds, while not entirely opposed to the new law, nevertheless question the need for the new local support centers. Supporting a thorough and evidence-based approach, they are
pushing for a swift revision of the eligibility criteria on which sickness funds provide long-term care benefits. Current eligibility criteria focus on somatic symptoms and deficits and thus disadvantage people with cognitive diseases such as dementia. A government advisory council is set to make recommendations in November 2008. LTC providers are also positive about the impending changes, but they question the sickness funds’ control over care centers and the cost of the support centers and case managers, claiming that the long-term funding provisions are insufficient.

Local authorities, responsible for planning social welfare and long-term care services for their citizens, have mostly welcomed the measures regarding quality improvement and promotion of home care. In line with sickness funds, their criticism is targeted at the lack of long-term strategies to ensure financial sustainability of long-term care insurance and local support centers. They argue that local authorities would be better suited to managing local support centers, given their more intimate knowledge of local infrastructure. However, that is beyond the scope of the Ministry of Health, which is not authorized to allocate tasks to the local governments in the German federal system.

The trade unions argue that the poor waiting conditions in residential homes and in home care are partly the result of years of under-investment in long-term care. The Trade Union Federation therefore proposes an increase in financial resources for long-term care, and an increase in benefits. Unions also endorse the employment of more qualified staff to reduce overwork and the physical and psychological burden among care workers.

Employers, for their part, are critical of the idea that they allow six months unpaid leave, arguing that it would impose an unacceptable burden particularly on small and medium-sized companies. Employer groups also argue that the proposed increase in contribution rates would further raise their “non-wage” labor costs. Instead, they favor voluntary agreements between employers and employees, along with more individual responsibility among beneficiaries, promoting supplementary private insurance.

Measures proposed in the new law are expected to improve care for people with mental diseases. Benefits for this group will quintuple by 2015, and more money will be spent on pilot proj-
ects. However, rethinking what the notion of “in need of care” means and changing the eligibility criteria will be important to ensure that the needs of people with mental diseases are taken into account. The Ministry of Health is developing recommendations for fall 2008.

The increase in contribution rates will help finance benefit increases and new services until 2014. Further steps to stabilize the system’s finances will be needed. Some stakeholders envisage a one-time increase of the contribution rates, to 2.3 percent of gross income; others prefer a complete change from a public “pay-as-you-go” system, moving toward an individually funded long-term care insurance system; while still others advocate increasing personal responsibility through supplementary private insurance. Taken together, there is a tendency among policy makers to put greater responsibility in the hands of individuals. But there is a big difference between suggesting that people take on responsibility and actually persuading them to bear it properly.

**Sources and further reading:**


Austria: Legalizing illegal home care

A new law passed in July 2007 aims to improve access to round-the-clock home care and strengthen its legal basis. Caregivers and those they care for are now allowed to have contractual relationships, working hours have been extended, and significant state subsidies are granted to reduce the financial burden on those who need care.

The vast majority, around 80 percent, of home nursing in Austria is provided in informal arrangements at home, an approach legislators have actively supported. People caring for incurably sick family members or seriously ill children have been able to take unpaid or partially unpaid leave since 2002. Work, health and pension insurance protection will be paid for a maximum of six months (see Health Policy Developments 2, p. 39). But relatives are often overwhelmed by the demands of providing 24-hour care while being unable to afford legal care services. So, in recent years, this kind of care has increasingly been provided by immigrants with no work permits. According to estimates, up to 20,000 people from Austria’s population of 8.3 million receive care in this way. The caregivers, mostly from Eastern European countries on or near its border, have no work permits and pay no taxes. There is almost no information available about the training of caregivers.

By changing employment, social security and occupational rights, the new law makes 24-hour care legal. The new “Home Care Law” allows for direct employment contracts between those needing care and caregivers. No explicit restrictions are made regarding the status of a caregiver. Thus, family caregivers could also deliver care in contractual arrangements. This in turn would imply putting a market value on family help.

The new legal arrangements are far more liberal than they would be for regular employees. For a 10-hour working day and
11 hours on call, the law guarantees 3 hours rest, but it does not set any minimum rate of pay. According to agencies that place nurses in private households, the typical Slovak or Romanian caregiver can expect between €35 and €50 per day (Mapps-Niedieck 2008).

The idea is for the new scheme to apply to people in the high maintenance categories between three and seven, and patients in lower care categories where their mental condition justifies permanent surveillance. The sick person or their family members act as the purchasers of the care or the contractor of a self-employed caregiver. The services covered by the contract can include care and domestic assistance, but not medical help. The caregivers can work up to 64 hours a week, but the contracts automatically end on the death of the care recipient, even if the caregiver is self-employed. By the summer of 2008, all caregivers must have completed a course in providing home help.

Care recipients with an income of less than €2,500 a month and less than €7,000 in savings are entitled to a monthly subsidy between €250 and €800, depending on whether the caregiver is employed or freelance. Since the government introduced a long-term care allowance in 1993, it has only been increased once (in 2005). Austria spends €1.9 billion a year on care, equivalent to about 1.5 percent of gross domestic product—which would probably about double if informal caregiving and “illegally” provided services were delivered at current market prices. At this level, the spending share in Austria would reach current spending levels, as measured in percent of GDP, in Denmark or in Sweden (OECD 2005).

The new law, which is still controversial, was created amid a fierce public debate. The fact that so many illegally employed caregivers were involved in providing care services was a profound shock to many. The conservative Economics Minister used the public pressure to opt for a broad legalization of this form of care. The socialist Social Minister, meanwhile, attempted to reconcile the demand for this kind of care with the social and labor demands of unions.

The compromise that was arrived at pleased neither side. Even with the subsidy, the income of those needing care is most likely lower than expenses necessary for legalized 24-hour care. The
unions, meanwhile, say the law has weakened employment standards, so doing their bit to defend “Austrian jobs” from Eastern European rivals.

Employment lawyers have pointed out that Austria’s special clause to enable its citizens to employ Slovakian and Romanians for home care without also allowing them to perform other kinds of work is discrimination on the basis of nationality, which is illegal within the EU (Mappes-Niediek 2008).

Initial experiences with the new law have been disappointing: In the first six months, just 1,300 caregivers had registered. The reason for the poor response is that the large majority of those needing care exceed the asset limit of €7,000. An increase in this limit was being discussed at the start of 2008. In addition, there was initially no penalty for illegal employment. It is unclear whether public opinion would make such penalties possible in the future.

Sources and further reading:

Hofmarcher, Maria M. “Austria’s new Home Care Law: An assessment in the context of long-term care policy.” OECD working paper, to be published.


Israel: Long-term care services tendered

Israel’s government wants the purchase of long-term care services to begin with a public tender. A pilot project became a test of strength between the government and the operators of nursing homes.

In the background is a long-term move toward the privatization of services, a shift that has been going on for more than a decade. Until a few years ago, the Ministry of Health provided more than half of the acute, psychiatric and nursing beds in the country. The government is now looking to withdraw almost entirely from such service provision and instead take on more of a supervisory role.

For this purpose, the government plans to introduce a tender process. It is meant to

1. improve the uniformity of infrastructure, as well as the size and level of manpower;
2. improve the standards required of institutional facilities;
3. set the daily remuneration for institutional care, and provide bonuses for institutions based on achieving high standards of care;
4. define terms for receiving government funding—which will be publicized and more clear, promoting transparency;
5. increase supervision and control mechanisms over the quality of institutional services; and
6. develop sanctions against institutions that do not achieve the required standards of care.

The responsibility for awarding licenses to operate nursing homes in Israel lies with the Ministry of Health, which is also responsible for the supervision and purchase of long-term care. It has a dominant position in the market, since 7 out of 10 nursing home residents receive full or partial financial assistance from the ministry, depending on their own and their children’s economic situation.
This arrangement is now about to be changed. Instead, the ministry will advertise for quotes and award a contract on the basis of quality and price.

In a pilot study run in a mid-Israeli province during the year of 2007, the operators of over 20 nursing homes in the region were invited to take part in a tender, in which each would offer a daily rate. Each provider would also include statements about the amenities of their facility, their staff-patient ratios and an overview of the level of training achieved by employees, showing that it meets the required standards.

Most of the institutions invited to submit a bid decided instead to boycott the process, because the per diem rates set by the government were lower than the rate they received before the tender. Only four offers were received, two of them from homes that offered only low standards. However, these candidates offered as many beds as needed in the province, so that the pilot project could run its course.

The boycott, though, had serious consequences in the pilot region. The nursing homes that chose to boycott stopped receiving government-funded patients and have seen their number of residents and incomes fall, which threatens to lower their standard of care. The four nursing homes taking part in the pilot program claim that the remuneration is too low, which supposedly forces them to reduce staff or replace experienced staff with inexperienced new employees to cut costs. Meanwhile, those needing nursing care and relying on public financial assistance have much less choice than before; they must choose one of the four tendering homes, which are perceived to have lower standards than others in the region.

The dispute has a long history. Those operating nursing homes have long been suspected, particularly by the Ministry of Finance, of enriching themselves at the public expense. The operators, on the other hand, claim that they provided better service than the standard they were paid for. For years, the finance and health ministries have tried to make the Nursing Home Organization create quality standards, standardize equipment, increase transparency and reduce the daily rates, but they have ultimately failed. The one-year pilot project was the answer to this conflict, although stakeholders in the two ministries have openly expressed contrary views.
The Ministry of Finance and the financial experts in the Ministry of Health claimed that the new tender of nursing care services would yield better quality of care. However, nobody believed that their main concern was the quality of care provided. The ministry’s health specialists expressed fear that the nursing homes which admitted mainly government-funded patients will gradually have less money to invest in maintenance and development, and so will be unable to create the attractive environment needed to bring in better-paying private clients. This could result in a two-tier nursing home system: a basic one, serving mainly government-funded patients, and a superior one for private patients who can afford to pay for their institutionalized nursing care.

Following the pilot, several changes in the program were planned for January 2008 when the program was implemented nationally.

Sources and further reading:


New forms of delivery: The advance continues

The potential adverse effects of increasing market orientation and professional differentiation in health care include confusion for patients and professionals alike, as well as severe fragmentation.

Even a fully aware, educated and highly engaged consumer can find it hard to navigate a complex market with an enormous array of products and services. Aggravating the problem, the market’s most important “customers” are in the second half of their lives and, for a number of reasons, often find it harder to collect, record and process information. Nevertheless, many systems continue to operate under the comfortable premise that well-informed patients freely choose among their many different offerings.

Patients may find it hard to make choices, sometimes as a result of the health issue which led them to see medical help in the first place. A wide range of choices might even, in some cases, be harmful. Meanwhile, a failing coordination between providers, disorientation, shyness or simply forgetfulness can lead to patients being given multiple prescriptions, undergoing triple investigations, “doctor-hopping” in the worst case leading to unnecessary hospital admission. All this costs money, without improving the health or welfare of people in the slightest.

A high degree of fragmentation is known to entail problems in health care quality and cost efficiency. Its impact is linked not only to the level of sophistication of a healthcare infrastructure, but to how it is organized: a market, unlike a vertically structured public health system, tends to contribute to confusion. Each competitor attempts to show it is superior to its rivals. But deciding on the relative merits of these complex criteria is left to the consumer.

In response, one can observe many almost simultaneous efforts across the world to better coordinate health care delivery (see...
Integrating care delivery: a global trend

Health Policy Developments 6, “The concept of integrated care,” p. 33). The basic idea is that an increasingly confusing system can become more manageable through clear, logical and easily understood navigation. Patients should no longer need to acquaint themselves with the intricacies of the system, but should instead consult a manager who acts as a go-between with a wide range of providers.

Unsurprisingly, perhaps, the country most developed in this regard is the one with the highest degree of healthcare fragmentation: the United States. Where it appears nearly impossible to restructure the system from top to bottom, the only way forward seems to be more networking between existing structures, much of it bottom-up and pragmatic. Often, some would argue, the result is more convincing than any hierarchical system.

An early initial form of new care-delivery modes is disease management programs for the chronically ill (see Health Policy Developments 6, “The concept of disease management,” p. 35). Without such programs, chronically ill patients faced a “system” they could only hope to find their way through. The disease management program suggests a remedy: A diabetic, for instance, should no longer be expected to coordinate the many necessary visits to different specialists. Instead, a disease management program, run by a well-organized team, is supposed to serve as a one-stop shop providing this service.

However, inclusion in a disease management program requires a relevant diagnosis, and therein lies its weakness. In a “one-stop shop,” you may receive everything you need as a diabetes patient. But epidemiological data show that most patients suffer from not one but multiple chronic illnesses. One conclusion is that health care needs to be tailored to the individual patient, not to a disease. Older people, in particular those with multiple morbidities, have comprehensive health care needs; care must cover health problems of any kind as well as social causes and consequences.

Putting the patient in the center of care this encapsulates the idea underlying the “chronic care model” (see fig. 4) as laid out by health researcher Ed Wagner, head of the MacColl Institute for Healthcare Innovation in Seattle (Wagner 1998).

In the chronic care model, physicians, practice team and patients work as partners. The team supports the patient’s self-manage-
Figure 4: The Chronic Care Model


ment; community resources are included in care delivery. Physicians receive decision support and clinical information systems.

A further extension of the patient-centered approach is the “medical home,” which introduces Ed Wagner’s model—originally developed for the chronically ill—into regular care (American Academy of Family Physicians et al. 2007). Experts say the model has enormous potential, set to grow along with the size of the elderly population and the development of information technologies.

An example of such a change is currently implemented by Maccabi, an Israeli sickness fund. Maccabi is transforming single-doctor practices into doctor-nurse health care teams (see report on Israel, p. 39).

While new developments in the health sector are often opposed by doctors, GPs in the United States are in favor of the idea of the medical home (see report on the United States, p. 42). In fact, more and more doctors prefer the idea of a fixed, cooperative working environment. Many of them are dissatisfied with the system of lone practices. They want more professional exchange among themselves and better coordination between themselves and other health professionals.
The “advanced medical home” perhaps is valued particularly highly by U.S. doctors because it firmly binds patients to their doctors. Doctors also welcome the fact that it gives them the role of a spider-in-the-web: the “personal physician,” says a joint paper from American doctors’ associations, “leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients” (American Academy of Family Physicians et al. 2007).

A key challenge with the new provisions, wherever they are, is remuneration. The bodies that traditionally compensate doctors and other service providers—insurance companies, self-governing entities such as sickness funds, or the state—have yet to develop a convincing model to finance lasting and comprehensive patient care. In Catalonia, an autonomous region of Spain, the local administration has experimented with offering flat-rate payment for the responsibility for an agreed number of people (see report on Spain, p. 45).

Sources and further reading:


Website of the program “Improving Chronic Illness Care.” www.improvingchroniccare.org.
Israel: Care team replaces the lone practitioner

Maccabi, Israel’s second-largest sickness fund, has revolutionized its system of primary care, replacing the traditional solo-practicing doctor with a doctor-and-nurse-led team.

The approach is based on established models for chronic care where the practice team is responsible for active prevention, lifestyle counseling and follow-up. The aim of the new model, already implemented in fifty outpatient health clinics, is to improve the quality of care and patient experience.

Maccabi—named after Judah Maccabee, a Jewish freedom fighter of the second century AD—provides health insurance to 25 percent of the Israeli population. The insurer is also a large provider of health services, as is common in the Israeli system, and has an extensive community-based clinic infrastructure.

Previously, Maccabi’s primary health care system was largely designed around solo practices, where people could usually get a doctor’s appointment when they became sick. Prevention and health promotion services were not necessarily seen as an integral part of primary health care, thus not regularly offered.

The new model follows five principles:

1. Care is supplied by a multidisciplinary team of healthcare professionals, headed by a doctor and a nurse.

2. The healthcare team is responsible for a certain community of patients; tasks are coordinated among team members. They actively invite these patients to take steps to improve their health though health promotion, preventive treatments and follow-up on those who are chronically ill. Progress is monitored by the nurse who acts as the “care coordinator.”

3. The long-term relationship established between doctor and patient is intended to be one of comprehensive health management. Planned and structured doctor-patient visits allow time for a wide-ranging consultation which can include life-
style advice, regular tests for the chronically ill, or the diagnosis of emotional stress. In this way, nurses are also able to provide consultations that deliver consistent follow-up care and health management for the chronically ill.

(4) Preventive care follows the “one-stop shopping” philosophy, offering all routine checkup procedures at the clinic, or another location, during one visit.

(5) Care is patient-oriented and patient values and wishes are taken into account in all clinical decisions. The aim is to equip the patient with the tools needed to maintain good health and, where needed, to self-manage chronic illnesses.

Maccabi offers various incentives to doctors to switch to the new system. Doctors receive support in their efforts to improve the health of their patients by progressing through a series of 25 monitored clinical performance measures. For example, they receive funds for a nurse especially trained to work within Maccabi’s system. The nurse shares the burden of the caring and follow-up of chronically ill patients with the doctor.

The clinical performance measures relate to health promotion and early detection of breast and colon cancer among the general population, through fecal occult blood tests and colonoscopy. The monitoring of cardiovascular risk factors is done through assessments of blood lipid levels, body mass index and blood pressure. Routine tests for the chronically ill include hemoglobin A1C tests, LDL cholesterol and retinal examinations for diabetic patients; prescribed medication following myocardial infarction; and diagnosis and treatment for depression.

The model is a relatively new development at Maccabi, but some of its components are used by Clalit Health Care services, the country’s largest health insurer, and also abroad, particularly in the United States. The Maccabi program dates back to 2004 on the instigation of the Department for Quality Management. Change actually began in 2005 with the introduction of a “personal doctor” in 11 practices across all five Maccabi regions. After initial skepticism, Maccabi’s headquarters and most of its regional subdivisions have now introduced the new model into their work plans. Most patients have yet to notice the switch, but this should change when more consultations of the new form have taken place.
Training was a key to launching the new model of care, with nurses having to be ready to take on their new role as care coordinators. Meanwhile, the information infrastructure had to be ready to answer any questions. Then it had to be ensured that the parameters used to measure clinical success were being gathered. And, finally, individual health professionals were targeted to become “quality leaders,” received special training in quality improvement and were instructed to share their experiences with other doctors and nursing colleagues.

Some members of the union of the independent doctors working for Maccabi were initially skeptical. However, the union was involved from the beginning and accepted the introduction of the new model. The nurses’ management, on the other hand, recognized the change as an opportunity to enhance their profession and so provided active support.

Sources and further reading:

United States: The “medical home”

The “medical home,” an advanced model for the delivery of primary care, is gathering momentum in the United States.

The idea is to integrate services and to use information technology to expand cooperation among doctors’ practices, home care, and pharmacies, in line with agreed guidelines and evidence-based decision support tools. Although originally designed for children, those who stand to benefit most from the medical home are the elderly, because of the number of comorbidities many elderly experience.

The “medical home” was introduced in pediatrics, with the term first used in 1967. Yet, according to a study carried out by the American Academy of Pediatrics, in 2003 only half of children and adolescents received the care they could expect from a medical home (Strickland 2004).

Evaluating the cost-effectiveness of the medical home has been a major effort involving numerous demonstrations. Many pilot projects have produced good initial results: The numbers of hospitalizations and emergency room visits have declined, as did days of absence from work and school. There was also improved satisfaction. For example, in 2006 the Commonwealth Fund found that of adult patients with a medical home, 74 percent felt their care needs were met, compared to just 38 percent of people cared for under the conventional system.

Accordingly, there is increasing demand for the implementation of the medical home, particularly from pediatricians and geriatricians, whose patients have most to gain from the model. Today the medical home concept is given broad support by groups representing the medical professions. The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA) have been busy defining jointly
a common set of principles which characterize such a home. Other organizations are conducting analyses at the local level.

In 2006, the AAP formed two study groups together with state agencies providing services to children and adolescents with special needs. Each agency selected three practices to participate in the study. The same year, the AAFP launched a program called TransforMED, introducing the medical home model to 36 primary care practices across the United States.

The ACP has proposed that practices should receive a certificate if they use evidence-based guidelines, deliver care based on the chronic care model, develop comprehensive care plans with patients and their families, provide better access to care, use quality indicators, use information technology effectively, and provide feedback to doctors.

The state of North Carolina pays a bonus to doctors who implement medical homes. North Carolina has had good experience with the initiative: Between 2002 and 2004, approximately eight million residents have saved over US $60 million thanks to measures such as case management for the chronically ill.

The main obstacle to comprehensive implementation of the medical home is reimbursement. As a rule, insurers pay doctors for personal consultations, not for coordinating care. A demonstration project by Medicare has begun an evaluation of the medical home as a new form of care delivery in association with new forms of compensation. Family practitioners in eight states will try the new model for three years on chronically ill patients over 65. Tests are based on the concept of the medical home for the total transformation of primary care developed by the American College of Physicians. Subsequently medical practices are expected to provide comprehensive patient care and to undergo an official recognition procedure with patients and practice teams working on the model from then on.

One way the medical home stands out from many other new care-delivery models is its use of modern information technology. Patients’ body weight, blood pressure and laboratory results are all automatically recorded in a computer system—with visits to the doctor, physiotherapist and pharmacy all brought together. In addition, participants are linked to a supply team including social workers, nutrition consultants, physiotherapists and pharmacists.
The family doctor and practice team see themselves as guides who show the patient the way through the provider landscape. The team provides patients with understandable information on their condition and involves them in decisions regarding the care they receive.

Another component of the medical home is Ed Wagner’s “chronic care model.” The chronic care model encompasses support for the chronically ill, self-management, new forms of cooperation, more clinical information and a well-prepared, proactive practice team (also see fig. 4, The Chronic Care Model, on p. 37). The starting point is the patient. The model does not stop where the health sector ends, but reaches into the community.

Where disease management programs focus on diseases, the chronic care model radically recenters the health care process on individual patients and their needs. The idea of a medical home takes this idea developed for the chronically ill one step further. It could lead to a complete and irreversible restructuring of medical practice.

Sources and further reading:


Spain: New models of care compared and evaluated

The autonomous Spanish region of Catalonia has developed a number of models for the integrated delivery of health care, in which doctors work together with practitioners from other health and social professions (see Health Policy Developments 1, p. 50). Different goals together with varying legal and economic circumstances lead each model to develop very differently.
Now, for the first time, the new delivery models have been compared and evaluated. Appropriately, the Catalan government looked to its “Service for Research and Development in Health” (Servicio de Estudios y Prospectivas de Salud, SEPPS) to carry out the work. Its aim was to build on good experiences and to iron out weaknesses.

The study identified the various models and described them case by case. It then looked at the experience of the integrated facilities and analyzed the economic and health impact, before investigating the effects of the models on the Catalan health care. Finally, the investigation provided a practical output: Positive experiences were not only researched, but also disseminated. Another objective of the research was to identify ways to develop new initiatives to improve efficiency.

The various integrated models have largely emerged without a unifying central plan. The most striking difference is the degree of interorganizational networking and internal integration. The size of the population served by an integrated delivery structure is another meaningful distinction among the different models.

Unification is not necessarily the goal. While the systematic snapshot reveals an unplanned situation, it also reveals a high degree of innovation. The models have in common that they are more efficient and that users think they are better than the traditional forms of delivery.

The new structures are certain to play a larger role in future, with the prospect of growing numbers of chronically ill patients as well as a rise in the number of people with other problems, such as comorbidity and dependence on state benefits. All these challenges are expected to become more common in the years to come.

Since the early 1990s, 18 new organizations emerged in Catalonia offering alternative ways to organize health care, some more profoundly distinctive than others. The drivers were cost control and economies of scale more than furthering the idea of integrated delivery. While not directly part of the public health system, they all cooperate in various ways with it.

From this initial impulse, greater momentum has grown. Without further impetus from above, new public health initiatives developed at the local level, supported by hospital managers
and local administrations. The autonomous regional government also initiated pilots of integrated services with a capitation-based system in five different geographical areas. Overall, however, the state did not have much hand in the development of new models. Recently, however, the new administration has made the new form of delivery a high priority.

The bottom line is to realize better outcomes. The survey has shown that the integration of different forms of care leads to improved efficiency, coordination and control, and to a reduction of transaction costs and the delivery of unnecessary services.

All of these positive effects could be made stronger, the study found. The reason is that organizations were found to be tightly focused on internal integration, but not on cooperating smoothly with external systems. Secondly, the organizational and economic incentives to switch over to the new system should be strengthened. The most effective way would be to reorganize compensation by linking it to population size rather than to the number of cases. The Catalan regional government has included three of these integrated health care organizations in a trial of a population-based compensation scheme, but results are still preliminary.

One example of the new forms of integrated delivery is the health center of the small town of Castelldefels south of Barcelona. It is somewhat unusual because it is the only health center combining direct public funding with a private organizational model. In another sense, its distinctiveness makes it typical in the very varied landscape of integrated care models in Catalonia.

Catalonia’s autonomous government wanted to combine the benefits of private and public health centers. To this end, it formed a private consortium with public funding to explore the potential. Elsewhere in Catalonia, the Catalan Health Institute is the main provider of primary care, with public funds employed in line with the rules of public administration. Another organizational structure behind the integrated care suppliers is “associative base entities” (ABEs), modeled on the British idea of fund-holdings, which bring together several independently practicing doctors.

The creation of ABEs by the previous conservative regional government, as a measure to increase the management capacity of the primary care organizations, gave rise to a political dispute, because the socialist administration that took office in 2003 viewed
them as forerunners to privatization of the health system. Public-private hybrids of the kind formed in Castelldefels existed only in hospital care.

The consortium “Castelldefels Consorci de Salut d’Atenció Primària” (CASAP) was the first of its kind in Spain. It formed the primary care provider for the coastal town’s population of 24,000. In addition to the normal range of services, the center added nutrition counseling, day surgery and the fight against nicotine addiction. The consortium is 70 percent owned by the Catalan Institute of Health and 30 percent by the local authority. The CASAP management can operate effectively as a business, employing staff according to the same rules as a private company, because it is not bound by public service law.

So far, the health center in Castelldefels has produced good clinical results, there is no waiting list, and quality tests were positive. Also, the staff is no less motivated than in private institutions. The skepticism among health professionals has been laid to rest. Critics fear, however, that there could be government interference in management decisions.

Sources and further reading:


Cancer: Prevention and care

Cancer is the second most common cause of death in the world’s leading industrialized countries, after heart and circulatory disease. In some, like the Netherlands, it is the most common. Of the 58 million people around the world whose lives ended in the year 2005, according to the World Health Organization (WHO) 7.6 million were the victims of malignant tumors.

Worldwide, cancer is a leading cause of death. And the numbers are projected to continue rising, with an estimated 9 million people to die from cancer in 2015 and 11.4 million to die in 2030. Particularly developing countries suffer from high cancer-related mortality rates: Cancer deaths in developing countries account for seven out of ten cancer deaths worldwide. According to a formula developed by the WHO, earlier recognition and appropriate treatment could reduce cancer deaths by 40 percent (for all data, see WHO 2007a).

In 2005, around 142,000 people fell victim to the disease in the United Kingdom, 55,000 of them not yet 70 years old. In the United States, the figures were 579,000 and 259,000 respectively. Cancer death as a proportion of all deaths, 37 percent in the United Kingdom and 38 percent in the United States, is not expected to change by 2030 (WHO 2007). The most common cancer death among U.K. men was that of the prostate, followed by colon cancer. In the United States, prostate cancer was again the top killer of men, with lung cancer in second place. Breast cancer was the biggest killer among cancers among both U.K. and U.S. women, followed by bowel cancer in the United Kingdom and lung cancer in the United States.

Worldwide, around two-thirds of the diagnosed cancer cases lead to death. Medical research has for a long time focused on the
genetic and other causes: how healthy cells mutate into cancer cells and the conditions under which tumors grow. But this research effort has yet to deliver any major breakthroughs or spectacular successes. Consequently, the focus of public health policy in industrial countries is on prevention and early detection, facilitating access to appropriate treatment and improving palliative care.

Among the latest trends is the development of comprehensive national cancer action plans, as in New Zealand (see Health Policy Developments 5, p. 64), Australia (see Health Policy Developments 2, p. 86) and Japan (see report on Japan, p. 53). They include general screening programs, improvements in training and the information relayed to patients, and the establishment of particularly well-equipped facilities staffed by specialist personnel. In New Zealand, one of the countries pioneering this approach, the focus is on reducing lifestyle and occupational risks and preventing carcinogenic infections through effective screening, diagnosis and effective treatment. It is also looking to improve patients’ quality of life by better supporting them and their families, a better performance measurement, along with more research and health reporting.

Slovenia has made the fight against cancer one of the priorities of its presidency of the European Union during the first half of 2008. Growing differences in the survival rates and quality indicators between EU countries have led some to call for integrated programs across the EU. The Slovenian Minister of Health has promised a concerted effort to address all aspects of the problem (Albreht 2007).

Many countries are intent on improving the screening programs to improve the rate of early detection. X-ray is the most common way to screen for breast cancer. Universal smear testing for cancer of the cervix is already a reality in a number of countries, among them Australia, New Zealand and Scandinavia. In Australia and the United Kingdom, the age for a free colon-cancer test has been set at 55, which is already the rule in Germany (see Health Policy Developments 7/8, p. 198). Screening for colorectal cancer has been given the bulk of the credit for falling cancer mortality rates in the United States.

Increasingly, providers caring for terminally ill cancer patients place a greater emphasis on palliative care. If health professionals
lived under the illusion that the “fight against cancer” is nearly won, caring for terminally ill patients would be considered a form of “defeat.” Increasingly, the humility of those who fight against cancer is reflected in a closer focus on the actual needs of its victims (also see “Israel: End-of-life care policy”, *Health Policy Developments* V, p. 82).

With about 90 percent of cases of lung cancer being caused by smoking, another important element of the strategy against cancer is the increasing number of countries opting to impose smoking bans. Many countries in the European Union, for example, have recently banned smoking in public spaces (see *Health Policy Developments* 7/8, p. 211–222).

People are right to fear this still-mysterious disease. However, the high levels of public desire for therapeutic advances for cancer do not always lead to rational policy decisions. In Denmark, experts have criticized the government’s decision to abolish waiting times for chemotherapy while extending waiting time for other treatments (see report on Denmark, p. 56).

A current theme is the immunization against infection with the “human papilloma viruses” (HPV) (see reports on the United States, Switzerland, New Zealand and Canada, p. 58, and on Germany, p. 66). It has been known for 15 years that there is a link between HPV infections and cancer, especially those of the cervix. A vaccine against the four most dangerous HPV genotypes has been available since 2006. A course of three intramuscular injections over six months ensures 5–10 years of immunity.

There is no serious doubt about the effectiveness of the newly developed immunization: The two high-risk genotypes HPV 16 and 18 account for about 70 percent of cancers of the cervix and can also cause of a number of other forms of genital cancer (Muñoz et al. 2006). The sexually transmitted virus can cause infected cells to continuously reproduce themselves. Under normal circumstances, however, protective mechanisms inside the cell prevent uncontrolled proliferation. In 70 percent of cases, infections vanish without having to be treated.

Data on the prevalence of HPV infections among adult females differ. Estimates say that in industrialized countries, up to 70 percent of sexually active women are infected with HPV at least once in the course of their lives—very often without being aware of it.

... and smoking bans

Fear of the disease also leads to irrational decisions

New vaccine against cervical cancer

HPV vaccination source of intense debate

High prevalence of HPV but rarely high-risk infections
However, only a small proportion of infections is caused by the two high-risk genotypes of HPV (HPV 16 and 18), which are the major target of existing vaccines. A study in the United States showed the prevalence of HPV 16 and 18 to be 2.3 percent among women between 14 and 59 years of age (Dunne 2007). Men too are infected and act as carriers, but without inflammation.

Health economists and public health physicians are debating whether a general, publicly funded vaccination of the female population really is the right way to combat cervical cancer, given the high cost of the vaccine itself combined with the enormous effort involved. Public health experts fear that immunization might reduce acceptance of preventive screening. Since HPV-genotypes not targeted by immunization can also lead to cervical cancer, screening remains necessary for all women. Some experts argue that increasing screening efforts might be more cost-effective than investing in broad immunization strategies.

Long-term studies on the new vaccines are not yet available. Nevertheless, some countries have initiated immunization—thanks partly to the intense lobbying of the vaccine manufacturer and public pressure—without having waited for a consensus of international scientific opinion to emerge. We would like to give our readers an idea of developments regarding HPV immunization in different countries from a broad as well as a more detailed point of view. For this reason, we provide an overview on the situation in California, Switzerland, New Zealand and Canada as well as a detailed look at the debate and developments in Germany.

Sources and further reading:

Japan: Action plan for more integrated cancer care

The Japanese government took a range of measures to improve cancer care. The aim of a National Action Plan against cancer, which runs until 2011, is to develop integrated, comprehensive and coordinated care across the country. The focus is on widening the availability of radiation treatment, chemotherapy and palliative care, along with creating a cancer registry.

The action plan increased the government budget for cancer care from 41 billion yen (€252 million) in 2006 to 53.4 billion (€328 million) in 2007. Two-thirds of the amount will go into research and development, but this still leaves a large sum to improve education and training along with other measures.

Among the actions taken to improve cancer care, priority is given to diffusing integrated care with emphasis on the appropriate use of radiotherapy and chemotherapy as well as palliative care. Hospitals nationwide are being better equipped to provide cancer therapy, while patients in all parts of the country are gaining equal access to treatment. In home care, not only the patient’s needs are to be given attention but the needs of caring family members are also to be taken into account. The attitude and lifestyle of each patient is to be given more consideration than before.
Other objectives of the action plan are to widen screening programs, to carry out more epidemiological and general clinical research, and to take on a large number of workers in this area of research, treatment and care.

Other major measures of the cancer plan can be summarized as follows: making newly developed drugs more rapidly available to patients, diffusing quality palliative care through improved training of health professionals and palliative care teams in hospitals and developing new residential care models. Clinical workers and the patients themselves will have better access to clinical information about treatment, with information released to both groups at the same time. Plans are also underway for local cancer centers to use a new set of standards to update and assess their work.

There are preventive measures as well: essential advice will be posted on the Internet, with specialist pages posted for patients to find out more about cancer prevention and treatment. Also, more hospitals will supply information to the registry of cancer cases, and cancer research will be made more public and open to participation by patients.

Within 10 years, a significant reduction in the number of cancer deaths could be achieved. The target is to reduce cancer mortality among the under-75s by 20 percent. The aim is also to reduce the suffering of cancer patients and their families.

The inadequacies of the country’s cancer care system have been a matter of public debate since the late 1990s. Public interest in the plight of patients who searched in vain for adequate care led the media to coin the term “cancer refugees” in 2004. It is repeatedly claimed that the system needed to be made more “patient centered,” with patients more involved in developing their own treatment plans and in forming policy on cancer care to ensure that it genuinely serves their needs.

The Cancer Action Plan was launched in summer 2006, in the last few months of the Junichiro Koizumi administration, and was right at the top of the political agenda. First put forward by the opposition Democratic Party, the initiative was subsequently taken up by the ruling Liberal Democrats. The plan was implemented only after an agreement between the government and opposition. Civil society organizations representing the interests
of cancer patients also fed into the debate, having attracted extensive media coverage for their activities.

The various provisions of the action plan are part of a comprehensive ten-year anti-cancer strategy formed two years earlier. A report at the beginning of the strategy document made the spread of cancer therapies nationwide the main objective. A newly formed council for cancer care and prevention within the Ministry of Health, Labor and Welfare is responsible for voicing the opinions of specialized lawyers and cancer patients, along with those of doctors and other health professionals.

Cancer centers located in each of the country’s 47 prefectures have the job of implementing the action plan, especially the development of supply benchmarks and staff training (see Matsuda, March 2007). Cancer centers and some specialized hospitals, according to the action plan, should provide the standard against which integrated supply is measured.

Sources and further reading:


Denmark: Cancer patients need wait no longer

Cancer patients in Denmark are to be given faster access to adequate treatment: A new action plan has been developed to shorten the time between referral and first medical investigation to 48 hours.

An earlier plan introduced in 2001 allowed two weeks between the reference and initial investigation and, in cases there was a positive result, another two weeks until the start of medical treatment or surgery, or four weeks in cases where radiation therapy is needed. It further laid down that there should be no more than four weeks between the end of treatment and the start of aftercare. A second cancer action plan introduced in 2005 focused more on prevention measures and the development of “treatment pathways.”

In 2007, it became apparent that the goals set in 2001 had not been met, in part because responsibilities had not been clearly allocated to national and regional bodies.

Having clarified where responsibility lies, the Danish Association of Regions, a local government assembly, issued more precise guidelines:

- The regions guarantee investigation and therapy for cases of throat, head, lung, colon and rectal cancer within 48 hours of referral. No waiting time is allowed for treatment and aftercare unless there is medical justification for it.
- The regions are also required to establish treatment pathways for patients with breast cancer, as part of a national screening program.
- For each of the five types of cancers, each region is required to appoint a coordinator, responsible for ensuring that the treatment pathways are being followed and to avoid congestion and bottlenecks in the system.
- The regions are required to report every month on the progress of cancer treatment and on the length of waiting times.
– The regions are required to identify potential organizational, technological, and human resources barriers and to develop plans to reduce them.
– The Assembly of Regions will negotiate with the national government on funding, targets and strategic emphasis.
– The regional assembly will also assume responsibility for discussing the implementation of the plans with the professional groups involved.

The idea of “treatment packages” of standardized diagnostic and therapeutic procedures and with fixed time limits will be crucial to the assembly’s approach. This form of cancer care has already delivered very positive results in Vejle Hospital in South Jutland.

Despite these efforts, the minister has deemed the regional assembly’s commitment inadequate and is working on plans requiring that:
– All cancer patients are treated as acute cases
– Clinical guidelines are integrated into the “patient packages”
– The packages also include national standards for waiting times
– Clinical data are effectively collected and published
– Patient information is improved
– Contact people are established for patients and also coordinate care

What is new is that the minister promised the central government will provide additional funding to finance the extra requirements, although the amount is unspecified. Also new is the definition of cancer patients as acutely ill, which has long been a demand of the Danish Cancer Society.

Experts now fear that ministry pressure will lead the regions to simply shift resources from other areas into cancer therapy. While this might mean shorter waiting times for cancer patients, it might also mean longer waits for people suffering from other conditions.
Sources and further reading:


United States, Switzerland, New Zealand, Canada: Who should pay for HPV vaccination?

Since Merck, Sharp & Dohme developed Gardasil, a vaccine against infection with human papilloma virus (HPV), authorities, health insurers, governments and health services around the world have been considering to whom they should recommend vaccination and whom they should reimburse. Gardasil immunization protects against forms of the virus that are risk factors in the development of cervical cancer.

The manufacturer and some scientific groups are firmly in favor of general vaccination of the female population, preferably before their first sexual contact. The estimated cost of the three injected doses varies from one country to the next, with Austrian and Swiss authorities putting the cost at €495 and 700 Swiss francs (€422) respectively, while in Canada the cost is Can $400 (€276).
Critics argue that research on the HPV vaccine to date is insufficient for its performance to be taken for granted by bodies that fund and deliver health care services. Gardasil immunizes only against a few variants of the virus, and some fear that destroying these could lead to the mutation of others into carcinogenic forms. Moreover, some say that the introduction of more comprehensive cervical cancer screening could lead to a 90 percent reduction in deaths from the disease, diminishing the need for immunization.

The main obstacle to approval of Gardasil has been overcome: in June 2006, it was licensed for use in the United States and three months later in the European Union. Each country will make its own assessment of the vaccine’s performance. Opinions currently range from enthusiastic approval to outright skepticism.

A turbulent debate surrounding the HPV vaccine took place in California. At the end of 2006, state assemblywoman Sally Lieber brought in a draft law which would have seen all 11- to 12-year-old female school students vaccinated against HPV after the summer of 2008. Since then, the draft was withdrawn, revised, and reintroduced a number of times. By summer 2008, no final decision had been made.

Compulsory vaccination in schools is the norm in California and the U.S. School pupils are currently vaccinated against 10 other diseases, including measles, mumps, rubella, hepatitis and polio. Parents can only block their child’s vaccination for religious, moral or medical reasons. A doctor’s certificate is needed to endorse any medical explanation of why a child should not be vaccinated.

Immediately after the approval of Gardasil, the U.S. Advisory Committee on Immunization Practices, a 15-member panel authorized by federal law to say who should be immunized, recommended the vaccination of all girls between 11 and 12. But with such an early vaccination and Gardasil’s long-term efficacy still in question, another “catch-up” dose could be needed when they reach between 13 and 26 years. The committee also determined that the vaccine should be made available through Vaccines for Children, a federal program making immunizations available to children of low-income families.

Despite favorable recommendations, the Californian implementation plan soon lost momentum after the public learned
that Lieber’s husband owned Merck shares. Lieber, the Democrat assemblywoman, withdrew her name from the bill after her husband’s ownership of Merck shares was revealed. The new supporter bill’s, Ed Hernandez, also admitted that his campaign had received funding from the company, but said that it did not affect his verdict on the merits of the bill.

Critics say that too little time had passed since the admission of the vaccine to properly assess it. The manufacturer’s lobbying efforts have also sparked skepticism over the rationale behind the political decision.

Besides California, 21 other states have considered introducing Gardasil into their school immunization programs. A bill of this kind was narrowly defeated in the state assembly in Michigan. In Texas, the HPV vaccine was mandated by the executive decree of Governor Rick Perry, but critics later found out Perry is a longtime friend of one of Merck’s lobbyists, who was also once his chief of staff. Merck was also found to have made a donation of US $5,000 (€3,400) to Perry’s reelection campaign.

In Switzerland, by contrast, there has been more enthusiasm. The Federal Commission for Vaccination recommends vaccinating all girls between the ages of 11 and 14 and, for a transitional period, 15- to 19-year-olds. On 15 November 2007, the Federal Office of Public Health included the HPV vaccination in the benefit basket of the compulsory basic health insurance scheme. Starting in January 2008, all girls and women up to 19 years of age can receive the immunization free of charge. The 26 cantons are responsible for organizing canton-wide immunization programs. An economic evaluation has placed the cost-effectiveness of the vaccination at 26,000 Swiss francs (€16,200) per year of healthy life saved. The analysis is based on the disputed assumption, however, that the vaccination program would prevent 98 percent of the cases of cervical cancer.

New Zealand gave its approval for Gardasil in July 2006, after the United States and before the European Union. Since then, special interest groups and the gynecologists’ professional association have been pressing for a general vaccination program. Cervical cancer is currently the eighth most common cancer in the country, with the success of prevention measures very different between ethnic groups: Despite a national screening program for
women, Maoris and Pacific Islanders are affected by cervical cancer twice as often as women of other ethnicities.

The pharmaceutical industry is pushing hard for Gardasil vaccination for 11- to 15-year-old girls. Political pressure has come mainly in the form of open letters, with some examples signed by specialists such as gynecologists, pediatricians, sexual and general practitioners as well as by academics at the University of Auckland’s Immunisation Advisory Centre.

But the New Zealand Health Ministry remains hesitant, saying there is still no convincing cost-benefit analysis to justify the expenditure for a general vaccination program. A working group of the parliament has recommended that 15-year-olds should be given three doses or, if a booster dose at 15 could be financed, that the initial course of injections should be given to 11- to 13-year-olds. In Australia, whose gynecologists belong to the same association as their peers in New Zealand, all 11- and 12-year-olds are vaccinated against HPV.

The health ministry’s wait-and-see attitude has the backing of Hazel Lewis, who leads the country’s cervical screening program. The screening program is considered very successful, with 70 percent of its targets taking part. Since the early detection tests were introduced, the disease rate has fallen by half and mortality by 65 percent. Among Maori and Pacific Island women, the participation rate stands at around 45 to 50 percent.

The introduction of a successful HPV vaccination program requires screening and vaccination experts to clarify the following issues:

- Who should be vaccinated, and is a booster vaccination required? It is currently estimated that the cost of vaccinating each age cohort would cost NZ $10 million (€5.2 million).
- How would vaccinated people be screened? Should it be done just as it is at present? If not, could a change save money?
- How can girls and their parents be educated about the vaccination?
- Could the social differences in the incidence of cervical cancer be reinforced by the introduction of the vaccine if it is not effectively promoted to Maoris and Pacific Islanders?
- Should boys, who ultimately act as carriers of the virus, also be offered the vaccination?
Any case for the introduction of a vaccination program has to be weighed against the concerns. A general HPV vaccine would be expensive and would be directed against a health problem that is already in decline. The main beneficiaries of such a program might be ethnic groups who are already well represented in the screening program. The vaccination also presents the danger of fostering a false sense of security and a reduced uptake of screening. Moreover, the protective effect of the vaccination could wane over time because of mutations in the virus, perhaps ultimately leading to a greater incidence of cervical cancer.

In Canada, the central government allocated Can $300 million (€207 million) to support a national vaccination program in the 2007 national budget, having approved the vaccine in summer 2006. The issue now for the provinces and territories is who should be vaccinated and whether it should be free. Ontario, by far the largest province, has decided to offer the 13- to 14-year-old girls in its eighth-grade classes (84,000 girls) free vaccination. Nova Scotia, Newfoundland and Labrador, and British Columbia are expected to also offer free vaccination to school-age girls.

Controversy erupted around the vaccination in Canada only after the political decision had already been made. Researchers, including the Canadian Women’s Health Network, said more testing was needed before the vaccination was introduced across the board. The Public Health Agency and Health Canada’s National Advisory Committee on Immunization (NACI), meanwhile, defended their position, saying there was already enough evidence to move forward with a program for girls who have not yet become sexually active.

According to the Women’s Health Network, the primary care system in Canada has serious flaws when it comes to dealing with cervical cancer. Among the problems: a lack of female health care professionals, lack of time, the direct and indirect cost of health services, lack of child care, a failure to deal with linguistic and cultural differences, safety concerns, and the attitude of doctors toward cervical cancer. The Network added that vaccinating young men would help curb the spread of the virus.

Another key concern is suspicion at the lobbying activities of Merck Frosst, the Canadian manufacturer of Gardasil. Propo-

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nation should be seen as part of a broader strategy which includes the promotion of safer sexual behavior and lifestyle decisions, such as to abstain from smoking or to have a smear test.

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**Switzerland**

**New Zealand**

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Canada


Human papilloma virus (HPV) vaccination was added to the range of benefits paid for by statutory sickness funds in spring 2007, making it free for girls between 12 and 17. Discussion has, however, turned to the vaccination’s efficacy.

The Pap smear has been part of the annual cancer prevention program of statutory sickness funds since 1970. Since then, the prevalence of cervical cancer among German women has been decreasing. In Germany, cervical cancer is currently the 10th most common cancer among women, with incidence rates of 10.8 per 100,000 at around the European average (Globocan 2002 database). By worldwide comparison, however, Germany fares relatively well, with cervical cancer often being the second or third most common cancer in most other countries.

The introduction of the HPV vaccination was attended by a large media campaign targeted at mothers of 12- to 17-year-old girls. In some of the states (“Länder”), there have been initiatives to vaccinate schoolgirls. Some statutory sickness funds even cover immunization for women up to the age of 26. The HPV vaccination initially met with a positive response in Germany, but in recent months criticism regarding its efficiency and safety has attracted media attention. This is partly because of concerns over the nature of the vaccination policy recommendation.

The Standing Vaccination Committee (STIKO) is the national authority on vaccination. In March 2007, the committee said that all girls between the ages of 12 and 17 years should be immunized against HPV and that this would be most effective as part of a structured approach including all relevant actors. Its recommendation means that all sickness funds now offer vaccination as a health insurance benefit for this age group. A number of them even offer reimbursement for women up to the age of 26. Sickness funds had little choice than to go along with STIKO,
because starting in April 2007, the law obliged statutory sickness funds to cover all vaccinations recommended by STIKO.

Already in October 2006, the statutory sickness funds published a joint paper, criticizing their upcoming obligation to automatically include STIKO recommendations. They warned that this would lead to a tripling of costs, adding up to an extra €1.6 billion. And particularly the HPV-vaccination is indeed costly: The three necessary doses of Gardasil, the first product to gain approval in Germany, are sold to statutory sickness funds at €465 (US $680), far more than in other countries. In the United States, for example, it sells for US $360. The sickness funds paper also noted a close connection between STIKO and the pharmaceutical industry, and observed that some of its past recommendations had later been revoked because of new findings.

In October 2007, the Green party also implied that the connection between STIKO and the pharmaceutical industry was too close and called for greater transparency. The governing Christian Democrat and Social Democrat grand coalition rejected the notion, although it did require the committee’s members to publish possible conflicts of interest on the Internet since the end of 2007.

STIKO’s rapid recommendation of HPV vaccination has also raised public discussion about its independence. One issue discussed in the media was that former STIKO chairman Heinz-Josef Schmitt accepted a €10,000 award in 2006 for his efforts to promote immunization as an effective prevention measure. The award was paid for by Sanofi Pasteur, which produces Gardasil in Germany alongside Merck. In September 2007, Schmitt left STIKO to work for Novartis Vaccines and Diagnostics.

Substantially reduced cervical cancer incidence and deaths have been achieved in countries that have adopted routine cervical cancer screening programs. HPV vaccination, meanwhile, does not provide protection against all HPV types or against existing HPV infections, nor can it give 100 percent protection against cervical cancer. The vaccination is, therefore, not a replacement for routine, quality assured cervical screening, which the European Commission recommends countries to carry out population-wide before introducing the HPV vaccination.

Screening as a first policy option is also supported by the findings of a recent Health Technology Assessment on HPV vaccines
by the Austrian Ludwig Boltzmann Institute. The assessment concludes that immunizing 12-year-old girls in addition to screening will lead to 9 to 10 percent fewer cervix carcinoma cases and 11 to 13 percent fewer fatal cases between 2008 and 2060.

The response of providers, sickness funds, doctors and the scientific community to the HPV vaccination policy is diverse.

Among providers, opinion splits three ways: Those who consider HPV vaccination a good means to fight cervical cancer, those who criticize the very quick approval for reimbursement on slim data, and those who believe the money would be better spent on screening. The cost-effectiveness of the vaccination is currently difficult to judge, as both the long-term efficacy and the need for a booster vaccination are still unclear.

The scientific community is similarly divided over the relative benefits of HPV vaccination versus improved screening. Convinced by the results of clinical studies of Gardasil and Cervarix, some consider HPV vaccination a major weapon in the fight against cervical cancer. Opponents of the vaccine argue that the potential for cervical cancer prevention through widespread immunization is too small in relation to the costs—even if no booster shot is necessary. Furthermore, they fear vaccination might reduce awareness among women of the ongoing need for preventive screening. Some think that vaccination against some types of HPV might lead to an increase in cervical disease from vaccine-resistant strains.

Both the scientific community and providers believe the current price for the vaccine is too high. For sickness funds, the inclusion of HPV vaccination into the benefit range means higher costs. Still, many of them have been quick to advertise that they cover HPV vaccinations, even going beyond the age groups in the STIKO recommendation to attract new members.

The effects of the HPV vaccination policy are currently difficult to assess, as is the debate about its effectiveness, efficiency and safety. Further clinical studies will make such a verdict more reliable.

Whatever the results, HPV vaccination has to be seen as one part of the public health strategy against cervical cancer. Currently, only 50 percent of women take part in cervical cancer screening. To expand screening efforts to reach as many women as possible
would at any rate be a positive step to reduce the incidence of cervical cancer.

Sources and further reading:

Sickness funds: Payers to players

The rules of neoclassical economics, as they re-emerged in the nineties, advocate a clear division between the role of buyer and seller, no matter what the circumstances.

Only when costs are clearly defined, the orthodoxy holds, can needless expense be avoided. Any system based on a structure other than the neoclassical one comes with the built-in risk of spiraling costs, because it lacks actors with an interest in seeing a service provided at the lowest price.

For the health sector, abiding by this economic theory means that public and private health insurers—or, in systems based on taxation, health authorities—must be strictly limited to the role of the payer. The role of provider has to be played by other organizations—which was also the notion behind the “purchaser-provider split” introduced into tax-financed systems since the early 1990s. While the British and other systems have therefore been reorganized to split provision and finance, systems like those in France or Germany have been quite close to the neoclassical ideal for a long time, with the sickness funds or private insurers limited to reimbursing patients for the cost of care. In principle, they only indirectly influence the delivery of health care by being its biggest customers.

Other countries have not acknowledged the need for separation between healthcare buyer and provider, or they impose less rigid boundaries. Israel’s sickness funds, for example, are at the same time purchasers and sellers of healthcare services. In primary care, doctors are either directly employed by one of the four sickness funds or are a tied contractor to one (Rosen 2003: 6). The country’s biggest fund, Clalit, owns one out of every three acute hospital beds in the country (Rosen 2003: 8).
But even in countries which in principle separate supplier from buyer, funds still sometimes offer their own services. Some do it simply for historical reasons, prevented by organizational inertia from applying abstract principles of economics to their everyday workings. But there is also a higher motive: to establish a clinic that provides a benchmark against which to measure the value provided by private competitors. This same idea lies behind the establishment of fund-owned outpatient clinics in Austria, although their importance has declined over recent decades (Hofmarcher 2004: 212).

Despite widespread academic belief in neoclassicism among economists, the trend in recent years has been back in the other direction, with pure “payers” returning to their role as “players.” In Switzerland, for example, an HMO insurance model was created in 1995 which allows sickness funds to offer their own services (Hofmarcher & Durand-Zaleski 2004: 209).

The background to this new trend is the recognition that pure financiers are not particularly good at controlling costs. In health care, this role requires the purchaser to draw such sophisticated conclusions about the cost-effectiveness of services that market mechanisms do not apply. Healthcare purchasers are often ill equipped to make the complex decision on whether a service is appropriate in any particular case or whether it is cost effective to proceed. Even when statistical information is available, it may be insufficient to make a decision in some cases. Economists are well aware of the problem, which they call “information asymmetry” (Hofmarcher 2004: 207).

Similarly, doctors asked to try using statistical averages to guide individual therapeutic decisions often complain that they cannot apply generalized rules to individual cases. A truly satisfactory answer to such objections is impossible, because in reality every case is unique. What is considered to be the best “evidence-based therapy” or “best practice” by the payers is inevitably a form of abstraction.

The economic ideal of a clear division between payers and players has been inspired by developments in the United Kingdom. The objective of reform here, however, was not primarily to achieve cost reduction. Instead, the government has offered private service providers more freedom, with the National Health
Service taking on the role of purchaser while giving up part of its role as provider to private providers.

German health care has long been plagued by a dysfunctional relationship between health insurance and the supply sector, particularly visible in the case of dental services, where there is a large gap of expertise between providers and funders. The providers thus remained able to decide what was necessary and reasonable and to assume the role of patients’ advocate, sometimes exploiting the sympathy they could generate from a particular case to serve their own interests.

While sickness funds in Germany once had a role of “pure players” in health care, organizational reforms of the last couple of years handed sickness funds a few more options to act as “players.” The Statutory Health Insurance Modernization Act of 2004 and the 2007 SHI Competition Strengthening Act paved the way for better coordination and continuity of care. They enable payers to contract selectively and to become players responsible for quality and efficiency of services (Lisac et al. 2007, 26).

However, sickness funds had already been acting as players in prevention and health promotion, areas of work which are difficult to fit into patterns of supply and demand. This raises a new problem: The more clearly the sickness funds are hived off from private providers of health care, the more difficult it is to integrate care with disease prevention and health promotion.

France, meanwhile, which has a clear separation between healthcare buyers and sellers, is now in the midst of a debate on raising the level of co-payments, a debate in which the economic logic of health insurers and the medical and professional logic of service providers can be expected to meet head on (see report on France, p. 75). Japan is hoping to square the circle by narrowing the gap between the criteria used at the national level by the health insurance system and its healthcare providers, introducing an intermediate, local level of insurance administration (see report on Japan p. 78).

The separation between payer and provider does make some sense “in principle,” as the case of Israel shows. Here the government is setting up a fifth health insurance fund solely to provide the country’s large, state hospitals with patients (see report on Israel, p. 81).
All these examples show: When it comes to structuring healthcare systems, politicians would do better to look for tailored solutions than simply to follow an economic dogma.

Sources and further reading:


France: A “protective shield” against excessive co-payments

French patients have for some time paid co-payments alongside their insurance contributions. For some, these co-payments could be quite high. Now center-right President Nicolas Sarkozy is planning to extend the system of co-payments to other services and increase them on services for which they are already paid.

It is generally recognized that increasing co-payments will obstruct poor people’s access to health care. A personal contribution might put off many from visiting the doctor. Therefore, a new “protective shield” is being considered as a way to keep co-payments affordable. It has yet to be decided to whom and against what this shield will offer protection.

According to Sarkozy’s presidential program, the first €50 cost of doctors’ visits would no longer be reimbursed. The current cost-sharing requirements would then apply only to costs over this €50 threshold. It is also suggested that patients need to self-pay 50 cents for each drug purchased and €2 for each ambulance trip. The funds collected would be available to serve new needs, such as those of Alzheimer’s patients. The proposals have met strong public resistance.

Currently, exemption from co-payments is provided for the poorest 7 percent of the population and for people diagnosed with 30 “serious and expensive diseases,” including cancer and severe chronic mental or physical illness. However, for the latter group, it is not the patients themselves who are exempt, but the diseases. Cancer patients get free chemotherapy, but they have to pay the same as everyone else for all the drugs they use with no direct link to cancer.

Some critics now suggest that this is an artificial distinction and the cause of unjustifiable discrimination and distress. It is estimated that 16 percent of patients suffering from “serious and costly diseases” pay more than €500 for outpatient treatment.
Among those who do not have a “serious and costly disease,” only 9 percent are so financially burdened.

The High Council for Health Insurance calculates that more than 2.3 million French people pay more than €500 a year for their outpatient treatment. Most of the population has supplementary insurance to cover this cost, but it is known that around 8 percent do not.

In addition to safeguarding access to medical care for the vulnerable, the protective shield is intended as a mechanism for simplifying the health insurance scheme and controlling public health expenditure.

The idea was created by Martin Hirsch, a politician and social activist. As part of Sarkozy’s opening political gambit, he appointed Hirsch—previously head of the French homeless charity Emmaus, created in 1949 by workers’ priest Abbé Pierre—as “high commissioner for solidarity against poverty.” The same strategy saw socialist Bernard Kouchner installed as foreign minister. Hirsch feared that Sarkozy’s plans to raise co-payments would create too much of a burden for low-income groups. The protective shield is supposed to prevent this.

Together with the minister of health, Hirsch commissioned experts to explore different possibilities of this idea. The possible models can be divided into two groups: the “target” and the “withdrawal” scenarios. The target scenario model would be applied to all outpatient health services, with an equal percentage charged until a fixed annual threshold is reached. The only ones exempt from co-payments would be pregnant women and welfare recipients who already receive a number of free services. There are two ways of working out the annual threshold: either the same amount for all, or a maximum dependent on the household’s income. One proposal is to have five annual thresholds for five different income groups, with a different maximum for inpatient and outpatient treatment. Under the withdrawal scenario, a different percentage of co-payments would be collected depending on whether or not it was a lengthy and expensive disease.

The losers, the two experts agreed, would be the patients with the “serious and expensive illnesses” currently exempt from some co-payment charges. How many would be winners under the new system would depend on the co-payment threshold: At €900, 5 per-
cent of the population would benefit, while at €400 the percentage of winners would rise to 26 percent. At the same time, the co-payment rate would be 40 percent in the low threshold scenario, but just 25 percent in the high threshold one. Most policyholders, however, are not affected by the change because they have supplementary private insurance to cover these co-payments.

The public debate is currently focused on the co-payments increase proposed by President Sarkozy, not the effects of the protective shield for those who couldn’t afford the new system. In professional circles, there is concern that the protective shield model—if it were to come—could be too complicated. It would be simpler, they say, just to give poor people the additional co-payment insurance. Critics also say the protective shield will make the chronically ill suffer twice: under the physical and psychological effects of their illness, and then again under the new financial burden of co-payments.

It is difficult to predict the effects of the protective shield on private health insurance, which is the primary mechanism for settling co-payments. Since after a certain expenditure limit all the reimbursement would be covered by public health insurance, the risk level for private supplementary insurances would decrease significantly—premiums for private insurance might fall. On the other hand, many healthy people with supplementary insurance might decide to end their contracts, leaving just the high-risk patients as members. Ironically, they might once again be left paying more.

**Sources and further reading:**


Japan: A new insurance scheme for the elderly

The Japanese health insurance is undergoing two major changes: Responsibility for setting health insurance contributions in the government-managed scheme will be more devolved; and over-75s will start to pay an amount linked to their income, while at the same time there are plans to improve care for this group.

Under a Japanese health reform passed in 2006, a new National Health Insurance Corporation (NHIC) will take over from the Ministry of Health in setting premiums for the government-managed health insurance. It is not a step toward privatization. Rather, it is part of a government strategy to disperse administrative tasks to smaller, more specialized units. The goal is to give administrative staff more responsibility and so improve the scheme’s management, create more financial stability, implement better management practices and, ultimately, establish a more equitable system. While the management and the setting of premiums of health insurance will be delegated to the NHIC, collecting the premiums and approval of eligibility remain tasks of the health ministry. The ministry will transfer the premiums to the NHIC after deducting an administrative fee.

The government’s original plan was quite different: The collection of government-managed health insurance premiums was to become a task of the Social Security Agency. Then, just as it was about to put this plan into action, the agency came under fire
for mismanagement from the media and the Diet, the country’s parliament. Responding to these attacks, the government established a working group to reform the Social Security Agency. The working group’s report recommended that the agency be completely dissolved and that the government set up a separate body to administer public health insurance. The government accepted the suggestion, and a newly established National Health Insurance Corporation is set to start work in October 2008.

The main responsibility of the new body, which will have branches in each of the country’s 47 regional prefectures, will lie in the setting of contribution rates under a managing director appointed by the health ministry. The demographics and economic conditions in each prefecture will be measured and used to work out and propose a level of insurance premiums balancing revenue and expenditure. A national committee has been established to investigate imbalances and has the power to even out regional disparities, if required, through an interregional adjustment scheme. The last word on the contribution rate, however, rests with the health minister, because the state ultimately remains the setter of contributions. The new national body will be required to report every year and to produce a five-year financial projection every two years.

The change is, above all, expected to simplify administration. Problems could arise, however, because the collection of contributions and administration are no longer controlled by the same body.

**Reform in health insurance for the very old**

Japan also reformed its system of health insurance for the elderly. Until March 2008, Japanese people have been insured under special rules after their 75th birthday, making co-payments of only 10 percent while the usual co-payment rate is 30 percent. With the Japanese population aging rapidly, the limits of this system have now been reached. In the future, those over 75 will have to make higher co-payments, though they will be means-tested.

The change was driven by the wishes of parliament, with the health reform of 2006 giving the government the go-ahead to re-
think health insurance for the elderly and the overall health care of older people. To help determine the best course of action, the government formed an ad hoc committee consisting of a health economist, four doctors, a community nurse and three patient representatives. The committee was expected to open some controversial ethical issues around care for the elderly and the dying. It agreed that life, dignity and security were fundamental to any system of caring for them. It turned out that there is a large gap between this agreement and reality. Around 80 percent of people die in medical facilities, even though most people believe it would be better for dying elderly relatives to be at home with family. The reform program is not limited to resolving funding problems; it also includes proposals to increase patient dignity, home care and palliative care.

The main motivation for these still-vague reform projects is the rapidly growing number of old people. In 1990, people over 75 made up 4.8 percent of the Japanese population, a figure that had reached 7.1 percent by 2000. Demographers expect that this trend will continue for many years to come. In 2010, over-75s are expected to make up 10 percent of the population, and 15 percent just a decade later. This is, in part, because Japanese people have the world’s highest life expectancy, with boys born in 2003 expected to live until they are 78.4 years old and girls born the same year expected to live for more than 85 years. In the United Kingdom, by way of contrast, boys born that year were expected to live 76.2 years and girls 81.3 years, while in the United States the figures are 75.2 and 81.0, respectively. But holding this enviable world record has its price: In 2005, the elderly accounted for 28.8 percent of total health costs in Japan, excluding the cost of long-term care insurance.

One can conclude that the lively public debate has not yet delivered results. Despite widespread public attention, together with that of ethicists and policy makers, no one yet knows how the new insurance scheme for older people will look, how high the fees and co-payments will be or what the financial risk will be for patients and the young.
Israel: A fifth sickness fund to match changing needs

After years of discussion, an Israeli cabinet decision allows a fifth sickness fund, albeit in a very different form than initially intended. What had originally been conceived as a challenge to the state-run insurance system now seems likely to help reinforce it while helping one of the country’s largest state-run hospitals to overcome its problems.

When the Ministry of Finance first proposed the idea of the new fund, it envisaged it would be privately run. Such a fund would, they thought, encourage greater efficiency in the four public sickness funds through competition. It would receive less per patient than the public sickness funds, thus proving it possible to deliver services more economically by cutting costs, particularly in administration. Under the original plan, the new fund would not create any new health infrastructure, such as hospitals or clinics. Instead, it would simply commission treatment for its insurees from existing health facilities. This too was a break with tradition: Sickness funds in Israel traditionally maintain their own facilities.

The original concept was strongly driven by the finance minister’s fiscal objectives. The health ministry, however, was concerned...
New fund, a “payer” and not a “player” from the start about the equality and justice implications of such a system, such as the potential disadvantages felt by the elderly and chronically ill. The fear was that the new sickness fund, as a for-profit enterprise seeking to avoid the costs associated with risk, might give preference to low-risk patients, for example, or choose to focus its efforts in the affluent areas of major cities.

Amid such deep-seated disagreement, the effort to establish the fifth fund made slow headway, although it gained strong support in some quarters, especially among private health sector providers. Pharmacists, for example, hoped that a private sickness fund would buy more of their products than the public ones.

But public and health workers remained overwhelmingly skeptical. Meanwhile, the Adva Institute for Social Research, an advocate of social justice, described the idea as “neo-liberal” and a threat to public health care. There were even doubts about whether any insurance company would be willing to establish a new sickness fund in the difficult commercial conditions presented by the Israeli health sector.

As it turned out, in 2007 the Sheba Medical Center initiated a completely new concept for the fund—a non-profit fund much like the existing four, which can be approved without change in the National Health Insurance legislation. To avoid cherry-picking, the formulation requires the fund to sign up at least 40,000 contributors in the first year and 130,000 after three.

Gone too is the original insistence that the new fund not own health facilities. Instead, the new fund is now meant to solve a very different problem. State hospitals, including the country’s largest, the 1,700-bed Sheba Medical Center in central Israel, have long complained that the Clalit and Maccabi sickness funds are not referring patients to them. The funds prefer to send their contributors to their own facilities, such as Maccabi’s new Assuta Hospital in Tel Aviv. This practice has recently become even more prevalent: Sickness funds are not even sending cancer sufferers and other seriously ill patients to larger state-owned hospitals to cut costs. These state hospitals, however, still have to bear the cost of carrying out research and catering to sudden peaks in demand. The two largest funds also lower their costs by transferring patients requiring minor surgery to small private clinics. This practice takes away from the state hospitals the one steady
flow of patients they can efficiently treat. The dispute spotlights the problems of a system in which funding and supply of services are in the same hands.

To avoid losing out on transfers, the state-owned hospitals are eager to establish a connection with a fund. They believe the only way to survive economically in the Israeli health system in the long term is to ensure a flow of patients by making it “their” fund. Thus, the Sheba Medical Center, mentioned above, became the driving force behind the new concept for the fifth fund.

Some doubt whether competition from the new fund will inspire any greater efficiency in the existing sickness funds. The new fund might, therefore, bring benefits only to the immediate surroundings of its centers, for instance in the neighborhood of the Sheba Medical Center in Tel Aviv. The only certainty is that existing health funds will lose members and revenue without being able to downsize their infrastructure. Consequently, they may become more expensive rather than cheaper.

Also the new scheme has not eliminated concern that the new fund might skim off the “best” insurees: those who are younger and less likely to become ill. The new fund might well increase choice, shorten waiting times to see specialists, and provide better connections between the primary, secondary and tertiary sectors of the healthcare system. But it could still find it impossible to resist targeting young and healthy contributors while ignoring those who are old or chronically ill.

Sources and further reading:


Quality assurance: 
Shooting at moving targets

A debate on the quality of health care was the logical sequel to the debate about controlling health care costs that took place in many industrialized countries in the second half of the 1970s. Societies aware of their rising healthcare costs demanded that their money was at least being spent on valuable and useful services.

In Germany, quality assurance has been a legally binding part of medical care since 1993, although the first initiative in the area, to reduce mortality at birth, dates back to 1975–1977. The historic foundation for the concept of quality assurance was laid by Ignaz Semmelweis (1818–1865), a Hungarian gynecologist. Semmelweis’s observations showed that the mortality rates of one maternity ward of a Vienna hospital, which also happened to be a teaching ward, was much higher than in any others. The cause of the problem, he discovered, was that doctors contaminated their hands with pathogenic bacteria during autopsies; this led him to recommend routine disinfection with chlorinated lime, a bleaching agent.

Quality in health care is a target moving faster than the advances in measurement used to pinpoint it. Meanwhile, the methods used to bring quality indicators into reality are improving: it has proved effective, though expensive, for example, for randomly selected medical records to be audited by specialists based in another city or hospital.

A less onerous approach is the so-called “tracer method,” although it is only applicable in a few cases. The idea is simply that following the path of patients with certain diagnoses can provide useful information about the overall quality of a certain service. For surgery, a typical tracer diagnosis might be a hernia, for example, or a femoral neck fracture, appendicitis, gall stones or colon...
cancer. The hypothesis is that if patients with these diagnoses are treated well, other patients are likely to be well treated too.

The underlying problem of quality assurance is particularly striking where comparative measurement is applied to provide a performance indicator and incentive, a process known as benchmarking. In New Zealand and in Estonia, there is a rather traditional use of performance analyses in hospitals (see reports on New Zealand, p. 87, and on Estonia, p. 89). In Canada, meanwhile, healthcare quality is reported and assessed annually by a Health Council, giving rise to specific recommendations (see report on Canada, p. 91).

Other efforts aim to establish a completely self-sufficient system of quality assurance—a goal still far from met. This is the ambition of a Dutch initiative, expected to lead to “faster” and “better” inpatient care. The model was inspired by the “100,000 Lives” campaign in the United States, which set the goal of avoiding preoperative errors thought to lead to the loss of that number of lives. The Dutch idea was to make the avoidance of errors a fixture in the hospital system. Although the country has a long tradition of quality assurance and some of the most well-respected research institutions, the initiative remains stuck. While some of its objectives were achieved much remains unclear (see report on the Netherlands, p. 94).

A general trend in quality assurance is to move from trial-and-error methods to evidence-based action. According to this approach, practice is improved by systematically identifying and analyzing failures. The purpose of such initiatives is not to punish, but to avoid mistakes. The biggest obstacle to the use of this approach is still the Semmelweis reflex: the haughty rejection by well-trained experts of suggestions based on simple observations.

To help remove this barrier, German GP surgeries are participating in an error-reporting and learning system called “Every error counts.” The goal is to make the error notification not an admission of guilt, but the expression of a desire for learning and transparency. But such a system depends on a culture of people talking freely and honestly about their own mistakes. Elsewhere, such as in an initiative to protect witnesses of medical errors in Australia, the aim is to give people the courage to report other people’s shortcomings (see report on Australia, p. 97).
New Zealand: New hospital measures more patient-based

Key indicators on the performance of New Zealand’s hospitals are to be revised. The new measures are designed to increase transparency and utility. More generally, they will be geared more toward the interests of patients, with the collection, for example, of more precise data on waiting times.

The quarterly reviews, called Hospital Benchmark Information (HBI), should make possible local and national comparisons of the hospitals of the country’s 21 health districts, as well as underpinning improvements in the efficiency and quality of care.

The fifteen parameters include the triage time it takes a patient to be assigned to the correct department, patient satisfaction, the average length of stay, acute care readmissions, hospital infections, and a series of organizational matters, such as the number of workplace accidents. Table 1 shows which parameters were changed and which were not.

The revision of the indicators took a few years longer than expected. The new indicators, which are subject to further refinement, are the product of an ad hoc working group including nine
Table 1: HBI reports: New, old and removed measures

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<tr>
<th>Unchanged</th>
<th>Amended</th>
<th>New</th>
<th>Removed</th>
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<tr>
<td>Staff turnover</td>
<td>Sick leave</td>
<td>Acute readmissions</td>
<td>Staff stability</td>
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<tr>
<td>Workplace illnesses or injuries</td>
<td>Healthcare-associated <em>Staphylococcus aureus</em> bloodstream infections</td>
<td>Day of surgery admission</td>
<td>Percentage of complaints resolved/closed</td>
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<tr>
<td>Patient satisfaction</td>
<td>Day case procedures</td>
<td>Did not attends</td>
<td>Resource utilization</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>Emergency triage times</td>
<td>Revenue to fixed assets</td>
<td>Performance to contract</td>
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<td>Debt to debt and equity</td>
<td>Capital expenditure to depreciation</td>
<td>Return on net funds employed</td>
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<td></td>
<td>Staff cost ratios</td>
<td>Operating margin to revenue</td>
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<td></td>
<td>Revenue to net funds employed</td>
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members from the Ministry of Health and 29 members from 15 District Health Boards.

Sources and further reading:

Estonia: Hospitals pioneer WHO assessment tool

Six Estonian hospitals, four central and two regional, have formed a network to participate in the World Health Organization (WHO) program to improve quality.

The Performance Assessment Tool for quality improvement in Hospitals (PATH), was set up by the WHO’s European regional office in 2004. Estonia was invited to join the pilot project in 2005. Its goal is to make hospital managers conscious of the need for performance monitoring.

Performance data is currently gathered from over 200 hospitals in 10 European countries. Collating this data provides managers with the information they need to benchmark the performance of their hospitals, broadening their horizons beyond national boundaries. There are no direct financial incentives attached to the project, although the data required should be routinely gathered and monitored by hospital managers anyway. But this has not been enough to allay everyone’s fears: In some hospitals, there was initially concern that the Estonian Health Insurance Fund (EHIF) might cannibalize the data for its own purposes, such as a way to justify cuts. Suspicions of this kind, however, have now largely been put to rest.

Measurement of performance and quality has not been a priority in recent Estonian health reform. Foreign experts have repeat-
Program aims to spread performance measurement

edly noted that indicators have been developed, but never applied. Nevertheless a quality handbook has been developed, and most hospitals ask patients whether they were satisfied with the service or find other ways to measure performance and quality. Estonians hope that participating in the WHO program will instill a culture of systematic performance measurement.

Sources and further reading:

WHO/Europe—Hospital programme. A Performance Assessment Tool for quality improvement in Hospitals (PATH).
Canada: Renewing healthcare quality

Since the creation of the Health Council of Canada, health care professionals and the general public have been able to access regular reports on the progress of the priority health reform areas included in the 10-Year Plan to Strengthen Health Care.

The Health Council came into being in 2003 as part of a Health Accord between the federal government and the provinces and territories (see Health Policy Developments 2, p. 85). In 2004, a 10-year health reform plan was agreed upon, and the federal government committed Can $41.3 billion to the provinces over the 10-year time period to support provincial and territorial improvements in health care. The Health Council’s role is to foster accountability and transparency in the reform of the health sector by assessing its effectiveness and sustainability. Its first report was published in 2005.

In 2006, the Council issued a progress report on efforts to improve the quality of health care for Canadians. The report reviewed four areas of healthcare quality: patient safety, information management systems, the provincial quality councils, and health indicators and public reporting.

To improve patient safety, the Canadian Patient Safety Institute was created in 2003. Its first major effort has been the “Safer Healthcare Now!” campaign. The campaign goal is to encourage hospitals and other healthcare facilities to adopt six measures known to reduce the risk of death and disability: introduction of rapid response teams; delivery of evidence-based care for heart attack patients; prevention of adverse effects related to medication; avoidance of catheter-related bloodstream infections; prevention of infections related to surgery; and the prevention of pneumonia for patients on ventilators. Over 135 hospitals currently participate in the campaign, with more still joining.

The Council also reported on a parallel patient safety effort by the Canadian Council on Health Services Accreditation (CCHSA),
to embed patient safety in its accreditation requirements. Facilities are encouraged to achieve six patient safety goals: instill a culture of safety in the organization, improve the effectiveness and coordination of communication between service providers and patients; ensure the safe use of infused medications, create a workplace environment that supports safe delivery of care, and reduce the risk of infections acquired while in a facility. Currently, the accreditation process is voluntary in Canada, although the vast majority of healthcare facilities or regions participate in the process.

In its report, the Health Council is proposing that the CCHSA’s voluntary accreditation process test be made mandatory and that the accreditation reports for facilities be published. In addition, the Council recommends that the issue of no-fault compensation for victims of an adverse event be re-examined.

As part of the 2003 Health Accord, federal, provincial and territorial governments agreed to place priority on implementing electronic health records and telehealth technology, especially for those living in rural and remote areas.

The national target is for half of Canadians to have an electronic health record by 2010. Headway has been made in creating provider and patient registries and in providing a mechanism to store diagnostic images, as well as creating drug information systems and laboratory information systems. The Health Council recommended providing additional financial resources, and a more aggressive approach to meeting the goal for implementation of electronic health records. As well, the Council suggested the need to give the public and politicians more information about the importance of improving health information systems.

Some provinces, such as British Columbia, Manitoba and Saskatchewan, are farther ahead than others in developing drug information systems. Electronic prescription is still unusual in Canada, with only 8 percent of doctors using e-prescribing technology. The Health Council recommended that electronic health information be linked to electronic health records and that formal collaborations be developed to overcome the barriers to greater use of e-prescribing technology by physicians.

The Health Council’s work is supported by provincial quality councils set up in the provinces of Saskatchewan (see Health Policy Developments 1, p. 37), Alberta, Ontario and Quebec. The Health
Council recommends that more regional and local quality councils be established.

Finally, the Council reviewed the health system performance reports of the provincial First Ministers. The reports outline the status of health care in each province, and include structure, process and outcome performance indicators on such topics as waiting times, the availability of diagnostic and medical equipment, health human resources, and mortality rates. The council found that the reports from each jurisdiction are hard to compare, that they are difficult for the public to locate, and that they were based on outdated figures and did not include enough financial information, so it is not always clear how much money went where. The Health Council recommended, therefore, that reports be linked to specific health goals and that more comparable indicators are used. The Council also recommended that the reports be made available more regularly.

Sources and further reading:

Netherlands: Faster is not always better

“Sneller Beter,” meaning “faster better,” began as an ambitious project to improve hospital care in the Netherlands. After delivering some impressive early successes, it has now entered a more cumbersome phase of its development. An initial assessment indicates that more positive results are to be found where those involved feel the positive impact themselves—for example, when they stand to gain from any savings.

The program was originally developed by the government composed of the Christian Democrats (CDA), People’s Party for Freedom and Democracy (VVD), a center-right liberal party and the center-left New Democrats (D66), a coalition in power between 2002 and 2007. It grew out of a report commissioned from four top managers from the country’s private sector: Peter Bakker from the courier TNT, Rein Willems of Shell Oil, Johan van der Werf of the life insurance company Aegon, and Ad Scheepbouwer of the telecommunications company KPN. These four captains of industry submitted views that in most details aligned with the findings of the Dutch Organization for Quality Improvement in Health Care (CBO).

Organizationally, the Sneller Beter program was centered on the Dutch Organization for Health Services Research (ZonMw; see Health Policy Developments 2, p. 84), with CBO and the Erasmus University in Rotterdam playing a partnership role. Other institutions are responsible for the scientific evaluation: the Dutch
Institute for Primary Care Research (Nivel), the Free University of Amsterdam and the University of Maastricht.

The next step after consulting the elite business team was to formulate a set of indicators to pinpoint short-comings and areas for improvement. A working group, convened by the Health Care Inspectorate, brought together the Hospital Association (NVZ), the Association of University Hospitals (NFU) and the Society of Medical Specialists (OMS) and developed a wide array of original parameters. One, for example, was how many times in the first 72 hours after surgery pain rises above seven on a scale of one to ten. Another was the number of operations canceled less than 24 hours before the scheduled surgery. Other statistics included the working hours of emergency physicians on intensive care units and the percentage of diabetic patients who saw an ophthalmologist each year. From such indicators, a “diagnosis” of each healthcare institution was to be compiled. By making new measurements of each of the indicators over time, the rate of improvement could be measured.

The third element of the strategy was to use the indicators to identify “breakthrough projects.” To lend momentum to the initiative, its organizers chose five fields in which it would be relatively easy to achieve success and, importantly, to measure it. From the country’s total of 98 hospitals, 24 were selected and then this group was divided into three blocks: in the first block came the 8 probable front-runners, while the remaining 16 were divided into the two other blocks.

The five areas chosen as particularly promising and given priority were

- Patient safety, including decubitus, post-operative wound infections, medication safety and safe incident reporting.
- Patient logistics, including operating theater productivity, working without waiting period and process redesign
- Patient participation
- Professional quality
- Leadership and organizational development

In all these fields, measurable targets were set—for example, that the waiting time for a visit to the outpatient department should be one week at most; productivity for operations should increase
by 30 percent, while the target number of failed therapies should halve; and not more than 5 percent of ward patients should suffer from sore wounds. At the end of the program, one in five Dutch hospitals should have achieved these goals.

A study of the progress made by the first eight clinics, the front-runners, has been concluded. According to the figures, 77 project teams have set up 113 improvement teams. Actual progress achieved is closely linked to whether the employees see the results of their efforts and are given recognition, for example, by giving them an opportunity to invest in new improvements.

Among the front-runners, only one in five hospitals managed to implement the improvements within a year—a requirement that will apply to all hospitals, not just the strongest. A third of the top hospitals had definitely failed to achieve the objectives. In the rest of the cases, it was not clear how successful the projects had been. In all cases, there were some positive effects, commonly the systematic approach, the participation of top hospital management and the enthusiasm generated. No hospital had only successes or failures, with each scoring a mix of both. On the level of cost-benefit, the outcomes showed that initiatives to improve the productivity of operations were more successful than ones on patient safety. Despite the positive impact they made, it proved difficult to maintain the involvement of hospital managers in some locations.

Sources and further reading:

Wagner Cordula, Michele Dückers and Monique de Bruijn. Doing the right things right; results and diffusion of large-scale improvement actions. Utrecht: Nivel, 2006.
Australia: Protection for whistleblowers

Despite some special legal protection for health sector employees, errors, crimes and abuses in the workplace inevitably lead to a conflict between personal loyalty and social responsibility. In Australia, health workers are now being encouraged to report the professional shortcomings they know about.

In many places, the barrier is even greater. In some countries, there is not even a native expression equivalent to the term “whistleblower,” which is meant to conjure up an image of a person brave and independent enough to sound the alarm when they discover wrongdoing. Between 1993 and 2006, Australia put laws in place protecting whistleblowers in all of its states and territories: A person who reveals illegal, immoral and illegitimate practices by an employer or colleague is, in theory, protected. This protection is offered on the basis that whistleblowers have a vital role to play in the effective management of public sector organizations.

Within the clinical area, this view is confirmed by a special governance framework. The objective is to avoid unnecessary deaths and injuries of patients. But recent events have led many to conclude that the protection offered is still insufficient.

A key element of the existing legislation is an obligation on the government to investigate any disclosure or allegation of illegal activities, gross wastage or imminent threat to people’s health and safety. At the same time, the government is obliged to hide the identity and ensure the safety of the person who made such a report. The whistleblower is also spared from any disciplinary or criminal prosecution. Any attempt to take a disciplinary or criminal reprisal against the whistleblower is considered an offense.

It has yet to be tested whether the legal protection offered is sufficient and whether the clinical governance systems in the health sector support whistleblowing as a last resort. It is unclear how much information will get through, with the ever-present...
suspicion that whistleblowing may often just result in loss of trust among colleagues.

In line with whistleblower protection laws, Australian hospitals have introduced initiatives for quality improvement. Among the most important developments—as put in place by the largest state of New South Wales (NSW)—were the appointment of a director for clinical governance and the creation of an ombudsman to deal with complaints. The governance guidelines, as set out in the hospitals of New South Wales, for example, say that when a complaint arises, it has to be taken seriously and investigated properly, and complainants should be provided with the answer they deserve.

The health sector presents other barriers to whistleblowers. The framework of accreditation, credentialing, peer review, adverse event and mortality reviews, audits, risk management strategies and sentinel event reporting does not afford them the space the legislation presumes. Secondly, professional culture and ethics reduce people’s willingness to express themselves. Protecting complainants’ identity and protecting them from reprisals is not the full answer.

Sources and further reading:


Pharmaceuticals: Tug-of-war between financiers and industry

The rising cost of pharmaceuticals is a significant factor in the spiraling health care expenditure in many countries. The amount spent on pharmaceuticals per person, measured in terms of purchasing power parity over the last 25 years, tripled in Germany and multiplied by almost five in France and Italy (Mossialos et al., 2004: 4; see also table 2). In all industrial countries, these costs, fundamentally the result of an increasing volume of sales, have long been the subject of a tug-of-war between pharmaceutical manufacturers and their largest customers by far—the health insurance companies and state-run national health services.

Most European countries aim to affect the price of medicines through political regulation (see also Health Policy Developments 7/8, “Medicines politics and pricing,” p. 175). Almost everywhere, authorities seek to promote the use of generic drugs and cap the price of medicines on which the patents have expired to bring down costs. In the case of new products, they demand proof of a real additional benefit for patients when compared to available alternatives drugs that are structurally very similar to already known products, and show little or no medical improvement for patients, are not treated as “innovative.” Only drugs which are proven to be really superior to existing ones are treated generously with regard to pricing and reimbursement. Expert institutions are being created to tell true innovations from the rest.

In a marketplace with so many actors and intermediaries, it has proved impossible to apply rules that hold in other domains. In healthcare markets, beneficial price competition is impossible to achieve because they do not meet most of the requirements of a functioning market: freely available and understandable information about quality, performance and price; buyers who have

Almost all seek to influence medicine prices
Table 2: Pharmaceutical expenditure in OECD member states of the International Network Health Policy and Reform (1990–2005)

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<th>Total expenditure on pharmaceuticals (percent of GDP)</th>
<th>Total expenditure on pharmaceuticals (percent of total health expenditure)</th>
<th>Public expenditure on pharmaceuticals (percent of total pharmaceutical expenditure)</th>
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<td>Australia</td>
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<td>United States</td>
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Source: OECD Health Data 2007
clear preferences and exercise them in the market; no externalities; many buyers and sellers; easy access and the option to exit. These rules rarely apply to healthcare markets (Light/Walley 2004: 348). Allowing pharmaceutical manufacturers full pricing freedom, as they would have in a fully free market, would lead to unacceptable levels of extortion and exploitation of the purchaser by the seller.

On one side stands a large, prosperous global industry that can make up for temporary losses in one country with gains elsewhere. On the other side stand taxpayers and, in health insurance systems, also employers and employees.

Where the market fails, the decision on reimbursement most often falls to a public authority or expert arbitration panel (see also Health Policy Developments 5, “Pharmaceutical policy and drug evaluation,” p. 68). Making the discreet resolution of disputes through such a respected authority is getting ever more difficult in societies that are both skeptical and overloaded with information. Nothing now remains unquestioned; everything is an issue of public debate. This is especially true in the health sector, where the fundamental questions of life and death are decided. The pharmaceutical industry is even likely to fight the decisions of the National Institute for Health and Clinical Excellence (NICE), the British body in charge of implementing a pharmaceutical regulation system in place for fifty years (see report on United Kingdom, p. 105).

According to the laws of the popular media, a single tragic case can provide the basis for the all-encompassing indictment of a system. This has been the experience of the Polish government after it began to apply a cost-benefit ratio to the reimbursement for medicines (see report on Poland, p. 108). Almost as soon as it did, media uncovered cases of patients who would no longer be refunded by the government for their preferred medicine. According to Polish experts, the ultimate goal of the campaign is to damage the positive list of reimbursable medicines.

But even where no such public campaigns actually spring up, the possibility provides ammunition to the pharmaceutical companies. There is no shortage of conflicts in which this reserve arsenal is proving helpful. Australian reform created two classes of medicine, with different rules applying depending on whether
a medicine is innovative or copied. Classifying a newly developed medicine as “not innovative” is always controversial, as it is relatively easy to find patients for whom the development, even if not revolutionary, delivers some kind of improvement. Once again, this provides the potential for a press campaign (see report on Australia, p. 110).

In these conditions, large-scale reform of drug policy can lead to miserable results (see report on Finland, p. 113). Finland’s exclusion from reimbursement of medicines for minor ailments still formally exists despite opposition from the pharmaceutical industry, but in practice it is ineffective: In reality, not a single medicine was excluded. A rule that medicine patented in other EU countries need not be replaced by generics compensated the pharmaceutical industry for losses that did not actually occur. The only visible effect of the long-debated reform was that nicotine replacement products can be bought outside pharmacies, a move disliked by pharmacists but not the pharmaceutical industry.

Similar reforms also failed in Spain, where the pharmaceutical industry lobbied political parties directly, warning that the proposed reform could lead to supply bottlenecks (see report on Spain, p. 115). With great public attention focused on the relationship between the government and the pharmaceutical industry, the pharmaceutical industry association Farmaindustria won over popular opinion by promising to invest more money in research on rare diseases.

It is not easy to weaken the public concern for the individual cases highlighted in the media. Neither is it possible to return to the days of an undisputed authority deciding life-and-death issues behind closed doors without public debate. The joint conclusion of medical doctor James Sabin and philosopher Norman Daniels is that the best way forward is to decide on these matters after a public and transparent debate following a fair procedure allowing for appeal (Daniels/Sabin 2002).
Sources and further reading:

United Kingdom: Linking medicine prices to value

As in most industrialized nations, the U.K. government directly influences the formation of drug prices. It does so through a statutory Pharmaceutical Price Regulation Scheme (PPRS) based on capping the profit pharmaceutical manufacturers can make. While manufacturers are free to set the initial price of a branded drug, their profits are not allowed to exceed a certain percentage of their revenue. The system is now set to be reformed, with the value of each product being established though cost-effectiveness analysis. This kind of analysis is used to estimate the ratio between the incremental cost of a health-related intervention and
the incremental benefit it produces in terms of the number of years lived in full health.

Under the current system, in operation for 50 years, the PPRS has been a “profit cap, price cut” scheme: Companies are free to set the price of new products, subject to remaining within an overall maximum profit percentage of total revenues. Periodically, they face the need for across-the-board price cuts to keep company profits within the maximum allowed percentage. However, the price cuts take no real account of how much value for money the products offer.

This method of price regulation was strongly criticized by the Office of Fair Trading (OFT), the country’s consumer protection and competition authority. It argued that adding a cost-effectiveness component to the market would create new commercial opportunities, encouraging pharmaceutical manufacturers to bring more innovative products to market. In addition, the OFT said that this reform could release about £500 million (€700 million) of the total £8 billion (€11.2 billion) NHS budget for branded prescription drugs. This money could be used to buy drugs that patients might otherwise be denied.

According to the OFT plan, a cost-effectiveness analysis of a medicine should be done when it is approved, perhaps by the National Institute for Health and Clinical Excellence (NICE), a body providing guidance on health, health technologies and clinical practice. If a drug does not deliver enough value for money according to this assessment, the OFT says, the price should be renegotiated. The same should apply to all drugs in a class of drugs when the patent on one of its members expires. From that moment on, argued the OFT, the generic nature of the off-patent drug would mean there was potentially an unjustifiable price difference.

The British healthcare system is no stranger to the idea of cost-effectiveness—or more specifically, cost-utility—analysis. Since the government launched NICE in 1999, it has been putting selected medical interventions through this kind of analysis. Extending the system to the pricing of pharmaceuticals is an extension of this rationale. Nevertheless, the new system has yet to be laid out in detail and has not been the subject of a public discussion, although the pharmaceutical industry has already expressed its misgivings.
Medicine manufacturers say the scheme could reduce the amount they can spend on research and development. However, the cost-effectiveness analyses done by NICE so far have had the opposite effect, increasing the level of spending on medicines because the most cost-effective interventions also tend to be cost-increasing. Moreover, value-based pricing has already been introduced in countries such as Australia, Canada and Sweden, providing credible evidence that it can be made to work. The earliest date the new system could be implemented is 2010, when the Pharmaceutical Price Regulation Scheme is next due to be renegotiated with pharmaceutical manufacturers.

Sources and further reading:


A heated public debate erupted in the wake of relatively modest reform to the medicine reimbursement system. The controversial change aligns the Polish law of 2001 with new EU directives (see Health Policy Developments 7/8, p. 185–187). Its purpose is to ensure equal access to drugs and to set forth economically rational rules for reimbursement. The existing reimbursement lists will be elaborated by the Ministry of Health and merged into one list of reimbursable pharmaceuticals.

Few dispute the need to bring the law into line with European directives or the principle that reimbursement should be linked to the drug’s cost-benefit ratio. Nevertheless, significant stakeholders—patients, the pharmaceutical industry, the health ministry and the National Health Fund (NHF)—have each raised their own misgivings. The government and NHF advocated stricter price controls; the pharmaceutical industry opposed them. Meanwhile, the public (patients included) is proving fickle and easily influenced by the media. The biggest impact has been made by drastic cases reported by TV and in the press about people (mainly suffering from long-term or rare diseases) who were denied their usual medications reimbursement.

The pharmaceutical industry often opposes the proposed solutions concerning the lists of reimbursable medicines; companies fight for the placement of their particular drug on the list. Of course, their attitude is not currently out in the open. The industry is free to stand aside anyway, since the media is active in exposing the failings of the healthcare system. Corruption and the bribery of health workers, mostly doctors, by pharmaceutical companies are frequently exposed. Media interest also focuses on the impact of strikes on the sick, alongside cases where people have lost out under the new system for reimbursing medicine and therapy costs.
Pharmaceutical companies aside, the attitude of healthcare providers is mixed. Doctors in particular see themselves as under siege after programs exposing corruption were aired on television. On the other hand, they remain a professional group heavily influenced by the pharmaceutical industry. Some doctors have complained about the requirement to put patients’ health service identity numbers on prescriptions they issue, which is supposed to stop the uninsured from picking up prescriptions using the name of someone else who has insurance. Doctors argue that this is too time-consuming, given the low NHF payments for patient treatment and the high numbers of patients they must treat every day.

In Poland, prescribed medicines are free only when patients are hospitalized; otherwise, co-payments apply. All the drugs are divided into two main categories: basic and additional. For basic pharmaceuticals and pharmacy-prepared medicines that appear on the reimbursement list, there is a fixed rate. Patients pay 30 to 50 percent of the cost of additional pharmaceuticals. There is a maximum co-payment for each prescription: €1 for branded drugs and €4 for prepared ones.

Another drug classification on the list puts a particular drug into one of three categories: generic, innovative, or “unique” drugs—those with a therapeutic effect unmatched by any replacement. Generics are reimbursed only if they have passed a test of bioequivalence. A generic drug must cost 30 percent less than a branded one. Innovative drugs are reimbursed only if a minimum cost-benefit ratio is met and has been proven by the proper formal procedure.

Sources and further reading:
Through the Pharmaceutical Benefit Scheme (PBS), Australians enjoy subsidized access to medicines, but rising costs have led the government to initiate reform.

The goal is to gain better value for money by encouraging more price competition between generic brands while protecting a special group of drugs. A single formulary has, in effect, been divided into two groups. The first group includes branded drugs that are not considered interchangeable with others. This group includes patented drugs, but also some non-patent ones. Group two includes all drugs for which there is at least one clinical equivalent, taking in most generics.

The reform requires no mandatory price reduction in group one. By 1 August 2008, all pharmaceuticals newly listed in group two of the PBS scheme must reduce prices by 12.5 percent. Following this initial reduction, further price reductions will depend on the degree of competition among drugs listed in group two. For any single drug where price competition is low, manufacturers must reduce prices by 2 percent a year for the next three years, but when price competition is high, a one-time price cut of 25 percent is required.

These reforms create an incentive for pharmaceutical manufacturers to argue that their products should be given group one classification and thereby be exempt from group two price regulations. They might, for example, argue that their new drug, while equivalent to existing medicines on average, is more effective for some population groups and therefore “not interchangeable at the individual patient level”—one of the crucial criteria for group one.

The government is introducing these measures so taxpayers (i.e., the government) can reap more of the benefits of generic price competition. Prior to these initiatives, the beneficiaries of
price competition were primarily pharmacists when wholesale prices for some medicines fell below the government-agreed PBS price. With the advent of competition for any drug, the gap between the PBS-agreed price and the market price grew—and pharmacists could pocket the difference. This new initiative introduces compulsory price disclosures for generic medicines to ensure that the PBS reimbursement does not exceed their market price. In other words, the PBS-agreed price should more accurately reflect market prices over time (Department of Health and Ageing 2007a).

The new arrangements have already been compromised. The government’s initial requirement that all medicines listed in group two would be 12.5 percent cheaper met with protest from the pharmaceutical manufacturers. Four companies refused to lower their prices; for these products, patients are expected to pay more on top of their normal prescription charge of Aus $4.90 (€2.90) for patients entitled to a concession and Aus $30.70 (€18.30) for the rest. One manufacturer convinced the government of one product’s greater effectiveness, thus avoiding the price reduction. Consultations on the changes to the pricing scheme were then held, although pharmaceutical manufacturers’ concerns remained unresolved.

In addition, pharmacies dispensing medicines that cost the patient no more than the standard PBS co-payment are eligible for a bonus payment of Aus $1.50 (€0.90). This measure is designed to give pharmacies an incentive to dispense generic drugs in preference to expensive branded alternatives.

Critics argue that prices in the two newly created groups of medicines will not be compared against one another. Clinical trials may show a medicine listed in group one to be no better or even less effective than a drug in group two, and yet it will still cost more. Moreover, some fear that generic drugs will still be more expensive in Australia than in comparable industrialized countries. Currently, newly developed drugs are relatively cheap in Australia, generic ones relatively expensive.

It is feared that the government may be tempted to increase the level of patient co-payments for high-cost patented drugs and that pharmaceutical companies will fight for their patent rights on medicines in Australia all the more fiercely.
Sources and further reading:

Finland: Drug reform produces mixed results

Drug reform in Finland (see Health Policy Developments 6, p. 90) has produced its first—and highly contradictory—results: Prices have generally fallen, and nicotine replacement products are both cheaper and more accessible, while the scope of generic drugs has reduced.

The three cornerstones of the reform were to exclude some medicines from government reimbursement; to reduce the maximum wholesale prices by 5 percent; and to allow shops, kiosks and petrol stations to sell nicotine replacement products if they stock cigarettes. No longer would reimbursement be made for medicines if they are only used temporarily, act only against minor ailments, offer no significant benefit, or are not used to treat a disease. Previously, excessive price was the only grounds for denying reimbursement. To keep the Finnish market interesting to the pharmaceutical industry, medicines having only process patents in Finland but product patents in five other European countries are excluded from mandatory substitution with a generic alternative.

In practice, it has proved difficult to exclude medicines from reimbursement. The meanings of “temporary use” and “insignificant benefit” have been found ambiguous. Even if a medicine demonstrably has little effect in most cases, this is often not so for some small but significant groups of patients. To date, not a single drug has been excluded from reimbursement for reasons other than excessive price.

The 5 percent reduction in wholesale trade prices, by contrast, has been a success. The pharmaceutical manufacturers protested when the scheme was unveiled, saying it would mean they would have to withdraw products from the reimbursement system. But it was an empty threat. And, partly thanks to the price reduction, the total expenditures on medicines fell 0.7 percent between 2006 to 2007, having risen 6.7 percent in the previous year.
The generic substitution of prescription drugs was introduced in Finland in 2003, requiring pharmacies to substitute a prescribed drug with the cheapest corresponding medicine of the same pharmaceutical substance. Stipulations were that neither patient nor prescribing physician opposed the substitution and that the substitute was on the list of substitutable medicines issued by the National Agency for Medicines. While the reform has effectively reduced the prices of non-patented drugs by increasing competition (Vuorenkoski 2004), it faced strong opposition from the pharmaceutical industry. With the recent reform, the Finnish government heeded industry interests. Drugs that have a process patent but no product patent in Finland and do have product patents in five other European countries were excluded from generic substitution, even if generic alternatives are sold legally in Finland.

Experts expect the restriction of compulsory generic substitution to become much more expensive than the government’s forecast of €20 million. There was heavy criticism of the rationale behind the restriction, and it is now expected to come back on the political agenda.

The liberalization in the sale of nicotine replacement products broke a taboo, with strict rules traditionally applying to all pharmacy medicines. But by January 2007, not long after the reform came into force, nicotine replacement products were on sale in 2,375 shops, 355 petrol stations and 714 kiosks as well as the country’s 1,000 or so pharmacies. Wholesale sales of the products rose by 41 percent, although much of this can be attributed to the need to stock shelves. Prices fell about 15 percent because of the competition and because a pharmacy fee, which pharmacies are charged by the government and which makes products more expensive there than anywhere else, was removed from nicotine replacements. Nevertheless, pharmacies can still add value by providing a wider product range. A ministerial working group has recommended allowing restaurants to make nicotine replacement products available and dropping the requirement that retailers also sell cigarettes.
Sources and further reading:


Spain: Reform under pressure from industry

The powerful influence of the pharmaceutical industry, health sector employers and medical professionals meant that planned reform to the pricing of medicines has largely failed. Some had hoped that the promotion of more competition and a larger market share for generic medicines marked the beginning of a paradigm shift in Spanish pharmaceutical policy. But the result was simply another in the long line of regulations seeking to contain public pharmaceutical spending through the control of prices (see *Health Policy Developments* 7/8, p. 182, and *Health Policy Developments* 5, p. 78).
The key elements of the reform were a 20 percent discount on all drugs that have been on the market for more than 10 years with no generic equivalent on sale in the country and the introduction of the so-called “Bolar” provision. The latter allows manufacturers to produce a generic form of a branded medicine before its patent expires. The new law allows a gradual reduction in the producer’s price if the calculated reference price—the maximum price paid for the product by the National Health System—is 30 percent lower. Medicines with the same bioactive ingredient and method of administration were assigned to the same price reference group. A five-year exception is made to this if the medicine concerned is found to provide an additional therapeutic benefit. The law also introduced a ban on discounts, consolidated the key role played by doctors and strengthened vigilance mechanisms.

The new law defines the reference prices as the arithmetical average of the cost of the three cheapest daily doses of bioequivalent preparations. If the manufacturer fails to implement the price reductions, the National Health System will refuse to pay for the product. How often the newly established reference price is updated is at the discretion of the authority.

Experts do not think much of the reform, believing a more significant change is needed to rationalize the consumption and public expenditure on pharmaceuticals. It is also thought to impede the introduction of more sophisticated reimbursement mechanisms, such as evidence-based systems where medicines are financed according to the therapeutic benefits they deliver. Achieving this would require establishing a highly specialized, independent agency, similar to the United Kingdom’s National Institute for Health and Clinical Excellence (NICE). As it stands, the system offers pharmaceutical companies little reason to provide products that deliver a better cost-benefit ratio.

There is, therefore, concern among expert commentators that any short-term reduction in pharmaceutical expenditure will be short-lived. The main reason for any subsequent rise will be the lack of incentive to deliver cost savings and a lack of competition in all phases of production, marketing and sales.

The pharmaceutical industry had warned during development of the law that it could stifle growth and innovation and even that
it could lead to shortages. The law’s development, though it took place in the Inter-Territorial Council, left little leeway for initiatives at the regional level. In fact, the law as it appeared reinforced the pivotal role of central government, leaving regional government the responsibility only for execution. The doctors were content with a strengthening of their role: They are now allowed to prescribe generic medicines without the approval of a pharmacist in certain circumstances.
In the debate in the run-up to the new law, the country’s pharmaceutical industry association Farmaindustria and the employers’ federation confronted the association of generic drug manufacturers. The central issue separating them was the patent system. To explain the reform’s possible negative consequences, Farmaindustria lobbied political parties and, finally, offered to spend €300 million before 2012 on researching medicines for rare diseases if a proposed new patent system were rejected. For positions of the major stakeholders, also see figure 5.

No formal evaluation of the law’s consequences is planned, but the Ministry of Health estimated that savings of €1 billion might be made in 2007. Health economists are critical, fearing that although, as in previous reforms, a reduction in short-term expenses might occur, public drug expenditure will continue to increase. They criticize the weakness of the incentives to reduce costs and the lack of competition in all phases of production, distribution and sale of drugs.

Sources and further reading:


More choices through privatization and vouchers?

The long-running debate about the right balance between the role of the market and central planning in health care is losing its fervor. As in other areas, the debate over ideological principles has diminished, giving way to a more pragmatic debate. More or less everywhere, elements of market-driven supply and demand and of central planning are being combined (see Health Policy Developments 5, p. 15–32). This is reflected in the diversity of state, self-governance, non-profit and private providers on the supply and financing side.

That does not mean that public and private organizations have withdrawn from the debate about the correct level of market versus planned activity. On the contrary, the left and right remain mobilized, precisely because the balance remains a perennial issue. Only the extremes on each side are failing to gain outright victory.

Globally, private companies tend to be gathered on the provider side, particularly in primary and outpatient care services and (rarely) hospitals. That too is not always the most cost-effective option. On the financing side, collective systems, such as state funding or compulsory insurance schemes, are the norm. The partial privatization on the finance side takes the form of increasing co-payments, where patients are required to pay more from their own pockets (WHO 2002: 4–8).

Pure state systems, working according to the rules of public finance, face the danger of degenerating over time into a facade, behind which grows an illegal but particularly active and flexible form of market economy. Purely administrative rationing of scarce health services is almost impossible under the conditions of democracy and the market economy. Some administrative sys-
tems are cumbersome precisely because of their obligation to ensure equity, transparency and accountability—concerns that private players can disregard.

On the other hand, there is now greater sobriety about the limits of the market economy, revered in the 1980s and 1990s but coming up against hard reality today. In the United States, the nucleus of market economy thinking, even Republicans are now advocating general health insurance along the lines of the European model.

One of the strongest arguments put forward by those skeptical of market-oriented reform is the health market’s “information asymmetry.” The metaphor of the patient “shopping” for care is flawed: It does not apply to many patients, including those with the biggest needs. For patient-customers to make an informed choice, they must have highly specialized knowledge—and they do not. It is also important to note that health expenditure tends to be higher as a percentage of gross domestic product in countries with systems oriented toward the private sector.

The tendency toward either market or planned distribution tends to follow path development or national cultures rather than any formal estimate of their practicality (see WHO 2002: 3). A high level of regard for individual freedom and decision-making is a tendency common to most of the largest market-driven mechanisms, which are prevalent in many Anglo-Saxon countries and many parts of Asia. On the other hand, such arrangements are less prevalent in the continental European countries, with their long traditions of welfare, justice and solidarity. Where trends toward privatization occur in continental Europe, they move along a spectrum in which hybrid forms predominate (see fig. 6).

At first glance, one of the last refuges of a pure market organization of healthcare seems to be in the Asian city-state of Singapore. However, even there the state does not simply require its citizens to have the necessary savings to pay for treatment; it has backed up the Medisave system with a state-administered insurance program for high hospital costs (see Health Policy Developments 7/8: 80). Why does this work in Singapore (see report on Singapore, p. 122)? The health sector is a thriving part of the economy, attracting patients from all over Asia. It is an economic asset. New hospital beds bring with them long-term expense: while else-
where strenuous efforts are made to keep such costs under control, Singapore actively encourages growth.

In contrast, Denmark, another small country, sends patients abroad in an effort to create productive competition: Those who wait too long for an operation must be treated abroad—or in a private clinic—at the expense of the country’s national health service (see report on Denmark, p. 125).

Larger states do no have the same recourse to foreign countries. Here, market structures can lead to severe regional distortions in supply. Where purchasing power is low, virtually no private providers will choose to serve the population. By contrast, where purchasing power is high, an excess of specialists flows in to areas already well supplied.

In France, the organization of private nursing homes has led to a highly unequal distribution of resources across the regions, with Paris and its surrounding regions well served while the provinces suffer from a shortage of professionals. The state is now having to intervene again (see report on France, p. 128). Finland, with its extremely low population density, has had a similar experience: A voucher system for outpatient services is failing in its remote areas (see report from Finland, p. 130). Meanwhile, to alleviate their regional staff shortages, Australia and Canada are introducing nationally recognized qualifications (see Health Policy Developments 7/8, pp. 166–167, and Health Policy Developments 7/8, pp. 161–162).
Sources and further reading:

Singapore: Small state, big healthcare ambitions

While other countries seek to cut their health spending, Singapore is spending billions of dollars in a ten-year program to increase capacity and upgrade its health facilities. There are two reasons for expecting higher demand for quality healthcare services in Singapore in the coming years:

First, increasing population: In order to generate the human capital needed to sustain Singapore’s dynamic economy, the government has estimated that the population needs to grow from the present 4.5 million to 6.5 million, with the overwhelming number delivered through active encouragement of immigration, since the birthrate is expected to remain low.

Second, increasing private sector demand: The number of foreign patients treated in Singapore increased by over 20 percent a year between 2002 and 2005, doubling the total numbers from
200,000 to 400,000. Four out of five foreign patients were treated in a private hospital. This is partly due to stepped-up efforts by “Singapore Medicine,” a partnership between government and industry established in 2003, to turn the metropolis into a leading regional medical hub. The government hopes to increase the number of foreigners coming to Singapore for treatment to 1 million a year by 2012. The reward for this rise in health tourism, it says, will be a turnover of $3 billion a year and 13,000 new jobs.

About 21 percent of hospital beds in Singapore are owned by for-profit investors, mostly listed companies. The Health Ministry is seeking collaboration with the Ministry of National Development and the Urban Renewal Authority to identify suitable land for new private hospitals. In future, foreigners will also be allowed to make bids to build and operate the new private hospitals in the country.

As far back as 1993, the government has had a plan to increase the share of private hospital beds from 20 to 30 percent. But this growth has not materialized, largely because the tiny country’s inherent shortage of land has sent real estate prices skyrocketing.

The private sector has welcomed the move with one private hospital; investors are thinking of converting a block of apartments into serviced dwellings for foreign patients’ families. The grounds of existing public hospitals are proving to be favored locations, accounting for three out of four potential new areas identified for development. Though the idea of having private hospitals on the campuses of public hospitals is not new, it had been resisted on the grounds that it might not go down well with Singaporeans. Apparently times have changed; the government now thinks that the people are ready for the idea. It even argues that the drive is not simply part of an effort to attract foreign patients, but aims to benefit the local population: doctors might not gain enough experience treating rarer diseases if they were restricted to treating local patients, officials say.

Within the next five years, the Asian health tourism market is expected to grow into a huge business turning over $7 billion a year. More and more customers are expected to arrive from India and China. Singapore already has one of the best reputations in Asia as a health service provider. Half of all the hospitals in the Asian region accredited by the Joint Commission International, a
U.S. health standards body, are in the country. The city state’s main rivals are Thailand and India.

Singapore’s small size and flexibility offer advantages. Government agencies tend to work together to achieve a common goal. For example, the Economic Development Board aims to attract health care investors; International Enterprise Singapore, the international development arm, encourages regional expansion of health care service providers; and the Tourism Board concentrates on marketing people-oriented services in conjunction with
the Ministry of Health. Since 2006, the consulting firm McKinsey has been helping Singapore Medicine attain its goals.

Sources and further reading:
Lim Meng Kin. “Singapore to expand health services.” 

### Denmark: More competition for public hospitals

Since 2002, Danes could be treated in private hospitals at public expense if they were not admitted to a public hospital within two months. In autumn 2007, extended free choice allowing patients to choose freely among public and private hospitals has reduced the waiting period to one month.

The purpose of the scheme was originally to shorten the waiting for public hospitals. The competition clause applies not only to Danish, but also to foreign hospitals, with waiting time defined as the time between referral and the start of treatment. The shortening of the maximum waiting period comes on condition that the private hospital involved has signed a contract with the Danish regional authority for a given procedure. It must also show that no other public hospital in the country can offer the therapy within a month.

The shorter waiting time was the initiative of the liberal-conservative government elected in 2001, which also gained the support of the right-wing Danish People’s Party in parliament. The major political resistance came from the Social Democrats, the second-biggest party in parliament. Public sector hospitals remain
skeptical, arguing that the new maximum waiting time is too short. Local authorities, who must pick up the cost, are also unhappy with the reform because this is an open-ended reimbursement scheme where counties have little possibility to control expenditure.

It does seem, however, that public hospitals can find ways to improve their performance. For example, some regional governments have established “guarantee clinics” in public hospitals, which promise to treat all patients before the end of the waiting period. In return, they receive more compensation from the regional government.

Another problem that emerged is physicians’ dual practice: Many physicians set up a private clinic in addition to their work for the public health service. It is not uncommon for doctors to devote greater energy to the more lucrative private practice than to their work for the public health system. This makes public health service less attractive and leads to staffing problems, while the private sector becomes ever more attractive. Some see this as a form of creeping privatization. Calls for a ban on dual practice have so far gone unheeded by the government.

The winner from the change is the private sector, which now plays a far larger role in the health sector than before. Other winners are patients in urgent need of operations, and, indirectly, doctors and other health workers, who have more jobs to pick from. Among the losers are regional governments which face higher staffing costs in their hospitals and higher rates for treatment to meet the tight waiting time deadline.

An evaluation of the system has revealed positive response from patients and health care managers. Private hospitals, however, complain about the lack of information that patients receive from public hospitals and counties regarding the increased choice of hospitals.

In spite of positive stakeholder response, the number of patients actually making use of the extended free choice of hospital is less than expected. For many, it seems, getting treated locally is worth a longer wait.

There is a lingering suspicion that private clinics are creaming off the easy cases, but an investigation by the Danish Institute of Health was unable to find any evidence for it.
Sources and further reading:


France: Nurses’ role enhanced

An agreement signed in June 2007 between the private nurses’ unions and the national health insurance scheme has given nurses a larger part to play in the clinical and technical care of dependent elderly. At the same time, more stringent control of their work has been introduced to overcome localized supply bottlenecks. Restrictions will apply in areas already well served by home healthcare services, while incentives will be offered to work in underserved areas.

The agreement in detail:

- Fees for home nursing services have been increased, including reimbursement for travel expenses.
- Nurses now have new responsibilities for providing some extra medical services for older people with chronic diseases, and for delivering disease prevention and health promotion programs. Those who deliver established treatment plans, like one for diabetics, will receive a bonus. Earlier agreements placed far tighter control over the scope of their activities.
- Nurses are given greater power to prescribe pharmaceuticals and other therapies and to deliver a range of services themselves.
- The diploma obtained after education for the nursing profession is recognized in the university education system, with a nursing diploma being deemed equivalent to three years of a bachelor’s degree.
- To improve the distribution of home nursing across the country, nurses would not be granted a permit to work in oversupplied areas. However, this measure is hotly debated and not yet effective.
- For the first time a council for nurses has been set up. However, unlike the doctor’s council, it will not receive state funding.
The new agreement should provide better recognition of the nursing profession and make it more attractive and provide better access to home care. The uneven supply of health professionals in different regions is a complex issue, due in part to regional income disparities. The undersupply of general practitioners and specialists is a particularly serious problem in some areas. The transfer of new clinical roles to nurses and the attempt to improve their geographical distribution should help reduce the problem.

The union of hospital nurses did not accept the agreement. Paid by salary, they do not benefit from the financial incentives and fear that the new nurses’ council is a step toward privatization. Outpatient physicians oppose the mechanism to level out the regional distribution of nurses, fearing that a similar geographical redistribution scheme might one day apply to them.

Sources and further reading:

Finland: Little call for healthcare vouchers

A legal framework has been in place since 2004 allowing patients to use vouchers for local social and health services, with home care one of the services most called on. However, the implementation of the system has been rather slow (see Health Policy Developments 3, p. 24 f.). Another Act of 2007 expanded the voucher system to cover home nursing. Meanwhile, another working group was set up to look into how the system can be expanded.

The main obstacle to expanding the system is that local authorities are not obliged to issue vouchers and must provide people
with the opportunity to receive the same services directly from the local authority. In addition, third-party providers need prior permission from the local authority. In the case of home care, the co-payment when a patient redeems a coupon is often higher than the cost of having the service directly provided by the local authority.

At the start of 2007, around 25 percent of local authorities had a voucher system. In most cases, they cover help with household chores, cleaning services and support for the informal care provided by family members. The year before that, 4,000 people were granted vouchers. Most of the providers are very small private companies.

The capital, Helsinki, also awarded vouchers to people needing dental care, because a lack of dentists in the city has led to long waiting lists. The vouchers allow patients to see dentists in the private sector and pay the same user fee as in the municipal health centers.

The new government program plans to extend the use of private providers to other services (see Vuorenkoski 2007b), with special efforts to instill a customer-supplier relationship between provider and recipient of health services.

The local authorities have generally supported the new system. The private sector, meanwhile, is understandably enthusiastic about the prospect of a wider market for its services. On the political level, the left and right have argued more broadly about the role the private sector should play in delivering health care, with the left tending to oppose and the right being more positive.

One factor slowing implementation of the voucher system is the fact that they are not really sought after—nearly half of local authorities have integrated home care and home nursing services. Where this is the case, it is impractical to purchase home care services from the private sector with vouchers while the local authority provides home nursing. Another problem is that vouchers are of little help where there is a shortage of suppliers, as in the country’s more sparsely populated areas. Finally, there is little incentive for local authorities already providing adequate services to introduce the voucher scheme.

Despite the problems, an initial evaluation suggests that local authorities and those receiving services have generally been satisfied with the scheme. Providers usually have only a few clients
using vouchers, but their number is expected to increase in the future.

The impact of introducing the service voucher system was less dramatic than originally expected, with the new law only slightly increasing the number of municipalities using vouchers.

The new legislation will probably further increase the use of vouchers, especially in local authorities that have integrated home care and home nursing services, but additional government measures are needed to persuade local authorities to adopt vouchers more widely for health care services.

Sources and further reading:


The International Network
Health Policy and Reform

Since 2002, the International Network Health Policy and Reform has brought together health policy experts from 20 countries around the world to report on current health reform issues and health policy developments in their respective countries. Geared toward implementation, the Network aims to narrow the gap between research and policy, providing timely information on what works and what does not in health policy reform.

Participating countries were chosen from a German perspective. We specifically looked for countries with reform experience relevant for Germany. Partner institutions were selected taking into account their expertise in health policy and management, health economics or public health. Our network is interdisciplinary; our experts are economists, political scientists, physicians or lawyers. Many of them have considerable experience as policy advisers, others in international comparative research.
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<thead>
<tr>
<th>Country</th>
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<tr>
<td>Australia</td>
<td>Centre for Health Economics Research and Evaluation (CHERE), University of Technology, Sydney</td>
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<td>IRDES, Institut de Recherche et de Documentation en Economie de la Santé, Paris</td>
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<tr>
<td>Germany</td>
<td>Bertelsmann Stiftung, Gütersloh Department of Health Care Management, Berlin University of Technology (TUB)</td>
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<td>Israel</td>
<td>The Myers-JDC-Brookdale Institute, Smokler Center for Health Policy Research, Jerusalem</td>
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<tr>
<td>Netherlands</td>
<td>Department of Health Organization, Policy and Economics (BEOZ), Faculty of Health Sciences, University of Maastricht</td>
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<tr>
<td>New Zealand</td>
<td>Centre for Health Services Research and Policy (CHSRP), University of Auckland</td>
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<tr>
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<tr>
<td>Singapore</td>
<td>Department of Community, Occupational and Family Medicine, National University of Singapore (NUS)</td>
</tr>
<tr>
<td>Slovenia</td>
<td>Institute of Public Health of the Republic of Slovenia, Ljubljana</td>
</tr>
<tr>
<td>South Korea</td>
<td>School of Public Health, Seoul National University</td>
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<tr>
<td>Spain</td>
<td>Research Centre for Economy and Health (Centre de Recerca en Economia i Salut, CRES), University Pompeu Fabra, Barcelona</td>
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</tr>
<tr>
<td>United States</td>
<td>Institute for Global Health (IGH), University of California Berkeley/San Francisco; Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore</td>
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Survey preparation and proceedings

Issues were jointly selected for reporting based on what the network partners identified as the most pressing issues for reform. Subsequently, the issues were arranged into clusters:

- Sustainable financing of health care systems (funding and pooling of funds, remuneration and paying providers)
- Human resources
- Quality issues
- Benefit basket and priority setting
- Access
- Responsiveness and empowerment of patients
- Political context, decentralization and public administration
- Health system organization/integration across sectors
- Long-term care
- Role of private sector
- New technology
- Pharmaceutical policy
- Prevention
- Public health

Reporting criteria

For each survey, partner institutes select up to five health policy issues according to the following criteria:

- Relevance and scope
- Impact on status quo
- Degree of innovation (measured against national and international standards)
- Media coverage/public attention

For each issue, partner institutions fill out a questionnaire aimed at describing and analyzing the dynamics or processes of the idea or policy under review. At the end of the questionnaire, our respondents give their opinion regarding the expected outcome of the reported policy. Finally, they rate the policy in terms of system dependency/transferability of a reform approach.
The process stage of a health policy development is illustrated with an arrow showing the phase(s) a reform is in. A policy or idea does not necessarily have to evolve step by step. Also, depending on the dynamics of discussion in a given situation, a health policy issue may well pass through several stages during the time observed:

Idea refers to new and newly raised approaches voiced or discussed in different forums. Idea could also mean “early stage”: any idea present but not anywhere near formal inception. In this way, a “stock of health policy ideas in development” is established, permitting the observation of ideas appearing and disappearing through time and “space.”

Pilot characterizes any innovation or model experiment implemented at a local or institutional level.

Policy Paper means any formal written statement or policy paper short of a draft bill. Included under this heading is also the growing acceptance of an idea within a relevant professional community.

Legislation covers all steps of the legislative process, from the formal introduction of a bill to parliamentary hearings, the activities of driving forces, the influence of professional lobbyists and the effective enactment or rejection of the proposal.

Implementation: This stage is about all measures taken towards legal and professional implementation and adoption of a policy. Implementation does not necessarily result from legislation; it may also follow the evidence of best practices tried out in pilot projects.

Evaluation refers to all health policy issues scrutinized for their impact during the period observed. Any review mechanism, internal or external, mid-term or final, is reported under this heading.

Change may be a result of evaluation or abandonment of development.
Policy ratings

A second figure is used to give the reader an indication of the character of the policy. For this purpose, three criteria are shown: public visibility, impact and transferability.

Public Visibility refers to the public awareness and discussion of the reform, as demonstrated by media coverage or public hearings. The ratings range from “very low” (on the left) to “very high” (on the right).

Impact: Ranging from “marginal” (on the left) to “fundamental” (on the right), this rating criterion illustrates the structural or systemic scope and relevance of a reform given the country’s current health care system.

Transferability: This rating indicates whether a reform approach could be adapted to other health care systems. Our experts assess the degree to which a policy or reform is strongly context-dependent (on the left) to neutral with regard to a specific system, that is, transferable (on the right). The figure below illustrates a policy that scores low on visibility and impact but average on transferability.

Project management

The Bertelsmann Stiftung’s Health Program organizes and implements the half-yearly surveys. The Department of Health Care Management, Berlin University of Technology (TU Berlin), assisted with the development of the semi-standardized questionnaire.

Reports from the previous nine and the tenth survey round can be looked up and researched on the network’s Web site, www.healthpolicymonitor.org. Both these reports and this publication draw upon the partner institutions’ reports and do not necessarily reflect the Bertelsmann Stiftung’s point of view.
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