



EUROHEALTH

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

SENIOR EDITORIAL TEAM

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

EDITORIAL ADVISOR

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

FOUNDING EDITOR

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

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

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DESIGN EDITOR

Steve Still: steve.still@gmail.com

PRODUCTION MANAGER

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

SUBSCRIPTIONS MANAGER

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

Article Submission Guidelines

Available at: <http://tinyurl.com/eurohealth>

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List of Contributors

Karam Adel Ali • European Centre for Disease Prevention and Control, Stockholm, Sweden

Patrice Boyer • European Brain Council, Belgium and Paris 7 University, France

Frederic Destrebecq • European Brain Council, Belgium

Monica Di Luca • European Brain Council, Belgium and University of Milan, Italy

Giovanni Esposito • European Brain Council, Belgium

Gonçalo Figueiredo Augusto • Nova University of Lisbon, Portugal

Inês Fronteira • Nova University of Lisbon, Portugal

Maria M. Hofmarcher • HS&I HealthSystemIntelligence and Medical University of Vienna, Austria

Stefania Ilinca • Austrian Public Health Institute, Vienna

Sherry Merkur • European Observatory on Health Systems and Policies (London Hub), United Kingdom

David Nutt • European Brain Council, Belgium and Imperial College London, UK

Wolfgang Oertel • European Brain Council, Belgium and Philipps-Universität Marburg, Germany

Willy Palm • European Observatory on Health Systems and Policies (Secretariat), Belgium

Lucia Pastore Celentano • European Centre for Disease Prevention and Control, Stockholm, Sweden

Nataša Peri • Medical University of Vienna, Austria

Vinciane Quoidbach • European Brain Council, Belgium

Ricardo Rodrigues • Austrian Public Health Institute, Vienna

Andrea E. Schmidt • Austrian Public Health Institute, Vienna

Jorge Simões • Nova University of Lisbon, Portugal

Judit Simon • Medical University of Vienna, Austria

Ruth Waitzberg • Myers-JDC-Brookdale, Jerusalem, Israel

Daniel Weyermann • Federal Department of Economic Affairs, Education and Research – Civilian Service, Thun, Switzerland

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Eurohealth Monitor

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Gaining access to the health care services that a person needs is one of the cornerstones of universal coverage. This is particularly important for vulnerable groups who often need health services the most. Looking specifically at the rights of children to health care in the EU, the opening article by Willy Palm in the **Observer** section highlights that although all Member States have ratified the UN Convention on the Rights of the Child, there are still some ambiguities over eligibility and irregular residence status brings with it the risk of insufficient coverage.

At the other end of the age spectrum, Rodrigues et al focus on the largely overlooked issue of inequality and inequity in the use of long-term care services in Europe. With a focus on the use of informal care and formal care services provided at home they look at differences in use by socio-economic status and discuss whether these differences are unfair.

In our **International** section, we revisit efforts to inform health system performance assessment (HSPA). Hofmarcher and colleagues outline their work under the EU BRIDGE research project, sifting through more than 40 HSPA initiatives and over 2000 indicators in order to identify a priority set of indicators. The authors argue that the diffusion of a 'headline' set of indicators would enhance the evidence-based monitoring of key performance aspects of health systems and make the analysis of policy impacts more comparable.

The next article by authors at the European Centre for Disease Prevention and Control considers the challenges of vaccine hesitancy. The article outlines the multi-faceted public health challenges that immunisation programmes are encountering in the face of public concerns around vaccination. The authors call for novel thinking and intervention strategies to address new challenges, including targeted investment.

Moving to the impact of brain related disorders, Nutt et al explain the key findings from the European Brain Council's latest research on the current obstacles to optimal treatment for a range of conditions. The research provides evidence-

based solutions and recommendations for early diagnosis and effective patient-centred care.

The **Systems and Policies** section features reforms and initiatives from widely differing health systems. From Switzerland we learn about the use of state-run civilian and volunteer services to fill gaps in the care of older people. From Portugal, Simões and co-authors discuss the raft of health system reforms introduced between 2011 and 2014 under the country's financial assistance programme to cut costs and enhance efficiency. And in their article on Israel, Waitzberg and Merkur discuss the negative impacts of private insurance funding for hospital care and how the government is endeavouring to address these through a number of reforms that target the voluntary health insurance market, physicians working in public sector hospitals, and hospital payment systems.

This Winter issue concludes with our usual **Monitor** section, featuring two new publications on civil society and health and assessing the economic costs of unhealthy diets and low physical activity. There is also a round-up of the latest health policy news from Europe and beyond.

We wish you a happy holiday season!

Sherry Merkur, Editor

Anna Maresso, Editor

David McDaid, Editor

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CHILDREN'S UNIVERSAL RIGHT TO HEALTH CARE IN THE EU:

COMPLIANCE WITH THE UNCRC

By: Willy Palm

This article is based on the report by Willy Palm, Cristina Hernandez-Quevedo, Katarzyna Klasa and Ewout van Ginneken. *Implementation of the right to health care under the UN Convention on the Rights of the Child. Status report for the European Union, July 2017.*



Summary: The UN Convention on the Rights of the Child (UNCRC) establishes a fundamental right for every child to access health services, irrespective of nationality, residence or insurance status. Whereas all EU Member States have ratified the Convention, eligibility for health care services for certain groups of children is not always clearly defined or well-established. Only a few Member States have introduced a legal disposition that guarantees all children living in their territory a right to health care, regardless of legal status. Children with no regular residence status are the most vulnerable group, and others may fall between the cracks or be left with insufficient coverage.

Keywords: Human Rights, Children, United Nations, Eligibility to Health Care, Access Rights, Universal Health Coverage, Sustainable Development Goals

Introduction

Children take a special position in society but also in health. Not only given their vulnerable status, both physically and mentally, but also because of the impact that any harm inflicted on children has for their future development and opportunities in life, children deserve appropriate legal protection and care. This is why special legal rights for children were developed, also spurred by the United Nations Convention on the Rights of the Child (UNCRC).

The moral imperative to improve children's lives and health is not only reflected in this Convention but also for instance in the 2030 Agenda for Sustainable Development¹ with references to children to be found in most of the Sustainable Development Goals (SDGs) and 95 targets connected directly or

indirectly to children.² Despite the huge progress that has been made in Europe over the last few decades in improving child health status, there are still wide variations in outcomes between and within countries. It was estimated that across the EU27 countries over 12,000 child deaths could be avoided if all countries would align to the country with the lowest child mortality rate (Sweden).³ Next to addressing the broader health determinants that can help save children's lives and improve their health status, access to timely and effective health care is also essential.

The UN Convention on the rights of the child require states to provide necessary medical care

The UNCRC, which was signed in New York on 20 November 1989, establishes in

Willy Palm is Senior Adviser, European Observatory on Health Systems and Policies, Belgium.
Email: wpa@obs.euro.who.int

its Article 24 a fundamental right to health for all children.¹ This also includes a right to curative and rehabilitation services and entails a commitment for countries to ensure that no child is deprived of his or her right of access to such health care services (see Box 1).

While the UNCRC does not specify the exact range of services to which children should have access, it requires states to ensure the provision of necessary medical assistance and health care with an emphasis on the development of primary health care. The experts of the Committee on the Rights of the Child, who monitor the Convention's implementation and interpret the various different children's rights, see the right to health as an inclusive right in line with the WHO Constitution that should allow children to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health.² Besides access to essential health care services, they also highlight the importance of children's mental health and the need to give special attention and protection to children at risk because of their family or social environments and to children affected by humanitarian emergencies.

Next to children's rights to health services, the Convention also includes a fundamental right for mothers to pre-natal and post-natal health care. This is justified by the profound impact that maternal mortality and morbidity may have on children's own health and development. The Committee also considers that governments have an obligation to ensure that children's health is not undermined as a result of discrimination, which is a significant factor contributing to vulnerability.

All EU Member States have ratified the Convention. While the right contained in Article 24 UNCRC is a programmatic right, meaning that states have an obligation to strive towards its gradual implementation taking into account available resources, it would be difficult to argue for any of them not to fully implement universal health coverage for children. Although the EU has not signed the UNCRC as a separate party, children's rights are also explicitly included in the

Box 1: Article 24 UN Convention on the Rights of the Child (UNCRC)

1. States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
 - a) To diminish infant and child mortality;
 - b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
 - c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
 - d) To ensure appropriate pre-natal and post-natal health care for mothers;
 - e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast feeding, hygiene and environmental sanitation and the prevention of accidents;
 - f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realisation of the right recognised in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Source: ¹

Charter of Fundamental Rights of the EU, and therefore they also need to be guaranteed by EU institutions and by EU Member States when implementing EU legislation.

Many member states are not in full compliance with the UNCRC

A status report that was produced at the request of the European Commission assessed the minimal compliance of EU Member States with the legal obligation contained in Article 24 UNCRC to ensure access to health care services for all children.³ We looked at four main categories of children who more or less permanently reside in a country:

- own nationals,
- children with EU/EEA citizenship or any other nationality,

- children with asylum-seeking status and
- children with irregular residence status.


Only four countries (Croatia, Cyprus, Italy and Spain) have actually enshrined in their legislation a specific legal disposition that establishes an unconditional and universal right to health care for all children living in their territory, irrespective of their legal status. Both Cyprus and Italy actually explicitly refer to the UNCRC. In seven other countries (France, Greece, Malta, Poland, Portugal, Romania and Sweden) access to health care is ensured to all four mentioned groups of children through regular legislation by setting out the eligibility criteria or by organising special additional schemes for specific groups that fall outside of the main statutory coverage.

Table 1: Basic assessment of EU Member States' legal compliance

| children – legal situation population coverage | Belgium | Bulgaria | Czech Republic | Denmark | Germany | Estonia | Ireland | Greece | Spain | France | Croatia | Italy | Cyprus | Latvia | Lithuania | GD Luxembourg | Hungary | Malta | Netherlands | Austria | Poland | Portugal | Romania | Slovenia | Slovakia | Finland | Sweden | United Kingdom |
|---------------------------------------------------|---------|----------|----------------|---------|---------|---------|---------|--------|-------|--------|---------|-------|--------|--------|-----------|---------------|---------|--------|-------------|---------|--------|----------|---------|----------|----------|---------|--------|----------------|
| nationals | Green | Green | Green | Green | Yellow | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Yellow | Yellow | Green | Green | Green | Green | Green | Green | Green | Green |
| EU/EEA and third-country residents | Green | Green | Yellow | Green | Yellow | Green | Green | Green | Green | Green | Green | Green | Green | Yellow | Green | Green | Green | Green | Yellow | Yellow | Green | Green | Green | Green | Green | Green | Green | Yellow |
| asylum seekers | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Yellow | Green | Green | Green | Green | Green | Yellow | Green | Green | Green | Yellow |
| irregular residents | Yellow | Red | Yellow | Yellow | Yellow | Yellow | Red | Green | Green | Green | Green | Green | Green | Red | Red | Red | Red | Green | Yellow | Yellow | Green | Green | Green | Red | Yellow | Red | Green | Yellow |

Legend:

- = non-compliance with the obligations contained in Art. 24.2 (b) for each category of children;
- = intermediary compliance with the obligations contained in Art. 24.2 (b) for each category of children;
- = full compliance with the obligations contained in Art. 24.2 (b) for each category of children.

Source: Authors' own compilation 

In the remaining 17 Member States certain categories of children may not be covered or not sufficiently covered by law (see Table 1). Based on a traffic-light scoring system an intermediate position of partial compliance is allocated for situations where certain children within the group may fall outside statutory coverage or coverage is limited to a reduced set of services. Whereas access only to emergency care is clearly too restrictive, several countries use the concept of “urgent medical aid” to describe the range of services covered for children that are not covered by the regular system. While this is broader than just emergency care and would typically include regular primary care, pre- and post-natal services to new-born babies and their mothers, as well as preventive care (including vaccinations), it would exclude elective forms of care.

Health coverage is not always complete for all resident children

In general, depending on the type of health system, children are normally covered either directly on the basis of citizenship or residence status, or indirectly as dependants of their statutorily insured parents or legal guardians. Children are often granted a special status when it comes to entitlements to health care, as is also the case with pregnant women and mothers. This not only relates to general eligibility to statutory health coverage, but can also generate more comprehensive coverage compared to adults. Some

countries apply child-specific user charge policies (reductions, caps, or exemptions) to ensure affordable care for children. Also special attention is given to ensure children's access to preventive services. The special status generally applies until the legal age of 18, but is extended in many cases for as long as children are enrolled in education (or in military service) and remain financially dependent on their parents or guardians. For disabled children, this status is sometimes continued indefinitely or they are covered in their own right.

“ allow children to grow and develop to their full potential”

Especially in countries with statutory health insurance systems that are based on the professional status of the parent or on the payment of contributions or insurance premiums, certain children may fall between the cracks and be left without coverage, especially if parents or guardians are not in compliance with administrative or financial conditions for statutory health insurance. Also drawing on the hybrid social insurance models that were developed in some of the Central-European Member States after political transition, where children are insured

in their own right as non-contributing persons or based on state contributions, several Western-European countries have also introduced mechanisms to stabilise entitlements and ensure continuity of coverage.

In countries where statutory coverage is based on residence status, the definition of permanent residence can vary considerably. Some apply a looser notion while others are very strict in requiring permanent legal residence for obtaining statutory health coverage. Actually, in order to obtain residence status, countries will often require immigrants to provide evidence that they have, for themselves and their family members, sufficient resources and comprehensive sickness coverage in the host Member State. This is not only the case for third country nationals (non-EU/EEA citizens) but also for economically non-active EU/EEA citizens who reside in another Member State for longer than three months (Directive 2004/38/EC). Generally, seamless transition can be guaranteed through the Regulation 883/2004 on the coordination of social security systems but for children who were previously not covered by any social security system in an EU Member State (e.g. EU citizens with irregular residence status, privately insured, children of international civil servants, non-EU/EEA residents who were previously insured outside the EU/EEA), eligibility to health care coverage may

not be guaranteed. These are groups that often remain unnoticed in migrant policy documents and regulation.⁷

“certain children may fall between the cracks”

Migrant children are particularly vulnerable

The most vulnerable group are indeed migrant children who arrive in a country with an unclear or irregular residence status. The status of being a migrant is often more important than being a child when it comes to defining entitlements and eligibility.⁸ Their access rights are often conditional and restricted to a limited set of services (emergency care or ‘urgent medical aid’). Administrative requirements, lack of information and financial barriers (e.g. compulsory registration with a general practitioner, having a place of residence, prior assessment of the financial state of indigence, up-front payment) can further impede access to care and sometimes make eligibility rather theoretical.

In some countries, children with irregular residence status are better protected than adults. In France they are immediately covered on arrival under a specific state insurance scheme (called AME – ‘Aide Médicale d’État’) whereas adults are only covered after three months. Among children unaccompanied minor foreigners sometimes get broader entitlements, with direct statutory coverage in several Member States. While this can be justified by the specific needs that are generated by their precarious condition it also generates questions around discrimination by family status.⁹

When children apply for international protection and are registered as asylum seekers, they are formally granted protection, including access to health services. According to the Reception Conditions Directive 2013/33/EU, Member States need to ensure necessary health care, at least emergency care and essential treatment of illnesses and of serious mental disorders. However, most Member States award asylum seeking children the same protection and coverage as children within the statutory system. In some cases, this protection is extended to the period before starting the asylum process or maintained even after their application for asylum has been rejected. From the moment that a child is formally recognised as a refugee or stateless person, he/she is legally granted the same protection and treatment as a national.

The way ahead: the need for a rights-based approach to child health

Beyond the need to monitor the legal situation concerning children’s access to health care, actual implementation also needs to be closely assessed. Ensuring universal access for all children is only the first step in taking a rights-based approach to child health that underpins the UNCRC. Moreover, children’s rights in health care deserve special attention as evidence suggests that health services are often not well-adapted to their specific needs.⁸

For the future, some are already advocating a fuller development of children’s rights not only to health but also specifically as patients. Building on the guidelines on child-friendly health care that the Council of Europe adopted in 2011,⁹ a recent report reviews children’s human rights in the face of biomedical developments. That report, which was published on the occasion of the 20th anniversary of the so-called Oviedo Convention, suggests that children’s fundamental rights as patients could be further strengthened, including their participation in medical decisions that relate to their own treatment.¹⁰

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INEQUALITY AND INEQUITY IN THE USE OF LONG-TERM CARE SERVICES IN EUROPE: IS THERE REASON FOR CONCERN?

By: Ricardo Rodrigues, Stefania Ilinca and Andrea E. Schmidt

Summary: Possible inequalities and inequities in long-term care (LTC) use have thus far been overlooked in health policy. Two recent studies shed light on inequalities and inequities in the use of home care services and informal care, by socio-economic status, across Europe. Evidence suggests that use of home care services mostly reflects need and is therefore equitable. The picture is different for informal care, where use is concentrated among the poor, even after controlling for needs. This raises questions about possible unmet needs and the necessity to consider both informal and formal care when discussing equity in LTC.

Keywords: Long-term Care, Inequality, Inequity, Informal Care, Home Care

Introduction

Inequalities in the use of health care have consistently ranked as one of the most relevant issues in health care policy. In comparison, much less is known about possible inequalities in the use of long-term care (LTC) by older people. The policy relevance of this issue, however, is growing given the increasing share of the population in need of LTC and the significant out-of-pocket payments expected from people with LTC needs.¹ The European Commission has recently cautioned that failure to address LTC needs and the financial burden that it places on users and families may limit access to care to only those who have the means to pay for it.²

In addition, across Europe large differences exist in the availability and accessibility of home care. In recent years, many countries have sought to increase reliance on informal care provided by family members through the provision of cash-for-care benefits, often without a simultaneous extension of home care services (in-kind benefits). At the same time, eligibility criteria have also been tightened and mechanisms for increased provider competition have been introduced.³ These differences in the financing and delivery of LTC across Europe beg the question of whether there are significant differences between countries in the use of LTC across different socio-economic groups.

Ricardo Rodrigues is Head of Health and Care Unit; **Stefania Ilinca** is Researcher, European Centre for Social Welfare Policy and Research; **Andrea E. Schmidt** is Researcher, Austrian Public Health Institute, Vienna, Austria. Email: rodrigues@euro.centre.org

Possible sources of inequalities in LTC

It is typically presumed that because people of lower socio-economic status (SES) have on average poorer health, they are more likely to use LTC services. If this is true, there could well be unequal use of LTC (i.e. inequalities), but without inequity. The distinction between inequality and inequity is an important one, particularly from a policy perspective. While inequality refers to differences in LTC use between groups (regardless of the reasons behind these differences), inequity refers to differences that are considered unfair (i.e. cannot be ascribed to legitimate differences in care needs). As a case in point, proportionally higher levels of use for those with more severe care needs would without doubt be deemed a justifiable ground for unequal use. Yet, if older people with similar needs have different possibilities to use LTC services depending on their income, this could be considered an inequitable (as well as an unequal) outcome.

“unequivocal signs of unequal use of LTC for older people”

Beyond differences in need, what other factors could be considered sources of unfair inequalities in use of LTC and therefore lead to inequity? Firstly, and unlike in the case of health care, LTC services are seldom free at the point of delivery and higher out-of-pocket payments for LTC are common.⁴ Lower-income people could thus find themselves in need of LTC but unable to afford it financially. In addition to income, education is another potential source of unfair inequalities in LTC use. Not only is higher education correlated with ability to pay, but it may allow individuals to better grasp complex eligibility criteria or make more credible claims for accessing services.

Household structure (e.g. marital status or number of children) may also affect use of LTC. The size and composition of the household may determine whether older people can access informal care and, given the substitutability of LTC services and informal care, this could in turn also impact on inequalities in service use. Close relatives may also act as ‘advocates’ for older people to receive LTC services. Finally, the structure of the household can become an explicit eligibility criterion, linking access to services to the (non-) existence of family members as potential informal carers. This is the case of the Netherlands, for example, where the existence of co-residing relatives is considered when determining eligibility for publicly funded LTC.

Lastly, regional variation in service availability is a potential source of unfair inequalities. Since LTC in Europe is usually a policy prerogative of regional or local governments, more affluent regions or municipalities may be able to provide or fund more LTC services or attract a greater number of providers. This could create a sort of ‘postal code lottery’ in access and use of services.

Inequities in the use of LTC, particularly if these negative aspects affect the more vulnerable groups in society (e.g. the poor), are of particular concern for public policies. However, both inequities and inequalities in use of LTC are relevant as the latter might underscore undesirable outcomes in health and LTC policies in a given context. For example, differences in use of LTC between less and more affluent individuals may simply mirror differences in need between these two groups, but from a policy standpoint it would still be relevant to know that poorer individuals systematically have poorer health (and thus need more LTC).

Inequalities in use of LTC across Europe

Two recent studies have sought to assess possible SES inequalities and inequities in the use of LTC among older people living in the community across several European countries.^{5, 6} They included two types of LTC: formal care services provided at home (both personal care and

Box 1: Definitions of long-term care use

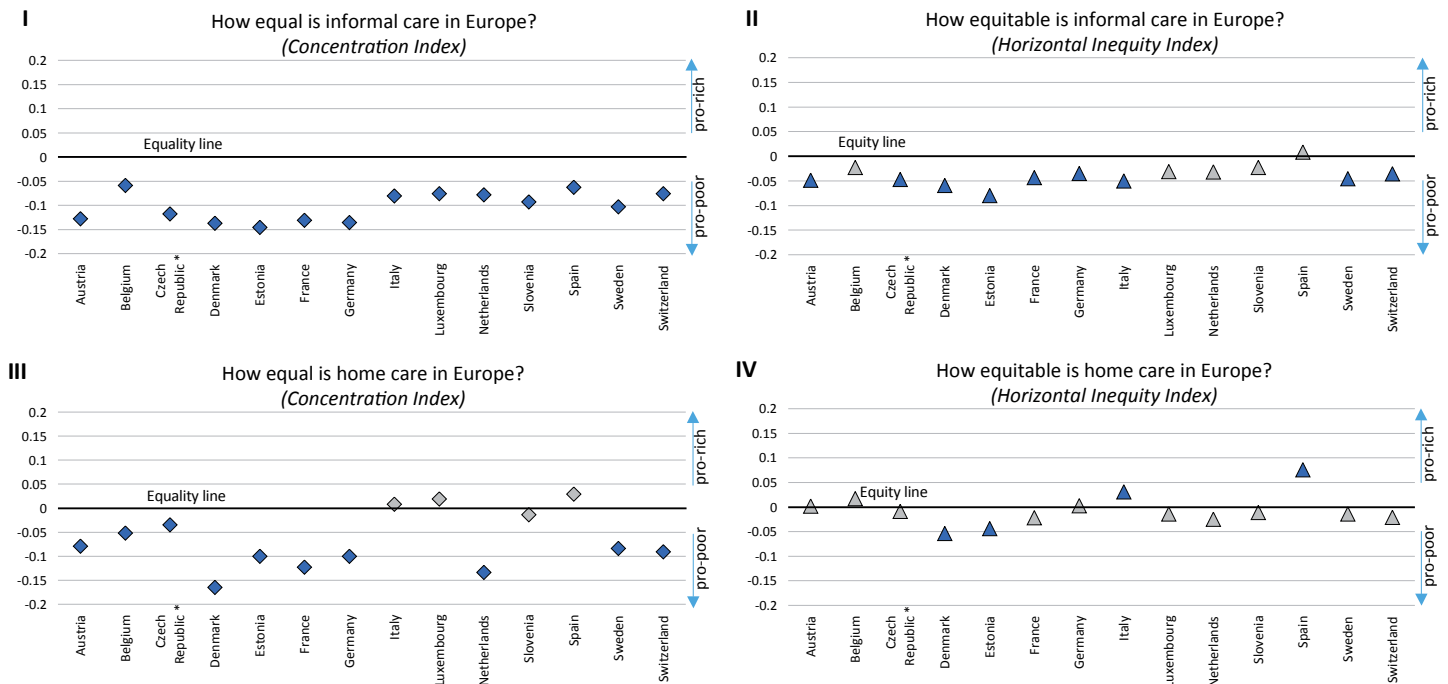
Home care refers to utilisation of professional or paid services in the home, including e.g. help with personal care, domestic tasks, other activities, and meals on wheels.

Informal care refers to receiving personal care or practical household help from a family member, friend or neighbour, inside or outside the care recipient’s household.

home help), and informal care provided by people living inside and outside the household (see Box 1). The countries considered include a wide and diverse mix of types of LTC systems according to breadth, depth and scope of coverage: Austria, Belgium, the Czech Republic, Denmark, Estonia, France, Germany, Italy, Luxembourg, the Netherlands, Slovenia, Spain, Sweden and Switzerland. Findings are based on a cross-country survey of older people carried out in 2013, the *Survey of Health, Ageing and Retirement in Europe* (SHARE). The dataset includes information on SES, health status, level of dependency and use of the aforementioned types of LTC. Inequalities were measured using the Concentration Index (CI), a standard method for assessing SES inequalities in health and health care use that allows for country-level comparison.⁷ The CI can assume values between [-1, 1], with negative values signifying pro-poor inequality (i.e. use of LTC services is concentrated among poorer individuals) and positive values depicting pro-rich inequality. Throughout, SES is proxied by income.*

The findings show that the use of LTC is fundamentally unequal for both formal home care services (henceforth home care) and informal care across Europe (see Figure 1). For informal care there is pervasive evidence that poorer older people are more likely to use this type

* SES is a complex concept that refers to individuals’ relative position in society, which may be determined by several factors (e.g. education, wealth, occupation). In these studies, income was considered as the main factor correlating with SES.

Figure 1: Inequalities and inequities in use of long-term care by income across Europe

Notes: Blue (darker) symbols represent statistically significant values ($p < 0.05$). Grey (lighter) symbols mean that values are not statistically significant ($p \geq 0.05$). Based on weighted data. The results presented here are based on the authors' publication in the journal Health Economics ⁵

of care for all the above-mentioned countries (quadrant I in **Figure 1**). The same is mostly true for home care, where use is also concentrated among poorer individuals for most countries (quadrant III in **Figure 1**). The exceptions are Italy, Luxembourg, Slovenia and Spain.

“mostly
no evidence of
inequity in home
care use”

To understand what drives the observed inequalities in LTC use, the CI can be disaggregated into individual contributions of each of the main variables likely to impact use. The decomposition for home care showed that differences in use are mostly related to care needs (which includes health, as well as age and gender), particularly lower health status and higher

dependency. Care needs are the main driving force in the use of home care and since higher need is concentrated among the poor, this accounts for a great deal of the pro-poor inequality in the use of home care that we find.

The second most important factor impacting on inequalities was household structures (in some countries this was even the most important factor), which included marital status, household size and number of children. Here too, we find that the household structure drives pro-poor inequalities in the use of home care (except for Spain). This is due to the fact that larger household size and co-residing with a spouse or partner mostly limit the use of home care – a sign of substitutability between informal and formal care – and more affluent older individuals tend to have a spouse or partner and live within larger households.⁶ Finally, income and education are also relevant factors in explaining inequalities.

Inequity in use of LTC across Europe

Although the CIs show unequivocal signs of unequal use of LTC for older people living in the community in Europe, the more important question is whether these differences are unfair. The same studies^{5, 6} also analysed inequity for both home and informal care taking income as a measure of SES. Inequity was assessed using a well-established method that first estimates how much care a person would have received if treated in the same way as the average person with similar needs, and then goes on to compare this with the actual care received. Results are displayed as a Horizontal Inequity Index (HII)[†], which can be read in much the same way as the CI above: negative values indicate pro-poor inequity in the use of LTC, while positive values indicate inequity favouring the rich.

[†] 'Horizontal' refers to the concept of 'horizontal equity', measuring whether there is equal use of care for equal care need levels.

Once differences in need are considered, there is mostly no evidence of inequity in home care use in the countries analysed (quadrant IV in **Figure 1**). The only countries for which there is evidence of inequity are Denmark, Estonia, Italy and Spain. Among these, the findings for Italy and Spain are particularly worrisome as inequity is found to disfavour the poor, while in Denmark and Estonia pro-poor inequity was found. The picture is somewhat different for informal care. There is evidence of pro-poor inequity for Austria, the Czech Republic, Denmark, Estonia, France, Germany, Italy, Sweden and Switzerland (quadrant II in **Figure 1**); while for the other countries there is no evidence of inequity.

“poorer individuals are found to make disproportional use of informal care”

Confronted with these results, should policy-makers worry about inequity in LTC? At first glance, the different LTC systems across Europe seem to essentially target home care on the basis of need and therefore are fairly equitable in how use of home care is distributed across people with different incomes. This picture may, however, change in the near future as some countries have started to discuss making access to LTC services conditional on household situation (similarly to England or the Netherlands) in order to better target scarce resources. Findings from at least one of the studies included here⁵ suggest that this could increase SES inequalities and inequities in the use of LTC services. Furthermore, the findings for informal care should also give policy-makers reason to pause. Poorer individuals are found to make disproportional use of informal care. While this could represent different preferences such as stronger filial norms among non-co-residing children of poorer older individuals,⁶ it could also signal

that some individuals may not be able to access LTC services and must be content with using informal care. At the same time, informal care may be less readily available to less affluent older individuals as they tend to live in smaller households and be single or widowed more frequently. Despite smaller (household) networks, poorer individuals disproportionately rely on informal care. Should this matter for European societies? This largely depends on who provides informal care and how. Several studies have linked high intensity informal care to adverse health and well-being among carers and limited ability to reconcile care with labour market attachment (for an overview see⁹). Furthermore, what is unquestionable is that women make up the majority of informal carers in Europe.

Conclusions

Despite the diversity of LTC systems in Europe, it seems that most countries are able to target LTC to those most in need regardless of their income. At the same time, however, there is strong evidence that informal care is mostly used by poorer older people. This may hint at the existence of unmet needs for LTC, either because individuals cannot afford services or because services provided only partially cover the needs of older people. As most informal carers are women, income differences in the use of informal care may also underscore gender inequalities in the provision of LTC. Informal care, besides LTC services, should thus be a key factor in the analysis and discussion of inequality and inequity in LTC.

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HEADLINE INDICATORS FOR STRUCTURED MONITORING OF HEALTH SYSTEM PERFORMANCE IN EUROPE

By: Maria M. Hofmarcher, Nataša Perić and Judit Simon

Summary: We propose a prioritised set of indicators identified in 43 national and international health system performance assessment (HSPA) initiatives with the aim to inform comparative analysis of policy impacts in a gradual manner. We documented over 2000 indicators which were consolidated for overlaps. Through implementing the euHS_I survey the resulting indicators then led to a balanced set of 95 indicators which were assessed by European experts for their relevance for specific HSPA domains, i.e. access, efficiency, equity and quality of care, and their priority levels. Headline indicators that monitor performance related to key objectives in public health were identified.

Keywords: Health System Performance Assessment, Indicators, Health Information, Policymaking, International Comparisons

The business case for comparative HSPA and indicators

Health System Performance Assessment (HSPA) receives high-level support at national, European Union (EU) and international levels (World Health Organization – WHO, Organisation for Economic Co-operation and Development – OECD) as an instrument to improve transparency and accountability, a broadly shared policy goal.^{1,2} The European Commission (EC) supports Member States directly in this work by providing analysis and forecasts, and recommending reforms based on evidence linked to robust and comparable information.³

Reflecting generic policy goals, health system performance (HSP) is mostly measured against access, efficiency, equity and quality, and their interrelation in order to understand the content and the scope of cross-country comparisons.⁴ There has been a proliferation of indicators for a variety of purposes, including informing policy development, evaluating policy initiatives, promoting accountability to citizens, managerial control, and research. This proliferation can cause both confusion and duplication of effort, and also leads to a lack of comparability over time and between countries. These consequences suggest a need to rationalise

Maria M. Hofmarcher-Holzacker is Director of HS&I HealthSystemIntelligence and Research Associate, Department of Health Economics, Medical University of Vienna, Austria; **Nataša Perić** is Researcher and **Judit Simon** is Professor of Health Economics and Head of Department, Department of Health Economics, Centre for Public Health, Medical University of Vienna, Austria.
Email: maria.hofmarcher@healthsystemintelligence.eu

the collection and dissemination of indicators if their usefulness and impact is to be maximised.

Evidence-based policymaking calls for a coherent HSPA framework and prioritised indicators

Clear evidence is needed in the prioritisation of HSPA indicators. Currently, no accepted and coherent HSPA framework for cross-country comparison exists at the European level.^{[4][5]} Even though the European Core Health Indicators (ECHI) initiative is an important source of relevant indicators, as are WHO and OECD, a short list of key indicators with unified reporting standards for data is missing.^[6]

Good practice HSPA is clearly a European matter. At the same time, many stakeholders including providers, are worried that comparative evaluations lead to a loss of reputation and resources. In the European project BRIDGE Health (hereafter, BRIDGE Health), we address this concern through a bottom-up approach by appreciating a broad spectrum of initiatives and their information content. Importantly, our proposed indicator hierarchy within performance domains is a practical alternative to creating composite indicators which are often difficult to interpret.^[7]

“a manageable set of meaningful indicators is needed at the EU level”

This article summarises important results of work in the stream *evaluation of health care systems* within BRIDGE Health that expanded the resources of the electronic handbook Health Data Navigator which was established to enhance comparative

performance assessment.^{[8][9]} Projects like these can serve as important mediators in bridging fragmented initiatives and brokering knowledge transfer for enhancing good practice HSPA (see Box 1). Through combining research prepared in two EU-funded projects, the relevance lies in the effort to inform priority setting and to contribute to the creation of a European health information infrastructure. The goal of this article is to present a set of headline indicators to frame and describe health care system performance.

Health system headline indicators should pave the way for better HSPA consistency

To provide a focused HSP overview at a glance, a manageable set of meaningful indicators is needed at the EU level. The concept of headline indicators is a well-established approach for prioritisation. It is an important monitoring tool to track and explain progress toward strategic targets, and has been adopted in various areas – for example, in the *Europe 2020* strategy, in the area of Sustainable Development,^{[10][11]} in macro-economics, and for the scoreboard of key employment and social indicators. We have adapted these concepts and defined *health system headline indicators* as being suitable to monitor overall performance in defined domains related to key objectives in public health and in health systems. Other criteria include being robust, widely used with high communicative and educational values, and available for most EU Member States, generally for a minimum period of five years. Headline indicators can give early warnings of policy impacts, highlight trends, indicate priorities for policy action, and promote accountability. Ideally, they also foster cross-country learning through stimulating further analysis. If they are used correctly, they have the potential to attract media attention, raise awareness and more importantly, provide quick and visible signals to policymakers and to the general public.^[12] To account for the complexity of performance assessment, headline indicators in our approach co-exist with larger sets of indicators for more in-depth monitoring and analysis of policymaking.

A systematic review and assessment sheds light on the existing indicator landscape

We first carried out a review of existing indicators used or proposed in HSP evaluation. This exercise resulted in a list of 2168 indicators reported in 43 HSPA initiatives of EU Member States, the EC, as well as international institutions (e.g. OECD, WHO-Euro WHO Regional Office for Europe and the Commonwealth Fund). Adjustments of overlaps reduced the list to 361 indicators which were grouped into chapters based on the OECD *Health at Glance* report. About two-thirds of the 361 indicators were quality of care indicators (34%), indicators of health status (15%), and determinants of health (13%). In contrast, indicators on financing, physical resources and health care activities represented only about 6% per chapter.

We conducted a two-stage online survey, the European Health System Indicator (euHS_I) survey with the aim to elicit preferences on i) the most relevant HSPA domain(s), e.g. access for a specific indicator, and ii) the importance of indicators regarding their information content, i.e. headline, operational, explanatory.

The construction of the survey was informed by a framework developed in EuroREACH^[13] and by the priority structure of an indicator pyramid developed by Eurostat.^[14] Whereas the first stage consisted of the full list of the identified consolidated (361) indicators, the second stage was reduced to a more balanced set of indicators prioritised based on the first stage results (95 indicators).^[15]

Indicator rankings benefited from a broad spectrum of qualified survey participants

In the first stage, we surveyed 92 experts actively involved in performance measurement and reporting, indicator development, or research of HSPA domains. In the second stage, a systematic selection of 209 experts from all 28 EU Member States, 11 non-EU countries and two international organisations were asked to complete the survey. At this stage,

participants were also asked to list their top three headline indicators per HSPA domain in writing.

The overall response rate in the second stage was 34%, up from 28% in the first stage. This increase was mainly achieved through an improved and representative response to the survey coming from EU countries. Almost three-quarters of respondents completed the survey fully in the second stage. Most respondents came from governmental or other public institutions and their level of expertise in the HSPA was high. Among a list of criteria of headline indicators provided in the survey most participants rated validity, reliability and that an indicator needs to be clear and easy to communicate and interpret as key. Frequency analysis was performed where “domain frequencies” and “headline level frequencies” were calculated for each HSPA domain. This was complemented by listing rankings of indicators based on individual preferences of participants.

Table 1 provides key survey results by listing indicators which received the highest average ranks. The average rank is calculated by summing-up ranks weighted with the respective response rate in the dimension headline, domain and individual preferences. Column one indicates the rank, followed by indicator name and the domain in which a respective indicator was mapped by survey respondents. The table also presents if a specific indicator is available in one of the key data repositories, and if it was selected as a relevant measure like OECD health data and Eurostat.

Identified headline indicators appear useful to frame comparative assessment of policy impacts

Life expectancy, the share of population covered by health insurance and the share of households experiencing high levels of catastrophic out-of-pocket spending rank top. This is followed by a group of useful and broadly available indicators, such as body mass index, a health determinants indicator, and a key structural quality indicator (rates of hospital acquired infections) which also has a process dimension.

“ foster cross-country learning through stimulating further analysis

Healthy life years ranks sixth reflecting a high level of awareness about the importance of policies to promote active and healthy ageing. Accessibility to acute care also received high priority on rank eight. As with other indicators, e.g. waiting times, our listing of headline indicators clearly shows the urgency to request Member States (via Eurostat) to collect and provide data with standardised quality information to make these indicators available.

Lessons learned and the way forward in a European approach to HSPA

With our approach, comparative analysis of policy impacts can be done in a gradual manner. The euHS_I survey allowed the quantification of overlaps and gaps in HSPA indicators, their expert allocation to domain areas and the establishment of an informed hierarchy structure. No similar consolidated indicator inventory exists. HSPA indicators from different initiatives largely overlap and public health indicators dominate over health systems aspects. The selected measures for the ongoing Euro-Healthy population health index also reflects this (see <http://www.euro-healthy.eu/research/population-health-index>).

We were able to show the feasibility of indicator priority elicitation across many stakeholders and the potential to make priority setting more evidence-based. Even though many criteria need to be considered and criteria priority vary depending on the targeted audience, headline information on health systems is crucial to observe the achievement of core policy goals in a structured and standardised manner.

While both the EU Health Strategy “Together for Health” and the corresponding EC communication,¹¹ referred to the high importance of efficiency, there is much work still to be

Box 1: What this research adds

- Appraises HSP reports in Member States at EU and international level
- Establishes a HSP indicator inventory by organising indicators used in 43 performance reports
- Surveys the relevance of HSP indicators in performance domains and the importance of their information content
- Proposes a set of headline HSP indicators for the first time
- Highlights the importance of indicator development in health system areas beyond public health
- Suggests that headline indicators are marked in Eurostat, OECD and WHO and in country health profiles like the ‘State of Health in the EU cycle’ initiative.

Source: Authors.

done in developing metrics that are able to compare health system efficiency across countries.¹² Our findings also suggest that more multidisciplinary work is needed to enhance efforts in making accurate, cross-country comparable efficiency indicators available for comprehensive HSPA. This is echoed in the 2018 work programme of the Expert Group on HSPA, a forum where Member States exchange experiences on the use of HSPA at national level and which looks specifically at tools and methodologies to assess efficiency.¹³

Furthermore, our findings are in line with the global priority areas reflected in the Sustainable Development Goals from 2015. It confirms the ultimate importance of financial protection in achieving comprehensive universal health insurance coverage. While the indicator, insurance coverage, might be obsolete for HSPA in some high-income Member States, it is an important source of information in Member States which are still catching-up in sourcing their welfare systems of which health is a central part. Thus, it is an important measure of system inequalities across the EU. Moreover, the priority is mirrored by the indicator, percentage of households experiencing high levels/catastrophic of out-of-pocket

Table 1: Headline indicators, average ranks and their availability

| Rank by weighted score | Name of indicator | Domain | Availabilities | | |
|------------------------|----------------------------------------------------------------------------------------------------------|---------------------|----------------|------|---------|
| | | | ECHI/Eurostat | OECD | WHO-EUR |
| 1 | Life expectancy | Health Status | ✓ | ✓ | ✓ |
| 2 | Share of population covered by health insurance | Access | ✓ | ✓ | - |
| 3 | Percentage of households experiencing high levels/catastrophic of out-of-pocket health expenditures | Equity | - | ✓ | - |
| 4 | Body Mass Index | Health Determinants | ✓ | ✓ | ✓ |
| 5 | Prevalence and incidence rate of hospital-acquired infections (% of patients hospitalised) | Quality of Care | * | - | - |
| 6 | Healthy Life Years (HLY) | Health Status | ✓ | ✓ | ✓ |
| 7 | Prevalence of different smoking status, self-reported | Health Determinants | ✓ | ✓ | ✓ |
| 8 | Accessibility to acute care | Access | - | - | - |
| 9 | Infant mortality rate | Health Status | ✓ | ✓ | ✓ |
| 10 | Total health care expenditure by all financing agents (total, public and private sectors) | Efficiency | ✓ | ✓ | ✓ |
| 11 | Average length of stay (ALOS), total and selected diagnoses | Efficiency | ✓ | ✓ | ✓ |
| 12 | Reported waiting times for access to specialist (care) | Access | - | - | - |
| 13 | Geographic distribution of doctors: Physicians density in predominantly urban and rural regions | Equity | ~ | ~ | ~ |
| 14 | Avoidable mortality rate: amenable and preventable deaths | Health Status | ✓ | - | - |
| 15 | Waiting times for elective surgeries | Access | - | ✓ | - |
| 16 | Opportunities for education: Participation in early childhood education | Health Determinants | ✓ | ✓ | - |
| 17 | Ambulatory Care Sensitive Conditions (ACSC) Hospitalisation Rate | Quality of Care | - | ✓ | - |
| 18 | Hospital Standardised Mortality Ratio (HSMR) | Quality of Care | → | → | - |
| 19 | Overall experience of life: Life satisfaction | Health Determinants | ✓ | ✓ | - |
| 20 | Number of surgical operations and procedures | Efficiency | ✓ | ✓ | ✓ |
| 21 | Self-reported/perceived general health | Equity | ✓ | - | - |
| 22 | Health expenditure per capita in PPP (purchasing power parities) in relation to life expectancy at birth | Efficiency | ~ | ~ | ~ |
| 23 | GINI coefficient (income distribution) | Equity | ✓ | ✓ | ✓ |

Source: Authors.

Notes: Average ranks are calculated are by summing-up ranks weighted with the respective response rate in the dimension headline, domain and individual preference.

(✓) indicator available

(~) not ready-made and needs to be calculated

(-) not available

(→) indicator available just for selected diagnoses

(*) provided by European Centre for Disease Control.

health expenditures, which is ranked third. These data mostly come from private consumption data within the System of National Accounts (SNA) which is widely standardised, at least in the Eurozone.

In **Table 1** lifestyle indicators, e.g. obesity (BMI), and other important measures

of equity and quality are included even though many of them are not included in the top ten. Overall, almost 50% of included indicators in the second stage of our survey and about two-thirds identified as headline are coming from ECHI and have predefined standards and are mostly available through Eurostat data.

In line with Europe 2020's headline indicators, we suggest the establishment of a similar structure in the area of HSPA. For example, an electronic repository could be created featuring headline indicators as classified. With such a structure, timely available benchmarks following the example of the macro-

economic database AMECO of the EC's Directorate General (DG) for Economic and Financial Affairs could be created. Similarly, data sheets could be published regularly as in the case of the OECD Main Economic Indicators (MEI). MEI present comparative and country-specific statistics to ensure reporting standards of important indicators for policymaking. Another example is the EU KLEMS database of Productivity and Growth Accounts on industry level that was initially developed within a Sixth Framework Programme (FP6) research project. Regular updates are funded by the EC, DG for Economic and Financial Affairs.

“public health indicators dominate over health systems aspects”

In a first step, identified and validated headline indicators of health and health systems should be highlighted in existing repositories like ECHI/Eurostat, as well as in the country profiles produced within the

“State of Health in the EU cycle” initiative. This would enable users, decision-makers and researchers to get a good overview about key performance aspects of health systems, a much-needed service to health and health system communities in Member States and beyond.

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Implementation of the right to health care under the UN Convention on the Rights of the Child

By: W Palm, C Hernandez-Quevedo, K Klasa, E van Ginneken

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Article 24 of the UN Convention on the rights of the child (UNCRC), which was adopted in 1989, establishes a fundamental right for every child to access services and facilities for the treatment of illness and rehabilitation of health. This study assesses the legal right to health care for children living in any one of the 28 EU Member States, all of which have ratified the UNCRC.

Irrespective of the actual implementation of this right to health care and the extent of coverage, the report highlights that even in terms of eligibility to health services certain groups of children are left with insufficient coverage or without coverage at all. Children living in a country with no regular residence

status are clearly the most vulnerable group. Access is often conditional and restricted to emergency care. But even other children may in some cases fall between the legal cracks. Only a few Member States have introduced a legal disposition that guarantees all children living in their territory a right to health care, regardless of their legal status.



Contents: Key messages; Induction and Objectives; The convention and the universal right to health care; methodology; summary of results; country overviews.

ADDRESSING VACCINE HESITANCY IN THE 'POST-TRUTH' ERA

By: Karam Adel Ali and Lucia Pastore Celentano

Summary: In the context of the so-called 'post-truth' era, immunisation programmes face a new set of challenges calling for novel interventions to prevent or address public concerns around vaccination. Understanding and undertaking necessary action to address the issue of individuals who have lost or are losing confidence in vaccines is a multi-faceted public health challenge, as the added benefits of vaccination require adequate uptake levels. Political commitment is required as well as additional investment, not only in finance, but also in the skillset necessary to appropriately design and implement culturally competent monitoring and intervention strategies and the flexibility to learn by doing.

Keywords: Vaccines, Vaccine Hesitancy, Immunisation, Communication, Trust

Introduction

Vaccines and vaccination are often praised for the immense benefit they have brought and continue to bring to individuals, populations, health, the economy, and society as a whole. No doubt vaccination is one of the most cost-effective public health interventions and remains a mainstay of prevention programmes worldwide. Vaccination has eradicated smallpox and will hopefully soon eradicate polio. In all European Union (EU) countries, the old predominant killers of our children such as diphtheria, tetanus and pertussis are now rare events, and there is hope that the success achieved in controlling measles makes this disease another possible target for elimination sometime soon.

Despite the recognised tremendous value brought by vaccination, increasing questioning, mistrust, scepticism and even outright denial of the effect and/or safety of vaccines are becoming a challenge for immunisation programmes internationally. This is of concern not only for disease-control public health goals, but also for health care systems' sustainability, and raises fundamental issues of health and social equity.

In reality, the history of concerns around vaccine safety is as old as vaccines themselves, and can be traced back to the first attempts to prevent and immunise against smallpox. In 2017, vaccines in use in Europe are highly complex and sophisticated biological products which undergo some of the most rigorous testing for efficacy and safety prior to licensing

Karam Adel Ali is Programme Manager of the Vaccine-Preventable Diseases Programme and **Lucia Pastore Celentano** is the Head of the Vaccine-Preventable Diseases Programme at the European Centre for Disease Prevention and Control, Stockholm, Sweden. Email: Karam.Adelali@ecdc.europa.eu

and approval for their introduction in national immunisation programmes. In the EU, Directive 2001/83/EC and Regulation (EU) No. 726/2004 provide regulatory authorities with the mandate to promote and protect public health by authorising the use of safe and effective vaccines, and by continuously assessing their benefit and risk profile following the granting of marketing authorisation. The European Medicines Agency plays a key role in this regard, and carries the responsibility of coordinating the pharmacovigilance system, which helps, inter alia, with identifying and informing (in a timely manner) on signals of possible unexpected adverse reactions or changes in severity, characteristics, or frequency of expected adverse reactions.²

The complexity of vaccine hesitancy

Nonetheless, in the so-called ‘post-truth’ or ‘post-factual’ society, the rapid spread of fake or unsubstantiated news through online media risks hampering the resilience of, and trust in, immunisation programmes. Sifting science facts from

science fiction and understanding which information to trust and which to ignore can become a real challenge for a parent seeking trustworthy answers to genuine questions concerning a given vaccine. More so, as disease rates go down and only poor knowledge or awareness is left, apprehensions triggered by potential or putative side effects of vaccination become more important to some individuals than the risks of the disease.

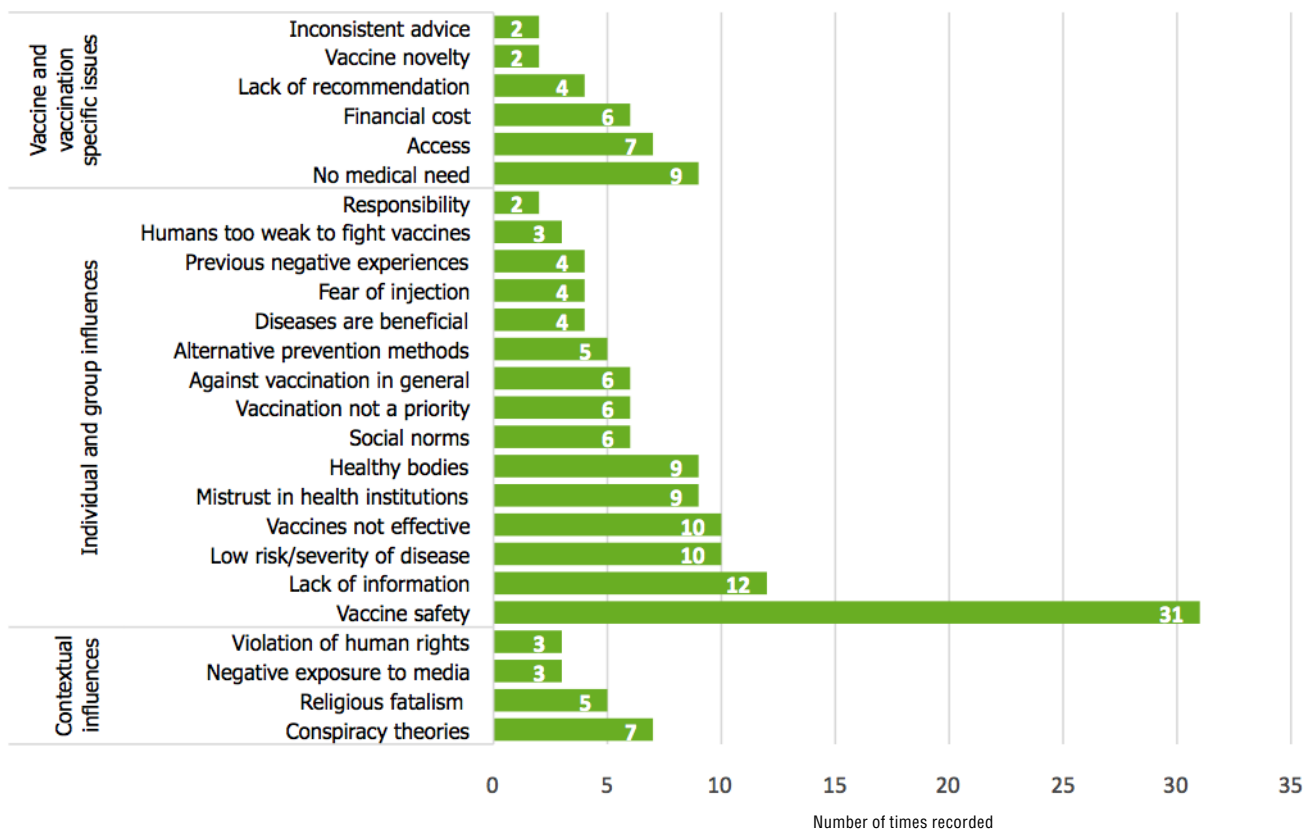
The Oxford Dictionaries chose ‘post-truth’ as the Word of the Year 2016 and defined it as ‘relating to or denoting circumstances in which objective facts are less influential in shaping public opinion than appeals to emotion and personal belief’. It has been argued that such a phenomenon has impacted several vaccination programmes in Europe and around the world, even before the definition of the term was coined. Known examples include the putative link between the MMR vaccine and autism, between the HepB vaccine and multiple sclerosis, and more recently the HPV vaccine-POTS (Postural Orthostatic Tachycardia Syndrome) claim, which have

all resulted in dramatic consequences on vaccination coverage rates in different countries, at different times and settings.

“Sifting science facts from science fiction can become a real challenge

The dynamic of attitudes towards vaccines and vaccination is often very complex and rooted in or impacted by several often hard-to-identify and/or address factors. Rightly so, the WHO Strategic Advisory Group on Immunisation has defined the now very widely used term ‘vaccine hesitancy’ as ‘the delay in acceptance or refusal of vaccines despite availability of vaccination services. Vaccine hesitancy

Figure 1: Main determinants of vaccine hesitancy in Europe



Source: ²

is complex and context specific varying across time, place and vaccines. It includes factors such as complacency, convenience and confidence.

This definition aims to capture the complexity and fluidity of the issue, as well as the fact that it can be a rapidly changing problem with no one-size-fits-all solution. The definition also highlights that the underlying determinants of hesitancy can be numerous and need to be studied in the specific setting where hesitancy is observed. Such determinants can be as varied as the perceived low risk of a disease or low efficacy of a vaccine (complacency) to a challenging or perhaps costly implementation or delivery service (convenience), or a fundamental issue of trust in the vaccine, the provider, the manufacturer, or even the public health system as a whole (confidence). Studies have shown that even vaccinated individuals can have apprehensions or doubts regarding vaccines. The term thus intends to capture concerns in both vaccinated and unvaccinated individuals.

This article aims to generate knowledge and awareness not only on what vaccine hesitancy entails, but on what key evidence shows as to how this manifests itself specifically in Europe. In addition, we provide perspectives on key trends to be factored into the design of intervention strategies, and describe the role of the European Centre for Disease Prevention and Control (ECDC) in supporting countries in addressing the issue.

Who is vaccine hesitant in Europe?

Although no group is entirely hesitant, evidence shows that pockets of hesitancy are to be found in potentially all population groups. In general, the most commonly studied groups are parents and mothers, health care workers, teenagers for vaccination programmes specifically targeting this age group, pregnant women, under-served populations, some religious or anthroposophic communities and, more recently, social media users.

This broad spectrum of populations has raised questions and concerns as to the extent to which such groups can influence each other, and, as a consequence, lead

to the formation of clusters of hesitant individuals that might expand more broadly and affect the general public.² Central to this debate is the role of health care professionals, where evidence has shown not only that they remain the most trustworthy source of information in the matter of vaccine decision-making, but also that they themselves believe it is their role to respond to and address patient hesitancy.

As a matter of fact, hesitant doctors and health care professionals have the potential to generate or further fuel concerns about the value of vaccination among hesitant parents and members of the public, and the issue of health care workers being hesitant – whether considering vaccinations for themselves, or for their patients – has been documented.³ Furthermore, the impact of doctors publicly condemning vaccination cannot be neglected, as it has been shown to bear a heavy impact on uptake rates.⁴

Qualitative research conducted by the ECDC has revealed some inconsistencies in perceptions about vaccinations amongst the health care workers surveyed.⁵ Though praising the benefits of vaccination, many have also shared concerns about its effectiveness and safety, with fear of side effects being the most important concern. In particular, some of the newer vaccines were singled out due to a perceived lack of sufficient data on their safety and effectiveness profile and, in some specific settings, doctors expressed strong feelings about their responsibility to protect patients. Furthermore, though having feelings of trust in health authorities, some also raised issues of mistrust in pharmaceutical companies,⁶ bringing to the fore the complex broader influential factors that can impact on attitudes.

That said, the proportion of hesitant health care workers in Europe is not known, and there is scope for identifying barometer-like tools that can be used and implemented to better monitor and understand trends in this regard.

Nonetheless, the evidence available corroborates findings that tailored training programmes for health care professionals, both pre- and in- service, can be crucial to

effectively respond to their own, as well as their patients' concerns. Such training can strengthen not only knowledge in vaccines and immunology but also interpersonal messaging and communications skills to effectively respond when faced with hesitant behaviours.

What are the main determinants of vaccine hesitancy in Europe?

Vaccine safety-related sentiment has been reported to be particularly negative in the European region.⁷ This is further corroborated by a previous literature review-based study conducted by the ECDC in collaboration with the London School of Hygiene and Tropical Medicine, which ranks the main determinants of vaccine hesitancy in Europe as shown in **Figure 1**.

It is evident that concerns around vaccine safety in Europe appear to be by far the most critical factor for both members of the general public and health care workers.^{2,5} Interventions aimed to build trust and confidence in immunisation should therefore address both parents and health care professionals, appropriately taking into account the fact that the specific underlying drivers are likely to be context specific.

It must, however, also be noted that it is often not possible to completely disentangle specific determinants of hesitancy from broader factors and influences, and the determinants can be linked and influence each other. To illustrate, a perceived or experienced lack of information can fuel concerns around safety, and mistrust in health institutions can lead to poor credibility of the information provided.

In addition, while attention is often primarily given to sentiments and behavioural patterns of the individual – that is on the part of the vaccinee, parent, or health care provider – **Figure 1** also brings to the fore that hesitancy can be triggered by aspects such as inconsistent advice and/or recommendation from providers within but also across countries. Hence, while acknowledging the challenges faced on the 'demand side' of immunisation, we cannot neglect

the question of how effective we are on the ‘supply side’ – that is, in designing programmes and access, delivery, and implementation mechanisms that do not result in unintentional consequences and fuel hesitant attitudes.

Moving forward

National responses

In this context, countries and immunisation programmes in Europe and worldwide are putting forth significant efforts in addressing the diverse situations in which vaccine hesitancy may be arising in their specific context. The range of measures being used differs and they are often geared towards a stronger engagement with health care workers and members of the public alike, as well as a wider and more strategic deployment of modern online means of communication to effectively promote vaccination and build trust. A catalogue of interventions being put in place has been made available by the ECDC⁹ with a view to informing on ongoing initiatives and encourage peer-learning, bearing in mind, however, that what works in one context may not necessarily translate into results in another.

There is certainly a continued need to research context-specific factors, as the end user perspective remains under-researched. This should feed the purpose of adopting tailored approaches to immunisation, in line with WHO recommendations. Moreover, evaluation is key, and should be implemented both *ex ante* – to listen to and understand real drivers of hesitancy and enable relevant practice – and *ex post* – to measure the effectiveness of interventions in time.

Some authorities are also responding to waves of hesitancy by considering changes in legislation by other direct or indirect measures aimed to increase vaccination coverage rates. Examples include the introduction of school mandates or mandatory vaccination policies. Ultimately, regardless of whether mandatory or recommended, a national health care system should promote and actively offer the vaccines that have been proven to be safe, effective and with a positive public health impact,

and that are included in the national vaccination programme. This should be optimally done using the means that are considered best in response to the local context, culture and habits, and in view of identifying the approach thought to be most suited to achieve the intended public health objectives.

“develop more targeted and effective public health interventions that can prevent or address hesitancy”

ECDC support

As part of its efforts to provide technical and scientific support to countries in the face of such challenges, the ECDC strategy in the area of vaccine hesitancy has aimed to strengthen know-how and capability to develop more targeted and effective public health interventions that can prevent or address hesitancy. The ECDC has developed communications guides and toolkits,^{9, 10} particularly targeted to health care professionals, in recognition of their fundamental and highly trusted role, and with a view to empowering them to become more effective advocates of vaccination. Such guides are the object of national adaptation projects where technical experts from the ECDC support immunisation teams in the Member States in translating and adapting the toolkits available into culturally relevant products that can be of use within the given local setting.

Furthermore, targeted research continues to be undertaken to shed light on vaccine-specific determinants of hesitancy, so as to inform relevant national practice and action accordingly. In this regard, an ECDC report on the specific determinants of vaccine hesitancy in relation to HPV

vaccination will soon become available. A pilot is also being set up to monitor online media messaging and conversations and capture relevant sentiment that can help to identify and evaluate, in advance, possible signals of a crisis and, at the same time, help to inform on the real needs of those who are truly hesitant (versus the vocal deniers of vaccination). Such a pilot also aims to better map and study the main drivers of negative sentiment towards vaccination, and understand how networked the actors behind rumours and fake news are, with a view to assessing the potential impact they might have on members of the public genuinely looking for answers.

Finally, and more recently, the ECDC has also set up a Technical Advisory Committee of experts representing different sets of stakeholders with a view to brainstorming and discussing creatively how to better support national communication campaign efforts, how to respond and build resilience in crises situations, as well as how to better engage with grassroots and civil society organisations that can support advocacy for vaccination.

Conclusion

With the polarised media and information landscape, immunisation programmes are ushered into a new set of challenges which require novel thinking and targeted intervention strategies. It is evident that the traditional, mechanistic and one-way communication has become obsolete, and novel multi-dimensional efforts are critical to developing meaningful solutions. This requires political commitment as well as a sound understanding of the ‘enabling’ factors that must be put in place to empower immunisation programme coordinators, public health managers, and health care workers to successfully address hesitant attitudes. This ultimately means investment and additional resources, not only in terms of finance, but even more critically in terms of the skill-set made available to appropriately design and put in place culturally competent monitoring and intervention strategies and, at the same time, have the flexibility to learn by doing.

Ultimately, we need to endeavour to inject into the delivery of vaccination programmes and the communications around them as much science as we put into the Research & Development of the vaccines themselves, bearing in mind that *“the best vaccine in the world is worth nothing if people don’t use it – be it because the vaccines don’t reach them, because they are too expensive, because the health system doesn’t reach out to the most vulnerable populations, or because people believe rumours about potential side effects”* (Geoghegan-Quinn, former EU Commissioner for Research and Innovation).

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In Memoriam: Heidi Langaas (1951–2017)

We commemorate Heidi Langaas, our dear colleague from the Norwegian Ministry of Health and Care Services, who passed away on 14 November 2017. For many years Heidi was an appreciated and respected member of the Observatory’s Steering Committee, always proactive, rigorous, and supportive to the Observatory’s work. Heidi was committed to the cause of sharing knowledge and experience for improving health systems in Europe. When



she was working as health attaché for the Norwegian EU Mission in Brussels from 2008 to 2012 she invited us to meet with Norwegian delegations of health stakeholders who were on a visit. Also after her return to Norway, she called on the Observatory to inform the health decision-making process. This was also the case for the last big project that she undertook and

successfully delivered, the National Health and Hospital Plan that was adopted by the Norwegian Parliament in 2015. Next to being a dedicated professional Heidi was also a kind, optimistic and had an enthusiastic personality. Our thoughts are with her family, friends and colleagues. She will be missed dearly!

THE VALUE OF TREATMENT: EARLY INTERVENTION TO REDUCE THE BURDEN OF BRAIN DISORDERS

By: David Nutt, Patrice Boyer, Monica Di Luca, Wolfgang Oertel, Frederic Destrebecq, Vinciane Quoidbach, and Giovanni Esposito



Summary: Direct health care and the non-medical costs of brain disorders make up 60% of the total costs associated with brain disorders, and are estimated at €800 billion per year in Europe. As prevalence and incidence are increasing for most mental and neurological disorders, we will need to manage several important challenges to achieve more value-based and patient-centred research and care. The health care sector in Europe is currently characterised by fragmented services for these conditions. The European Brain Council's recent report highlights the need for early, if possible prodromal, diagnosis and intervention; integrated, seamless care underpinning timely care pathways; and access to the best treatments available.

Keywords: Brain Disorders, Treatment Gaps, Value-based Care, Patient-centred Care, Early Intervention

David Nutt is President at the European Brain Council (EBC), Brussels, Belgium and the **Edmond J. Safra** Professor of Neuropsychopharmacology and director of the Neuropsychopharmacology Unit in the Division of Brain Sciences at Imperial College London, UK; **Patrice Boyer** is Vice President at the EBC, and Honorary Professor of Neuroscience and Psychiatry at Paris 7 University, France; **Monica Di Luca** is Vice President at the EBC and Professor of Neuropharmacology at University of Milan, Italy; **Wolfgang Oertel** is Treasurer at the EBC Hertie Senior Research Professor and Professor of Neurology at Philipps-Universität Marburg, Germany; **Frederic Destrebecq** Executive Director at EBC; and **Vinciane Quoidbach** and **Giovanni Esposito** are Research Project Managers at EBC. Email: d.nutt@imperial.ac.uk

Introduction

According to various large-scale studies conducted by the World Health Organization, about a third of the population worldwide have a mental disorder. Taken together with neurological disorders, these “disorders of the brain” account for 23% of the global disease burden. This surpasses both cardiovascular diseases (5%) and cancer (10%).^{1 2}

Such statistics may be surprising as there is a general lack of awareness regarding the pervasiveness of brain disorders. However, global data, and particularly those on the European Union (EU), can serve as a wake-up call. Brain disorders are major contributors to morbidity,

disability and premature mortality in Europe. Highly prevalent, they currently affect 179 million people (an estimated 38.2% of the EU population) annually, with a peak in early adulthood (between 20 and 30 years) for mental and substance abuse disorders compared to neurological disorders, where DALYs (Disability-Adjusted Life Years) are more constant across age groups.^{3 4}

The prevalence of brain disorders is growing due to the so-called epidemiological transition from acute to chronic diseases and the increase in life expectancy, but also because of a number of socio-economic, environmental and behavioural health determinants,

some of which are still not entirely understood. The causes of brain disorders are heterogeneous, ranging from neurodegeneration or dysregulation of the immune process to developmental and functional abnormalities, and frequently implicate a complex interplay between genetic and environmental factors. Better understanding of these causes is a necessity to improve treatment and primary or secondary prevention. Major depression together with stroke, dementia and alcohol use are among the top four causes of the burden of disability in the European region.^{1 2}

“ brain disorders cost in excess of €800 billion per year in Europe

The consequences extend well beyond the health care system: high costs of technological progress, loss of healthy life years* and quality of life, burdens on the social welfare systems, implications for labour markets with prolonged impairment, great physical dependency requiring care by informal caregivers and significant reduced productivity. The European Brain Council (EBC)'s *The Value of Treatment* project builds on its earlier reports on the economic costs of brain disorders in Europe, which gave robust estimates on brain disorders costing in excess of €800 billion per year in Europe (of which 60% are related to direct health care and non-medical costs).^{3 4}

Effective implementation of early diagnosis and treatment varies widely across health systems and many European countries are still lagging a long way behind, with wide clinical practice variations even within countries. There is a considerable gap in terms of diagnosis and treatment, which is true for all brain disorders ranging from schizophrenia to

Alzheimer's disease, Epilepsy, Headaches, Normal Pressure Hydrocephalus, Parkinson's disease, Multiple Sclerosis, Restless Legs Syndrome and Stroke (see Box 1). The *Value of Treatment* study covers these disorders and addresses major obstacles to optimal treatment through case study analysis while providing evidence-based and cost-effective solutions. The two-year research project highlights necessary public health policy implications for prevention, patient-oriented and sustainable care models as well as the need for more basic and applied research.

Addressing the treatment gap: a value-based and patient-centred care approach

Numerous needs of patients and individuals at risk are unmet. Up to eight out of ten people living with a brain disorder remain untreated, or inadequately treated, although pharmacological and psychosocial treatments exist.^{7 8} There are unmet needs not only within the provision of medicines and medical devices, but also within medical research, health care systems and services. Analysing the treatment gap and its underlying causes has been a central focus in the *Value of Treatment* study. The treatment gap is defined as any time the care offered to a patient does not correspond to his or her needs and to the stage of the disease, or the lack of any treatment. It is used as an outcome measure in health care.

All too often, discussions on health care focus on the substantial increase in per person health care spending, rather than the benefits and the value that patients and society derive from improved health. While costs are undoubtedly an important part of the health care debate, they should be considered in the context of the benefits achieved. Together, these emphasise the need for more value-based and patient-centred care for brain disorders, and for the scaling-up of an integrated, care model. Such a model encompasses the whole care process from prodromal, early diagnosis to disease management and patient empowerment. In many current health care reforms, new organisational arrangements for better health outcomes are being analysed, focusing on more

Box 1: Case studies objectives

CASE STUDIES (9):

- **Mental health:** Schizophrenia.
- **Neurology (*):** Alzheimer's disease, Epilepsy, Headaches, Parkinson's disease, Multiple Sclerosis, Restless Legs Syndrome, Stroke.
- **Neurosurgery/Neurology (*):** Normal Pressure Hydrocephalus.

OBJECTIVES:

- Identify treatment gaps and causing factors along the care pathway, and propose solutions to address them.
- Evaluate the socio-economic impact of these solutions.

Source:⁹

coordinated and integrated forms of care provision or care pathways, with the support of multidisciplinary care teams and care provided in more than one setting.

“ need more value-based and patient-centred care for brain disorders

The *Value of Treatment* study tested this model and developed a series of qualitative and quantitative benchmarks to: 1) identify treatment gaps and causal factors along the care pathway (patient care pathway analysis) and 2) assess the socio-economic impact and health gains from best practice health care interventions (economic evaluation). Case studies were developed in collaboration with hundreds of EBC Experts across Europe

* The Healthy Life Years (HLY) indicator measures the number of remaining years that a person can expect to live without disability at different ages.

to support the research framework with analysis based on datasets from different WHO European Region countries (United Kingdom, France, Germany, Italy, Spain, Luxembourg, Czech Republic, Sweden, Switzerland and Russia).

Matching data to policy: main findings and conclusions

The conclusions of the study case studies highlight the value of prevention, early diagnosis and intervention as a solution to improve patient quality of life, to sustain health and social care systems and to significantly rationalise costs. Research links early intervention to measurable health gains such as improved survival rates, reduced risks, complications and disability, better quality of life and lower treatment costs. The study findings also emphasise the need for integrated, underlying seamless care, as this is intrinsic to timely care pathways as well as the importance of using the best treatments available (see Box 2).

There is still no cure for many brain disorders. This often reflects the challenge to fully understand brain functioning and to efficiently translate knowledge

Box 2: Policy recommendations for brain disorders

Across the case studies the key findings highlighted:

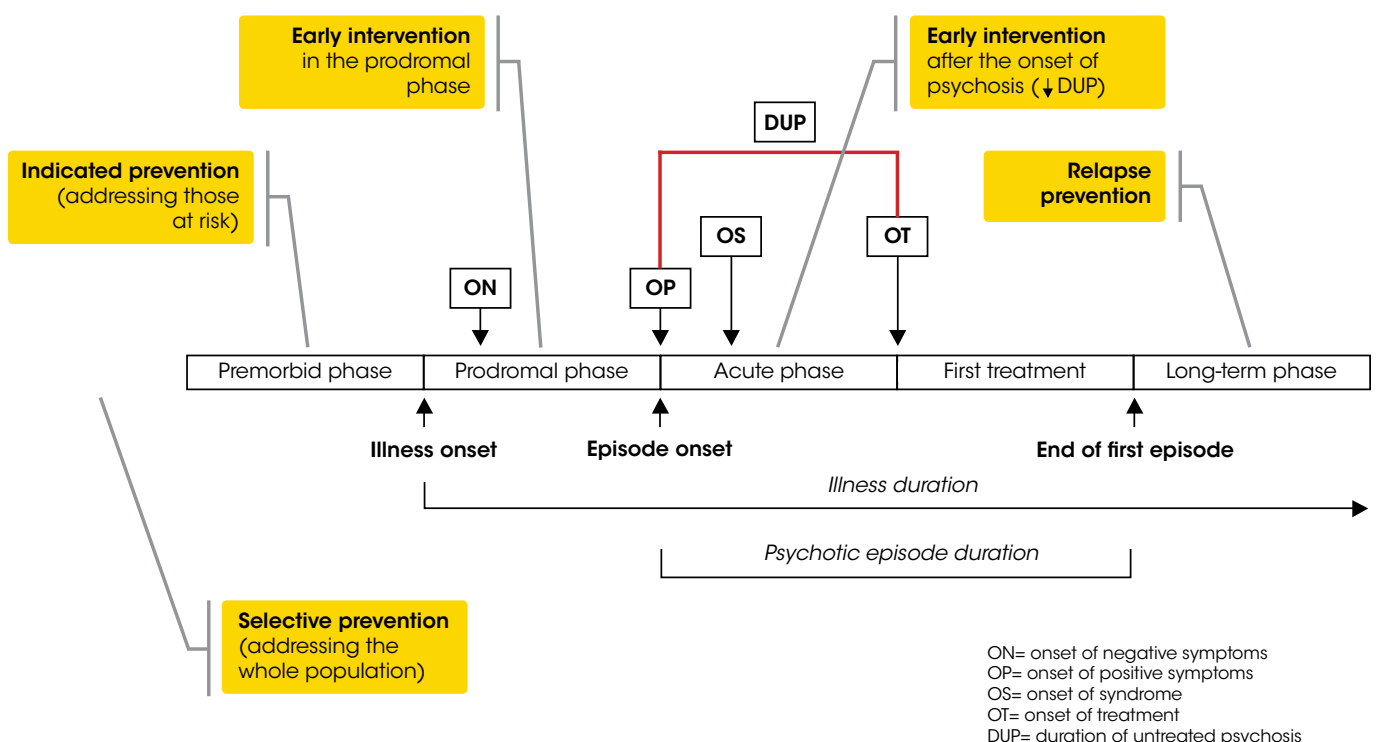
- Low understanding of the disease aetiology, risk and preventive factors
- Lack of disease awareness among the general public and lack of training for health care providers
- Lack of primary and secondary prevention programmes
- Lack of timely and adequate diagnosis and treatment
- Fragmentation of health care services and lack of coordination between health and social services

Conclusions and recommendations in alignment with economic analysis

- Invest in more basic, clinical and translational neuroscientific research to continue developing new treatments that can improve quality of life, functioning and reduce associated direct and indirect costs
- Increase brain disease awareness, patient empowerment and training for health care providers at all levels of care (education of primary care practitioners can play a key role in increasing diagnosis, proper treatment and appropriate referral to tertiary level care for the most complex cases)
- Address prevention and timely intervention as a priority based on needs
- Address health care service delivery and support clear patient pathways
- Foster seamless care through validated models of care and tools implementation, legislation and incentives

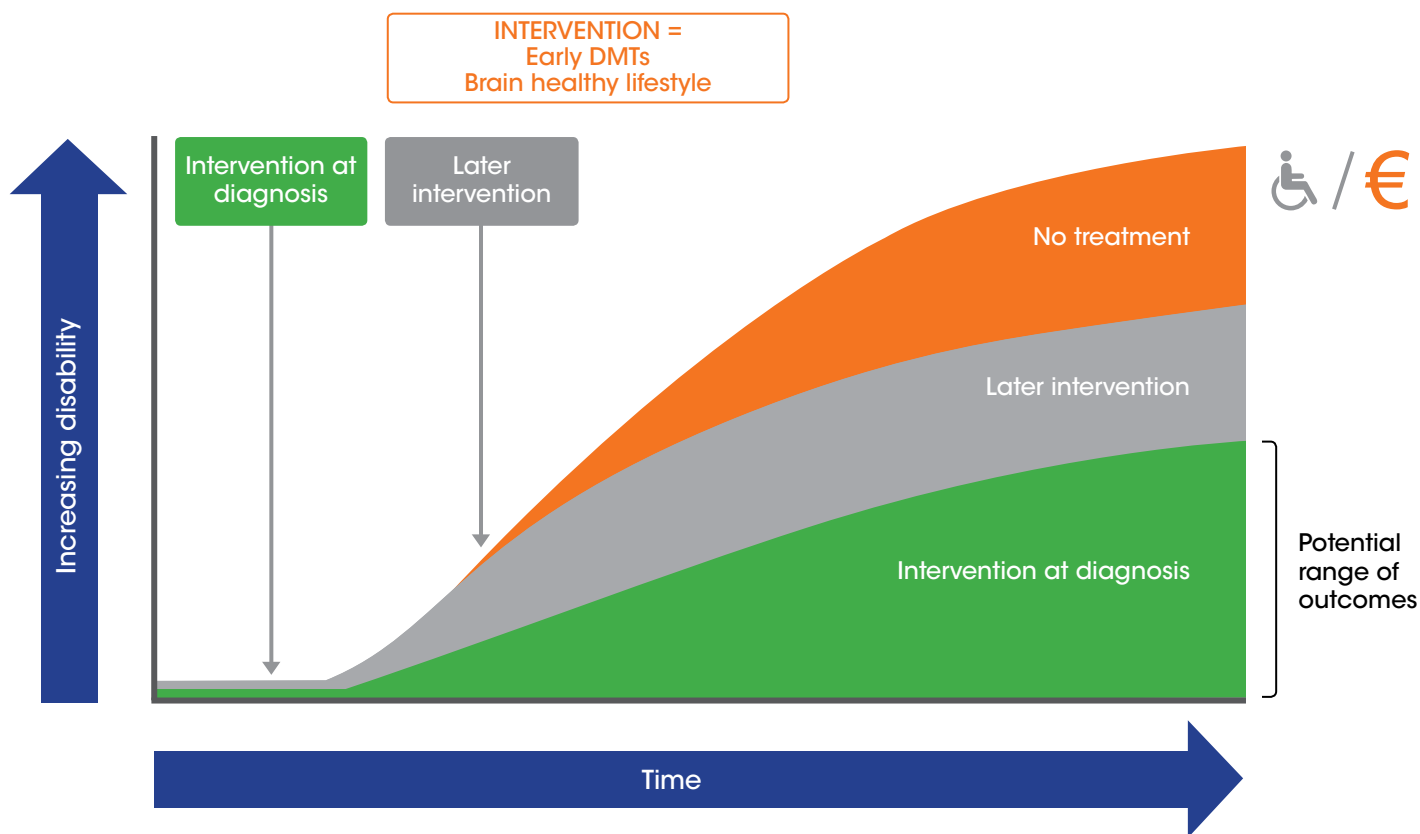
Source: ⁹

Figure 1: Care pathway analysis – interventions strategies early in the course of schizophrenia



Source: ¹²

Figure 2: Care pathway analysis – early intervention and new treatment paradigm in MS



Source: ¹⁵

into cures. It is necessary to focus on risk reduction, preclinical and early detection and diagnosis, and timely intervention. Primary and secondary prevention remain essential (available diagnostic tools for neurological disorders, including biomarkers and routine mental health screening). More research is needed to understand the causes, but also the progression, of brain disorders and to develop new treatments that not only symptomatically improve the condition, but may modify, i.e. slow down, or even stop, their course.

Results from the case studies provide important new insights into recent progress in the areas of pharmacology and the biopsychosocial approach, as well as in relation to the delivery of health care services and integrated care. Here we look at two conditions: one related to a mental disorder, “schizophrenia”, and one related to a neurological disorder “multiple sclerosis”. Case study results (see Figures 1 and 2) highlight the need to implement evidence-based guidelines

that emphasise cost-effective, integrated health care interventions to develop better prevention and timely treatment.

Schizophrenia is one of the most severe and disabling mental illnesses (affecting an estimated five million Europeans). The treatment success rate can be high if patients at risk are identified, psychotic symptoms are detected early, and early intervention at the prodromal phase is activated. Depending on the stage of the disorder, antipsychotic medication, psychosocial interventions or both are needed.^{10 11} A strong interaction between community mental health and hospital care is recommended (see Figure 1).

Multiple sclerosis (MS) is the first cause of non-traumatic disability in working young adults, with clinical onset in the prime of life (affecting an estimated six million Europeans). Quality of life is poor in relation to ‘invisible’ symptoms such as fatigue and cognitive impairment. In MS, the key paradigm is early diagnosis and early use of disease-modifying treatments (DMTs) through a personalised medical approach, and optimised target

treatment. DMTs at the early stage of relapsing-remitting multiple sclerosis (RRMS), including clinically isolated syndrome (CIS) with visible abnormalities on MRI scans, are available to slow down the progression rate and disability accumulation (see Figure 2). Not only early DMTs but also primary and secondary prevention of modifiable risk factors avert MS long term disability and its economic burden.^{13 14}

Concluding remarks

For urgent humanitarian, medical, scientific, political and economic reasons, it is imperative that there is a step-change in the prevention, treatment and management of brain disorders. The EBC *Value of Treatment* study sets out very clearly in its recommendations what needs to happen to address both treatment and research gaps.

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In Memoriam: Uwe Reinhardt (1937–2017)

At Eurohealth we were deeply saddened to hear of the passing in November of Uwe Reinhardt, James Madison Professor of Political Economy and professor of economics and public affairs at Princeton University's Woodrow Wilson School of Public and International Affairs. Uwe was one of the giants and pioneers of health economics and a past



president of the International Health Economics Association. Many of the tributes written in the wake of his passing speak at length about his near 50 year career at Princeton, as well as his influence on US health policy and commitment to public service. He argued at length that a key failing in the US was the sheer complexity of the market, requiring costly administration that led to much higher health care costs than seen in other comparable countries.

Yet his influence stretched well beyond the US. He played a central role in the development of the health insurance system in Taiwan. He also maintained a great interest in European health policy and played a pivotal role in the evolution of the Bertelsmann Foundation's Health Policy Monitor and its successful 2011 merger with the Observatory's own network of national lead institutions. Uwe and his wife May were very much the godparents of the resulting Health Systems and Policies Monitor and he supported its growth and increasing dynamism with clear critical insights and with real affection. In 2016 the Deutsche Gesellschaft für Gesundheitsökonomie (German Association for Health Economics) awarded Uwe its Gerard Gäfgen Medal for his extraordinary contribution to the discipline in Germany. He had already, in 2010, been awarded the Federal Cross of Merit by the German Government in recognition of his contributions to the development of German health policy.

On a personal note we shall remember not just his academic prowess but also his kindness and great sense of humour. He was never afraid to poke fun at himself, but equally did not pull punches when highlighting health policy failings and challenges around the world. Our thoughts are with his wife May and their family at this difficult time.

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THE POTENTIAL OF STATE-RUN CIVILIAN AND VOLUNTEER **SERVICES** **TO ADDRESS LONG-TERM CARE** **SHORTAGES: A REPORT FROM** **SWITZERLAND**

By: Daniel Weyermann

Summary: Forthcoming demographic changes, where people will live longer and the population over 80 years will increase, will bring about staff shortages in long-term care. Against this imminent shortage, policymakers in Switzerland have proposed measures in four main areas: staff recruitment, education, staff retention and staff deployment. Yet, policymakers will need to consider all possible effective means to tackle this challenge. In certain European countries, such means include state-run civilian or volunteer services, which can ease the pressure on health care staff and thus increase the quality of nursing and long-term care.

Keywords: *Demographic Change, Staff Shortages, Nursing and Long-term Care, Civilian Service, State-run Volunteer Service, Switzerland*

Introduction

Demographic changes expected in the coming decades pose major challenges for European societies and policymakers. People in Europe are going to be older, more numerous and more diverse than previously. Key factors spurring the change are fertility rates that remain low, people living longer and healthier lives, migration to and within Europe, and the sizeable baby-boomer-generation reaching retirement age. An important demographic megatrend is thus the overall ageing population in Europe, the so-called “grey revolution”. This article will consider the case of Switzerland.

The “grey revolution” and demographic challenges

In Switzerland, the reference scenario is that the population aged 20 to 64 years will grow moderately from 5.1 million to 5.6 million between 2015 and 2045, whereas the population over 64 will grow more rapidly from 1.5 million to 2.7 million during that time. The share of the population aged over 64 will thus grow from 18% to 26.4%. This shift is forecast to be particularly intense between 2020 and 2035, when the bulk of the baby-boomer-generation retires.

Daniel Weyermann is Scientific Officer at the Federal Department of Economic Affairs, Education and Research – Civilian Service, Thun, Switzerland. Email: daniel.weyermann@zivi.admin.ch

The situation is even more poignant when the population over 80 years is considered. This group is projected to grow very rapidly, from 420,000 (in 2015) to 1.1 million (in 2045), such that by 2045, 39% of those over 65 will be 80 years or older.²

“The challenges posed by an ageing population are numerous

This is how the grey revolution looks in Switzerland. The age pyramid shifts shape, such that the tip of the pyramid becomes broader and moves further up. The old-age dependency ratio will grow from 29.1 in 2015 (i.e. there are 29.1 people older than 65 years per 100 people aged between 25 and 64) to 48.1 in 2045.² Other European countries face similar changes.

The challenges posed by an ageing population are numerous, and they concern different policy areas. Challenges include shrinking tax revenues, the stability and funding of social security and health care systems, a shortage of skilled workers and other disruptions to the labour market, more older people in need of nursing or long-term care, and adjustments in how people plan and live their (longer) lives. A key demographic challenge is workforce ageing and the influence it will have on the long-term care sector: demand for care is increasing, while the supply of nurses and carers will be decreasing.

Who is going to take care of older people in need of care?

European countries and policymakers faces an important question when it comes to the growing number of people in their sunset years: how is the long-term care sector in Europe preparing for the grey

revolution? Or, more to the point: who is going to take care of the increasing number of older people in need of care?

In Switzerland, the demand for care staff is already growing. Between 2010 and 2014, the number of people working as nurses or carers increased by 13.9%. During that same period, the number of people graduating with professional certificates in nursing and care also grew – by 31.3%. Even though the growth in graduates is laudable and the result of great efforts by the Swiss care sector, the overall result is sobering. Switzerland is currently training only about 56% of the professionals that it will need in nursing and long-term care every year over the two decades to come.³

Trained nursing and care staff from European or other countries are compensating for the lack of home-grown professionals in Switzerland.³ Arguably, it would be very difficult for the Swiss health care system to function without the staff from abroad. They will continue to play an important role in the Swiss care sector in the years to come³ – be it in formal long-term care settings, as in nursing homes, or in more private, informal settings.

In some European countries, expanding the recruitment of nursing and care staff abroad is seen as a prime solution for labour shortages.⁴ This, however, may not be a particularly sustainable solution, since the situation in the care sectors of receiving countries can quickly become worse if the working conditions in sending countries improve and fewer care staff wish to find work abroad.⁵

Solutions in Switzerland

Towards tackling these challenges, a national report on the supply of health care professionals was published in 2016 by influential Swiss health policymakers – the Swiss Conference of the Cantonal Ministers of Public Health (GDK) and the National Organisation of Swiss Health Professions (OdASanté) – who proposed a mix of measures in four policy areas. The target is to provide for a sufficient number of trained staff in nursing and care in Switzerland.⁶ The

various measures address different actors (Federal authorities, Cantonal authorities, organisations of health professions, educational institutions, health service providers and other employers etc.), depending on their responsibilities and expertise. The policy areas and main measures are: staff recruitment, education, staff retention and staff deployment.

1. Staff recruitment

In order to be sustainable, the Swiss care sector needs to be able to recruit nursing and long-term care staff, as far as possible, in Switzerland. The Swiss care sector thus needs enough people who are interested in working as a nurse or carer – these can be school-leavers or adults who want to change career. One way to increase the number of people interested is to increase the appeal of the professions in question. The national report suggests improving the marketing for jobs in nursing and care, for instance through better information about nursing and care work and by improving the image of jobs in the care sector.⁶

Furthermore, people interested in working in the care sector could have access to open-house presentations, short internships and similar efforts so that they can understand what is involved in the different jobs. This is how people get inspired for working as nurses or carers. Furthermore, basic education programmes for assistant jobs in nursing and care could be as accessible as possible – i.e. with minimal formal requirements – and provide a perspective for a career in nursing and care. In Switzerland, the Red Cross offers such an educational programme for health care assistants.⁶

2. Education

A further important factor for providing enough nursing and care professionals are the capacities of the education system. Thus, health care institutions in Switzerland have been obligated – through service agreements with the Cantons or on a legal basis – to train more nurses and carers.* This requires adequate funding and a favourable general policy framework.

* In Switzerland, health care institutions provide vocational training in certain nursing and care professions.

3. Staff retention

Once people are working, it is key to keep them in nursing and care, otherwise efforts in the area of recruitment and education are futile. The national report suggests that the care sector should therefore strive for favourable working conditions and adequate remuneration.

4. Staff deployment

To do a proper job requires adequate resources, skills and motivation. Staff should therefore be deployed in tasks they are trained and motivated for. To achieve this end, health and long-term care managers should assess tasks and plan workflows in order to deploy staff adequately. This contributes to job satisfaction and staff retention.

“
improving the
marketing for
jobs in nursing
and care

At the political level, the Swiss association of nurses (SBK) has recently launched an initiative to include the right to accessible, sufficient and good nursing and care in the Swiss constitution. Most prominently, the initiative demands a sufficient number of trained staff in nursing and care, as well as their deployment according to training and skills. The initiative puts the issue of staff shortages in nursing and care on the political agenda.

An additional contribution: state-run civilian and volunteer services in Europe

The examples outlined above suggest that relevant stakeholders recognise the challenge of avoiding staff shortages in nursing and long-term care. Still, given the magnitude of the challenge, they should consider all possible effective means to avoid such shortages.

One such resource is service days spent in state-run civilian and volunteer services. State-run civilian and volunteer services support institutions working in the public interest that are in need of helping hands. These institutions and organisations can receive civilian service members and volunteers to support them in their tasks. Policy and decision-makers can plan and steer the resource of days spent in institutions working for the common good. Switzerland, Finland and Austria, for instance, all have universal conscription of young men for military service, and state-run civilian services for conscientious objectors.

Similarly, other European countries have institutionalised state-sponsored volunteer services, such as the “Bundesfreiwilligendienst”[†] in Germany, the “Service Civique”[‡] in France, the “Servizio Civile Nazionale”[§] in Italy, or the “National Citizen Service”[¶] in the United Kingdom. At the European level, the so-called “Solidarity Corps”^{**} was initiated at the end of 2016, joining other programmes by the European Union to promote civic engagement, such as the European Voluntary Service^{††}.

In Switzerland, the state-run civilian service (“Zivildienst”) provides additional helping hands in the form of civilian service members to support formal nursing and care staff. They are a precious contribution – one that might become indispensable during the decades to come.[¶] In 2016, Swiss civilian service members undertook a total of 1.7 million days of service. Three-quarters were performed in health care or in social institutions, such as hospitals, nursing homes or reception centres for asylum seekers.[¶] In light of the huge demand for nursing and long-term care, this is a modest contribution – but a valuable one.

Even though there are considerable differences between the diverse services in the various countries – regarding the number of days served, the age of those serving, or the image and agendas behind the services – they all provide state-sponsored opportunities for citizens to engage and support the common good. These days served by volunteers and civilian service members are a resource and asset that policymakers can take into account to tackle societal challenges. For instance, to help mitigate the staff shortage in nursing and long-term care.

What state-run civilian and volunteer services can do – and what they cannot

State-run civilian and volunteer services can provide untrained but motivated helping hands for the care sector. Policymakers can steer the number of days spent by volunteers or civilian service members in certain domains, for instance through image campaigns or special incentives. In Switzerland, civilian service members are required to spend a certain number of days in core areas with high priority, such as nursing or care. With such measures, Swiss authorities guarantee that the civilian service contributes to domains with particular needs.

It is important to note, however, that civilian service members or volunteers cannot substitute for trained nurses or carers. They can only assist or aid trained staff. As assistants, however, they can be very precious. For example, they might have the time to talk or take part in social activities with older people in a nursing home – time that professional staff might lack. Civilian service members and volunteers can thus help to reach some of the policy goals mentioned above. For instance, civilian service members and volunteers can support institutions in the care sector to deploy their professional staff more effectively. They also help to unburden professional staff, and thus increase the quality of nursing and long-term care. Additionally, volunteers or civilian service members might consider taking up a job in nursing and care after their experience in the service.

[†] See <http://www.bundesfreiwilligendienst.de/> (in German)

[‡] See <http://www.service-civique.gouv.fr/> (in French)

[§] See <http://www.serviziocivile.gov.it/> (in Italian)

[¶] See <https://www.gov.uk/government/get-involved/take-part/national-citizen-service>

^{**} See https://europa.eu/youth/solidarity_en

^{††} See <http://europeanvoluntaryservice.org/>

Importantly, however, the services need to be organised in such a way that they do not endanger jobs or put pressure on wages in the care sector. Otherwise, they will lose legitimacy in the eyes of the public and undermine achievements in other policy areas.

“ provide
untrained but
motivated
helping hands
for the
care sector

Conclusion

As we have seen, the challenges posed by the grey revolution in Europe are formidable. It will bring about considerable social change to the European care sector during the decades to come. Countries need to undertake measures to face this challenge. In doing so, it will also

be worthwhile to consider the resources of state-run civilian and volunteer services, and to deploy them where suitable. Research is needed regarding the impact of civilian and volunteer services in nursing and care of older people. Undoubtedly, such insights will enhance policy decisions to tackle the challenges of demographic change.

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Portugal: health system review

By: J Simões, GF Augusto, I Fronteira & C Hernández-Quevedo

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While overall health indicators for Portugal have notably improved in recent years, they still hide significant health inequalities, which are mostly related to health determinants, such as child poverty, mental health and quality of life.

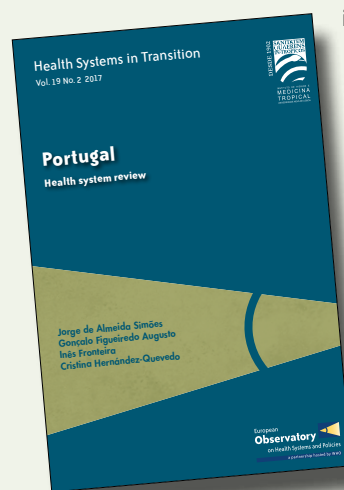
Even though the Portuguese National Health Service (NHS) is universal, comprehensive and almost free at point of delivery, there are also inequities in access to health care, mostly related to geography, income and health literacy. The so-called health subsystems, the special health insurance schemes for particular professions or companies that exist next to the NHS, as well as private voluntary health insurance, provide easier access for certain groups.

Since the financial crisis, health sector reforms in Portugal have been guided by the Memorandum of Understanding that was signed between the Portuguese Government and three

international institutions (the European Commission, the European Central Bank and the International Monetary Fund) in exchange for a €78 billion loan.

Measures were implemented to contain costs, improve efficiency and increase regulation. Nonetheless, financial sustainability of the Portuguese health system remains a challenge. Due to cuts in public workers' salaries the increasing migration of health care

workers risks negatively affecting the quality and accessibility of care. While several reforms are aimed at improving coordinated care and developing the use of Health Technology Assessment, there is still scope for increasing efficiency in the health system.



THE PORTUGUESE HEALTH SYSTEM IN THE AFTERMATH OF AUSTERITY

By: Jorge Simões, Gonçalo Figueiredo Augusto and Inês Fronteira

Summary: The financial assistance programme given to Portugal in 2011 and the associated Memorandum of Understanding imposed changes in the Portuguese health system. The main objective was to reduce costs and increase efficiency. More than three years after the end of the programme (in 2014), some of the changes still remain, while other measures were only transitory. However, the debate on National Health Service sustainability has not ended with the programme, and the system faces new challenges in the near future.

Keywords: *Austerity, Reforms, Pharmaceutical Market, Health System, Portugal*

Introduction

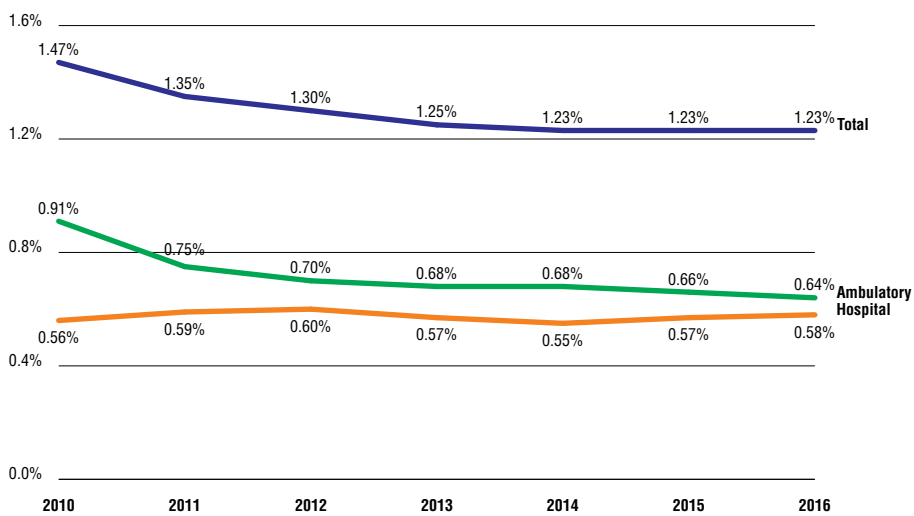
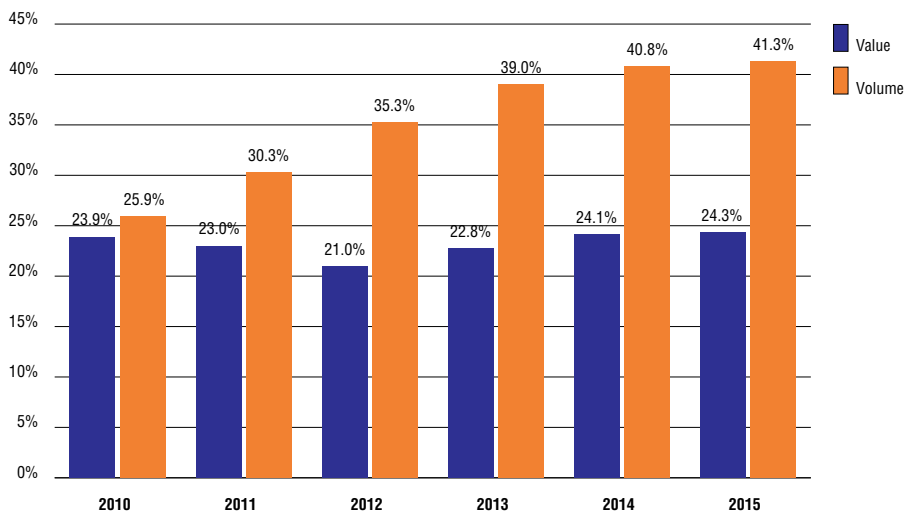
The international financial crisis that started in 2008 resulted in a sovereign debt crisis that forced a number of countries, including Portugal, to request financial assistance from the European Financial Stability Facility. Facing increased difficulty in accessing financial markets, in May 2011 Portugal agreed a Memorandum of Understanding (MoU) with the European Union, the European Central Bank and the International Monetary Fund in exchange for a loan of €78 billion.¹

The Economic and Financial Adjustment Programme, implemented between 2011 and 2014, brought about a number of broad cost containment measures in the public sector, including in the health sector with the aim of cutting costs and increasing the system's efficiency. Overall, most of the adjustment in health spending resulted from price effects, few from quantity cuts, and only a small part was

due to a shift of financial responsibility from the government to citizens. This was achieved through both a direct and indirect reduction in the level of salaries paid to public servants (including health workers), cuts in public pharmaceutical expenditure, and price review regarding private institutions that contracted with the National Health Service (NHS), especially in diagnostic tests and exams.^{2 3}

Since the end of the Economic and Financial Adjustment Programme, the performance of the Portuguese economy has improved. In fact, the country was able to reduce its public deficit to -2.1% of Gross Domestic Product (GDP) in 2016 (in contrast to -9.8% of GDP in 2010) and GDP is expected to grow 2.5% in 2017 (in contrast to -4.0% during the economic recession in 2012). However, public debt is still very high (132.2% of GDP in June 2017) and the country remains under tight surveillance from international institutions.

Jorge Simões and Inês Fronteira are Professors; Gonçalo Figueiredo Augusto is a Public Health Doctor and a PhD Candidate, Institute of Hygiene and Tropical Medicine – NOVA University of Lisbon, Portugal. Email: jsimoes@ihmt.unl.pt

Figure 1: Public pharmaceutical expenditure (% of GDP) in Portugal, 2010–2016Source: ⁵**Figure 2:** Share of generics in the total (reimbursed) pharmaceutical market in Portugal, 2010–2015Source: ⁶

This article discusses some of the major initiatives that have taken place in Portugal to increase efficiency and reduce costs in the health sector, initiated by the MoU, their sustainability and the main challenges the health system still faces.

Pharmaceutical policy spearheaded many cost-cutting measures

The MoU brought important changes to pharmaceutical policy. On the one hand, it set targets for public pharmaceutical expenditure. On the other hand, it required changes to the structure of distribution margins. These two demands

constitute new approaches to containing the high growth rate in Portugal's public pharmaceutical expenditure.

Expenditure targets

The MoU set clear expenditure targets: the Portuguese government was to decrease such expenditure in both the hospital sector as well as in ambulatory care. Pharmaceutical expenditure was cut and a target set to reach 1.25% of GDP by the end of 2012 and 1% by the end of 2013. However, Portugal's total public pharmaceutical expenditure at the end of 2011 was 1.35% of GDP, and only in 2013 was it possible to achieve the decrease to 1.25% of GDP.⁵

“The MoU brought important changes to pharmaceutical policy”

From 2010 to 2016, there was a 15% decrease in total pharmaceutical expenditure, which was mainly achieved through a 27% reduction in ambulatory medicines, since expenditure on hospital pharmaceuticals increased by 6% over the same period (see Figure 1).

Generics

Additional requirements of the MoU included: promoting the use of generic drugs; the use of clinical guidelines; and redefining international referencing rules that establish the prices of new pharmaceutical products. The latter now focuses on the prices in the three countries with the lowest prices in Europe, but which have some broad similarities with the Portuguese economy.⁶

Increasing the use of generics has been one of the most relevant cost-control goals of pharmaceutical policy in Portugal. Several measures included in the MoU aimed to increase competition from

generics, focusing on price regulation of the market and administratively forcing lower prices. The measures included: setting the maximum price of the first generic in its class to enter the market at 60% lower than the price of the originator product; automatic reduction of the price of the originator product when the patent expires; and resolving the legal dispute over intellectual property to ensure faster entry of generics in the market. Moreover, pharmacies are legally required to have available at least three of the five lowest-price generics in each class defined by a branded product.²⁴

“the share of generics in the pharmaceutical market has increased”

Also, the MoU stipulated that a new structure of margins, using a combination of fixed fees and regressive margins over the wholesale price, must be defined. One of the aims of this change was to save €50 million in distribution costs. The savings target is reinforced by the requirement for wholesalers and retail pharmacies to pay a special contribution (claw-back) if not enough savings are generated (although pharmacies in remote areas with low turnover may be exempt from this pay-back mechanism). A second objective of the new margins is to increase the incentives to pharmacies to offer patients the option of purchasing generics. Under the previous system, where margins were defined by a constant percentage over the final price, pharmacies had the incentive to favour the dispensing of products with higher prices. Hence, the new rules mitigate this relative incentive to dispense more expensive products (by not carrying generic products), resulting in a decrease of prices.²⁴

As a result of these policies, the share of generics in the pharmaceutical market has increased since 2010, both in terms of value and volume (see Figure 2). In 2015, generics represented 24.3% of the total value and 41.3% of the total volume of the reimbursed pharmaceutical market (see Figure 2).

Prescribing patterns

While many of the other measures implemented in Portugal during the Economic and Financial Adjustment Programme in the pharmaceutical sector aimed to lower prices, some also acted on volume; that is, the prescribing patterns of doctors. This is usually a delicate matter and previously has not been explicitly and directly addressed by the Portuguese authorities. The MoU required a monitoring system that regularly provides information on both the volume and value of prescribing by individual doctors.²⁵ The system has been in place since October 2011, as implemented by the Central Administration of the Health System (ACSS), and it is used to provide feedback to doctors. This has been made possible by another MoU condition: the establishment of a mandatory electronic prescription system for pharmaceuticals covered by the NHS. The system has been operating since August 2011. In addition, the MoU called for the adoption of international prescription guidelines in Portugal, to provide clear rules for more rational prescribing patterns, which has been implemented since 2011–2012. These guidelines aim to complement the feedback mechanism provided to doctors on their own prescribing.

Funding hospitals

Measures taken in the context of the Economic and Financial Adjustment Programme had the effect of increasing central control, because some of the agreed targets required financial, employment and other limits imposed from the central government.²⁶

As a result, hospital management became much more centralised and hospitals saw their (limited) autonomy reduced, with employment of new staff being subject to the government's approval through the Ministry of Finance.²⁶ The critical

problem in 2011 was NHS hospitals' debt to suppliers, which reached €3 billion by 2011. In 2012 and 2013, that value was reduced through extraordinary payments (from the government to clear some of the arrears in payments) of a total amount of €1.9 billion. Figure 3 shows the typical trend in NHS institutions of delaying payments to suppliers (a delayed payment is defined as due for more than 180 days) until the government transfers funds to the hospitals.

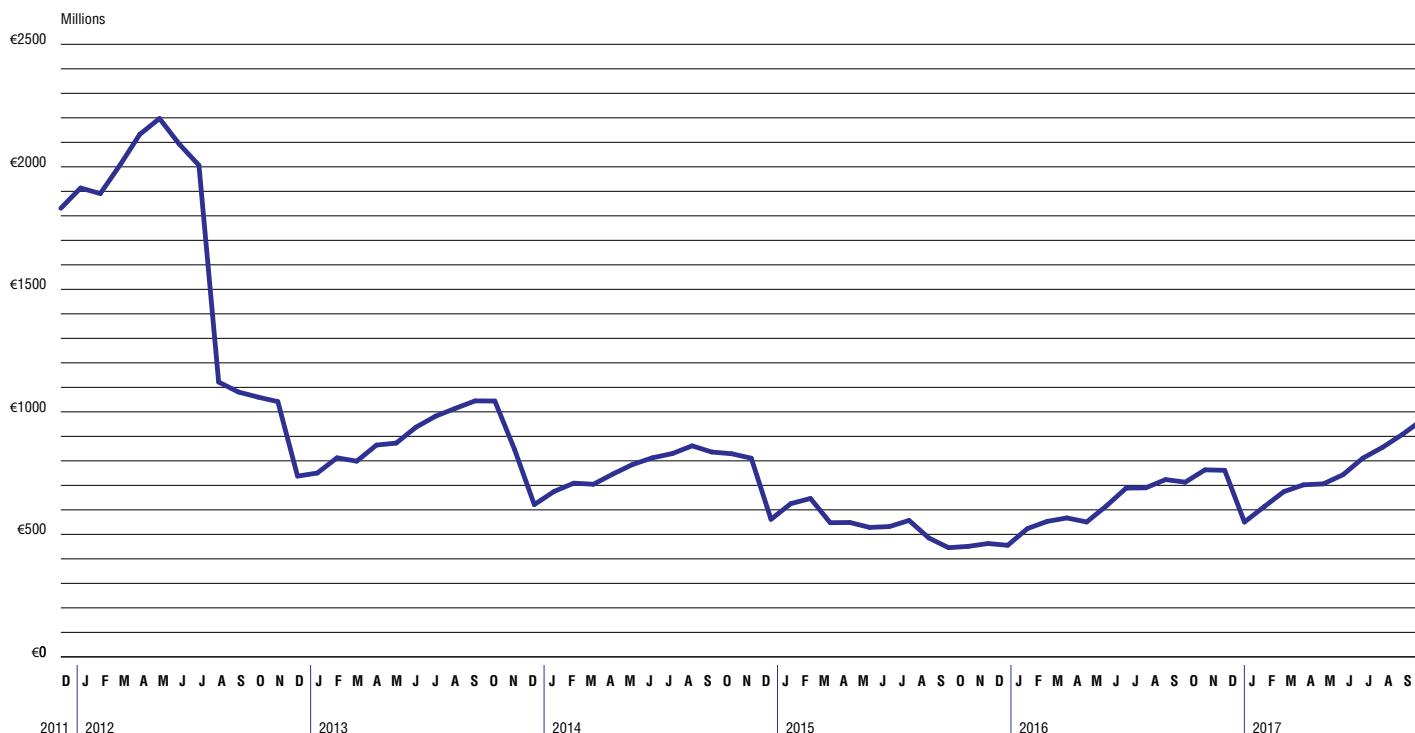
As no extraordinary transfers have been made since December 2016, the total amount of delayed payments to suppliers has reached €966.6 million and the total NHS debt peaked at €2 billion in September 2017. Despite efforts to improve hospital management and increase efficiency, the chronic problem of NHS debt to suppliers has not been solved during the financial bailout and shows the same trend as before the rescue plan.

In the MoU, the Portuguese Government agreed to “set up a system for comparing hospital performance (benchmarking) on the basis of a comprehensive set of indicators and produce regular annual reports”. To fulfil this commitment, in 2013 the ACSS published the first quarterly report highlighting their benchmarking analysis, which covered both public hospitals and hospitals under public-private partnership. The report aimed to assess the potential for improvement within each hospital in each major area of activity and to identify best practices and cross-cutting programmes to launch in the near future that may lead to improvements across the system. In 2014 and 2015, new reports for hospitals were launched, and in 2014 primary care centre groups (ACES) were also included in the benchmarking analysis, to improve monitoring within the NHS (results are available online²⁷).

Future challenges

The recent evolution of the Portuguese health system suggests that improvements have been made in terms of providing value for money. In particular, health gains and increased activity in the NHS were obtained without adding extra resources, indicating both an improvement in

Figure 3: Monthly evolution of delayed payments (> 180 days) to suppliers in NHS institutions in Portugal, December 2011 – September 2017 (in Million €)



Source: Authors' own based on ⁵

value for money provided and that large inefficiencies were (and still are) present in the system.²

Increases in productivity, measured by a higher growth in activity than in expenditure, have been present over recent years, and were the major goal of the Economic and Financial Adjustment Programme. Overall, the system became cheaper (due to cuts in spending) and more productive (due to increased working hours and contracting with institutions).

Overall, structural measures such as the reform in the pharmaceutical market and the reduction of public expenditure with private providers had very positive results that are still maintained. However, transitory measures such as salary cuts had natural limitations. The government formed in November 2015 reversed most of the salary cuts and re-established a 35-hour working week for public servants.

“ hospital management became much more centralised

In addition, three years after the financial bailout, health care professionals, including doctors, nurses and ancillary workers, are demanding that the Ministry of Health provide improvements in their career progression and working conditions. This is happening while Portugal is still under tight surveillance from the European Commission regarding the control of public finances. In 2017, the NHS debt to suppliers reached €2 billion, which shows that the financial sustainability of the publicly funded health services network is still at stake.

In the near future, productivity gains in the NHS will most likely entail an increase in spending, as opportunities for waste reduction become exhausted.

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POLICY EFFORTS TO STRENGTHEN PUBLIC HOSPITALS IN ISRAEL

By: Ruth Waitzberg and Sherry Merkur

Summary: Although Israel has a national health insurance system which provides universal access to basic health care services, a majority of adults take out voluntary health insurance (VHI). The VHI enables them to seek specialist and hospital care in for-profit hospitals rather than the already overstretched public hospitals. The problem with private funding is its regressive nature that exacerbates disparities in access and quality of care. Private provision also negatively impacts on the public system by drawing away physicians, patients and revenues from public hospitals. The government is addressing these challenges through a multi-pronged effort aimed at reforming the VHI market, encouraging physicians to work full-time in the public sector, and moving to activity-based payments in public hospitals.

Keywords: *Voluntary Health Insurance, Public Hospitals, Procedure-Related Groups, Israel*

The Israeli health care system has a relatively low level of public funding

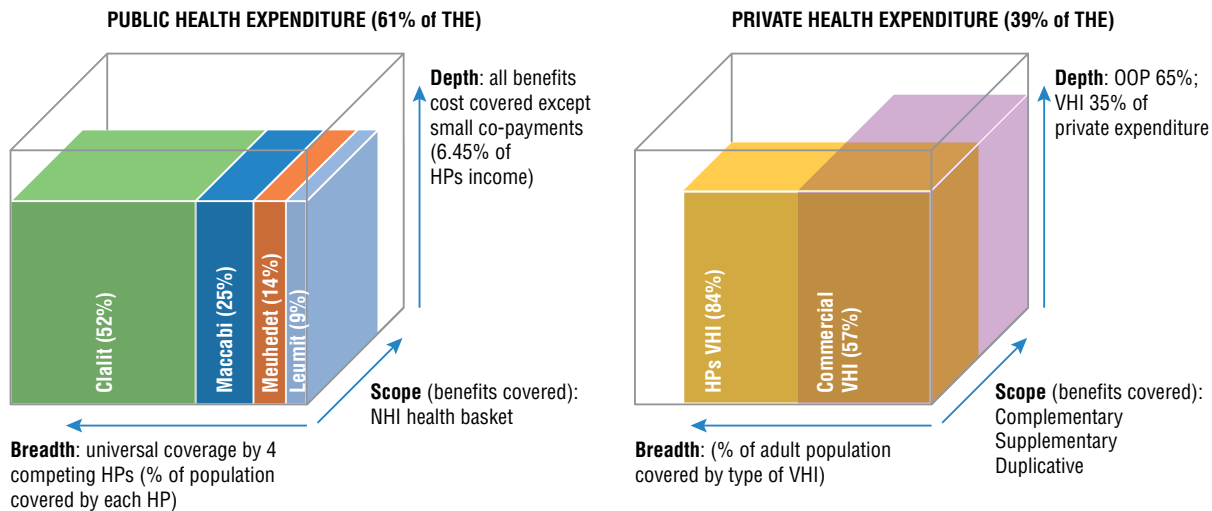
Since 1995, Israel has had a national health insurance (NHI) system that provides for a broad benefits package to all Israeli citizens and permanent residents, which the government updates each year. The benefits package includes an extensive list of services including inpatient, ambulatory, emergency and preventive care, diagnostic tests and medicines.

Four competing, non-profit health plans (HPs) are responsible for providing all their members with the NHI benefits package and for ensuring reasonable accessibility and availability of health services. They provide care in the

community and procure, or directly provide, hospital services. The NHI pays a premium to the HPs primarily according to a capitation formula that considers the person's age, gender and whether they live in the periphery or centre of the country.¹

Each year, the government determines the level of funding for the NHI, which is financed primarily from public sources (via payroll and general tax revenues). When compared to other OECD countries, Israel has relatively low rates of health care spending. In 2016, health expenditure in Israel as a proportion of gross domestic product (GDP) was 7.4%,² well below the OECD average of 9%.³ The share of public financing declined from 70% in 1996

Ruth Waitzberg is Research Associate, Myers-JDC-Brookdale, Jerusalem, Israel; Sherry Merkur is Research Fellow, European Observatory on Health Systems and Policies, LSE Hub, London, United Kingdom. Email: ruthw@jdc.org

Figure 1: The Israeli health insurance market

Notes: HP: health plan, NHI: national health insurance, OOP: out-of-pocket payments, THE: total health expenditure, VHI: voluntary health insurance.

Source: adapted from [4, 7]

to 61% in 2016 of total health expenditure (THE), which is considerably below the OECD average of 72.5%. Accordingly, the share of private financing (at 39% of THE) is one of the highest among OECD countries. This increase was accompanied by a sharp increase in spending on voluntary health insurance premiums. [4, 5]

“ Israel has the fourth highest VHI coverage rate among OECD countries

Voluntary health insurance and the dual coverage problem

On top of the NHI, two forms of voluntary health insurance (VHI) are available in Israel: VHI offered by the HPs to all of their own beneficiaries; and commercial insurance, offered by commercial insurance companies to individuals or groups.

- Health plan voluntary health insurance (HP-VHI) is a collective insurance

plan that offers a standard package to all policyholders, with fees determined solely by age by each HP. HPs provide the HP-VHI plans in addition to the mandatory health basket they provide under the NHI Law.

- Commercial insurance companies market both collective and individual commercial voluntary health insurance (C-VHI) policies, tailored to the preferences of the purchaser.

VHI has a complementary, supplementary and duplicative role in the Israeli health system. VHI policies cover (a) services that are not included in the NHI basic health care package (for example, dental care for adults or alternative medicine); (b) services that are covered by the NHI, but only to a limited extent (for example, in vitro fertilisation and physiotherapy); and (c) services that are covered by the NHI, and can be purchased in the private sector. Such services are provided in the private sector with enhanced choice of provider, faster access or improved facilities. VHI does not cover or reduce co-payments in the public system. [4, 6]

Even though the Israeli NHI benefits package is broad compared to other OECD countries, Israel's VHI market is still one of the largest. In 2016, 84% of Israel's adult population had HP-VHI, and 57% had C-VHI [7] (see Figure 1). Accordingly, Israel

has the fourth highest VHI coverage rate among OECD countries, behind France, Slovenia and the Netherlands (based on OECD data for 2015). One distinguishing feature of the VHI market is the prevalence of multiple coverage: 97% of C-VHI owners also own HP-VHI, and 47% have more than one commercial insurance plan. This raises concerns that consumers may be paying twice for policies that provide the same or overlapping coverage. [8]

Public hospitals function under pressure

Of the 44 general hospitals* in Israel, 35 are non-profit owned by the Ministry of Health (MoH), municipalities, HPs or NGOs. They are considered “public hospitals” in Israel. The remaining nine are smaller for-profit hospitals and operate 3% of the beds. [9]

Public general hospital care in Israel is one of the most crowded among OECD countries. Table 1 shows that, compared to the OECD average, Israeli public hospitals function with about half the average rate of acute care beds and nurses per population. Average length-of-stay (ALoS) in Israeli hospitals is also one of the shortest, and occupancy rates of acute care beds is one

* Israel adopts the OECD definition for general hospitals, see <http://stats.oecd.org/fileview2.aspx?IDFile=5700cad3-3cc3-4055-b732-0d4ba59faf17>

Table 1: Hospital activities indicators, Israel and OECD average, 2016

| | Israel | OECD |
|--------------------------------------|--------|--------|
| Acute care beds/1,000 population | 2.3 | 3.7 |
| ALoS (acute care) | 4 | 6.7 |
| Occupancy rate of acute care beds | 93% | 78% |
| Nurses/1,000 population | 4.9 | 8.9 |
| Physicians/1,000 population | 3.1 | 3.4 |
| Discharges rate/100,000 (all causes) | 15,890 | 15,815 |

Source: ⁸ ¹⁰

of the highest among OECD countries, reaching almost full capacity at 93%. Over the last decade, although the physical capacity of public hospitals has increased, it has roughly paralleled the natural growth of the population. For example, between 2010 and 2016, the number of acute care beds increased by 6%.⁹ Yet, the rates of beds per population have remained stable over the last decade. ALoS in general hospitals is four days, and has also remained unchanged over the last decade.

Challenges facing the public hospital sector

Over the last decade, budget deficits in hospitals and HPs have been a major concern. Strengthening the public system has been one of the main efforts of the MoH and Ministry of Finance (MoF), which convened a National Committee for

this purpose in 2013–2014.¹¹ Challenges related to the hospital market, which are discussed below, represent a growing concern that is now being addressed by changes in policy.

Private funding, the fuel for private activities

VHI is the main source of funding for private hospitals' activities. Individuals with VHI coverage (and often multiple coverage) look to private hospitals in order to access care. The main reasons for preferring private hospitals is the possibility to select the surgeon, which is not allowed in public hospitals, and shorter waiting times for certain elective procedures.

Over the last decade, Israel's for-profit hospitals' activities have grown significantly, particularly for surgery.

Between 2007 and 2011, the number of elective operations increased by 58% in for-profit hospitals, compared with an increase of only 4% in public hospitals. By 2013, almost two out of every five (38%) elective procedures were carried out in for-profit hospitals. The shift in volume from public hospitals to for-profit hospitals has raised a number of concerns including: a two-class system of care; loss of revenue for public hospitals; many senior physicians undertaking private work in for-profit hospitals in the late afternoons and evenings, raising concerns about quality of care provided during those times of day and longer waiting times for elective operations in public hospitals.¹² ¹³

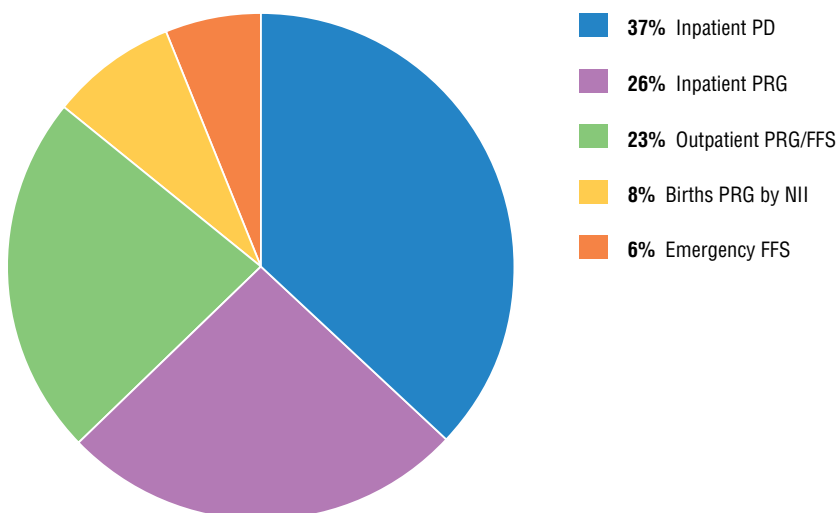
Moonlighting is drawing away public hospitals' doctors

The increasing private health care funding is to some extent crowding out the public sector in the competition for physicians' time: prices in the private sector are higher, and physicians in that sector are paid on a fee-for-service basis. Therefore, physicians have strong incentives to prefer private practice. Many of the best and more senior physicians have reduced their publicly-paid activities, which leads to increasing waiting times in the public sector. Moreover, it increases the gaps in access and quality of care between those with VHI and those without.¹⁴

Prices do not reflect real costs

The main source of income for Israel's public hospitals comes from the sale of services to HPs. Hospital reimbursement rates are determined by a joint MoH and MoF pricing committee, under the "Price List for Ambulatory and Inpatient Services". This maximum price-list also determines the type of payment, which can be per diem; per activity, so called procedure-related groups (PRG); or fee-for-service (FFS).

As shown in **Figure 2**, in 2015, a quarter of the gross revenue of government-owned hospitals was for inpatient care paid by PRG, 37% for inpatient care paid by per diem, 23% for ambulatory care paid by FFS or PRGs, 8% for births paid by PRGs and 6% for emergency care paid by FFS.¹⁵

Figure 2: Distribution of Governmental hospitals' gross income by type of service provided and type of payment, 2016

Note: PD: per diem; PRG: procedure-related group; FFS: fee-for-service; NII: National Insurance Institute.

Source: ¹⁵

Box 1: Changes to the C-VHI market

- Creation of a “standard policy” for surgery and specialist consultations: insurance conditions and policies must be the same for all insurers and insured, including coverage, premium and co-payments. The premium can vary according to eight age-groups and gender, and a few personal risk factors, such as previous medical conditions.
- Insurers must offer the different policy packages separately, each with its own price and without mutual dependency of ownership. Examples of insurance policies are policies for surgery and specialist consultations; medications not in the NHI; transplants overseas; and severe diseases.¹⁷

Until 2010, MoH price lists were not based on a methodical costing process. Per diem and FFS rates were set about three decades earlier based on the historical expenditures of certain hospitals. Since then, rates were updated for inflation, but no major recalculations were undertaken, despite significant changes in cost structure due to technical and medical advances. Therefore, some activities are underpaid and others are overpaid. The gaps between costs and prices create a series of inefficiencies caused by the influence of economic considerations on medical decisions.

“physicians have strong incentives to prefer private practice

In addition to the imprecise costing and pricing mechanism, the unbalanced competition of public and private hospitals poses further difficulties to public hospitals. For-profit hospitals can, on the one hand, select the low risk or low cost patients and, on the other hand, do not incur the cost of emergency care or teaching and research activities. In

addition, for-profit hospitals are not subject to the MoH price-list and charge FFS. This situation creates negative spill-over effects on the public sector: cream skimming of patients by for-profit hospitals leaves the most severe and costly cases for public hospitals. Furthermore, the public hospitals usually receive patients with complications and readmissions from for-profit hospitals. Consequently, over the past decade, the case-mix treated in public hospitals has become more costly than the average, but hospitals have not been reimbursed for these additional costs. Since MoH prices are set as national-use averages, and PRGs are not adjusted for severity of case, these costs are not reflected in the price list, and public hospitals are under-funded and are finding themselves in chronic financial deficits.¹⁷

Three measures to strengthen public hospitals

Since 2015, the MoH and MoF have been addressing the aforementioned challenges through a series of policy reforms, some of which are described here.

1. VHI reform to limit private funding

Since 2015, the government approved several changes to the C-VHI market to address the multiple coverage issue and protect consumers.¹⁸ The changes create simplified and more transparent insurance products to help refine consumer choice and potentially enhance market competition based on quality rather than price (see Box 1). Another change was that VHI can cover services provided only by physicians with selective contracts with the insurer, and providers cannot extra-bill patients. This measure intends to limit private funding, and consequently limit the private provision of care.

2. Cooling-off period to limit diversion of patients to private practices and the full-timers programme

In December 2015, new legislation stipulated that a physician who has started treating a publicly-funded patient cannot provide that patient with privately-funded services during a period of at least four months. This law attempts to limit the diversion of patients from the public to the private system.¹⁴

Box 2: Specific objectives of the full-timers programme

- to increase the availability of senior physicians in public hospitals outside of regular work hours, thus improving quality and safety of care;
- to contribute to the development of the next generation of clinical leaders in public hospitals, and develop physicians who look to the publicly financed system as a sole and satisfying source of income;
- to improve the image of the publicly financed system and related public trust;
- to increase the volume of care provided by public hospitals; and
- to reduce waiting times for elective operations and ambulatory treatments.

In mid-2016, the MoH put forward a plan according to which selected physicians in public hospitals would be offered significantly enhanced pay in return for working additional hours in a public hospital and agreeing not to work in the private sector. The overall objective of the full-timer initiative is to strengthen Israel’s publicly financed health care system by improving its availability, quality and safety (see Box 2). The initiative may also contribute to efforts to constrain the private provision of care.¹⁸

3. Adoption of Procedure-Related Group (PRG) payments to improve payment for public hospitals

The MoH has been working to build a consistent costing and pricing mechanism for public hospitals to reduce gaps between costs and prices. A hospital payment reform (the PRG reform) began in 2010, which consisted of costing hospital activities and setting differential pricing for inpatient care per procedure by medical fields. Once the price for a specific procedure has been set, the per diem payment is replaced by the PRG. In 2015, there were over 300 PRGs codes, which account for half of all procedures and a quarter of all discharges.^{15 19}

PRGs differ from diagnosis-related groups (DRGs) because they classify patients based on the main procedure they

undergo rather than the diagnosis, and the former also do not adjust for severity or case-mix. Nonetheless, DRGs and PRGs create similar economic incentives to increase the volume of cases, increase the income per patient and reduce costs per patient. Theoretically, hospitals can work to decrease their cost per patient by reducing the number of services provided to each case, reducing the length of stay and selecting patients with low risk and morbidity. On the other hand, hospitals can increase the number of income-generating procedures. In Israel, some initial evidence has shown that volumes are increasing and hospitals are shifting PRG-paid activities to outpatient settings in order to save costs.¹⁹

Conclusions

The low and stable total expenditure on health has been a source of pride for the Israeli health care system. However, the decrease in the share of public funding and concomitantly, the increasing growth of private expenditure, has raised serious concerns about a shortage of resources in the public system and rising inequalities.

As discussed, the government has undertaken a series of steps which, together, work to enhance regulation in the VHI market, limit the diversion of patients and physicians from the public to the private system, and endeavour to make hospital payment based on activity rather than per diem rates. Each of these health policy reforms will need to be analysed over the medium term in order to determine whether they have helped to correct for the inefficiencies and incentives inherent in the public/private model of the Israeli health system and to strengthen the position of public hospitals in Israel.

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NEW PUBLICATIONS

Civil society and health: contributions and potential

By: by: SL Greer, M Wismar, G Pastorino and M Kosinska

Copenhagen: World Health Organization 2017 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Number of pages: xvi + 183; **ISBN:** 978 92 890 5043 2

Freely available for download: http://www.euro.who.int/__data/assets/pdf_file/0011/349526/Civil-society-web-back-cover-updated.pdf?ua=1

Civil society organisations (CSOs) can make a vital contribution to public health and health systems, but harnessing their potential is complex in a Europe where government-CSO relations vary so profoundly. This study is intended to outline some of the challenges and assist policymakers in furthering their understanding of the part CSOs can play in tandem and alongside government. To this end, it analyses existing evidence and draws on a set of seven thematic chapters and six mini case studies. They examine experiences from Austria, Bosnia-Herzegovina, Belgium, Cyprus, Finland, Germany, Malta, the Netherlands, Poland, the Russian Federation, Slovenia, Turkey and the European Union and make use of a single assessment framework.

The evidence shows that CSOs are ubiquitous, varied and (typically) beneficial. The topics covered in this study reflect such diversity of aims and means: anti-tobacco advocacy, food banks, refugee health, HIV/AIDS prevention, and social partnership. This book guides policymakers working with CSOs and helps avoid some potential pitfalls.

Contents: Foreword; What is civil society and what can it do for health?; What civil society does in and for health: a framework; Working with civil society for health: policy conclusions; Specific programme chapters; Social partnership, civil society, and health care; Mini Case Studies.



Assessing the economic costs of unhealthy diets and low physical activity: an evidence review and proposed framework

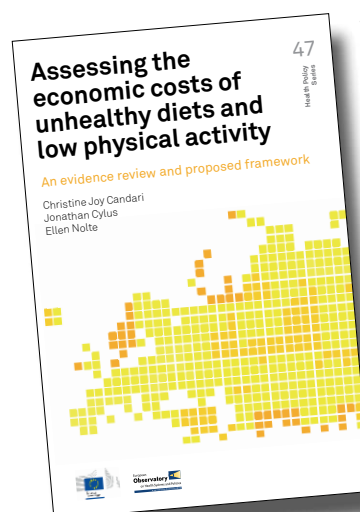
By: CJ Candari, J Cylus and E Nolte

Copenhagen: World Health Organization 2017 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Number of pages: xv + 91; **ISBN:** 978 92 890 5042 5

Freely available for download: http://www.euro.who.int/__data/assets/pdf_file/0004/342166/Unhealthy-Diets-ePDF-v1.pdf?ua=1

Unhealthy diets and low physical activity contribute to many chronic diseases and disability; they are responsible for some two-in-five deaths worldwide and for about 30% of the global disease burden. Yet surprisingly little is known about the economic costs that these risk factors cause, both for health care and society more widely. This study pulls together the evidence about the economic burden that can be linked to unhealthy diets and low physical activity and explores how definitions vary and why this matters; the complexity of estimating the economic burden; and how we can arrive at a better way to estimate the costs of an unhealthy diet and low physical activity, using diabetes as an example.



The review finds that unhealthy diets and low physical activity predict higher health care expenditure, but estimates vary greatly. The study's findings are a step towards a better understanding of the economic burden that can be associated with two key risk factors for ill health and they will help policymakers in setting priorities and to more effectively promoting healthy diets and physical activity.

Contents: Foreword; Introduction; The economic costs of unhealthy diets and low physical activity: what does the published literature tell us?; Estimating the economic costs of unhealthy diets and low physical activity is complex; Taking available approaches to determining the economic costs of unhealthy diets and low physical activity further: a proof-of-concept approach applied to five European countries; Discussion and conclusions; References; Appendices.

NEWS

International

State of Health in the EU analysis published

A lack of context-sensitive, comprehensive analysis has long been identified as a major obstacle for health policy makers. To fill this knowledge gap, in November 2017 the Commission completed the first two-year cycle of its State of Health in the EU analysis. 28 country health profiles were prepared in cooperation with the OECD and the European Observatory on Health Systems and Policies. They look at the health of the population and important risk factors, as well as at the effectiveness, accessibility and resilience of health systems in each EU member state. The profiles clearly reflect shared objectives across the member states, and reveal potential areas where the Commission can encourage mutual learning and exchange of good practices. The profiles are complemented by a companion report summarising key cross-country findings.

Vytis Andriukaitis, Commissioner for Health and Food Safety, noted several key issues identified in the analysis saying that “*spending only 3% of our health budgets on prevention, compared with 80% on the treatment of diseases, is simply not enough.*” He also said there was a need for “*better access to primary care so that the emergency room isn’t people’s first port of call and to enshrine health promotion and disease prevention into all policy sectors to improve people’s health and reduce pressure on health systems*”.

The 28 Country Health Profiles, the Companion Report and more background information can be found at: https://ec.europa.eu/health/state/summary_en

Financial hardship linked to inadequate health coverage policies

A new working paper from WHO/Europe, released on Universal Health Coverage (UHC) Day alongside a global UHC

monitoring report, compares financial protection in the Czech Republic, Estonia and Latvia. It concludes that households in these broadly similar countries experience markedly different levels of financial hardship when using health services. According to the report, the incidence of catastrophic and impoverishing out-of-pocket payments – payments that exceed 40% of a household’s capacity to pay for health or push a household into poverty – is very low in the Czech Republic, higher in Estonia and among Europe’s highest in Latvia. Co-payments (user charges) for outpatient medicines in Estonia and Latvia disproportionately shift the burden of health care costs onto those who can least afford to pay out of pocket: poor people, people with chronic conditions and older people. In the Czech Republic, the design of co-payment policy is more robust: people pay a low, fixed co-payment for health services and medicines, rather than a percentage of the price; vulnerable people are exempt from co-payments; and there is a cap on co-payments for everyone, with an even more protective cap for those who are under 18 years of age or 65 years of age and over.

In the coming months, WHO/Europe will publish a series of individual reports on financial protection in 25 countries. Findings from a regional comparative analysis will be presented at a high-level technical meeting in Tallinn, Estonia in June 2018 – Health Systems for Prosperity and Solidarity: leaving no one behind – hosted by the Government of Estonia to celebrate 10 years of the Tallinn Charter: Health Systems for Health and Wealth.

The working paper can be downloaded at: http://www.who.int/health_financing/events/who_europe_uhc_day_report_web.pdf

Long term residential care: costs to users increasingly a barrier to access

With people living longer, the need for affordable care of high quality to support Europe’s population increases. In November 2017 the European Foundation for the Improvement of Living and Working Conditions published a new report *Care homes for older Europeans: public,*

private and not-for-profit providers. The report provides a picture of the quality, accessibility and efficiency of services. Over the last ten years, there has been a substantial increase in private care homes, while at the same time, the number of public care homes is either decreasing or growing at a slower pace.

As demand increases so too does the challenge to maintain public funding and spending for long-term care, which may ultimately lead to higher co-payments from service users. The report finds that some countries already have schemes in place to limit the percentage of a service user’s assets that can be used. However, as private provision increases, costs to users are likely to become a more significant barrier issue unless there is an increase in public benefits to subsidise use. The report also finds that private care homes more likely to be found in affluent urban areas. Differences in the types of residents are influenced by the profitability of the services they require. There is also a lack of agreed quality indicators, particularly on quality of life for service users in long-term care.

The report is available at: <http://goo.gl/4rejYA>

The Netherlands: Reduction in out of pocket payments for long term care

From January 2018, out of pocket payments for long term residential care will be reduced for people receiving intensive home care at home or living in a residential care home with a partner living at home. These payments will be reduced from 12.5% to 10% of personal income. 30,000 people will benefit from the measure, typically reducing out of pocket costs between 30 and 150 euros per month. There will also be a reduction in personal contributions related to capital assets in 2019.

More information (in Dutch) at: <http://goo.gl/sL9VX6>

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 Tel: + 32 2 235 03 20
 Fax: + 32 2 235 03 39
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State of Health in the EU

Country Health Profiles

A new series of concise and policy-relevant profiles that summarise the performance of health systems in the 28 European Union Member States.

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