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EUROHEALTH

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

The views expressed in *Eurohealth* are those of the authors alone and not necessarily those of the European Observatory on Health Systems and Policies or any of its partners or sponsors. Articles are independently commissioned by the editors or submitted by authors for consideration.

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

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Design and Production: Steve Still

ISSN 1356-1030



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Providing timely emergency medical services for life-threatening situations as well as urgent care appropriate to patients' clinical needs are the most enduring challenges facing national health care systems, particularly in light of rising numbers of unnecessary emergency department attendances in many countries.

In this issue's Observer section, Sagan and Richardson provide an overview of the main aspects of emergency care, highlighting some of the strategies being adopted to consolidate emergency care and divert patients to more appropriate parts of the health system. In a related second article, they put the spotlight on out-of-hours urgent care most appropriately provided at the primary care level and how this may be improved in order to relieve the pressure on hospital emergency departments. Providing an example of a telephone-based service designed to improve access to urgent health care, Turner et al discuss the piloting and national implementation of NHS 111 in England which is well liked by users but to date has not delivered the expected efficiencies or checked the growth in emergency ambulance activity. Finally, it has been argued that one factor determining patients' possible use of emergency care is excessive waiting times for various treatments which can exacerbate conditions to the point of requiring urgent care. In the last article in this section, Siciliani et al assess the main policy tools that have been used in OECD countries to try to tackle long waiting times, with varying degrees of success.

In the International section, the article by Brooks looks at EU health policy in the current climate of fiscal and economic coordination. The author points to the European Semester and Health System Performance Assessment as competing processes which are changing the policy landscape at EU level and are increasingly shaping policy responses at the national level. On the topic of eHealth services in the European Union, Ellis and colleagues discuss the variable levels and speeds of adoption and provide country examples. Rounding up this section, Alarcón-Jiménez explains how the international MEDICRIME Convention adopted by the Council of Europe functions as a major tool to criminalise the counterfeiting of medical products and similar crimes involving threats to public health and to protect the rights of victims.

Covering a neglected area, in our Systems and Policies section, Baker discusses Ireland's National Men's Health Policy, which ran from 2008 to 2013, the first of its kind in the world. Reporting the results of an independent review that he conducted, the author concludes that such plans could also reap benefits if adopted by other EU countries. Moving to the hospital sector, in their article, Quentin et al look at recent payment reforms in Switzerland, where the introduction of diagnosis-related groups considerably improved hospital planning and co-ordination across the country's 26 largely independent cantons.

As usual we also feature new publications in our Monitor section, this time highlighting the study *Promoting Health, Preventing Disease: the economic case*, as well as a new policy brief on *How can countries address the efficiency and equity implications of health professional mobility in Europe?* The News pages provide a round-up of what's been happening in health policy around Europe.

We hope you enjoy the Winter issue!

Sherry Merkur, Editor

Anna Maresso, Editor

David McDaid, Editor

Cite this as: *Eurohealth* 2015; 21(4).

THE CHALLENGE OF PROVIDING EMERGENCY MEDICAL CARE

By: Anna Sagan and Erica Richardson

Summary: Emergency medical care is a politically important aspect of health service provision as it is often the first contact point with the health system for many patients requiring urgent care and delays in access to treatment are understood to be a matter of ‘life or death’. Increasing pressure on emergency medical services has led to the adoption of various strategies, including a greater consolidation of emergency care and diverting patients to other parts of the health system. While there is great scope for cross-country learning, research on international comparisons of emergency medical services remains scarce and there is no universal group of evidence-based performance indicators.

Keywords: *Emergency Medical Care, Health Care Provision, Health Care Organisation*

Introduction

Emergency medical care is the provision of medical care to patients with life-threatening conditions who require urgent treatment. From a policy perspective, emergency medical services (EMS) are one of the higher profile aspects of the health system as they are the first point of contact with the health system for many people. EMS also serve as a sentinel for weaknesses in the wider health system, such as financial or organisational barriers to accessing primary care or shortcomings in the provision of care for people with long-term conditions.

Until recently, there were two distinct typologies in the provision of emergency care. The first is the Anglo-American “load & go” model, with a focus on bringing the patient as quickly as possible to the hospital, usually to the emergency department (ED). This model has greater

reliance on paramedics during the “load” phase. In contrast, the Franco-German “stay & stabilise” model, relies more on mobile medical doctors who provide advanced medical care on site, with transported patients being admitted to the hospital directly rather than through the ED. In response to changes in medical technologies and population health trends, most European EMS now have elements of both organisational models – load & go for complex trauma care, such as in the case of road traffic accidents, and stay & stabilise for medical emergencies, such as heart attack or stroke. Neither model, on its own, is superior.¹

EMS can be divided into out-of-hospital EMS and in-hospital EMS. Out-of-hospital EMS typically refers to the delivery of medical care at the site of the adverse medical event, including dispatch services and mobile medical care units, such as

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ambulances. In-hospital EMS refers to those subsets of medical institutions and hospitals that have the capacity to deliver uninterrupted emergency care on a 24 hours-a-day, 7 days-a-week basis. In addition, urgent care services, mainly provided within primary care services, including out-of-hours (OOHs) primary care and services such as the fire brigade and police, contribute to providing, ameliorating and supporting EMS.² (See also the article on access to OOHs primary care in this issue).

Out-of-hospital EMS – ambulance and dispatch services

There are two main types of road ambulances used for EMS in European countries: emergency ambulances designed and equipped for the transport, basic treatment and monitoring of patients; and mobile intensive care units designed and equipped for the transport, advanced treatment and monitoring of patients.³ In some countries, ambulance services are considered part of primary care (e.g. Slovenia, Lithuania), in others they are hospital services (e.g. Latvia and Belgium), but they are often provided by local governments (e.g. Finland, Norway) or are integrated into other emergency services, such as fire departments (e.g. France and Germany). As with primary care, EMS are often organised in relation to the resident population served – so policy-makers aim for a particular ratio of ambulance teams per capita. However, this can place great burdens on hospital teams in big cities which have large commuter populations (as the daytime population is far greater than the resident population) and in areas popular with holiday makers which may have a small resident population, but a very large number of seasonal visitors.

A review of information provided in the Health Systems and Policy Monitor⁴ found that as communications technology has improved, greater centralisation and consolidation of ambulance services has been made possible, and this has been a common aim in many reform strategies (e.g. in Bulgaria, Croatia, Estonia, Ireland, Latvia, Lithuania, Norway and the UK). Consequently, it is quite rare for services to still be organised at the municipal level

(as in Finland, Germany and also Norway, but with increased collaboration between municipalities). The concentration and consolidation has often occurred in order to make efficiency gains.

“only eleven EU Member States have triage guidelines based on national standards”

Most European Union (EU) countries have integrated dispatch centres, i.e. they have dispatch centres that coordinate the dispatch of vehicles and personnel of at least two principal emergency management agencies (security services, EMS, fire department, etc.) Moreover, in most EU countries dispatch centres transfer the call to another centre when a medical consultation is needed; as yet, computerised triage systems in dispatch centres are not common in the EU.⁵

In-hospital EMS

Emergency Departments

During the 20th century, EDs developed in response to an increased need for rapid assessment and management of critical illnesses; they represent one of the most important changes in the structure of hospitals and provision of health care in Europe.⁶ In all EU countries, EDs are now a legally required component of hospitals.⁷ In the past, a patient arriving at an ED was often seen by a physician specialised in resuscitation or by an unsupervised trainee doctor. Nowadays, a greater percentage of patients is evaluated by more senior physicians. In most EU countries, trainee doctors in many different specialties may rotate to the ED as part of their postgraduate training, although their supervision is primarily by non-emergency

medicine specialists located elsewhere in the hospital. However, an increasing number of European hospitals now staff EDs with either emergency specialists or trainee doctors in emergency medicine.

Many countries have stepped up efforts to rationalise and reconfigure hospital care, categorising their hospitals into distinct levels that specify their remit both in geographical terms and in the types of care to be provided, then integrating them into networks to encourage greater collaboration and coordination. The need for a more concentrated and structured provision of specialised hospital services, including emergency care, is not only motivated by the need to increase efficiency and contain costs but also by the need to ensure patient safety and improve quality of care. Policy-makers have sought to increase the throughput of patients in order to maintain the skills of emergency care specialist doctors and nurses (e.g. in Sweden and the UK). Research conducted in the UK found that concentrating expertise in trauma care led to a 30% improvement in survival rates despite longer travel times.⁸

Diversification of hospital emergency care and concentration of the most complex cases are often also motivated by the need to construct viable staffing rotas. Staff shortages in emergency medical care are a problem across Europe as emergency medicine is not considered the most prestigious branch of medicine to pursue (i.e. in Bulgaria and Hungary). In addition, the challenge of recruiting and retaining staff in remote rural regions affects all branches of medicine, and emergency care is no different. For this reason, building capacity in air ambulance services is a priority in some countries (e.g. Ireland).

Triage

Triage ensures the efficient use of available resources, e.g. personnel, supplies, equipment, means of transportation and medical facilities; thus it affects the extent and quality of care delivered by the EMS system. Almost all EU Member States use triage protocols in their hospitals, while in 21 countries, the ambulance service also uses triage. Detailed and specific guidelines and protocols can improve the quality of the

dispatch centre response. Potentially, the use of different triage scales within the same EMS system may pose a patient safety risk. In only eleven EU Member States do triage guidelines for dispatch centres follow national standards.² In addition, it seems that most hospitals or EDs use their own protocols, without coordination or standardisation within the country and with other parts of the EMS (i.e. out-of-hospital EMS).

Given the ever-increasing demands on the EMS system and referral of acute care patients between different hospitals, triage guidelines and protocols that are recognised and shared throughout the EMS system, especially in the in-hospital environment, are seen as a way to improve the referral network and increase efficiency in the whole system. New information and computer technology can help to better manage patient records at all levels. Computerised versions of some of the most popular triage protocols may modify health care provider behaviour positively and significantly improve the evaluation and assignment of priority, although its clinical significance is still under discussion.³ Nurse-led triage is now common in EDs in some countries, for example the UK, and has been shown to be an accurate method of identifying high risk patients.⁴

Challenges and conclusions

Changing population health trends, particularly increasing multi-morbidity, have been putting pressure on emergency care services, especially on hospital EDs and ambulance services, which are often the most accessible points in the system. Many reform strategies have involved a

greater consolidation of both ambulance services and hospital care, including emergency care. This has the benefit of increasing efficiency and reducing cost but also increasing throughput of patients in order to maintain the skills of emergency care staff. Strategies focused on diverting patients to other parts of the health system are seen as a potential solution for reducing pressure on EMS as in a number of countries a significant proportion of some ED admissions can be considered inappropriate.^{5,6} These strategies include increasing the accessibility of primary care (especially OOHs), improving patient pathways in the system, and using financial incentives to reduce demand for emergency care (See article on access to OOHs primary care in this issue). While international comparative evidence in these areas remains scarce, there is potential for countries to learn much from each other. In particular, there is a need for greater monitoring and evaluation of innovations in order to build a knowledge base.

The main indicators used to evaluate EMS are process indicators: response times for ambulances and waiting times for patients in EDs. While timely access to emergency care is a frequently quoted concern, only some countries have indicators around minimum travel times. It is also not clear to what extent process indicators have an impact on care outcomes; there is currently no core group of evidence-based performance (outcome, process, satisfaction, equity and structural/organisational) indicators which can be recommended universally.⁷

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OUT-OF-HOURS PRIMARY CARE AND DEMAND FOR EMERGENCY MEDICAL SERVICES

By: Anna Sagan and Erica Richardson

Summary: Major trauma and medical emergencies often constitute only a proportion of the workload of emergency medical services, as they also have to deal with many patients suffering from conditions better treated within primary care. This has renewed focus on urgent care as a means of reducing demand for emergency care services. While demand for emergency care is closely related to changes in population health trends and improvements in medical technologies, improving access to primary care through the provision of urgent care services has the potential to improve quality of care and financial efficiency.

Keywords: *Emergency Medical Services, Primary Care, Access, Urgent Care*

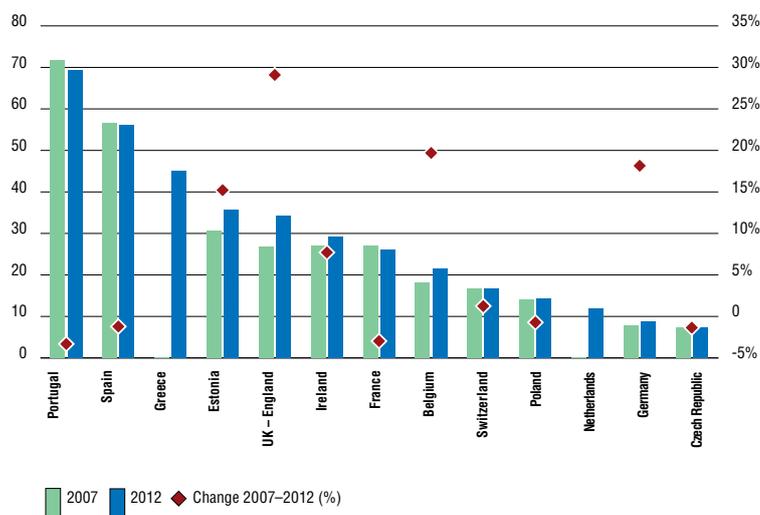
Introduction

Emergency departments (EDs) provide highly visible and critical services that often form the frontline of health care systems for patients facing difficult circumstances.¹ The 2007 World Health Assembly Resolution 60.22 “Health Systems: Emergency Care Systems” highlighted the role that strengthened emergency care systems can play in reducing the burden of disease from acute illness and injury. Further, it called on governments and WHO to take specific and concrete actions. However, in many OECD countries, the number of visits to EDs has increased since 2007 (see Figure 1), which poses questions about the efficient use of ED resources, especially as a significant proportion of patients attend EDs for non-urgent conditions that could be managed in primary and community care settings.

According to an OECD review, a lack of access to primary care and a shortage of out-of-hours (OOHs) services are the main supply-side factors influencing demand for emergency care.² On the demand side, ED visits are influenced by individual preferences (EDs are convenient to access, especially OOHs), health needs (population ageing and increased prevalence of chronic conditions) and socio-economic factors (deprivation and lack of social support are associated with increased ED use). Bottlenecks in other parts of the health system can also affect the demand for emergency care. Shortages of specialist beds can contribute to overcrowding in EDs as patients cannot be moved on from emergency care services to the appropriate department for further specialist care (e.g. in France and the UK) and staff shortages in other parts of the system can put greater pressure on emergency care services as they can reduce accessibility.

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Figure 1: Number of ED visits per 100 people in European OECD countries, 2007 and 2012



Source: Based on data from Table A3 in Ref. [3]

Notes: 2007 and/or 2012 data was not available for all countries included in the figure. Due to different definitions and identification of emergency care services, caution is needed when comparing countries.

Blurred line between urgent care within primary care and emergency care

There is often not a strict delineation between urgent care to be provided through primary care and emergency care. In many EDs, major trauma comprises only a part of the overall workload, with many patients suffering from minor ailments that could be better treated within primary care.^[2] In many of those cases primary care provision is superior also in terms of lower costs, better continuity and improved coordination.^[3] However, patients may not realise this and primary care services may not be accessible when they need them, for example at evenings or weekends, and emergency services by their nature are often the most accessible points in the system.

“major trauma comprises only a part of EDs' workload”

Primary care providers, such as General Practitioners (GPs)/family doctors, are generally required to have space in their schedule to provide urgent care to patients in normal working hours and to make provisions for primary care services to be available OOHs. The most common models in OOHs care seem to be non-practice-based provision (see Table 1). Where there are weaknesses in the provision of urgent and OOHs primary care, the patient traffic to emergency medical care will be greater – either because patients will access these services instead, or because they will delay treatment and will need to access them as a medical emergency. The extent to which EDs contribute to OOHs care varies across Europe, but it is notable that in countries such as Cyprus, Estonia, Latvia and Lithuania EDs have the sole responsibility for OOHs primary care service delivery (see Table 1). A by-product of overuse is overcrowding of EDs and long waiting times. This is a particular problem where EDs are part of the social safety net^[4] as these services are often free of charge, whereas patients have to pay out-of-pocket to access care elsewhere in the system (e.g. as in the USA, Canada, Cyprus and Bulgaria). In some countries, certain population groups, such as undocumented migrants, only have access to emergency care and not to other forms of care.^[5]

It has been argued that gate-keeping may lead to inappropriate use of EDs at acute hospitals with patients using emergency care directly in order to bypass referrals to specialists.^[6] However, while increasing numbers of non-emergency visits at EDs have been observed in several gate-keeping countries, such as England, Portugal and Spain, the same trend is also evident in Germany and Switzerland, where gate-keeping remains weak.^[6] Moreover, in Norway, where patients can access EDs only with a referral from primary care or by ambulance, inappropriate use of EDs has not been eliminated. According to one analysis of emergency referrals from a single OOHs primary care centre, around a fifth of all referrals could have been avoided.^[7]

The Netherlands is one country where gate-keeping by GPs plays a major role in low ED attendances, but it is supported by a number of other measures. Many Dutch hospitals collaborate with GP posts (centrally located offices with a GP present after hours) to provide emergency care in lieu of EDs, reducing the number of unnecessary cases. Collaboration between these GP posts and EDs is encouraged and the majority of hospitals have a GP post. In addition, financial incentives are being developed to keep patients out of EDs. For example, as part of the health insurance system, a compulsory annual deductible of €375 for accessing health services includes ED care but excludes GP services, thus incentivising the use of a GP. Moreover, a recent proposal has suggested that insurers do not need to cover patients going to EDs without a referral from a GP, if it turned out that emergency care was not required. In the Netherlands, co-payments for patients using emergency services unnecessarily have been deemed unlawful but such co-payments already exist in Belgium and Italy; however, there is no conclusive evidence of any change in inappropriate use of ED after their introduction.^[8]

The way forward?

A 2009 survey among key informants from 25 countries found that most of the countries had plans to reform OOHs care, mainly by centralising the provision of OOHs care: moving toward larger scale organisations, integrating primary care

Table 1: Ease of access to OOHs primary care in selected EU countries

Country	Provision of OOHs primary care
Ease of access : low	
Belgium	Practice-based services (mainly) and hospital EDs . There are also primary care cooperatives providing OOHs care and rather fewer OOHs primary care centres
Bulgaria	Urban areas: GPs working in single practices or organised in a group of practices or outsourcing. Rural areas and small towns: hospital EDs
Cyprus	Telephone consultation with private GPs and private and public hospital emergency rooms
France	Voluntary GPs in practice-based services, primary care cooperatives known as <i>SOS médecins</i> and hospital emergency units
Greece	GPs and nurses in their centres
Ireland	GP cooperatives/OOHs services
Latvia	Hospital EDs , OOHs primary care centres (occasionally)
Luxembourg	Hospital EDs and (since December 2008) GP walk-in centres
Malta	Public primary health care centres
Ease of access: medium	
Austria	Urban areas: primary care cooperatives (sponsored by City Councils) and/or hospital departments. Rural areas: GPs within one practice or organised in a group of practices on OOH schedules
Estonia	Medical emergency service or ambulance service
Finland	Increasingly organised in conjunction with hospitals; often, a health centre GP provides services from 4 p.m. to 10 p.m. in their own health centre. Some of these services are also outsourced (and provided by specially trained staff)
Germany	Outpatient emergency services, hospital ED
Italy	OOHs physicians (special type of physician) usually working in different premises (such as independent ambulatories of local health authorities)
Romania	Family physicians have to provide medical assistance, including in emergency situations, for all insured persons on their own list
Slovakia	Walk-in centres and (limited) special deputising services* or hospital EDs
Sweden	Hospital based acute wards ; a few primary health providers have organised OOHs care
Ease of access: high	
Czech Republic	OOHs services are organised by local authorities and GPs are obliged to provide these services (it may be on a rotation basis or by finding substitute GPs)
Denmark	Primary care cooperatives (includes telephone triage and advice, an office for face-to-face contact and house calls)
Hungary	Usually outsourced to deputising services*
Lithuania	Hospital EDs
Netherlands	General practice (usually within large-scale primary care cooperatives)
Poland	Can be contracted (by the National Health Fund) directly with specialised services or with primary care physicians (the latter can use a rota with the neighbouring practices or subcontract with the deputising service*)
Portugal	Practice based GPs within one practice or organised in a group of practices available all night when there is no hospital nearby or only in the evening if there is a hospital nearby
Spain	Primary health centres (open 24 hours a day, 365 days a year in rural areas. In urban areas there is always a primary health care centre on duty within a 30-minute radius; also call-centre triage units, which coordinate and activate the most appropriate health care service for each consultation
United Kingdom	GPs, walk-in centres, minor injuries units, urgent care centres, NHS 111 or equivalent, local pharmacists, local mental health teams, Accident and Emergency (A&E) departments at general hospitals, and ambulance services

Source: Based on References [9](#), [3](#) and [1](#).

Notes: Hospital-based provision of OOHs primary care is marked in **bold**.

* This is a form of outsourcing whereby centres/companies employ doctors to take over provision of after-hours care.

with EDs and introducing one national telephone number for OOHs calls and triage for emergency calls. The major reasons given for these changes were work dissatisfaction among family doctors, a shortage of family doctors and lack of

motivated family doctors to provide OOHs care. Other reasons were the overcrowding of EDs by primary care patients (self-referrals), reducing costs and improving safety, quality and continuity of care.¹⁰

Primary care telephone services have been developed in some countries in order to reduce the burden on emergency care and to improve the accessibility of timely primary care services (e.g. France, the UK, and Hungary). In Spain, Hungary and

France such advice lines are essentially integrated with dispatcher services, as clinical teams are on hand to advise patients and make triage decisions to direct them to OOHs care, emergency care or dispatch an ambulance. In England, NHS Direct (with calls answered by a non-clinical call handler and assessed by a nurse either immediately or with a later call back), established in 2000 was not found to reduce demand for either hospital or primary care; it did, however, improve patient satisfaction.² NHS Direct was fully replaced in 2014 by NHS 111, a more easily recognisable phone number, where calls are answered and assessed immediately by a trained non-clinical call handler (preventing waiting or call backs) and some calls are then assessed by a nurse. In addition, the assessment system is integrated with some services, enabling direct referral and appointments. Despite these improvements, NHS 111 did not deliver the expected system benefits of reducing calls to the 999 ambulance service or shifting patients to urgent rather than emergency care. Studies also found that this type of service had the potential to increase overall demand for urgent care without reducing the demand for emergency care (See the article by Turner et al, in this issue).

Coordination of care, in particular for chronic conditions and emergency care, remains problematic in most countries. Particularly in northern Europe, there is a trend to reorganise the OOHs primary care system to better support and cooperate with EDs (i.e. Denmark, the Netherlands, the UK, and Germany). In Denmark, some past attempts at strengthening collaboration between primary health care and hospitals have not always been easy to achieve in practice.¹¹ The most recent solution being implemented in the Capital Region (Hovestsaden) involves the co-location of urgent and emergency care services, as well as the integration of OOHs primary care with EDs into a single entry point, reachable by dialling a designated telephone number, co-ordination and delivery of urgent and emergency care, and nurses (rather than doctors) becoming the first point of contact for patients; they decide whether the patient will be re-directed to a doctor on the phone, be attended by a doctor, go to an ED or stay at home. The new scheme

has been heavily debated and has raised substantial criticism from GPs and the Danish Medical Association, prompting an evaluation in August 2014 that has yet to be concluded.¹²

There is also some evidence that closer cooperation of GPs with local nursing homes in Norway (and the proximity of nursing homes to the GP practice) may contribute to reduced referrals to EDs.¹³ A good example of successful cooperation with other health care providers is the Capio St Görän (CSt) hospital in Stockholm. CSt has developed a good dialogue and cooperative relationship with several geriatric hospitals, whereby patients requiring direct admission from EDs are clearly defined and more elderly patients are sent directly to external geriatric care providers. There is also an active dialogue about the opposite flow, where geriatric hospitals can send patients with greater care needs directly to the relevant department at CSt. CSt now has the largest share of direct admissions to geriatric hospitals of all acute hospitals in Stockholm.¹⁴

Conclusions

A shift towards developing urgent care and reorganising OOHs primary care has been taking place in many European countries in order to relieve pressure on high cost emergency care services. While this shift cannot address the demand-side factors which are so closely related to changes in population health trends, such as population ageing and increased prevalence of chronic conditions and improvements in medical technologies, it does have the potential to improve efficiency and quality of care.

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MANAGING DEMAND FOR URGENT CARE – THE ENGLISH NHS 111 EXPERIENCE

By: Janette Turner, Alicia O’Cathain, Emma Knowles and Jon Nicholl

Summary: NHS 111 is a telephone-based service in England designed to improve access to appropriate care for urgent health problems. Evaluation of four pilot sites revealed that the service was well liked by users but did not change the way people accessed care or produce expected system efficiencies; it also increased emergency ambulance activity. National roll out without results of the evaluation led to significant challenges when the service was introduced. NHS 111 is now firmly embedded in the NHS in England but it is recognised that there is scope for further improvement and a programme of work is in place to enhance the service.

Keywords: NHS 111, Emergency Medical Care, Urgent Care Services, Pilot Evaluation, NHS England

Introduction

Internationally, demand for emergency and urgent care grows every year. In England, demand for emergency department care has been reflected in growth in emergency department attendances, calls to the 999 ambulance service and contacts with other urgent care services, including primary care and telephone-based services.

Since the 1960s, demand for emergency department services has doubled, with population utilisation increasing from 138 per 1000 people per year to 267 per 1000 in 2012/13. Similarly, calls to the 999 ambulance service increased by 160% between 1994 and 2014.¹ The reasons for this relentless rise in demand are only partly understood but comprise a complex mix of changing demographic, health and social factors.²

Over the last twenty years there have been a number of reviews of urgent care, policy recommendations for service changes and service-level innovations, all of which were aimed at improving access to and delivery of urgent care. As the range of additional services available to address urgent care needs has grown (for example, primary care out-of-hours services, minor injury units, walk-in centres, urgent care centres) a central theme has been the uncertainty and complexity this presents for the public in making decisions about how to access urgent care. Telephone-based services were introduced to try and simplify this process, with NHS Direct, a nurse-led telephone assessment and advice service, implemented from 2000 in England and followed by similar services in Wales and Scotland. However, subsequent consultations with the public revealed that confusion about accessing

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services remained a problem and in response to this a new telephone-based service, NHS 111, was developed.

The NHS 111 service

The objectives of the NHS 111 service is to simplify access to non-emergency health care by providing a memorable number – 111 – that is free to the caller, provides consistent clinical assessment at the first point of contact, and routes callers and patients to the right NHS service, first time. The service is available 24 hours a day, 365 days a year to respond to requests for health care where the situation is not life-threatening and callers are unsure about what service they need, or if they need to access care out-of-hours. The expected benefits of this service are that it should improve the user experience by providing a modern entry point to the NHS and easy access to more integrated services, and improve efficiency in the emergency and urgent care system by matching patient needs to the right service. The key features of the service are given in **Box 1**.

As a first step, the Department of Health in England identified four pilot sites in Durham & Darlington, Nottingham, Luton and Lincolnshire to implement NHS 111 and at the same time commissioned an independent service evaluation to assess the impact of the service and provide robust evidence on effectiveness to inform decisions about any subsequent national roll-out. These four pilot sites became operational between August and December 2010.

Pilot site evaluation

A mixed methods study was designed to assess processes, outcomes and costs for the new service. This included a controlled before and after design to measure the impact of NHS 111 on system activity and population use of services in the four pilot and three control sites; qualitative studies to assess patient experience and satisfaction and to identify the challenges, barriers and facilitators associated with introducing the service experienced by the pilot sites; and an economic evaluation.⁴

During the first year of operation, the four pilot services managed just over 350,000 calls. All of the services met national quality standards of less than 5% of calls abandoned and at least 95% of calls answered within 60 seconds. On average, across all sites, 11% of calls were sent for an emergency ambulance response, 6% were advised to go to an emergency department, 56% were directed to primary care, 5% to other services and 22% were provided with advice and did not need a service.

Impact on the emergency and urgent care system was assessed by measuring monthly activity for five key services: emergency department attendances; urgent care services attendances/contacts (e.g. general practice out-of-hours, walk-in centres); calls to the NHS Direct telephone service; calls to the emergency ambulance service and ambulance service incidents where a response was needed for two years before and one year after implementation of NHS 111 in each pilot site; and a matched control site. For all sites combined, there was no statistically significant change in emergency ambulance calls, emergency department attendances or urgent care contacts/attendances. There was a statistically significant reduction in calls to NHS Direct of 193 calls per 1000 NHS 111 triaged calls per month. There was also a statistically significant increase in emergency ambulance service incidents of 29 additional incidents per 1000 NHS 111 triaged calls per month.⁴ This equates to a 3% increase in ambulance activity or, for a service responding to 500,000 calls per year, an additional 15,000 responses.

A postal survey of users of the new service in each pilot site found that satisfaction with NHS 111 was very good, with 73% of respondents reporting that they were 'very satisfied' and 19% that they were 'quite satisfied' with the new service. Satisfaction levels were lower for some aspects of the service than others, in particular relevance of questions asked and advice given. 85% of respondents indicated that NHS 111 had enabled them to contact the right place first time although this may not have occurred for at least 2% of users. Compliance was high

Box 1: Key features of the NHS 111 service

- Calls to NHS 111 are assessed by a trained, non-clinical call adviser using the NHS Pathways clinical assessment system to determine both the type of service needed and the timescale within which help is required.
- The call handling system is electronically linked to a skills-based directory of local services so that callers can be advised about the appropriate services available at the time of their call.
- Where possible, appointments can be made with the correct service at the time of the call.
- Calls that require further clinical assessment can be transferred to a clinician within the same call with minimal need for a call-back.
- If a call requires an emergency ambulance response, a vehicle can be dispatched without the need for further triage.

Source: Authors.

with 86% indicating they had complied with all of the advice given, and 65% reporting the advice given had been very helpful. Respondents were also largely clear about when to use NHS 111.⁵

In addition, a population telephone survey was conducted before and after the introduction of NHS 111 in both the pilot and control sites to assess use of urgent care services. The surveys did not identify any change in perceptions of urgent care for recent users of emergency and urgent care services or any change in satisfaction with urgent care or the NHS following the introduction of NHS 111. The population surveys did reveal a high level of awareness about the new service in two pilot sites (>70% of the population had heard of NHS 111) but lower awareness in the other two sites (<50%).⁶

Box 2: Activities associated with successful implementation of NHS 111

- The strategic, management and operational processes involved in delivering the service are complex, difficult and time consuming
- A clear and explicit service specification is needed to support planning and development
- Success is dependent on the committed engagement of relevant agencies and a dedicated project team to manage the process from start to implementation and maintenance
- There are significant technical issues around licensing, adaptation and integration of different telephone and IT systems that need to be linked to deliver seamless call handling
- A robust period of testing to ensure consistency of assessment, alignment of dispositions to services and system resilience is critical before a service goes live
- The Directory of Services linked to dispositions and appropriate referral is crucial
- There needs to be sufficient capacity to support technical implementation and training for the call assessment system used
- 111 is just a telephone number – it is what is behind it that is important and how it operates as part of an integrated 24/7 urgent care system.

Source: Authors.

Developing and implementing the new service posed significant challenges within the pilot sites. The key issues identified that contribute to successful implementation are described in **Box 2**. Despite some positive findings, particularly patient experience and satisfaction, NHS 111 did not have a significant impact on system efficiency during the first year of operation. This might be explained by the small ‘dose’ of NHS 111 within the wider emergency and urgent care system or the early stage of development at which it was evaluated (one year). It takes time for early problems to be identified and resolved, for a new service to become established with users, and for reflection on how the service can be improved. The evaluation highlighted some issues that needed further exploration, the most important of which were further scrutiny of the relevance of some questions during the assessment process and the reasons for the increase in ambulance utilisation. Also importantly, during the pilot site testing the NHS Direct service was still operating. This meant that the impact of “turning off” this service and transferring all of the existing

call activity to the new service could not be measured and the effects could not be predicted.

National roll-out

The initial four pilot sites were identified in 2009, with implementation during 2010 and at the same time the evaluation of those sites was commissioned with a publication date of 2012, after a full year of operation, followed by decisions about providing a national service. However, during 2010 there was a general election, a change of government and an early decision made in Summer 2010 that NHS 111 would be rolled out as a national service by 2013. This meant that across the NHS plans had to be made and services procured and developed without reference to any findings from the pilot sites evaluation. The final evaluation report was published in Autumn 2012 but by this time there was little scope for services in development to benefit from the findings. By the end of 2012 there were fourteen operational NHS 111 sites covering just over 20% of the population. In order to meet the original 2013 deadline

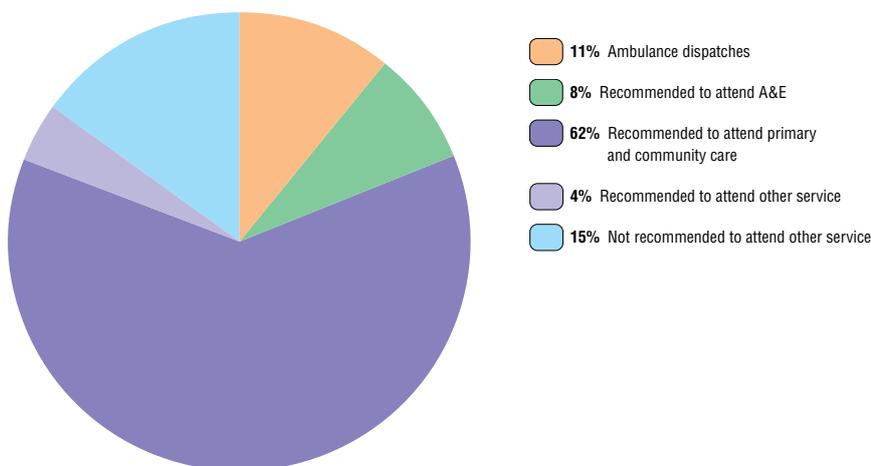
a large number of services went live in April 2013 when coverage increased sharply to 70% of the population. At the same time, the NHS Direct service began to be discontinued although the impact of transferring all calls for urgent care to the NHS 111 service had not been established.

Introducing a large number of services that had been rapidly established without the benefit of evaluation information resulted in a difficult period for the NHS. Some services were unable to cope initially in terms of answering and assessing calls in a timely manner and a substantial amount of negative publicity about the service in the UK media was generated. However, as services became established these problems were resolved and by the end of 2013 there was almost universal coverage across England.

“there was a 3% increase in emergency ambulance service incidents

Since the inception of the first pilot sites in 2010 NHS 111 has, to date, answered 27.9 million calls and triaged 23.6 million. In the year 2014–15 the service dealt with 12.1 million calls and of the 10.3 million triaged calls, the distribution of dispositions has remained largely unchanged from that found in the original pilot sites: See <https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/> (and **Figure 1**).

Nevertheless, the pressure on emergency and urgent care services and managing this demand has continued to present a serious problem to the NHS. In 2013, NHS England began a wholesale review of emergency and urgent care provision and in November 2013 published a strategy for reforming services.⁷ NHS 111 remained a cornerstone of the vision for

Figure 1: Disposition of triaged NHS 111 calls

Source: ³

managing emergency care with its central role in assessing and signposting requests for urgent care to appropriate services. However, the review also recognised that there was scope to further enhance this service and reduce the burden on ambulance services and possibly emergency departments and provide better integration with community-based services by, for example, introducing additional senior clinician assessment in to the triage process. As a result, there is an ongoing programme of work with the aim of refining, improving and redesigning the service specification for the NHS 111 service so it provides a better fit with the aspirations of the broader vision for emergency and urgent care delivery.³

Conclusions

NHS 111 was conceived as a telephone-based service that could both improve patient experience and emergency and urgent care system efficiency by assessing and signposting to the right service, requests for urgent (not life-threatening) health care. Evaluation of pilot sites showed there were some benefits for the service but not all of those expected were realised. In particular, one service NHS 111 was expected to decrease pressure on, the emergency ambulance service, actually saw additional activity. This continues to be a substantial problem requiring further research to understand why this happens and to identify potential

solutions that might resolve it. More broadly, the limitations of the service are realised and there is an ongoing programme of work to further develop and enhance NHS 111 so that it might better assess and direct users through the complex system of services and pathways present in a modern emergency and urgent care system. Ongoing efforts to evaluate the effects of changes will be needed to assess whether they deliver the intended benefits. The successes, challenges and failures associated with introducing NHS 111 highlight the dangers of implementing policy without allowing sufficient time for evaluation and evidence gathering to inform important decisions about significant change in health care provision.

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WHAT WORKS? WAITING TIME POLICIES IN THE HEALTH SECTOR

By: Luigi Siciliani, Valerie Moran and Michael Borowitz

Summary: Various policy tools have been used across OECD countries to reduce excessive waiting times in the last decade. The most common policy is some form of maximum waiting-time guarantee. Increasingly, such guarantees are backed with targets for providers and sanctions for non-compliance. The guarantees often go hand-in-hand with choice, competition and an increase in supply. These policies have been successful in reducing waiting times. Demand-side policies attempt to define more rigorous clinical thresholds. However, they have proved difficult to implement. A promising policy is to link waiting-time guarantees to different categories of clinical need, a form of prioritisation.

Keywords: *Waiting times; Guarantees; Targets; Patients' choice; OECD countries*

Introduction

We review various policy tools that OECD countries have used to reduce excessive waiting times in the last decade. Compared with an earlier OECD study¹ where supply-side policies predominated, the most common policy identified in the second OECD waiting time project,^{2,3} is some form of maximum waiting-time guarantee, which often combines supply-side and demand-side measures.

Increasingly, such guarantees are backed with targets for providers and sanctions for non-compliance. The guarantees often go hand-in-hand with choice, competition and an increase in supply. These policies have been successful in reducing waiting times. In contrast, most attempts to increase supply temporarily in order to decrease waiting times have met limited success. This suggests the need to work simultaneously on supply and demand-side policies; for example, by conditioning increases in supply on

simultaneous reductions in waiting times (to limit subsequent increases in demand). Demand-side policies attempt to define more rigorous clinical thresholds for treatment. However, they have proved difficult to implement. A promising policy is to link waiting-time guarantees to different categories of clinical need, a form of waiting time prioritisation. This article outlines some of the key country evidence from our OECD study.^{4*}

Maximum waiting-time guarantees, targets and sanctions: England and Finland

England and Finland have combined waiting-time guarantees with sanctions for failure to fulfil the guarantee. In England, maximum waiting-time guarantees were set at twelve months in 2002–03, and progressively ratcheted down to

* The content of this article draws heavily from Chapter 3 of the report.

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eighteen weeks by 2006, where they remained. In 2010, patient entitlements for waiting times were codified into the NHS Constitution, a quasi-legal instrument, establishing a maximum wait from General Practitioner (GP) referral to treatment of eighteen weeks. The Department of Health monitors the eighteen-week target monthly and expects 90% of patients to be treated within target; a breach results in reductions of up to 5% of revenues for the relevant speciality in the month of the breach.

Evidence from England indicates that guarantees with sanctions reduce waiting times. Waits of over six months have virtually disappeared. Targets with penalties were introduced during 2000–05, with strong political oversight from the Prime Ministerial Delivery Unit and the Health Care Commission.² Senior health administrators risked losing their jobs if targets were not met. Compared to Scotland (where no penalties were introduced), Propper et al.³ found that in England the proportion of patients waiting over six months fell by 6–9 percentage points.

Finland also introduced a strong waiting time guarantee combined with targets as part of the *Health Care Guarantee 2005*, subsequently incorporated into the Finnish Health Care Act of 2010: primary care services are provided within three days; and patients are referred from primary care to an out-patient specialist within three weeks. For elective surgery, any evaluation should occur within three weeks; diagnostics within three months; and surgery within six months of assessment. The introduction of the legal guarantee resulted in the number of patients waiting over six months to decrease from 126 per 10 000 population in 2002 to 66 per 10 000 in 2005. The National Supervisory Agency (Valvira) supervised the implementation of the guarantee and penalised municipalities failing to comply. Valvira provided targets to municipalities for the number of patients waiting over six months, progressively lowered from 15 per 10 000 population in 2007 to 7.5 in 2009 and 5 in 2010. Almost all hospital districts met the

targets, but Valvira had to issue 30 orders for improvement, including eight threats of fines.⁴

The use of waiting-time guarantees raises concerns over incorrect prioritisation, gaming or changes in referrals. For England, Propper et al.³ did not find evidence for such behavioural changes. However, Dimakou et al.⁵ found that the probability of patients being treated increases when the wait approaches the target, and falls when the wait is above the target, which may be consistent with incorrect prioritisation: giving priority to lower severity patients approaching the target and increasing waits for higher severity patients below the target.

Maximum waiting times linked to choice: Denmark and Portugal

In some countries, patients can be treated by another provider if the waiting time guarantee is not fulfilled or when the patient reaches a threshold level. In Denmark, free hospital choice was introduced in 1993 within or outside the patient's region. Patients were given an intended maximum wait of three months from GP or specialist referral to treatment. In 2002, this was formulated explicitly as a maximum waiting time guarantee (extended free choice) and reduced to two months, and in 2007 to four weeks. If the hospital can foresee that the guarantee cannot be fulfilled, the patient can choose another public or private hospital. If treatment is outside of the region's own hospitals, treatment expenses are covered by the originating region. On average, the proportion of patients using a private hospital increased from 2% to 4.2% between 2006 and 2008 and to 4.8% in 2010 (up to 10% for orthopaedic surgery). The expected maximum waiting time declined significantly after 2002, and free choice likely played an important role. With free choice, reimbursement policies also changed. Until 1999, each county received a low per-diem from other counties. From 2000, counties instead paid the diagnosis-related group (DRG) tariff, reflecting average costs, making it profitable to keep patients within the county.⁶

For the past two decades, Portugal has tried to solve its waiting time problem with bursts of additional funding under four initiatives during 1995–2009. In all four cases, waiting times declined initially but subsequently increased. Portugal has found an innovative solution through a combination of guarantees coupled with a new integrated system to collect wait information from all public and private hospitals, known as Integrated Management System of the Waiting List for Surgery (SIGIC). One key feature of the SIGIC is the use of a treatment voucher to operationalise the guarantee. When patients on the list reach 75% of the maximum guaranteed time, a voucher is issued that allows them to seek treatment at any public or private provider. This creates incentives for public hospitals to treat within the guarantee. The national waiting list for surgery declined by 39% from 2005 to 2010, even though demand increased. The improvement is partly due to better management, the shift from a decentralised to centralised information technology (IT) system, and the use of the IT system to implement the guarantee, allowing patients to find other providers, thus introducing choice and competition.⁷

Activity-based funding and socially acceptable waiting times: the Netherlands

A common policy to encourage providers to increase the volume of patients treated is to use activity-based funding (ABF) that pays a price for each additional patient treated. The change of hospital payment methods towards ABF and the removal of a hospital spending cap was the key policy that resolved long waits in the Netherlands. In 2000, the government considered introducing a maximum waiting time guarantee for hospital care, which was motivated by a court decision in 1999 that patients have an enforceable right to timely care. A formal guarantee was ultimately not introduced because of concerns about the cost of operationalising the policy. However, the national associations of hospitals and insurers agreed on a *socially acceptable waiting time* (known as 'Treek norms') of six weeks for day treatment (80% within four weeks), seven weeks for in-patient treatment (80% within five weeks), and

four weeks for hospital specialist diagnosis and medical assessment (80% within three weeks). In 2001, the fixed budget scheme was replaced by ABF. The government also abolished restrictions on medical specialist positions in hospitals. Hospital and specialist incentives were aligned, and production rapidly increased and waiting times decreased substantially. The Dutch combined a relatively soft guarantee linked to choice with competition linked to ABF. In 2011, mean waiting times for almost all surgical procedures were four weeks or less. There is an on-going discussion about re-introducing hospital budget caps as part of a policy to curb spending.²

Prioritisation of patients on the waiting list: New Zealand

A demand-side policy to reduce waiting times involves introducing clinical thresholds below which patients are not entitled to publicly-funded surgery, thus decreasing the “inflow” to the list. New Zealand has been at the forefront of using demand-side policies, where a patient is entitled to elective surgery conditional on need and ability to benefit as assessed by the specialist. Patients are referred by their GP, and the specialist assessment determines whether the patient goes on the list. Patients are classified into: booked; certainty of treatment; and active care and review. Patients in the first and second groups are treated within six months. Patients in the third group have the least severity and do not enter the waiting list. They are referred back to their GP, who treats them and monitors their health status. If the condition deteriorates, these patients can change group.

This innovative scheme of demand management dates back to the 1990s, when the country developed clinical prioritisation assessment criteria (CPAC) tools to manage waiting lists. A distinction was made between the clinical threshold where patients benefitted from treatment and a higher “financial threshold” which the health system could afford. Many CPAC tools were multi-dimensional, integrating objective and subjective clinical criteria combined into a composite score. Integrated tools were also developed in some specialty areas (orthopaedics, ophthalmology and plastic surgery),

where clinicians first ranked conditions against each other, with each condition being allocated a score from 1 to 100. At one point, CPAC tools for 29 specialities were listed on the Ministry of Health website. One critical implementation issue was whether to use national or locally developed tools. Even when national tools were used, there were still variations in scoring and clinical thresholds. There were also issues with developing valid and reliable tools for measuring patient need/severity and the benefit from surgery.

With these caveats, the focus on clinical prioritisation has resulted in the number of patients with a commitment to treatment (booked or given certainty) waiting more than six months to decline from around 7000 patients in 2002–06 to around 3000 patients in 2007–10.²

Individualised maximum waiting time guarantee: Norway

Given the concern with incorrect prioritisation caused by maximum waiting-time guarantees, Norway has tried to condition the guarantees on the basis of need using criteria such as severity and effectiveness of treatment. This is essentially an “individualised” guarantee, where a maximum wait is determined by the patient’s condition, need and severity. It was introduced in 2002, with patients classified into three groups: emergency patients who should receive treatment with no further delay; elective patients entitled to an individual maximum waiting time; and less severe elective patients not entitled to a maximum wait. If the individual guarantee is not fulfilled, patients can be treated in another hospital or abroad.² Unfortunately, evidence suggests that increased prioritisation did not take place.²

Dedicated/additional funding has not proved successful

One policy commonly used by countries is some type of targeted-funded programme to reduce waiting times. Despite being the most common approach across OECD countries, it has invariably failed. These programmes are short-term bursts of funding that are insufficient to raise capacity significantly. Furthermore,

it is not only funding, but the wider institutional setting that determines incentives to increase production. In general, short-term funding targeted at waiting lists and waiting times has proved unsuccessful. This may be because it fails to address the structural issues that determine waiting times, leads to a subsequent increase in demand, or is targeted at a specific waiting list. Although it should be possible to spend sufficiently to reduce and even eliminate waiting times, this would require massive investment, which is unlikely to be available in a time of fiscal constraint. One possible way forward is to fund higher supply conditional on reductions in waiting times (i.e. funding is not provided if the higher supply does not translate into lower waiting times) in order to control potential demand inflows.

Conclusions

Over the past decade, waiting-time guarantees have become the most common policy tool to tackle long waiting times, but are effective only if enforced. There are two approaches to enforcement. The first entails setting targets and holding providers to account for achieving them. The second allows patients to choose alternate providers, including in the private sector, if the wait exceeds a maximum time. In England and Finland, hospitals were penalised for exceeding targets. As a result, waiting times decreased. This method is, however, unpopular with health professionals and difficult to sustain long-term. Portugal, the Netherlands and Denmark successfully introduced choice and competition, and this is the direction recently taken by England. The Portuguese model has been effective in decreasing waiting times. The model entails a unified information system containing data on waiting times for public and private providers, and vouchers that allow free choice issued to patients when 75% of the waiting time guarantee is reached. The Netherlands successfully eliminated waiting times by a combination of ABF, lifting a cap on hospital spending, allowing choice and competition, and introducing waiting time norms. However, these policies tend to be expensive and, given the current economic environment, may not be feasible in all countries.

A complementary approach to reducing waiting times is to implement demand-side policies by introducing tools to improve clinical prioritisation. They have been used in New Zealand, with some success. Implementation can be difficult, as it is necessary to set a clinical threshold in a valid and reliable manner. In Norway, clinical prioritisation is linked to waiting-time guarantees, with guarantees varying according to need. This appears to be a promising approach, but requires better tools for clinical prioritisation that reliably measure clinical need and the benefit of the elective procedures.

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The author sincerely thanks Bernard Merkel and Paul Belcher for their support in the writing of this article.

HEALTH OWNERSHIP OF HEALTH POLICY?

CHALLENGES AND CONCERNS IN THE NEW ERA OF EU HEALTH POLICY

By: **Ellie Brooks**

Summary: In the post-crisis era, EU health policy increasingly risks to be overshadowed by a patchwork of competing processes and policies, such as the European Semester and Health System Performance Assessment. This re-focusing poses challenges for the collection of necessary health system data and could threaten the ownership of health issues by health actors. In the current climate of fiscal and economic coordination the public health community must be vigilant in safeguarding EU health policy and protect the achievements made in recent decades.

Keywords: *Economic Governance, Health System Performance Assessment, Better Regulation, Health Systems, Health Data*

Background

Health policy at European Union level has entered a new era. The revised economic governance framework which was introduced in the wake of the crises of the late 2000s challenges traditional processes and adds a new dimension to policy-making at European level.¹ This dimension is macroeconomic – it scrutinises the budgets and financial commitments of national governments sector by sector, identifying in each the policies and developments which present a threat to sustainability and thus to the

economic stability of the region. The macroeconomic dimension of health catalogues the people, institutions and resources of the health sector in terms of their fiscal and economic impact. Though it focuses primarily on expenditure, it has prompted debates about financing models, service delivery and how to ensure universal access to high quality care. As such, the European Union (EU) is increasingly engaged in analysing and evaluating health policies, trying to identify, quantify and target specific areas of value or concern.

Two early observations can be made about this ‘new era’ of health policy and the future development of the field. Firstly, monitoring, comparison, guidance and control require access to comprehensive, coherent and comparable data. This will be the next governance challenge for the EU. Secondly, the context of the new health policy mandate risks the potential loss of ownership by health actors. This presents a much deeper political question.

Contemporary challenges

Each era of EU health policy is defined by its challenges. In the 1960s and 1970s, the free movement of workers exposed diverging occupational health and safety practices, forcing the establishment of common standards and providing the foundation for a series of EU social policy measures. In the 1980s, the battle to present a ‘People’s Europe’ and a ‘human face’ of economic and monetary union was fought using the Europe Against Cancer programme, which offered genuine EU ‘added value’ and stimulated significant activity in the public health field. In the 1990s and 2000s, the free movement of services and patients was brought to the fore, raising important questions about the balance between economic and social priorities in the EU project and promoting the recognition of health as an issue inherent in all policies. Furthermore, throughout this period health policy has responded to and been shaped by sporadic crises; scandals involving thalidomide, BSE, blood contamination and breast implant products have each made their mark upon the structure and content of contemporary EU health policy.

financial crisis has necessitated a shift in focus to fiscal sustainability and led, in some countries, in some countries to implementation of an austerity agenda, further exacerbating anti-European sentiment. These challenges have forced the EU to, once again, re-evaluate its approach in health, as embodied in the Better Regulation agenda and the proliferation of activity which assesses, evaluates and structures health policy.

It might be argued that the EU has gone as far as it can go in health under the current Treaty – competences have been stretched, provisions creatively interpreted and opportunistic extensions made into many unforeseen areas. Put less theatrically, the EU is now engaged in an impressive range of health policy activities and increasingly faces, with each new undertaking, a tougher ‘sell’ with regard to the necessity and appropriateness of its actions. As such, there is some logic to the new Commission’s notion of ‘being big on the big things and small on the small things’;⁶ whilst political will and public support is lacking, it is perhaps natural to turn to improving the efficiency of existing activities rather than seeking further expansion. For health, this could mean that the immediate future would be characterised by ongoing processes of audit and revision. The risks here are significant – the Better Regulation agenda has already labelled important public health policies, such as those protecting workers from exposure to dangerous chemicals, as ‘regulatory burdens’, whilst limiting new policy initiatives and fostering an increasing reliance on soft law.⁷

EU Health policy in the ‘new era’

In addition to turning its attention inwards to improve the efficiency of its health policy activity, the EU has also redirected its focus in response to the political priorities of the post-crisis Union. The financial crisis and economic recession forced an overhaul of the economic governance framework, the most notable innovation of which has been the European Semester. The Semester embraces all policy areas and applies the same fiscal-sustainability framework to each, generating recommendations which

set the parameters of subsequent policy decisions. As one of the largest areas of public expenditure, health is a central focus of this process and recommendations have commonly targeted the cost-efficiency of national spending on pharmaceuticals, the balance between primary and secondary care provision and health and long-term care sector reform.⁸ Though the recommendations are non-binding for most Member States, the issues they identify and the analysis upon which they are based increasingly define the parameters of national reforms and European policy*.

In aid of the Semester process, the new Health Commissioner was charged with further developing the EU’s competence in health system performance assessment (HSPA). This involves establishing methodologies and indicators to assess how health systems are performing, which in turn feed into the evaluations and analyses undertaken in the Semester and other processes. An expert group has been established to map the national activity in this area, based on the understanding that ‘Knowing how health systems work is the precondition to design effective health system reforms for the benefit of citizens’.⁹ Policy-makers now face the challenge of ‘measuring’ health and assigning value to the outcomes that health systems produce, whilst ensuring that these outcomes reflect patient experience and societal wellbeing, and not simply clinical or financial end-points.⁷

Finally, and also prompted by the post-crisis focus on financial sustainability, the role of the EU in health systems policy has become at least tacitly recognised. Last year DG Santé published an ‘agenda’ for effective, accessible and resilient health systems and, whilst this is far from a coherent, stand-alone policy strand, it reflects a broader understanding that addressing sustainability issues and implementing health reforms efficiently requires some central coordination of health systems policy. For the moment, activity is centred on issues such as cross-border health care, professional

* The legal character of the recommendations differs for members of the euro area, for states which rely heavily upon EU funds and again for those countries subject to economic adjustment programmes. See also (5).

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The challenges defining EU health policy in the current era are two-fold. Firstly, Euroscepticism amongst the general public and national governments has risen sharply in recent years. Secondly, the

mobility, patient safety and pricing and reimbursement of medicines but the potential scope for this new avenue of EU policy is substantial.

Implications for the future

Two important observations can be made about the implications of these ‘new era’ undertakings – the European Semester, HSPA and the early fragments of an EU health systems policy – for the future of EU health policy. Firstly, each of them will require consistent, comprehensive and comparable data. This is both the silver bullet and, arguably, the third rail of EU health policy; whilst vital to perform the kind of policy activities which seem likely to characterise health policy in the coming years it is notoriously difficult to acquire. One of the most critical elements is the presence of reliable eHealth systems, such as electronic prescriptions and health records, which can collect vast quantities of data without putting excessive burden upon health care professionals, administrators or patients. Sufficient systems are in place in only a handful of Member States and are particularly weak in the poorer health systems, immediately creating a data bias. Within those countries which, via eHealth or other systems, do collect health system data, there is substantial variation in the kind of information recorded and the methodologies used. This makes comparison difficult and often precludes thorough assessment of specific features. Moreover, even where reliable systems collect the appropriate data, national governments have historically been reluctant to transmit health system data beyond national borders. When the World Health Organization published its World Health Report in 2000, producing for the first time a ranking of health systems, a significant backlash was experienced, particularly from the poorer-performing countries.⁹ Since this episode, national governments have remained wary of international comparison and its power to impact upon policy agendas.

A second implication is far more concerning: if the ‘economisation’ trend continues the latest era of health policy might see a loss of ownership for health actors. The European Semester, and

renewed focus on HSPA and health systems policies target the infrastructure of national health policy and scrutinise some of its most fundamental elements. This shift is not exclusive to health – all-encompassing ‘economisation’ introduced by the Semester is forcing most policy areas to engage in some form of streamlining. This progression could be read positively; a policy area has to reach a certain level of institutionalisation and success before it can undertake the kind of efficiency-drive and internal-stocktaking which DG Santé is currently unofficially engaged in. This might be interpreted as an achievement in itself.

“importance of health has become so well recognised”

In practice, however, it the importance of health has become so well recognised that it can no longer be entrusted to the DG Santé. Its role risks being confined to a technical and analytic role and ‘in support’ of those colleagues in the Commission responsible for the Semester and the policy recommendations it makes. This is made clear in the mandate given to the Health Commissioner, which outlines how he should develop expertise to ‘inform’ national and EU level policies and contribute to the European Semester, leaving leadership and substantive development of health systems policy to the economic and finance officials in DG ECFIN and their colleagues from the Member States. The Better Regulation agenda looks set to perpetuate this ‘streamlining’ work programme, reducing active leadership and policy initiatives and instead investing resources in implementation of legislation, review of existing directives and production of technical reports. As such, characterisations of decline seem increasingly apt¹⁰ – the EU health community must be vigilant in safeguarding the progress made over

the past decades and vocal in supporting the continued role of the EU in health protection and promotion.¹⁰

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WHY HAS THERE BEEN VERY VARIABLE IMPLEMENTATION OF eHEALTH SERVICES WITHIN THE EU?

By: Margaret Ellis, Tony Cornford and Sofia Moreno-Perez

Summary: Published data about eHealth services, both potential and actual, and their introduction within the European Union are observed and reported on. It was found that the levels and speeds of adoption are very variable. Some of the variables can be linked to the education and understanding of eHealth opportunities by some health professionals and policy makers. More readable data dealing with cost-effectiveness and user benefits would be of special value.

Keywords: eHealth, Education, Integrated Approach, Cost Effectiveness

Introduction

eHealth encompasses a growing range of demonstrably cost-effective policies, services and equipment available to support greater independence for European Union (EU) citizens. The term embraces telecare, telehealth (itself embracing telemedicine) and health informatics. As illustrated in **Figure 1**, there are overlaps. Nevertheless, these subdivisions are useful, but a problem is they are not yet sufficiently inter-connected in the real world of health and social care.

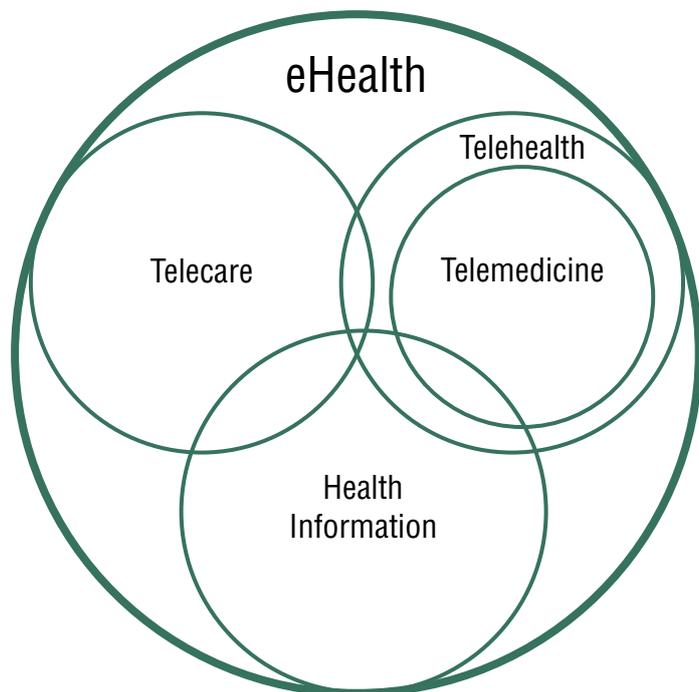
Telecare has now been a part of the policy dialogue in health and social care for over two decades. As with many other eHealth innovations, e.g., electronic patient records and electronic prescribing, it is experiencing a particularly slow and painful maturation.

It is hard to argue that telecare has achieved in any substantial sense the

status of a mature or ‘taken for granted’ component of systems or pathways of care for people living in their own homes. One reason may be that, in some EU Member States, social care and health care are administered separately and telecare pathways, which should link services are impeded by that boundary. Technology that facilitates more efficient procedures needs to be embraced and existing organisational structures adapted accordingly to achieve cost-effectiveness and better outcomes for service users.

Telehealth encompasses those health care services delivered via telecommunications media, over any distance. Service delivery may be done in real time or stored and broadcast through media, ranging from simple telephonic conversations and Internet to video conferencing across national boundaries. The services could involve consultation, patient monitoring, diagnosis, prescription, treatment or even

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Figure 1: eHealth and some of its constituent sub-fields

surgery. Real-time telemedicine services may involve tele-cardiology, tele-dentistry, tele-mental health, tele-neurology, tele-nursing, or tele-rehabilitation. Outwith telemedicine, but within telehealth are remote keep-fit systems and health apps, etc. Many telehealth systems encourage self-care and personal responsibility for areas of health such as blood pressure and sugar level measurement which enable people to be treated at home, and so reduce hospital attendance and costs.¹

Health Informatics facilitates the collection, analysis, and dissemination, as well as access to health information. Thus, access to their medical data by patients, provided for 300,000 people in Estonia,² improved patient health outcomes and decision making, reduced health care costs, travel time, redundant diagnostic procedures and tests, waiting time and led to improved early diagnostic, administrative and communication capabilities. Other EU countries have been slower to adapt their systems and thus effect the improved outcomes and efficiency savings. Some media scare stories, which attribute a ‘big brother’ or intrusive nature to open access medical records, have discouraged development.

Our review has disclosed a wide variation in levels of adoption of eHealth services in the EU. This article identifies and discusses some of the reasons.

We argue that there are three key components that need to be coordinated in every eHealth initiative:

1. Suitable technology
2. The existing models of care with which the technology must integrate or which must be adapted to increase the efficiency enabled by the technology
3. The broader institutional settings, and the mobilisation of relevant interests, users and workforce personnel, around eHealth

Facilitators and Blockers

User-friendly technologies are now available in many areas of eHealth and their conceptual utility has been demonstrated.³ User’ technology both develops and changes quite rapidly. It is generated by an active community of eHealth innovators who are eager to place new technologies, via the “Digital Industry,” literally into peoples’ hands. For example, the thriving App development

sector has shown strong interest in consumer health as a core market. New products and services are continually being delivered. Both providers and the users need to be competent to appreciate both the capability and the limitations of the technology on offer. Education is the key to this, and the lack of it is the most apparent and continuing reason for both variable and slow introduction of eHealth services.

“Better-informed, bolder, timely decision-making is needed”

Currently, the existing supporting infrastructures for user technology, such as the reliability and availability of digital networks, accessible constellations of expertise and education, and supply chains with which ‘user’ communities (individuals, families or local care commissioners and providers) can confidently connect, is weaker than the current status of ‘user’ technologies themselves.

However, it is encouraging that models of care and their funding in many EU countries are moving in directions that seem increasingly compatible with eHealth provision. Patient-centred care, which in part may involve the shift of health resources to primary care, and various efforts across Europe to integrate primary health care with social care are two examples. Innovation in models of care should be driven both by the reality of demographic change and by the increasing proportion of the population living with multiple chronic conditions. Changes are, in part, also driven by a growing perception that the old ways will soon become impractical both financially and organisationally. Provision of eHealth services can offer cost-effective solutions which users approve, as shown in Scotland and Newham.⁴

Yet policy decision-makers are at times still not being presented with a clear, balanced case, including the cost-effectiveness of eHealth services, and so hesitate to agree changes for fear of increasing costs. Of course, an eHealth service that is not a better (cheaper, more reliable and more user-friendly) way of doing what we do now should not be considered. But eHealth services may, while involving radical or disruptive shifts away from current procedures, result in better services. Initial disruption leading to better future outcomes should be accepted. Better-informed bolder timely decision-making is needed.

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A large scale project in the United Kingdom, the Whole System Demonstrator (WSD) 2011, provided compelling evidence that telecare and telehealth were viable solutions for older and disabled people living independently and taking control of their own health and care. Furthermore, the WSD programme found that, “if delivered properly, telehealth can substantially reduce mortality, reduce the need for admissions to hospital, lower the number of bed days spent in hospital and reduce the time spent in Accident and Emergency”⁸ A follow-up scheme, “3MillionLives”,⁹ offered services to 3 million users, but was then shelved. This is an example of a national government applying the brake to eHealth service development. In September 2014, NHS England published a new proposal, Technology Enabled Care Services (TECS),⁷ which asks for Commissioners ‘to support the programme that takes the NHS into a new and exciting technological era that will help empower patients and improve health outcomes’. There is a very real danger that different schemes being introduced will not be inter-compatible or permit easy transfer of data. One

section of TECS emphasises the need for cost-effective data. In consequence TECS is funding the evaluation of stakeholder schemes.

Some innovative examples

There are many examples of the effectiveness of eHealth services. We set out a few of them below.

In 2010, the Scottish Government launched *Reshaping Care for Older People*,⁸ including a national Telecare Development Programme to help people live at home longer – Scottish Patient at Risk of Re-admission and Admission (SPARRA)⁹ – resulting in an estimated gross saving of €110.6 million (£78.8m) up to the end of the financial year 2013. Scotland is planning a coordinated system between health and social work, introducing legal requirements for these services to work together.

In England, the East London Foundation Trust, used an eHealth service which provided for 353 people, with long-term conditions, to be treated at home rather than in hospital – ‘a virtual ward’ and reported a total gross saving of £597,940 (€839,500) and a total net saving of £162,826 (€228,600) over a twelve month period. In an earlier twelve month period, where 1,000 people were treated at home, approximately £500,000 (€702,000) was saved. Users not only approved of this eHealth service, but they had fewer infections, did not block hospital services, did not require transport to and from hospital, and were able to maintain normal contact with friends and families.

In Sweden,⁹ mobile telephones provided to people with mental health problems enabled them to select services on medication, housing, etc., and have greater direct control of their own health, reducing the need for hospital visits.

In England, some general practitioners (GPs) have already established an open access system for their patients to access and read their own records. The Royal College of Physicians of London acknowledges that such access is cost-effective and encourages self-care. Their

Landscape Review with NHS England will highlight the variability of introduction. Expansion is expected later in 2015.

In Spain, the Andalusian e-Health Strategy¹⁰ has enhanced the quality of life of its citizens and the coordination of their health and social carers through the integration of health information. It is cost-effective: ePrescription enabled early saving of €6.3 million; hospital admissions decreased from an average stay of 7.5 days in 2008 to 7.16 in 2012 and consultations in family medicine reduced by 16.11% from 2007 to 2012. In Catalonia, the government has established integrated technology (ICT) services, which are now well known to users and service providers. The main Pulmonary Medicine Department reached a significantly lower (10%) rate of early readmissions after discharge than those observed in the whole region (15%), in Spain (30–35%) or at EU level (30–35%), a pattern that is being repeated elsewhere in Spain.

In 2007, the *EU Ageing Well in the Information Society Action Plan* acknowledged the demographic change in the European Agenda. The focus on the ageing population forced a change of vision, from the traditional acute illnesses approach to chronic conditions. eHealth appears as a necessary enabler of the change from reactive to preventive medicine to embrace the integrated ‘care & cure’ approach. Many initiatives have been launched at European political level with the aim of fostering a triple win: better quality of life for citizens, improved sustainability for public services, and new opportunities for the European Industry. Another EU report, *Excellent innovation for ageing. A European Guide* (2013),¹¹ includes more than 30 examples from twelve countries classified from one to four stars, although none has yet achieved the highest ranking.

The need for more action

EU officials are concerned that despite acknowledging changes in demography, too few Member States have addressed the need to plan and introduce eHealth services. At a March 2015 EU Summit,¹² the EU Digital Commissioner stressed the need for more digital services. “We

want to continue this program, secure and deepen it, and for the quality of life of elder European citizens”.

A broader understanding across the EU of what eHealth is, what it can do, and how it serves various interests and generates value, is urgently needed. While both technology and models of care matter, eHealth's future is ultimately most dependent on its being able to integrate appropriate multiple interest groups. Thus, users and their representatives should press for greater access, involvement, and training themselves. In addition, special emphasis needs to put on the education of all health care professionals in computer/communications technologies and, particularly, on its inclusion in their initial education syllabuses.

Conclusion

Where better education of the workforce, policy makers and governments exists, eHealth services have proved highly popular with users and are cost-effective. We are convinced that faster progress in the introduction of these services depends on placing more emphasis and more resources in appropriate education at all levels.

This topic was addressed at European Knowledge Tree Group (EKTG) debates in 2015 at the House of Lords in London

and the Ambient Assisted Living¹³ Forum (AAL) in Ghent. EKTG are now planning for a Symposium in January 2016 in London.

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New HiT on Switzerland

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Copenhagen: WHO Regional Office for Europe

Number of pages: 288, **ISSN:** 1817-6127

Freely available for download at: http://www.euro.who.int/__data/assets/pdf_file/0010/293689/Switzerland-HiT.pdf?ua=1

Life expectancy in Switzerland (82.8 years) is the highest in Europe after Iceland. The Swiss health system offers a high degree of choice and direct access to all levels of care with virtually no waiting times.

As this new review of Swiss health care makes clear, public satisfaction with the system is high and quality is generally viewed to be good or very good. Despite this positive assessment a number of challenges remain. In particular, improving financial protection and fairness of financing is

becoming important because rising premiums and an exceptionally high share of out-of-pocket payments place an increasingly large financial burden on households with lower and middle incomes.



THE **MEDICRIME CONVENTION** — FIGHTING AGAINST COUNTERFEIT MEDICINE

By: Oscar Alarcón-Jiménez

Summary: The Council of Europe has adopted a criminal law convention on “counterfeiting of medical products and similar crimes involving threats to public health” (MEDICRIME Convention), drafted from a public health perspective. The Convention’s main goals are to criminalise certain acts, protect the rights of victims, and promote national and international co-operation. The counterfeiting of medical products and similar crimes is a growing threat for many countries due to the low level of deterrence within national and international legislation. As the only international legal instrument to fight against falsified medical products, the Convention represents a milestone in tackling transnational organised crime.

Keywords: *Public Health, Counterfeiting of Medical Products, Criminal Networks, MEDICRIME Convention, Council of Europe*

Introduction

Given its lucrative character, the counterfeiting of medical products and similar crimes is a new global threat facing the international community. The control by criminal networks of both the production and trade of counterfeit goods facilitates the infiltration of these counterfeit medical products into the legal supply chain and their sale as authentic products. The opacity of these networks makes it difficult to combat these new crimes.

The counterfeiting of medical products violates basic human rights by effectively denying patients necessary and authentic medical treatment and constitutes a direct threat to individual and public health. It is a trans-border crime which needs to

be efficiently combated through close international co-operation. The factors which contribute to this state of affairs are corruption, the ineffectiveness of systems for monitoring the production and distribution of medical products, and the lack of a legal framework to prosecute such crimes. The criminals are attracted by the risk-benefit ratio involved. In fact, this activity is more profitable than drug trafficking with a significantly lower level of risk, due to the relatively low risk of prosecution and detection, the potential high gains, and the ease of advertising and supply around the world through the Internet. Moreover, it is not an isolated crime: it affects the economies of all states, with organised networks operating at a global level and jeopardises the health and lives of individuals.

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Note: The views expressed in this article are those of the author and may not under any circumstances be regarded as stating an official position of the Council of Europe.

Global international response

Adoption of the MEDICRIME Convention

When facing organised crime, no single response can be effective. On the contrary, the response needs to be global. With a view to tackling this crime, international action by states was needed, in particular, harmonised international legislation to overcome loopholes, the establishment of sanctions to deter this activity, and the promotion of international co-operation. The Council of Europe (CoE), the oldest intergovernmental organisation which has been at the forefront of promoting human rights, the rule of law and democracy in Europe over the last 60 years, sees the eradication of this phenomenon as the common responsibility of the global community. It elected to take on this challenge as the counterfeiting of medical products violates human rights and undermines the values upon which the CoE is based. Thus, in 2010, the CoE's Committee of Ministers adopted the Convention on the counterfeiting of medical products and similar crimes involving threats to public health (hereafter MEDICRIME Convention)² which was opened for signature on 28 November 2011 in Moscow.

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Harmonised definitions

The MEDICRIME Convention is a criminal-law convention² with the ultimate goal of protecting everyone's right to life by introducing new offences and providing for the establishment of penal and other sanctions that are proportionate and dissuasive for these offences. It aims to prosecute certain acts, protect the rights of victims, and promote national and international co-operation against

these crimes (Article 1). The scope of the Convention is expressly limited to medical products by covering both medicines (for human and veterinary use), their active substances, excipients, and medical devices, parts or materials designated to be used in the production of medical products, and accessories designated to be used together with medical devices (Article 3).

It is important to stress that intellectual property rights do not fall within the scope of the MEDICRIME Convention. Moreover, the term “counterfeit” is defined as a false representation with regards to identity and/or source. Any natural person suffering adverse physical or psychological effects as a result of having used a counterfeit medical product or a medical product manufactured, supplied or placed on the market without authorisation or without being in compliance with the conformity requirements as described in the Convention should be considered a victim.

Criminalising certain acts

The MEDICRIME Convention introduces four new independent criminal offences considered dangerous to public health:

- 1) **Intentional manufacturing of counterfeit medical products**, their active substances, excipients, parts, materials and accessories (Article 5); related to this offence, the adulteration of medicines and other listed products is also considered a criminal offence.
- 2) **Intentional supplying, offering to supply and trafficking** in counterfeit medical products' active substances, excipients, parts, materials and accessories (Article 6). This includes the activities of brokering and advertising online or at a distance, such as social media and through various parts of the Internet.
- 3) **Intentional falsification of documents** (Article 7). This can take place either through the making of a false document from scratch or through unlawfully amending or changing a document with regard to its content or appearance. In both cases, the aim is to deceive the person reading the document into

believing that the medical product which the document accompanies is legitimate and not a counterfeit. The MEDICRIME Convention defines the term “document” by covering not only certificates and similar documents used in trade and commerce, but also the packaging and labelling of medical products, as well as texts provided on internet sites which are specifically designed to accompany the product in question.

- 4) **Similar crimes involving threats to public health**: despite not being counterfeited, products intentionally manufactured, kept in stock for supply, imported, exported, supplied, offered to supply, or placed on the market without authorisation (medicinal products) or without being in compliance with the essential conformity requirements (medical devices) equally pose a serious threat to public health (Article 8). Therefore, these crimes are considered to be similar to the counterfeiting of medical products. An example of this offence is the existence of a sprawling black market for medicinal products for hormonal treatment produced without authorisation. This Article shall only apply when the previous Articles (5-7) are not applicable.

The above criminal offences should be made punishable under domestic law by those countries which have ratified the MEDICRIME Convention and which should foresee and lay down accompanying “effective, proportionate and dissuasive sanctions”.

Aggravating circumstances

When sentencing offenders, judges may take into consideration some circumstances (although they are under no obligation to apply them) in the determination of the sanction for the above offences, such as:

- the offence caused the death of, or damaged the physical or mental health of, the victim;
- the offence was committed by persons abusing the confidence placed in them in their professional capacity;

- the offence was committed by persons abusing the confidence placed in them as manufacturers and suppliers;
- the offences of supplying and offering to supply are committed through the use of large-scale distribution, including through information technology systems (the Internet);
- the offence involved a criminal organisation;
- the perpetrator has previously been convicted of offences of the same nature as those established under the Convention.

Enhanced co-operation of authorities and information exchange

The MEDICRIME Convention paves the way for solid co-operation and information exchange at both national and international level. Networking at national level based on a multidisciplinary and multisectorial approach is a key element in the fight against the counterfeiting of medical products and similar crimes. The wide range of authorities (justice, law-enforcement and health authorities) involved in this new crime usually requires a strengthening of the existing frameworks for co-operation. The CoE model based on a network of Single Points of Contact (SPOC model) is a successful system already used in other fora (i.e. EU, WHO, INTERPOL).

The MEDICRIME Convention clearly provides a legal basis for a platform for co-operation, with a view to avoiding any requirement for further bilateral agreements. Mutual legal assistance is a formal process by which states grant assistance to one another with the purpose of gathering evidence for use in criminal trials. The Convention encompasses all existing forms of Mutual Legal Assistance (e.g. rogatory letters*, transfer of proceedings). For some states, the Convention may be the only treaty between itself and other states, particularly since one particular aspect

of the Convention is that it provides the possibility for third states to join (see below).

The legal bases applicable in the context of extradition and the principles enunciated there are applicable, *mutatis mutandis*, in the field of mutual legal assistance, which is broader than extradition. Moreover, given the importance of the victims of counterfeit medical products and similar crimes, whether as a result of their suffering or because of the potential they offer as witnesses, special attention is paid to them even in the provisions relating to international criminal co-operation.

“special attention paid to victims”

Prevention and protection measures

One innovation introduced by the Convention is the inclusion of victims. It should be recalled that the protection of, and assistance to, victims of crime has long been a priority in the work of the CoE. Taking into account the potential grave consequences for victims of counterfeited medical products and similar crimes, the Convention provides for the protection of such victims (Chapter VI), ensures that they be kept informed by the competent national authorities on relevant developments in their cases, and gives them the possibility to be heard and to supply evidence.

Additionally, the MEDICRIME Convention provides for some preventive and protective measures (Article 18) in combating the counterfeiting of medical products and similar crimes, namely the introduction at national level of quality and safety requirements for medical products as well as measures ensuring the safe distribution of such products. Additional preventive measures (capacity building activities for justice, law-enforcement, health care professionals and providers in order to better prevent and combat these crimes; awareness-raising campaigns;

the prevention of illegal supply) are also envisaged. Moreover, victims would have access to information, assistance in their physical, psychological and social recovery and have the right to compensation from the perpetrators.

A global Convention

The MEDICRIME Convention is not confined to CoE Member States. Any state wishing to sign and ratify the Convention is welcome to do so (Article 28.1), recognising that the world is facing a global problem as a result of such crimes. Apart from the seventeen CoE Member States that have signed the MEDICRIME Convention so far, Israel and Morocco have also signed the Convention while the Republic of Guinea ratified the MEDICRIME Convention on 24 September 2015, initiating the procedure for its entering into force on 1 January 2016. Belarus has also been invited by the CoE's Committee of Ministers to sign this Convention. To date, five countries have ratified the Convention: Ukraine (2012), Spain (2013), Hungary (2014), Moldova (2014) and Guinea (2015). Undeniably, more countries are needed to sign and ratify the MEDICRIME convention in order for it to be effective internationally.

Conclusion

The MEDICRIME Convention offers a valuable tool for combating the counterfeiting of medical products from the standpoint of protecting health. Through the harmonisation of criminal provisions, the Convention lays the foundation for efficient and effective national and international co-operation among all competent authorities involved, namely judicial, health and law enforcement authorities, protecting, above all, the most vulnerable people, patients.

The counterfeiting of medical products and similar crimes are crimes that ultimately could kill or at the very least make people ill or not treat their illnesses. It is a universal problem that demands strong responses: the MEDICRIME Convention can provide them.

* A rogatory letter is a formal request from a court to a foreign court for some type of judicial assistance.

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WORTH THE PAPER THEY'RE WRITTEN ON? THE POTENTIAL ROLE OF NATIONAL MEN'S HEALTH POLICIES

By: Peter Baker

Summary: The Irish government was the first to introduce a national men's health policy. It ran for five years, from 2008–2013, and has recently been independently reviewed. The review found, overall, that the policy had a positive impact on men's health in Ireland. The conclusions of the review suggest that national strategies on men's health in individual European states, as well as in Europe as a whole, could be beneficial. Existing health policies should also take explicit account of the specific needs of both men and women.

Keywords: Men's Health, Gender, Health Policy, Ireland

Introduction

Men's health in Europe is unnecessarily poor. Life expectancy for women on average across European Union (EU) member states reached 82.2 years in 2012, compared with 76.1 years for men. The gap between the EU member states with the highest and lowest life expectancies was 7.6 years for women and 11.5 years for men.¹ Across all EU member states in 2011, the male mortality rate was nearly 60% higher than the female rate.

Professor Sir Michael Marmot, one of the world's leading authorities on the social determinants of health, has suggested that men's poorer survival rates across Europe

'reflect several factors – greater levels of occupational exposure to physical and chemical hazards, behaviours associated with male norms of risk-taking and adventure, health behaviour paradigms related to masculinity and the fact that men are less likely to visit a doctor when they are ill and, when they see a doctor, are less likely to report on the symptoms of disease or illness.'²

Men's health policy

Marmot believes that national governments should develop strategies that 'respond to the different ways health and prevention and treatment services are

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Note: Peter Baker was commissioned by the Health Service Executive in Ireland to lead the independent review of the National Men's Health Policy.

Box 1: Ireland's National Men's Health Policy 2008–2013: Where was progress made?

Most progress was made in four areas:

- Increasing the focus on men's health research
- Developing health promotion initiatives that support men to improve their health (see Box 2)
- Tackling social isolation and disadvantage in men through community development work
- Developing men's health training for health and other professionals

Progress was slower in seven areas:

- Establishing structures nationally and locally to support and monitor implementation of the policy
- Increasing the proportion of men working in education, the caring professions and community work
- Developing health services (especially in preventative health) which take men into account
- Developing policies that improve the health of men at home in their roles as husbands, partners, fathers and carers
- Improving the health and personal development of boys through work in schools and colleges
- Developing men's health initiatives at workplaces
- Increasing men's access to sport and recreation facilities.

experienced by men [and] women ... and [ensure] that policies and interventions are responsive to gender.²⁴ In a subsequent report on health inequalities in the UK, Marmot highlighted the fact that deprivation has a greater negative impact on men's health outcomes than women's and called for a greater policy focus on men's health to help tackle this.²⁵

Ireland: the first to act

The Irish government was the first in the world – and to date remains the only

government in Europe – to have responded to the health problems facing men with a dedicated National Men's Health Policy (NMHP).²⁶ This set out ten strategic aims – and 118 specific action points – for the period 2008–2013. Among the problems it aimed to tackle were male life expectancy five years below that of females, a steep social gradient in male mortality, and the second highest suicide rate in young men out of the 30 OECD member states.

As well as being the first comprehensive attempt to address men's health at a policy level, it moved beyond the traditional 'medical model' and was based on a social determinants approach. It advocated a 'whole-system' response, with roles for a wide range of government departments, non-governmental organisations, employers and others.

The focus of the NMHP was on prevention and the importance of supporting men through a community development approach. Significantly, it did not seek to blame men for their poor health and, instead, embraced an understanding of masculinities and the ways men are socialised to behave. It also aimed to support men to become more active advocates for their own health. The European Commission's report on the state of men's health across Europe called the publication of the NMHP 'a significant landmark'.²⁷

Making a difference?

But was the NMHP actually effective? What difference did it make to men's health in Ireland? And does it provide a template for the development of men's health in other European countries and perhaps beyond? An independent review of the NMHP, commissioned by Ireland's Health Service Executive and published in 2015, provides some answers to these important questions.²⁸

It was not possible for the review to assess the impact of the NMHP quantitatively. No clear time-framed performance indicator outcomes were established at the start of the NMHP and it was implemented during a period when, because of cuts in public expenditure, there was a dearth of official data on health behaviours and outcomes. Even if good data had been available,

it still would have been challenging to demonstrate a link between the NMHP specifically and any changes in men's health outcomes.

The wide range of health professionals, health service and government officials, men's health advocates and others consulted for the review were nevertheless overwhelmingly of the view that, overall, the NMHP made a significant and important contribution to making the issue of men's health more prominent in Ireland, to providing a framework for action, and to implementing many important new initiatives. However, it was also generally acknowledged that its impact had been stronger in some areas of activity than others and very weak in some (see Box 1).

The achievements of the NMHP were in large part due to its very existence (which validated and encouraged work in a previously overlooked field), the thorough pre-publication consultation process (which engaged a wide range of organisations and individuals), its holistic approach to men's health, and the commitment of a core group of individuals from the statutory and non-statutory sectors who took responsibility for co-ordinating its implementation. The involvement of several significant non-governmental organisations, including the Irish Cancer Society and the Irish Heart Foundation, was also important.

The NMHP was, however, published at a time of economic crisis. The impact of this on implementation cannot be underestimated. Although some government money continued to be provided for men's health work, including the annual Men's Health Week in June, this was not on a scale commensurate with the ambition of the NMHP.

Other implementation problems concerned the large number and scope of specific policy recommendations and actions, the lack of clearly-stated priorities, and the problem common to many jurisdictions of securing action across government departments. In Ireland, the latter problem was compounded by significant reorganisations within some departments and the loss of staff who had been closely involved in the initial development of the NMHP. There was also a lack of

Box 2: Health promotion with men in Ireland

One area of clear progress in implementation of the NMHP was the development of new health promotion initiatives. A wide range of male-targeted health information resources was produced, including by the Men's Health Forum in Ireland, the Irish Cancer Society, the Irish Heart Foundation, An Post (Ireland's postal service), and Saferood (the statutory body that promotes awareness and knowledge of food safety and nutrition issues in Ireland).

Evaluated health promotion pilot and longer-term programmes aimed at men included the Men on the Move initiative (which engaged men in sociable physical activity programmes), The Larkin Unemployed Centre's Men's Health and Wellbeing Programme (a ten-week intervention for men aged over 30 years in a disadvantaged part of Dublin) and Farmers Have Hearts (a cardiovascular health screening programme for rural men).

sustained high-level government official or ministerial support which could have helped drive progress on implementation.

Other countries

Two other countries, Australia and Brazil, have also introduced national men's health policies. Although the evidence suggests their outcomes, like those of the Irish policy, were mixed, many men's health researchers and advocates around the world now believe that dedicated and comprehensive national men's health policies represent the best way forward. In Europe, this view is taken by the Danish Men's Health Society, the Men's Health Forum (England and Wales) and the European Men's Health Forum.

This is despite evidence that progress in men's health can be made in the absence of a specific national men's health policy. In England and Wales, for example, the Men's Health Forum has successfully argued for the male perspective to be integrated into

cancer and mental health policy, as well as for men to be included within the national chlamydia screening programme and for the introduction of abdominal aortic aneurysm (AAA) screening for men. In Denmark, the government has recently allocated €1 million to develop initiatives with unskilled and unemployed men and additional funding for 'Men's Sheds'* in rural areas. Nevertheless, in England, Wales and Denmark, as well as Europe generally, the principal advocates for men's health still perceive progress to have been patchy and fragile and in need of underpinning by clear national strategies.

Most advocates also consider that progress should be made within a broader gender mainstreaming framework (GMF), and that attention must be paid to the health needs of both men and women. But there are concerns that a GMF alone is not able to drive sufficient action on men's health. This is primarily because 'gender' is still widely interpreted to refer to women alone and, where GMFs exist (as in Ireland), they have in practice proved difficult to implement. Because gender mainstreaming tends to be framed as a binary issue (male/female), there is an additional risk that it will overlook lesbian, gay, bisexual, transgender and intersex issues.

Where next?

The conclusions of the review of Ireland's NMHP point to a need for national strategies on men's health in individual European states, as well as for existing policies, whether on cancer, cardiovascular disease or obesity, to take explicit account of the specific needs of men. There is also a case for Europe as a whole to develop a strategy on men's health which takes account of the conclusions of the European Commission's report on men's health.⁵ This was published in 2011 but has not yet been followed up with any recommendations for action.

There are also obvious implications for women's health policy, as it would seem anomalous for gender-specific policy

to apply only to men. Women may live longer than men but they nevertheless still have a wide range of unmet health needs that require attention. The value of national women's health policies is an issue women's health advocates may wish to consider and, if there is support for this approach, there is potential for collaborative working between men's and women's organisations.

How men's health will be taken forward in Ireland, specifically now that the NMHP has come to an end, is still to be determined. The review found very strong support for the continuation of a dedicated national policy on men's health in order to maintain momentum. But it was also felt that men's health should now be addressed, in the form of a dedicated Men's Health Action Plan, within the country's new overarching public health policy, *Healthy Ireland*. This policy has the high-level political support and the governance and implementation structures that make it much more likely that it will successfully make progress through co-ordinated cross-sectoral activity.

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* Men's Sheds are defined as dedicated and friendly meeting places where men come together to undertake a variety of mutually agreed activities, with the aim of sharing skills, learning new ones and generally participating in group projects. The overall objective is to enhance the social connectedness and well-being of participating men.

HOSPITAL REFORMS IN SWITZERLAND

By: Wilm Quentin, Friedrich Wittenbecher, Anne Spranger, Luca Crivelli, Isabelle Sturny, Paul Camenzind and Carlo De Pietro

Summary: The health reform process in Switzerland is complicated and almost always takes a very long time due to the fact that particularly broad consensus of the main stakeholders is required. One important area of reform in recent years has been the acute inpatient sector: Diagnosis Related Group (DRG-) based hospital payment was introduced in 2012 and hospital planning was considerably improved through the adoption of detailed planning criteria and increased coordination across cantons. This article provides an overview of hospital reforms in Switzerland and highlights interesting features of the hospital planning model that was adopted by most Cantons in 2015.

Keywords: Hospital reforms, Hospital planning, Hospital payment, DRGs, Switzerland

Introduction

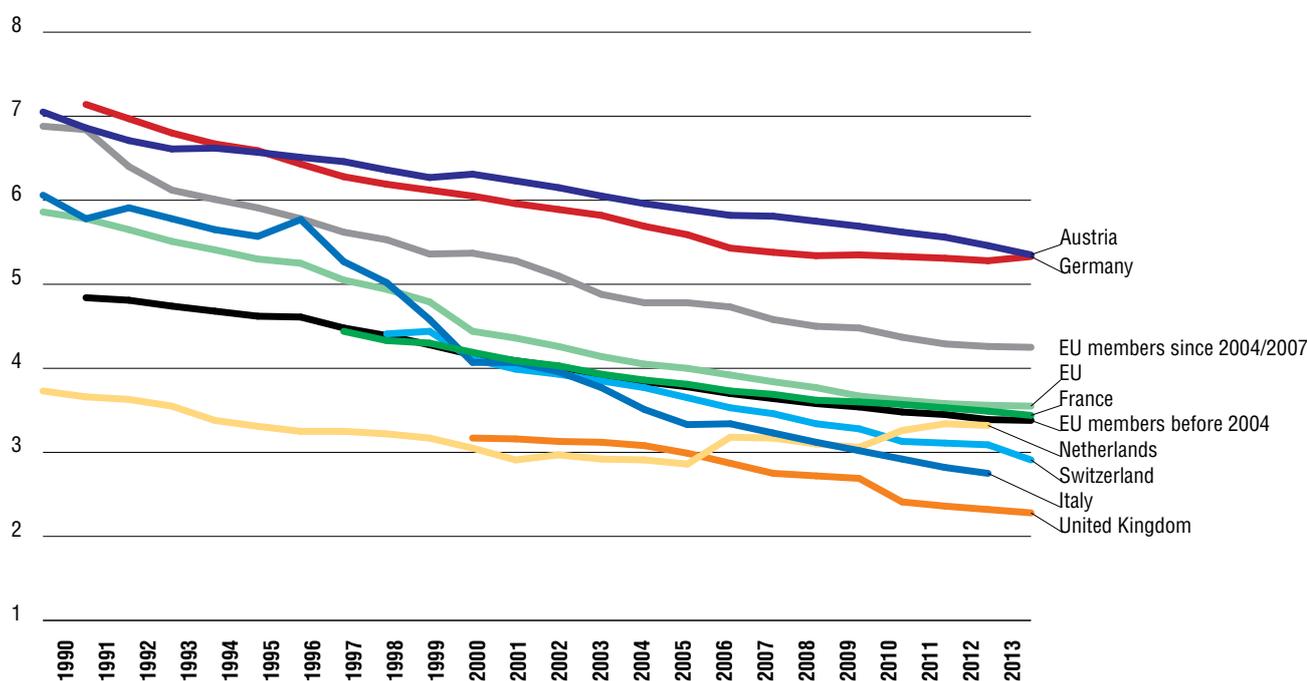
The Swiss health system is often viewed by outsiders, in particular from the United States, as an example of a “consumer-driven” health system.^{1 2} This perception derives from two important features of the system. First, residents in Switzerland have a lot of choice when purchasing their standard mandatory health insurance (MHI) package from one of 59 competing companies, which offer thousands of different insurance plans. Second, patients have a lot of choice when choosing their physician or hospital, and traditional insurance policies allow direct access to all levels of care, including hospital inpatient care, without the need for a referral.

However, what is often overlooked (at least by outsiders) is the strong role of the federal government and of the 26 cantons in shaping the health system through

regulation and direct intervention. In fact, in the acute hospital inpatient sector, cantons are by far the most important actors in the system. They own most of the larger hospitals in the country, they plan hospital capacity, and they are the largest payer, financing almost half (about 46% in 2012) of all expenditures for acute inpatient care. Consequently, cantonal planning and investment decisions determine the supply of inpatient care in the country.

Over the past two decades, many European countries have aimed to reduce inpatient capacity because advances in medical technology have allowed faster discharge of patients and treatment in day care settings. In comparison with its neighbouring countries, including Austria, France and Germany, Switzerland has been able to reduce bed capacity considerably more strongly since the

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Figure 1: Beds in acute hospitals per 1000 population in Switzerland and selected countries, 1990 to 2013Source: ⁵

year 2000 (see Figure 1). In 2013, there were 2.91 acute care beds per 1000 population in Switzerland, which was almost 20% below the average of countries that had joined the European Union (EU) before 2004.

This article describes the most important hospital reforms in Switzerland since the year 2000. These reforms do not necessarily explain the comparatively faster decline in bed capacity in Switzerland than in neighbouring countries. However, they have supported this trend through changes in financial incentives and by improving planning of inpatient capacity in the country. Furthermore, a recently adopted model for the planning of inpatient capacity might provide inspiration for improved hospital planning in other countries.

Focus on financing, planning, and quality of care

Table 1 summarises the most important reforms and other significant developments in the hospital inpatient sector since the year 2000. The hospital financing reform has had particularly

far-reaching consequences on the hospital sector. It introduced Swiss-DRGs as the basis for hospital payment; it increased choice for patients (and competition for hospitals) because patients can now choose to be treated in private hospitals and in hospitals outside their canton of residence; and it mandated cantons to improve their planning of hospital inpatient care and to coordinate planning activities with other cantons, in particular in the area of highly specialised care. Consequently, two of the other three reforms mentioned in **Table 1**, i.e. the inter-cantonal agreement on highly specialised medical services, and the adoption of the Zurich model for hospital planning, are directly related to the hospital financing reform. Finally, the establishment of the National Association for Quality Improvement in Hospitals and Clinics (ANQ) has promoted the collection of data in order to improve the quality of care of acute, rehabilitation, and psychiatric hospitals.

Cross-border health care within Switzerland

One part of the hospital financing reform introduced inter-cantonal portability

of insurance coverage for cross-border inpatient care (i.e. for care provided in one canton to residents of another canton) which is now systematically covered by MHI. Prior to the reform, out-of-canton services were covered by MHI and cantons only in the case of emergency or if the services were not available in the insuree's canton of residence. Patients wishing to have choice of provider in other cantons had to take out supplementary voluntary health insurance (VHI) or pay directly.

The new rules for the financing of cross-border care in Switzerland are interesting for EU Member States because regulations in Switzerland are similar to regulations that apply to cross-border health care in the EU. Swiss residents can choose to be treated in any hospital in Switzerland and they receive reimbursement up to the level of costs that would have been paid in the canton of residence for the same service. However, the introduction of Swiss-DRGs has solved a problem that still persists in the EU: in Switzerland, it is now possible to compare costs for a particular service across cantons because inpatient services are defined by the Swiss-DRG system. In contrast in the EU, it is not possible

Table 1: Major reforms and other significant developments in the hospital inpatient sector, 2000–2015

Reforms	Contents	Year passed	Year implemented
Hospital Financing Reform	Adoption of Swiss DRGs for payment of inpatient care. Inter-cantonal portability of insurance coverage for inpatient care (with limitations). Inter-cantonal hospital planning for highly specialised medicine.	2007	2012
Inter-Cantonal Agreement on Highly Specialised Medical Services	Organisation of the inter-cantonal planning of highly specialised medicine.	2008	2009
Creation of the National Association for Quality Improvement in Hospitals and Clinics (ANQ)	Agreement of hospitals, cantons and insurers to merge two previously existing quality initiatives into one national association.	–	2009
Adoption of the Zurich model of hospital planning by most cantons	The Zurich model defines groups of hospital services and specifies quality criteria that hospitals have to fulfil in order to be allowed to provide these services.	–	2015

Source: based on ⁴**Table 2:** Service-specific requirements for hospital planning group GEF2 – Intraabdominal Vascular Surgery

Specialist qualifications	Surgeon with sub-specialisation in vascular surgery
Specialist availability	24/7, intervention starts within ≤ 30 min
Emergency department	24/7, during day time a surgeon and a specialist in internal medicine are available within 5 minutes; during nights and weekends, a surgeon is available within 15 minutes, a specialist in internal medicine within 30 minutes, in-house availability of an anaesthetist and intensive care specialist
Intensive Care Unit (ICU)	Level 2 ICU according to national standards
Applicability of other service requirements	GEF2 can be provided only if hospitals fulfil service requirements for other hospital planning groups (1) ANG2 - intraabdominal interventional angiology + (2) RAD1 – interventional radiology + (at least in cooperation with another hospital) (3) HER1.1 – cardiac surgery or vascular surgery with heart-lung machine
Minimum volume threshold	10 per year
Other requirements	Interdisciplinary conference for confirmation of indication

Source: Authors' own compilation based on ⁷

to compare costs for inpatient services across borders because different countries have different DRG systems or do not use DRGs at all.

Improved cantonal inpatient planning supports better purchasing

The hospital financing reform has fundamentally changed the planning of inpatient capacity in Switzerland. It specified that cantons should plan hospital capacity on the basis of objective criteria, and that the selection of providers for inclusion in the cantonal hospital list

should be based on quality, efficiency and geographic accessibility. Cantonal hospital lists are important because they determine which hospitals are allowed to provide which MHI-reimbursable services. The Canton of Zurich has been very influential in promoting objective planning criteria and in developing a planning model that was adopted by most other cantons in 2015 (see Table 1). This model could potentially provide inspiration also for other countries that work on improving hospital planning.

In a first step, the Zurich Department of Health developed a methodology for

estimating future care needs, including numbers of patients and bed days for different areas of acute inpatient care on the basis of epidemiological extrapolations to the year 2020.⁸ In a second step, a hospital planning model was developed, which defines about 140 hospital planning groups, which group together similar hospital services.⁹ For each of these groups, certain structural requirements are specified concerning the availability of an emergency department, an intensive care unit (ICU), other specialty departments and minimum volume thresholds. Table 2 provides an example of service-specific requirements for the hospital planning group GEF 2 – Intraabdominal Vascular Surgery.

Providers have to apply to be included in the hospital list. The cantonal department of health then follows a two-step procedure for checking if hospitals fulfil the requirements. First, general requirements are evaluated at the level of the hospital for quality (e.g. having implemented discharge pathways or quality management systems), efficiency (i.e. having case-mix adjusted costs that do not exceed by more than 15% the average costs of cantonal hospitals), and geographic availability. Second, service specific requirements are evaluated for each of the hospital planning groups, using the criteria specified in Table 2. Subsequently, hospitals are included in the hospital list for the specific hospital

planning group. Because inclusion in the hospital list is a prerequisite for providing MHI-reimbursable services, hospitals are, in fact, awarded with a contract for providing the related service.

“hospital financing reform has had far-reaching consequences

In the Canton of Zurich the new rules for hospital planning have had an important impact on the structure of care provision. Since 2012, only the University Hospital of Zurich is allowed to provide services for most of the 140 hospital planning groups.⁸ All other hospitals are allowed to provide only a small proportion of these groups. In other cantons, the impact of the hospital planning reform has often been weaker for various reasons, including the absence of a university hospital, greater importance of assuring geographic availability, stronger influence of private hospitals vis-à-vis cantonal politics and government, etc.

Highly specialised medical care and reference centres

Hospital planning has improved not only within cantons but also across cantons. The hospital financing reform obliged cantons to coordinate their planning activities for highly specialised medical care with the aim of promoting concentration of highly specialised care in reference centres. In response to this requirement and to avoid federal regulation in this area, the Conference of the Cantonal Ministers of Health (GDK/CDS) adopted an inter-cantonal agreement on highly specialised medical care (IVHSM) in January 2009.⁹ Since then, 39 highly specialised medical fields have been identified, including stroke, neurosurgery, severe trauma and severe burns, organ transplantations, stem cell transplantations, proton therapy, cochlear implants and visceral surgery.

Planning for these areas of medical care is now carried out jointly by cantons, and decisions are binding for all cantons. Quality requirements have been defined for each area of highly specialised medicine concerning structures and processes. Providers have to comply with these requirements if they wish to be included in the hospital list for a particular area of highly specialised medicine. The result of the planning process is a national list of hospitals that are allowed to perform one or several of these highly specialised medical services in Switzerland. Therefore, in addition to the hospital plans of the 26 cantons, an inter-cantonal hospital list exists, specifying for each field of highly specialised medical care, where these services can be provided in Switzerland.¹⁰

Conclusion

Hospital reforms in Switzerland since 2000 have focused on financing, planning, and quality of care. The 2007 hospital financing reform has some important implications for policy-makers, always bearing in mind the specificities of the Swiss health system: first, it shows that in the context of cross-border health care, it would be important to have a common definition of hospital activity in order to determine if costs of care delivered in one country are higher or lower than in another country. Second, the Zurich model for the planning of inpatient capacity is promising and might provide inspiration for improved planning and purchasing of inpatient care in other countries. Third, the approach of the GDK/CDS for defining areas of highly-specialised medicine and specifying quality requirements for each of these areas could be useful also for other countries that are working on designating reference centres for highly-specialised medical care.

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NEW PUBLICATIONS

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Edited by: D McDaid, F Sassi and S Merkur

Maidenhead: Open University Press, 2015

Number of pages: 337; **ISBN:** 978 03 352 6226 7

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

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

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

The book practically illustrates methods and measures of cost and outcome used in the evaluation of interventions and covers specific risk factor areas. It is designed for health policy makers and all those working or studying in the areas of public health, health research, medicine or health economics.

Contents: Introduction; Supporting effective and efficient policies; Measurement; Curbing tobacco smoking; Tackling alcohol-related harms; Promoting physical activity; Improving the quality of nutrition; Addressing environmental risks for child health; Preventing road-related injuries; Protecting mental health; Social determinants of health; Health inequalities; Translating evidence into policy; Intersectoral action; The way forward.



How can countries address the efficiency and equity implications of health professional mobility in Europe?

By: IA Glinos, M Wismar, J Buchan and I Rakovac

Copenhagen: World Health Organization, 2015
Observatory Policy Brief 18

Number of pages: 28; **ISSN:** 1997-8073

Freely available for download: http://www.euro.who.int/__data/assets/pdf_file/0008/287666/OBS_PB18_How-can-countries-address-the-efficiency-and-equity-implications-of-health-professional-mobility-in-Europe.pdf?ua=1

The health workforce is a key contributor to health system performance. Shortages, mal-distribution and skill-mismatches of



health professionals can have immediate consequences for the efficiency and equity of health systems. The in- and out-flows of health professionals change the composition of the health workforce in both source and destination countries, and may improve or aggravate health workforce problems.

In the European Union, EU health professionals are free to move and seek work in any Member State. Intra-EU mobility is increasing;

some countries rely on foreign inflows while other Member States experience important outflows. At the global level, the WHO Global Code of Practice on the International Recruitment of Health Personnel calls on countries to mitigate the negative effects of migration and encourage positive ones.

This brief analyses the impact of free mobility of health professionals for destination countries, source countries and the EU as a whole, and presents the policy tools which decision-makers can use to address its effects on efficiency and equity. While health professional mobility is not in itself "good" or "bad", targeted well-conceived policy measures can make it work better.

Contents: Key messages; Executive summary; 1. Introducing the Efficiency-Equity Conundrum; 2. Trends in Mobility: A New Map of Europe?; 3. Unpacking the Efficiency-Equity Conundrum: A Matrix; 4. Policy Options: How to make mobility work better; 5. Implementation Considerations; 6. Conclusions; Acknowledgements; References.

NEWS

International

Report: Cross-Border Health Threats Decision has improved health security in the EU

The European Commission adopted Decision 1082/2013/EU on serious cross-border threats to health, on 22 October 2013. It has now published a report that assesses progress with implementation over the subsequent two years. The report, in particular, includes an assessment of the operation of the Early Warning and Response System (EWRS) and of the epidemiological surveillance network, as well as information on how the established mechanisms and structures complement other alert systems at Union level while not duplicating them. The report concludes that the established mechanisms have worked well and that the Decision has improved health security in the EU. The EWRS has been instrumental to notify alerts as well as measures undertaken by the Member States. The epidemiological surveillance network, the EWRS, the European Centre for Disease Prevention and Control (ECDC), and the Health Security Committee (HSC) have operated effectively, and to the required quality level, during serious cross-border threats to health. These systems have complemented EU rapid alert systems which cover other areas (e.g. food, animal health, etc.), while avoiding any duplication.

Measures successfully carried out during the Ebola outbreak include information to travellers, guidance to health professionals, and medical evacuation to the EU of patients and health workers infected or suspected to be infected with the Ebola virus. The report notes that while overall communication in the HSC has been reasonably effective, some important lessons have been learned. During the peak of the Ebola outbreak there was a strong focus on the exchange of information while the impetus to discuss and coordinate the response was less considerable. A major conclusion from the Ebola outbreak is that there is scope for improving the implementation of provisions

whereby Member States are to co-ordinate their national responses.

The report is available at: <http://tinyurl.com/zwl2b3e>

Commission launches new version of ECHI data tool

On 11 November at the Expert Group on Health Information (EGHI) meeting in Luxembourg, the Commission launched the European Core Health Indicators (ECHI) data tool to replace the existing "Heidi" data tool. The new tool presents relevant and comparable information on health at European level in an interactive way, covering five groups of indicators: 1) demographic and socio-economic factors, 2) health status, 3) health determinants (smoking, alcohol, etc.), 4) health interventions/health services, and 5) health promotion.

More information at: http://ec.europa.eu/health/indicators/echi/index_en.htm

Tobacco: specifications for health warnings on cigarette packages adopted

An implementing act adopted on 9 October lays out specifications for the new combined health warnings on packages of tobacco products for smoking (in particular cigarettes and roll-your-own tobacco), which are required under the Tobacco Products Directive (2014/40/EU). The new health warnings will comprise a colour photograph, a text warning on the harmful effects of smoking and smoking cessation information. These should collectively cover 65% of the front and back of packages, in accordance with the aforementioned Directive. The implementing decision gives technical specifications for the layout, design and shape of the combined health warnings taking into account different packet shapes. These new health warnings will appear on packages across the EU from May 2016.

Transatlantic Taskforce on Antimicrobial Resistance meets in Luxembourg

On 22–23 October, nearly 80 international experts in antimicrobial resistance came together in Luxembourg for a meeting of the Transatlantic Taskforce on Antimicrobial Resistance (TATFAR). This was created following a 2009 US – EU presidential summit on combating antimicrobial resistance. Intended to fortify relationships and collaborations on activities relating to antimicrobial resistance (AMR), the biennial in-person meeting provide members and the TATFAR partners (Canada, EU, Norway and the US) the opportunity to plan, coordinate, and comment on technical activities for its next implementation period.

Attendees heard opening remarks from the TATFAR co-chairs; the European Union (EU) Commissioner for Health and Food Safety, Vytenis Andriukaitis and Luxembourg Minister of Health, Lydia Mutsch, who both emphasised the need to improve antibiotic use in humans and in animals, surveillance of resistant infections, and drug development. Commissioner Andriukaitis remarked specifically that new business models to pique drug development, partnerships to harmonise surveillance, and national actions plans where they have yet to be developed, are needed. Minister Mutsch also pointed to the gains that can be made in reduction of unnecessary antimicrobial use by robust stewardship policies, such as has been experienced in Luxembourg. She stressed the commitment of the presidency to supporting international action on AMR, including attention to the new proposals on veterinary medicines in the EU legislative programme.

Attendees participated in discussions that produced proposals for joint actions to be taken over the next five years. These include work to standardise the definition of appropriate antibiotic use for surveillance; to produce a review of AMR reduction targets; to characterise transmission, surveillance, and communication related to AMR interventions in veterinary medicine; to have policy dialogues on regulatory

control and on actions to strengthen surveillance and compliance. These proposals will be further refined by the TATFAR members before adoption.

More information at: <http://www.cdc.gov/drugresistance/tatfar/>

High-level meeting on refugee and migrant health

In 2015, nearly two million refugees and migrants have taken shelter in Turkey, while over 700,000 have entered other countries in the World Health Organization (WHO) European Region. It was in this context that a WHO high-level meeting on refugee and migrant health, hosted by the Italian Government, took place in Rome on 23 and 24 November.

Opening the meeting, Beatrice Lorenzin, Minister of Health of Italy, emphasised that the Region must not renounce its values of solidarity and called on countries to come together to provide leadership and offer refuge and health care to those seeking greater security. "We cannot turn away our eyes", she said.

Dr Zsuzsanna Jakab, WHO Regional Director for Europe said that the objective of the conference was to start to prepare a framework for long-term action on refugee and migrant health that could be discussed and agreed by the Regional Committee in September 2016. She noted that "the European public health community must do what we can to respond to the needs of those fleeing, to see that they are cared for in both the short and longer terms, and that our health systems are able to deal effectively and humanely with these extra demands, whilst continuing to offer full services to resident populations."

Key points in an outcome document developed at the meeting included integrating the needs of refugees and migrants into existing health structures as quickly as possible. Systems collecting data on migrant health also need to be reinforced and be available to other countries as an individual moves around. It was also stressed that health assessment and mandatory screening should not be seen as a solution, as migrants do not pose a threat to public health. Participants also noted that it was important to demystify the perception that communicable diseases

come with migrants as in that respect, they do not pose a greater risk than international travellers; efforts should be directed to the most vulnerable parts of the population e.g. children, women, older people and those in need of mental health care.

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

Country News

Refugees: Commissioner Andriukaitis presents the Personal Health Record in Greece

On 19 November during a visit in Greece, Health and Food Safety DG Commissioner Andriukaitis presented the "Personal Health Record" (PHR) to Greek authorities in Athens and to non-governmental organisations on the island of Lesbos, where he visited a centre for refugees. This document prepared by the Commission, together with the International Organisation for Migration, will be made available at hotspots, to evaluate migrants' medical needs and help reconstruct their medical history. The PHR is accompanied by a handbook to be used by health professionals.

The personal health record is available at: <http://tinyurl.com/nerzug5>
and the handbook at: <http://tinyurl.com/nhy2hkl>

Nordic Summit on Mental Health

The Danish Ministry of Health hosted the first Nordic Summit on Mental Health in cooperation with The Nordic Council, The Danish foundation Trygfonden and the Social Network on 6th November 2015. The Summit was opened by Crown Princess Mary of Denmark who is also Patron of the Danish Mental Health Fund. It focused on improving services for people with mental disorders, and creating the framework for knowledge and experience exchange between the Nordic countries. Danish, Swedish, Norwegian, Icelandic and Finnish researchers, specialists, experts, users, relatives, politicians and ministers came together in Copenhagen to discuss how to overcome the stigma surrounding people with mental health

problems. Danish Health Minister Sophie Løhde stressed the importance of sharing experience of what works across the Nordic countries in the effort toward people with mental disorders, adding that she hoped that the summit would be the starting point for closer cooperation in this area in the future,

Materials from the summit are available at: <http://www.xn--nordiskpsykiatritopmde-pjc.dk/>

Ireland: Original plans for universal health insurance will not go ahead

On 18 November Minister for Health Leo Varadkar definitively ruled out pressing ahead with the Government's original plans for universal health insurance. The decision comes after publication of a new study from the Economic and Social Research Unit (ESRI) which reports that the proposed model of Universal Health Insurance (UHI) would increase overall health spending by up to 11%, or as much as €2 billion a year. The proposals would have made health insurance mandatory with every individual having equal access to a standard package of primary and acute hospital services, including acute mental health services. The system would have had open enrolment, lifetime cover and community rating, with a choice between competing insurers who would have been obliged to offer the same package of services to all. Lead-author of the ESRI report, 'An examination of the Potential Costs of Universal Health Insurance in Ireland', Dr Maeve-Ann Wren, stated that competition law would have limited the government's ability to control pricing and insurers' margins. The report recommends further research into alternative UHI models.

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

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The Gastein Health Outcomes 2015

Securing health in Europe – Balancing priorities, sharing responsibilities

The 18th edition of the European Health Forum Gastein (EHFG) explored how to respond in an age when “crisis is the new normal”. In an ever-changing political and social environment for health, how can we safeguard past gains to our health systems while responding to new threats and opportunities?

Key Outcomes of the EHFG 2015

- We need “more Europe” – deeper cooperation – to develop a comprehensive, sustainable and collective strategy to respond to the challenges and opportunities presented by key societal challenges. The costs and consequences of non-Europe should be considered.
- This is not a refugee crisis, this is a reception crisis. Human mobility is the new norm in our increasingly globalised world.
- A paradigm change is needed in the way we finance, organise and operate our health systems; particularly to take into account demographic changes, rising healthcare costs, new patterns of disease and a shortage of skilled health workers. Strengthened primary healthcare, a better workforce skills-mix and technological innovations, amongst other things, can play a major role here.
- We need to build-in mechanisms to ensure joint accountability for Health in All Policies (HiAP) across government ministries and European institutions. Improved inter-sectoral collaboration is a pre-condition for health security.

For full details, see the *Gastein Health Outcomes 2015*.

Available at: http://www.ehfg.org/fileadmin/ehfg/Programm/2015/EHFG_Gastein_Health_Outcomes_2015.pdf

Save the Date: 19th EHFG
28th – 30th September 2016
Bad Hofgastein, Austria

www.ehfg.org

