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Nearly 25 years after the dissolution of the Soviet Union all of the countries in the region are actively engaged in the process of reforming their health care systems, with various degrees of success. This issue's *Observer* section looks in closer detail at the main challenges and achievements. Looking first at primary care, Kühlbrandt and Boerma highlight the heterogeneity between the countries in the region in their struggles to operationalise the family medicine model and to overcome the many infrastructural, financial and human resources obstacles facing the reconfiguration of primary care services.

The next article looks at attempts over the last two decades to downsize and rationalise the extensive hospital sectors inherited by all the countries in the region. With overwhelming (and unsustainable) investment of resources in inpatient services the challenge here is to not only rebalance the provision of health care away from hospitals and towards primary care but also to improve the management, efficiency, appropriateness and quality of inpatient care. Pharmaceutical care provides the third focus of this section, with Richardson et al assessing the impact of price increases following the liberalisation of pharmaceutical markets across the region in the early 1990s, the financial access barriers posed by significant out-of-pocket payments for medicines and factors impeding the implementation of rational prescribing policies. Finally, the two country case studies in this section put the spotlight on Ukraine and Uzbekistan which both face many of the challenges highlighted in the thematic articles, particularly Ukraine which must meet the additional challenges of providing essential services under conditions of conflict and crisis.

In the **Eurohealth International** section, the health priorities of the upcoming Luxembourg Presidency of the Council of the European Union (1 July 2015 to 31 December 2015) are showcased, which scope the areas of medical devices, personalised medicine, dementia, cross-border health care, and health security. Further, they express the intention to always put patients at the centre of discussions.

In the first article of the **Eurohealth Systems and Policies** section, Saltman and colleagues examine new reforms which they characterise as

an “aggressive multi-pronged effort to efficiently and effectively deal with the growing number of elderly patients”. They describe the introduction of a series of inter-linked structural, financial, and care coordination reforms in both Denmark and Norway. The next article analyses views from the Dutch public on their out-of-pocket payment system and draws conclusions as to why this policy tool, in this context, might not meet the goal of limiting health care expenditure. Third, García-Gómez et al. report on Spain’s universal access to long-term care services for those with certain levels of dependency. They present findings of horizontal inequity both in terms of use and unmet needs across socioeconomic groups.

**Eurohealth Monitor** features two new books that provide country reports. The first focuses on a dozen European countries to understand and evaluate the diverse range of contexts in which new approaches to *chronic care* are being implemented. The second comprises structured case studies to summarise the state of *primary care* in 31 European countries. The News section brings you a range of health sector developments from across Europe and around the world.

We hope you enjoy the Summer issue!

*Sherry Merkur, Editor*

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# PRIMARY CARE REFORMS IN COUNTRIES OF THE FORMER SOVIET UNION: SUCCESS AND CHALLENGES

By: **Charlotte Kühlbrandt** and **Wienke Boerma**

**Summary:** This article examines primary care reforms in countries of the former Soviet Union. It places reforms in their wider political context and points to infrastructural, human and economic successes and challenges. There is great heterogeneity between countries regarding the effectiveness of their gatekeeping systems, their ability to reduce out-of-pocket payments and the levels of training for primary care staff. With the possible exceptions of Kyrgyzstan and the Republic of Moldova, most former Soviet countries are not yet in a position to provide the bulk of health services that are normally included in a fully operational family medicine model.

**Keywords:** *Health Systems, Primary Care, Family Medicine, FSU countries*

## Introduction

Many countries of the former Soviet Union (FSU) have pledged to transform their inherited, centrally planned and hierarchically organised health systems into a ‘family medicine model’. However, in most of the countries, reality has not matched rhetoric. Across the twelve countries of the former Soviet Union considered here (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russia Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan), this model has been adopted to different degrees, at different points in time and with regional variations.<sup>1</sup>

The transition to the family medicine model necessitates an increase in the

role of first-contact ambulatory care, the provision of the majority of health services for all patients in primary care, and control over access to secondary and tertiary care.<sup>2</sup> Only a limited number of these features have been implemented and often only in certain regions or only in rural practices. Most countries have retained major features of the Semashko model of health care, where primary care is confined to a narrow range of conditions and delivered by inadequately trained doctors.<sup>3</sup> More comprehensive approaches towards family medicine reform have been apparent only in Kyrgyzstan, the Republic of Moldova, and in recent years also in parts of Ukraine.

This article highlights successes and challenges experienced by former Soviet

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countries in reforming primary care. First the wider political context and the role of governance in primary care reform is considered, followed by an examination of the infrastructure, human and economic challenges of implementing a functioning primary care service.

## “obstacles to the family medicine model”

### Political and economic context

The success of primary health care reforms largely depends on the scope and continuity of broader health system reforms. Positive examples of this can be seen in Kyrgyzstan and the Republic of Moldova, where the role and status of the Ministries of Health have been strengthened in contrast to other post-Soviet countries. Both countries have avoided health system fragmentation by reversing the trend for decentralisation and abolishing regional (*oblast*) and district (*rayon*) health departments. In this way, Kyrgyzstan and the Republic of Moldova were able to implement important reforms, including the family medicine model and a single-payer system, ensuring a more equitable allocation of resources.<sup>1</sup>

In other countries, such as the Russian Federation and Uzbekistan, large scale decentralisation has weakened the power of Ministries of Health, and key responsibilities over the health system have been dispersed among multiple actors without clarity over roles and accountability. Where Soviet health care structures were largely maintained, such as in Belarus, Ukraine and Azerbaijan, the Ministries of Health continue to set norms, but in the absence of political will and support from Ministries of Finance, fundamental primary care reforms were not achieved.

Privatisation, heavy public budget cuts and decentralisation, as seen in Georgia and Armenia, have functionally disintegrated

the primary care network, despite financial assistance by donor agencies such as USAID and the World Bank. These countries show that donations to improve the infrastructure of health care alone may not be a strong enough stimulus to change health care systems.

### Primary care infrastructure

From the Semashko system, FSU inherited relatively dense networks of primary health care facilities, though severely underfunded, and basic in rural areas. As resource allocation in these countries still prioritises secondary and tertiary care, the development of primary care is hampered. Indeed, many polyclinics have been refurbished, but their underlying operating principles have remained largely unchanged: normally patients are first seen by a primary care internist (*terapevt*) who acts as a dispatcher who often dispatches patients to specialists within the same polyclinic, instead of treating them at the primary care level.

The old polyclinic system in urban areas has been substantially remodelled only in Georgia, Kyrgyzstan and the Republic of Moldova. In Uzbekistan, it is expected that specialists in polyclinics be replaced by general practitioners (GPs) (see the article by Ahmedov et al. in this issue). Belarus and the Russian Federation provide examples of positive change that was only partially rolled out. The Belarusian *Programme for the Revival and Development of Rural Areas* has successfully improved the condition of rural general practices, but the model of delivering primary care in cities has remained unchanged. In the Russian Federation, due to political tensions between regional authorities and variation in reform processes, the situation is extremely heterogeneous. Some richer republics and autonomous territories have introduced family medicine, while others suffer from highly fragmented and outdated systems.

The countries of the FSU were endowed with an emphasis on secondary care. This has led to lasting challenges in provision of adequate care to the rural population. Part of the reforms towards the family medicine model has been an

effort to reduce utilisation of hospital and specialist services, thereby increasing the technical efficiency of health systems, providing better access to the population, and improving the equity of health service provision.<sup>2</sup> However, as the secondary and tertiary care sectors have more lobbying power, realising these objectives continues to be a challenge.

The inherited vertical health programmes and parallel health systems have posed additional obstacles to the implementation of the family medicine model. In some countries, such as Belarus, parallel health services are gradually being absorbed into the health system while in others, such as Armenia and Georgia, they have been turned into private hospitals. In Ukraine and the Central Asian countries, parallel systems have remained largely in place. Parallel systems often prevent integrated care at the primary care level for family planning as well as maternal and child health. The lack of a holistic approach to primary care also prevents risk factor management for chronic and non-communicable diseases,<sup>3</sup> including advice on lifestyle issues related to alcohol, diet, tobacco, and exercise.

In contrast to the other FSU countries, the Republic of Moldova and Kyrgyzstan have transformed the old primary care structures into family medicine centres in both rural and urban areas, and have substantially remodelled the polyclinic system, at least nominally introducing a gatekeeping function to primary care. Furthermore, both countries have developed quality assurance mechanisms, offered patients a choice of physicians, and introduced capitation-based financing via a single mandatory health insurance fund. International donors have played a major supporting role to the national governments in facilitating these changes.

Nevertheless, challenges remain also in these two ‘model countries’. In the Republic of Moldova, the range of services provided at each level has not changed fundamentally and self-referrals may still occur when patients take on the full financial burden of specialist care, or within some specific diseases. Given the incomplete insurance coverage and the limited benefits packages, self-referrals in

the Republic of Moldova and Kyrgyzstan do not necessarily cost uninsured patients more than GP referrals.

### Primary care staff

Primary health care facilities in rural areas in particular struggle to attract and retain health workers. Higher salaries of primary health care staff in Kazakhstan not only facilitate staff retention but also attract staff from neighbouring countries, like Kyrgyzstan. The Russian Federation has also benefited from one-way flows of medical staff from the poorer Central Asian countries. Furthermore, the preference of medical professionals to work in cities leaves rural facilities understaffed. The Soviet Union used to maintain the availability of primary care in rural areas through the obligatory placement (*raspredelenie*) of new graduates in posts throughout the country. While the 1990s saw the abolition of obligatory placements, a few countries (Kazakhstan, the Republic of Moldova, the Russian Federation and Tajikistan) have introduced financial incentives to attract and retain health workers to rural areas.

Under the Semashko system, primary care doctors (*terapevty*) had a low status: they were poorly paid, had access only to limited equipment or medicines, and little influence on organisational matters.

The status of GPs and family medicine is still generally low, despite salary increases that may match or surpass specialist salaries. Patients' trust in GPs and the perception of primary care quality are relatively low, and they resist restrictions on their choice.<sup>24</sup> Specialist physicians have also opposed the strengthening of family medicine, for fear of a decline within their professional domain. Partly related to this, family medicine has often not been acknowledged as an academic discipline and many countries still lack research, journals and specialised institutions for family medicine.<sup>25</sup> Again, Kyrgyzstan and the Republic of Moldova differ in this respect. In Kyrgyzstan, professionals have been involved in the design of health care reforms, and in the Republic of Moldova most family doctors have currently been retrained.<sup>26</sup> In most other countries, GPs work 'de facto' as

family doctors only in rural areas, where physical access to primary care is better than to specialist care. Time and continued education will be needed to train a large enough cadre of GPs and nurses who can sustain a health care system based on the family medicine model.

### Primary care financing

New funding arrangements and external financial aid have played a large role in the success of health system reform. Some countries have had comparatively little involvement from international partners: in some cases because they are relatively wealthy (Russian Federation and Kazakhstan), in other cases (Belarus, Turkmenistan and Uzbekistan) because donors have been reluctant to work with these governments.<sup>27</sup> In contrast, Kyrgyzstan and the Republic of Moldova have been recipients of large international and bilateral donations. In both countries, external resources accounted for around 10% of total health expenditure in 2012. While they are not the only countries to have received such funds (see Armenia, Tajikistan and Georgia), only Kyrgyzstan and the Republic of Moldova accepted external influence on reform processes and donors were able to contribute to a successful 'whole-system' health care reform. In Kyrgyzstan, this development has been largely attributed to the relatively fast democratisation after independence.<sup>28</sup> In other countries, external donor support has mainly been limited to improvement of the health system infrastructure.

“  
professionals  
involved in health  
care reforms

Financial barriers to accessing primary care in FSU countries have emerged in both formal and informal out-of-pocket (OOP) payments. OOP payments can make primary care less attractive to patients and in some countries the major mode of funding of primary care is through

OOP spending (e.g. Armenia, Azerbaijan, Georgia and Tajikistan). As a result, patients circumvent primary care in order to avoid associated costs by self-referring to medical specialists. A split between purchaser and provider was introduced in six countries (Armenia, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova and Russian Federation) as a means to create incentives for health professionals to provide better quality care and to retain patients at the primary care level if possible.

### Conclusion

The remaining gaps in access to high quality primary care in many FSU countries, in part, result from monetary support for primary care lagging behind rhetoric. Indeed, at least some aspects of family medicine have been implemented, but most of these countries still struggle with incomplete or fragmented primary care reforms. The lack of governmental effectiveness, coupled with lack of political will has created a situation where more fundamental and far-reaching reforms have not been realised. An additional consideration may be the declining importance of the region in the eyes of the international community or a loss of momentum after 25 years of reforms.

The full implementation of the family medicine model will not be achieved without more clearly defined levels of care and responsibilities. It is important to note that many of these health care systems are in low-income countries and their poor infrastructure reflects a general lack of resources, rather than a specific primary care problem. The lack of resources has been an obstacle in developing populations' trust in primary care, particularly when secondary and tertiary care facilities are often in better physical condition, better equipped and better staffed. The rural population suffers disproportionately from their lack of access to secondary care, and rural health care staff are often compelled to deliver services beyond their level of training.

The substantial private OOP payments (both formal and informal) in many of these countries mean that neither old

funding mechanisms (where staff are state employees such as in Azerbaijan, Belarus, Tajikistan, Turkmenistan, Ukraine and Uzbekistan), nor reformed mechanisms (where staff are contracted by insurance companies, such as in Kyrgyzstan, the Republic of Moldova and Russian Federation, or state health agencies in Armenia, Georgia and Kazakhstan) capture the full picture of how health services are purchased. Patients who self-refer and bear the cost of specialist treatment illustrate that legal and financing reforms alone have not been sufficient to change the health-seeking behaviours of patients. These may be rooted in beliefs stemming from the Soviet era rather than the result of comparison. Investment in high quality primary care coupled with public campaigns can help to change attitudes towards primary care. In order to strengthen primary health care in the region, a shift of human and financial resources away from secondary and tertiary care will be needed. Countries will have to invest in training staff and reforming medical education, including continuing medical education.

On the whole, primary care systems in most FSU countries are not yet in a position to provide the bulk of health services that are normally included in

a fully operational family medicine model. Governments seeking a more fundamental reform of primary care could learn from positive experiences in Kyrgyzstan and the Republic of Moldova.

## References

Note: This article draws on numerous resources, not all of which could be referenced below. In particular we would like to acknowledge our indebtedness to the authors of the *Health Systems in Transition* series published regularly by the European Observatory, as well as the NIVEL evaluations of primary health services in six of the twelve countries under review. We have also drawn on chapters from the recently published book *Trends in health systems in the former Soviet Union*.<sup>1</sup>

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## HiT on Uzbekistan

**By:** M Ahmedov, R Azimov, Z Mutalova, S Huseynov, E Tsoyi, B Rechel

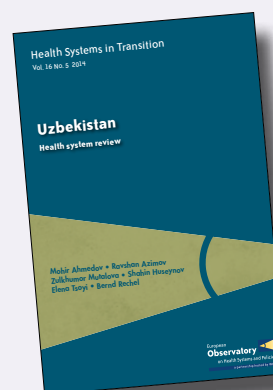
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Since the country's independence in 1991, Uzbekistan has embarked on several major health reforms, which included changes to health financing and the primary health care system. The country has also retained some features of the Soviet period, as most health care providers are still publicly owned and administered and health workers are government employees.

Health expenditure is comparatively low when compared to the rest of the WHO European Region. The government has increased public expenditure on health in recent years, but private expenditure in the form of out-of-pocket payments remains substantial. The government has implemented a basic benefits package, but, for most people, this does not include secondary or tertiary care and outpatient pharmaceuticals.



This new health system review (HiT) on Uzbekistan examines the changes and reforms that have taken place and the challenges that still remain.



# CHALLENGES IN SPECIALISED AND INPATIENT SERVICES IN FORMER SOVIET COUNTRIES

By: Ketevan Glonti

**Summary:** Post-Soviet countries inherited health systems in which hospitals dominated the provision of care. All countries embarked upon plans to improve management, quality and access to specialised and inpatient services, encountering various noteworthy successes but also challenges: attempts to reduce excess hospital capacity did not necessarily reflect actual need; lengths of stay tend to be longer than necessary; and hospitals have limited autonomy in managerial decision-making. Obstacles to improving quality often remain, including lack of appropriate hospital equipment or evidence-based medical practice. The financial burden on patients due to growing out-of-pocket payments also poses another barrier to accessing hospital care.

**Keywords:** *Hospitals, Inpatient Services, Quality, Access, Former Soviet Union*

## Introduction

This article explores specialised and inpatient services in twelve countries that emerged from the former Soviet Union: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russia Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan. It draws on a recent study on health system trends in the former Soviet countries.<sup>1</sup>

During the Soviet era, the Soviet government had placed a heavy emphasis on quantitative targets based on inputs, leading to the building of more hospitals and the training of more medical personnel.<sup>2</sup> Hospital budgets were mostly determined by existing bed capacity and staff levels, creating incentives to maintain

or increase both. Most health resources, accounting for about 60–75% of total health expenditure, were designated for inpatient services. In the long run, this resulted in the Soviet Union having one of the highest numbers of physicians and hospital beds per population.<sup>3,4</sup> At the same time, the health system was chronically underfunded, resulting in low salaries for health workers and a general lack of medications.<sup>5</sup>

Health services were provided across a number of administrative tiers, from the national to the regional (oblast), city and district (*rayon*) level. These were often funded from separate budgets, leading to the duplication of functional responsibilities and overlapping population coverage.<sup>6</sup> Yet another differentiation

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among hospitals was by patient occupation or other characteristics. A closed parallel health system for the so-called ‘elites’ existed, in which a small number of hospitals under the responsibility of various ministries and state companies received a disproportionate share of health funding and could offer more modern equipment, better paid staff and, potentially, higher quality of care.

“  
specialised  
hospitals  
remained largely  
unaffected  
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The provision of emergency care consisted of two elements. Basic emergency care on site or at home was the function of the ambulance system, while more sophisticated emergency care requiring health facilities was provided by almost all hospitals. Ambulances were generally staffed by a driver and at least one health professional. Whenever possible, the emergency care needs of the patient were addressed on the spot, but if needed, the patient was transported to an inpatient facility for further care. In rural areas, rural hospitals, district hospitals or central district hospitals were the primary location for more sophisticated services.

Following the dissolution of the Soviet Union, all post-Soviet countries inherited an extensive hospital-based system. It became increasingly hard to sustain when government revenues collapsed during the crisis that accompanied transition in the 1990s, triggering wide-ranging changes in the organisation, service provision, financing and ownership of hospitals. Many countries recognised the need to downsize their hospital sectors and strengthen the previously neglected primary health care system. However, reductions in hospital capacity were often only nominal or affected only small rural facilities, rather than large well-equipped

hospitals in urban areas. Most hospitals remained in state ownership, with the exception of Georgia where the majority of health facilities were privatised. Despite various changes, the quality of services remains a challenge and geographical and financial access is a problem for some groups of the population across all countries.

### The legacy of infrastructure

Some of the former Soviet countries reduced their excess hospital capacity in the 1990s, but the reductions in acute care hospital bed numbers did not necessarily reflect actual needs. In urban areas, the number of hospital beds was often reduced without being accompanied by the downsizing or closure of facilities; whereas, specialised hospitals remained largely unaffected by health reforms.<sup>9</sup> In parallel to the drop in acute care hospital bed numbers, the average length of stay (ALOS) in acute care hospitals generally decreased. However, the rate also differs substantially among the countries. Patients in Georgia have a significantly lower ALOS than patients in Western Europe. This decreasing trend can also be observed in Armenia. Possible reasons for this could lie in the privatisation of services, resulting in increased hospital stay costs for patients.

In the remaining countries, patients still tend to stay much longer in acute care hospitals compared to the EU, with the longest stay in Russia. Reasons for this might include outdated clinical protocols and financial incentives for hospitals that reward lengthy patient stays. While decreasing lengths of stay might suggest an increasingly efficient use of hospital resources, bed occupancy rates in several countries are very low, indicating substantial scope for further improvements.

### Organisation and provision

During the Soviet period hospitals were vertically organised into tiers, mirroring the public administrative system. At the lowest level were rural or village hospitals, with district (*rayon*) hospitals in larger towns. City hospitals and regional (*oblast*) hospitals comprised the next two levels,

while national (tertiary care) hospitals were at the highest administrative level. Specialist hospitals also operated at district, regional and national levels. In addition, parallel health systems provided services in their own hospitals.<sup>10</sup> Although some countries have made alterations to this organisational structure, the general setup has remained largely in place, particularly in urban areas. However, some differences exist in the way former Soviet countries have organised their administrative and health systems. The merging of administrative levels, the introduction of intermediate levels and the removal of others has resulted in distinct national systems, making attempts to broadly categorise current setups difficult.

For the most part, countries have retained public ownership of secondary and tertiary care facilities. While there are no privately owned hospitals in Turkmenistan and Belarus, in Belarus diagnostic centres are a significant part of private sector activities in the health system. Other countries, such as Kyrgyzstan, Ukraine, Republic of Moldova and Tajikistan have only a few private hospitals. However, in contrast, almost all health facilities in Georgia have been privatised. This seems also to be the new direction in Armenia, where health care is being increasingly privatised.<sup>9, 10, 11</sup>

In some countries, the governance and management of public hospitals have not changed greatly since the Soviet period and are characterised by a strict hierarchical structure. For example, in Tajikistan and Uzbekistan, hospitals are still managed by head physicians, while in Belarus and Ukraine, where Soviet structures are also still largely in place, individual hospitals have very limited autonomy in managerial and financial decision-making. In other countries of the region, such as Kazakhstan, however, attempts were made to increase the managerial autonomy of hospitals; for example by granting hospitals a new legal status and allowing the use of extra-budgetary funds.

### Obstacles to improving quality

All countries of the region have embarked on plans to improve the quality of hospital

and specialised care, but major challenges remain. There is no tradition of evidence-based medical practice, and a dearth of legal or administrative mechanisms to support its implementation. In some countries, such as Tajikistan, treatment protocols and guidelines are either missing or generally outdated, resulting in inappropriate hospital admissions and too long lengths of stay. This highlights the common practice of keeping patients in hospitals for the wrong reasons. A systematic observational assessment of hospital care for children carried out in the Russian Federation, Republic of Moldova and Kazakhstan reported unnecessary and lengthy hospital stays, with most children receiving excessive and ineffective treatment. In some countries of the region, patients are up to ten times more likely to be hospitalised for hypertension than in OECD countries, a condition that is best treated in primary health care.<sup>12</sup>

Another common challenge is that most health workers have little or no access to up-to-date international literature or opportunities for continuous medical education (CME) such as through attending conferences.<sup>13</sup> A survey in 2011 found that only about 30% of hospital doctors in Tajikistan would correctly diagnose a heart attack and only 38% had received any kind of CME in the preceding twelve months. This share, at 40%, was only marginally better among hospital doctors in the Kirov region in the Russian Federation.<sup>14</sup>

In addition, many hospitals and other health facilities are poorly equipped, following years of underinvestment. Other issues of concern include the emigration of health workers to other countries, resulting in a “brain drain” from the poorer countries of the region, particularly Kyrgyzstan and Tajikistan, as well as difficulties in assessing the quality of health services, as the necessary data for standard indicators are not routinely collected or made available. As a rule, quality assurance mechanisms are underdeveloped. In a survey conducted in 2011, only an average of 65% of hospitals in Armenia, Georgia, the Russian Federation (Kirov region) and Tajikistan had a committee to oversee quality of care. An even more extreme case is Georgia,

which, in contrast to other former Soviet countries, has liberalised its minimum standards for health service provision and certification regulations, resulting in significant changes to the licensing of medical facilities and the certification of medical personnel.

There are also problems with the quality of emergency care. Pre-hospital and in-hospital emergency services tend to fall behind internationally accepted standards in terms of the skills of personnel and the available equipment and supplies. Challenges in many countries include a lack of adequate communication technologies, the inappropriate location of ambulance units, outdated technical equipment, a shortage of ambulance vehicles and the resources to maintain them, low salaries and high staff turnover. Emergency posts often have poorly maintained ambulances or insufficient vehicles to cope with the work load. They also experience fuel shortages, and a lack of medicines. In an emergency, patients may have to be transported for long distances, as was noted in Kazakhstan.<sup>15</sup>

### The need to improve access

Two main barriers to accessing hospital and specialised services have emerged in the former Soviet countries: geographical and financial barriers. The closure of rural hospitals has, in some countries, exacerbated problems in accessing hospital care for people living in rural areas. This is particularly a concern, especially with regard to emergency care, in countries with vast territories and low population densities (Russian Federation and Kazakhstan) or those with mountainous terrains (Kyrgyzstan and Tajikistan). Rural areas are often disadvantaged in terms of life-saving equipment (including ambulance vehicles) and modern communication technologies.

Financial access has deteriorated as a result of growing out-of-pocket payments (both formal and informal) by patients. These payments are more common for inpatient care, where services and pharmaceuticals should generally be provided free-of-charge. Hospitalisation has thus become a major – and sometimes “catastrophic” –

expenditure for many households, which can lead to impoverishment and greater social inequalities. In some countries, such as Tajikistan, it is common for patients’ families to take on the nursing responsibilities of bathing and feeding their hospitalised family members. Food and other items such as bed linen are also commonly provided in many countries by patients and their family members.<sup>16</sup>

### Conclusion

Despite various reforms, the Soviet legacy persists in many countries, with disproportionately large infrastructure and outdated organisation and provision of hospital services. This entails a waste of resources and perverse incentives for hospitals and health workers. Reductions in hospital capacity have often shied away from politically contested hospital closures in urban areas and have not necessarily reflected the actual needs of the population. The quality of services and their accessibility are other issues of concern that will have to be addressed in future reforms.

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# ACCESS TO MEDICINES IN THE FORMER SOVIET UNION

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By: Erica Richardson, Nina Sautenkova and Ganna Bolokhovets

**Summary:** Rapid liberalisation of pharmaceutical markets following the collapse of the Soviet Union helped to address supply problems which had caused severe shortages in the early 1990s. However, this was accompanied by concomitant price increases which have served to limit financial access to medicines as across the region most outpatient medicines are purchased out-of-pocket. Policy responses have sought to encourage the rational use of medicines through initiatives such as evidence-based prescribing and generic substitution. However, while regulation of the pharmaceutical sector is weak and there is widespread distrust of generics, implementing rational prescribing policies will face significant challenges.

**Keywords:** Access to Medicines, Essential Medicines Lists (EMLs), Affordability, FSU Countries

## Introduction

In the Soviet Union access to medicines was limited by local production capacity and substantial imports were needed to meet the needs of the population. The range of medicines available in pharmacies was limited and there were frequent shortages, but prices were fixed at a comparatively low level. Outpatient medicines were available free of charge to vulnerable or high priority groups (such as pregnant women) and were free to all inpatients.

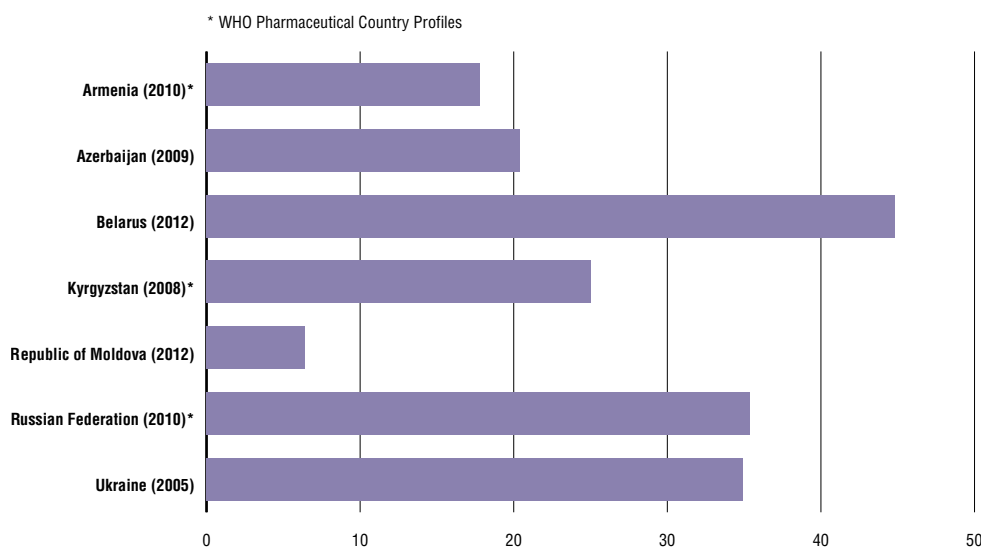
Following the collapse of the Soviet Union, disrupted supply chains initially led to severe shortages of essential medicines. The early 1990s saw the swift

liberalisation of the pharmaceutical market across the territory of the former Soviet Union (FSU) and this helped to address supply problems, but access was now limited by the patient's ability to pay the new market price as opposed to the strictly controlled prices under the previous system. The formal exclusion of outpatient pharmaceuticals from full cover in the Soviet-era benefits package was retained in the post-Soviet period, although with exceptions for some population or patient groups. Not only was this easier politically, but public expenditure on health was cut in the face of severe fiscal constraints.

The combination of high prices of pharmaceuticals and the increasing burden

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**Figure 1: Public pharmaceutical expenditure as % of total pharmaceutical expenditure, latest available year**



Sources: [2] [3]

of chronic diseases means that access to outpatient pharmaceuticals and the related burden of out-of-pocket (OOP) spending have subsequently become some of the most pressing health policy issues in all former Soviet countries.<sup>[1]</sup>

### Access to medicines

When compared to the Soviet era, the availability of pharmaceuticals has improved drastically in all countries of the FSU, particularly in terms of the range of drugs now available on the market. However, this improved availability is largely confined to urban areas and community pharmacies are often better stocked than hospital pharmacies. Consequently, there are significant geographical disparities in access to pharmaceuticals, as well as logistical barriers to obtaining medicines that are nominally covered in public benefits packages. Currently, in countries of the FSU, patients have very little financial protection from the high prices of medicines. Generally, only a few population groups (such as veterans and pregnant women) receive at least some help in purchasing a comprehensive range of outpatient pharmaceuticals.

The depth of coverage under different benefits packages varies among and within countries and by eligibility. For

example, in Belarus veterans are covered for 100% of the fixed price, while other categories of patients are expected to co-pay a variable percentage of the fixed price. In Kyrgyzstan and the Republic of Moldova, the benefits package only covers reimbursement of a very limited number of outpatient medicines. In different countries, restrictions over which pharmacies are allowed to dispense medicines under government schemes can also mean that not all drugs are available at all times, and in these cases patients or their families still need to purchase them OOP even if they are formally eligible for free or subsidised medicines. Across the FSU, the same is true of the narrow ranges of outpatient medicines for certain conditions which are theoretically covered for the whole population. This usually includes treatment for HIV infection, tuberculosis, epilepsy, certain psychiatric conditions, asthma and diabetes. Particularly rare or expensive conditions may also be included, for example haemophilia and post-transplant care. However, the range of medicines that can be reimbursed or subsidised for specified conditions tends to be limited and, while the treatment for the specific condition may be covered, co-morbidities or complications rarely are.

For population groups and conditions not included in statutory benefits

packages, the full costs of outpatient pharmaceuticals have to be paid for OOP by patients. Indeed, in FSU countries the overwhelming majority of outpatient pharmaceuticals are not covered by government-guaranteed benefits packages and the publicly financed share of total pharmaceutical expenditure is low across the region (see Figure 1). Government subsidies and reimbursement mechanisms only affect pharmaceuticals purchased with a prescription and often only cover cheaper generics. If patients want brand name drugs, they have to pay the full price themselves.

Shortages of pharmaceuticals also occur in hospitals, often as a result of underfunding, weak procurement capacity and a lack of transparency in procurement procedures. Inpatients (or their relatives) often need to purchase drugs at full price from private pharmacies to take into hospital, even though officially in all countries of the region inpatient pharmaceuticals are included in benefits packages. Sometimes inpatients also choose to purchase their own pharmaceuticals because they believe them to be of higher quality than those dispensed in hospital. In 2010, it was estimated that, be it by choice or necessity, 80% of inpatients had to pay part of the costs of their medicines in the Russian Federation.<sup>[2]</sup> In 2011, 62.7% of hospital inpatients in the Republic of Moldova reported buying their own medicines because the hospital was incapable of providing all the medicines necessary for treatment.<sup>[3]</sup>

“preference for newer and more expensive drugs”

As a consequence, pharmaceutical costs dominate OOP payments throughout the region, posing a major threat to financial equity and access.<sup>[4]</sup> There is evidence that pharmaceutical costs still constitute a major barrier to care and that patients forego necessary treatment

as a result.<sup>8</sup> In rural areas, recourse to traditional remedies is also commonplace in some countries, particularly Kyrgyzstan and the Republic of Moldova.<sup>9</sup>

### Rational use of medicines

Relative to other countries in the European region, medicines are expensive across the FSU and this contributes to the burden of household pharmaceutical spending. The pharmaceutical sector in all countries of the region is highly profitable and profit margins are generous, even in those countries that have adopted policies to control prices. Essential medicines lists (EMLs), which support and encourage the use of generics, are in place or under development in all countries of the FSU. These should guide and support the rational use of pharmaceuticals. Alongside clinical efficacy and public health impact, the main consideration when deciding which medicines should be included in the EML is affordability. However, implementation of EMLs varies; selection procedures are not always consistent, evidence-based or transparent. Across the region, not all pharmacies carry the full stock of drugs on the EML and the EML it is not always used to inform selection procedures in pharmacies, although a wide range of other 'off list' drugs are stocked.<sup>11</sup>

Across the region, measures to influence the behaviour of those prescribing or dispensing pharmaceuticals do not yet sufficiently promote the most cost-effective use of pharmaceuticals. There are strong incentives for doctors to over-prescribe and there is a preference among both doctors and pharmacists for newer and more expensive drugs, as these are perceived to be safer and more effective than well-established generics. This belief is often shared by patients, as is the preference for brand-names. The substitution of brand-name pharmaceuticals with generics continues to be challenging in many countries. For example, prescribing policies in the Republic of Moldova require doctors to use generic names on prescriptions and in theory a dispensing pharmacist needs to obtain permission to substitute this with a brand-name product. However, in practice, this is decided between the pharmacist and the patient without the doctor's knowledge.

In Georgia, even when the prescription uses the generic name, pharmacies have incentives to dispense brand-name medicines and doctors are similarly incentivised to use brand names when prescribing because they are paid bonuses by pharmaceutical companies based on the medicines they prescribe.<sup>12</sup> Consequently, even where prescribing studies show a high level of generic prescription, about 70% in Kyrgyzstan and Tajikistan,<sup>10</sup> it does not necessarily follow that generics will be dispensed.

The weak enforcement of prescription-only rules also acts as a barrier to the rational use of medicines. In theory, there is a strict delineation between those pharmaceuticals that are available over-the-counter (OTC) and those that are available on prescription only. However, in practice this distinction is only strictly enforced for narcotics, psychotropics and their precursors. The easy availability of first- and second-line antibiotics for the treatment of tuberculosis, for example, has been identified as a serious obstacle for the control of multiple drug resistance in this disease.<sup>13</sup> Restricting OTC access to antibiotics and other medicines by enforcing prescription-only rules has been attempted in most countries of the region, but has not yet been fully enforced anywhere, partly because there is little support for such restrictions among patients and pharmacists. However, OTC access (at a price) to almost all pharmaceuticals means that potentially a significant proportion of household budget expenditure is spent on ineffective and possibly dangerous use of pharmaceuticals. It also greatly limits the scope for influencing prescribing patterns and generic substitution.

Medicines are marketed directly to the general public through all media channels, although there are strict restrictions on the advertising of prescription-only medicines to non-specialist audiences. While direct marketing to doctors can lead to distorted prescribing practices, it is also an important source of continuing professional development, because many physicians would otherwise have no way of updating their knowledge or attending international conferences. Nevertheless, illegal, "kick-back" payments to doctors

are not strictly controlled. Research in the Republic of Moldova has shown that this had a negative impact on patients' trust in primary care physicians, because patients were well aware of the bonuses doctors received for prescribing certain products.<sup>12</sup> In Tajikistan it has been found that payments from pharmaceuticals companies are the only 'perk' keeping many general practitioners in the profession.<sup>13</sup>

### Conclusion

This article has described significant progress in physical access to medicines in post-Soviet countries, but also a number of challenges remain. Financial access is a problem throughout the region, as patients have to shoulder much of the financial burden of paying for medicines themselves. Furthermore, there continues to be a reliance on more expensive brand-name pharmaceuticals. In low-income countries like Kyrgyzstan and Tajikistan, where generics dominate the market and generic prescribing is heavily promoted, generic prescribing is high; it is also higher in countries where the state bears more of the cost of paying for pharmaceuticals. Nevertheless, implementing rational prescribing policies in an environment where most drugs can simply be purchased without a prescription OTC is another significant challenge. The weak regulation of pharmaceutical marketing also contributes significantly to the irrational use of medicines. Consequently, although rational prescribing policies usually envisage informing primary care doctors, there is also a need for patient information, as well as incentives to reduce self-treatment which can lead to the harmful overconsumption of pharmaceuticals.

It has also proved difficult to encourage generic substitution in the region, at least in part because patients, pharmacists and doctors perceive brand-named pharmaceuticals to be of better quality. While this is by no means unique to the region, weak regulation of the pharmaceuticals sector throughout the FSU has contributed not only to this lack of trust in generics, but also to the distrust of rational prescribing policies. It will be interesting to see whether the attempts to build national pharmaceutical capacity

in line with good manufacturing practice (GMP) standards will help in fostering public trust, as well as ensuring access to pharmaceuticals by reducing the exposure of pharmaceutical prices to volatile currency markets.

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## HiT on Ukraine

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Since Ukraine gained independence from the USSR in 1991, successive governments have struggled to overcome funding shortfalls and modernise the health care system to meet the population's health needs. Life expectancy in Ukraine in 2012 was low by European standards (66.2 years for men and 76.2 years for women) and it was estimated that a quarter of all premature deaths in 2004 could have been avoided with timely access to effective treatment.

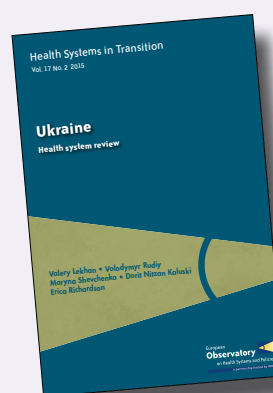
No fundamental reform of the Ukrainian health system has been implemented and consequently it has preserved the main characteristics of the Soviet Semashko model, but with a large proportion of total health expenditure being paid out of pocket (42.3% in 2012). Ukraine has a very extensive health

infrastructure and incentives in the system favour inpatient over primary care.

The most recent health reform programme began in 2010 and sought to strengthen primary and emergency care, rationalise

hospitals and change the model of health care financing from one based on inputs to one based on outputs. Conflict and political instability meant the programme was abandoned in 2014. More recently, the focus has been on more pressing humanitarian concerns as more than 1 million people have been displaced by the ongoing conflict. It is hoped that greater political, social and economic stability will provide a conducive environment for

addressing shortcomings in the Ukrainian health system, but also that these reforms will also draw on the best available international evidence of what works to promote equity, quality and efficiency.



# REFORMING THE UKRAINIAN HEALTH SYSTEM AT A TIME OF CRISIS

By: Valeria Lekhan, Dorit Nitzan Kaluski, Elke Jakubowski and Erica Richardson

**Summary:** Ukraine has retained the extensive Semashko model health care system it inherited on gaining independence from the Soviet Union in 1991 and it is largely unreformed. A large proportion of total health expenditure is paid out of pocket (42.8% in 2013) and households face inadequate protection from impoverishing and catastrophic health care costs. These weaknesses have been exacerbated by the strain of caring for conflict-affected populations since 2014. The government faces the challenge of implementing fundamental reform in the health care system to rebuild universal health coverage against a background of resource constraints and ongoing conflict.

**Keywords:** Universal Health Coverage, Health System Reform, Internally Displaced Persons, Ukraine

## Introduction

Ukraine gained independence from the Soviet Union in 1991 and successive governments have struggled to overcome funding shortfalls and modernise the health care system to meet the population's health needs. The system retains many of the core features of the Semashko model health system, with an extensive infrastructure and a strong bias in the system towards inpatient care. This has meant that most resources are spent on running costs for health infrastructure rather than on patient care, and primary care has remained weak.<sup>1</sup> However, the main strength of the Semashko system – universal health coverage – has been lost and health care in Ukraine is now inaccessible to many. Overall, access

to health care has improved across the former Soviet Union since the turmoil of the 1990s, but in Ukraine it has worsened.<sup>2</sup>

Chronic underfunding has allowed the gap to widen between the Constitutional promise of universal coverage and the reality of what is provided for free at the point of use. Formal salaries for health workers are extremely low and this, with the absence of sustainable health financing, has resulted in a plethora of formal, quasi-formal and informal payments in the system. A large proportion of total health expenditure is paid out of pocket (42.8% in 2013) and households face inadequate protection from impoverishing and catastrophic health care costs, particularly if they have chronic conditions. Most out of

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pocket payments are to cover outpatient pharmaceutical costs, which is why people with chronic conditions are so severely affected.

“5 million people are affected by the humanitarian crisis in Eastern Ukraine

Successive Ukrainian governments have struggled to raise sufficient revenues to cover the full cost of the extensive social spending commitments guaranteed by the Constitution. Rapid marketisation and hyperinflation following independence from the Soviet Union in 1991 caused severe socioeconomic hardship and, while there was some stabilisation in the economy from 2000 and even growth from 2003–2004 and 2006–2007, the global economic downturn has hit the Ukrainian economy hard and the country has not recovered. By the end of 2012, Ukraine was back in recession due to a poor harvest and lower than expected demand for steel which is a key Ukrainian export. The conflict in the east of Ukraine has also had a negative impact on the economy. Early in 2015, the Ukrainian government approached the International Monetary Fund (IMF) for an emergency loan to prop up the beleaguered economy. The IMF agreed, but with certain conditions, including a requirement for Ukraine to reform government services. Due to the crisis, the government has made cuts across the government budget, including to funding for the health system.

### Overview of the system

The Ukrainian health system is tax-funded from national and regional budgets, and voluntary health insurance plays a very minor role in health care financing. There has been considerable decentralisation in the system since independence; however, in most other respects, the system

remains largely unreformed. Allocations and payments are made according to strict line-item budgeting procedures as under the Semashko system. This means payments are related to the capacity and staffing levels of individual facilities (inputs) rather than to the volume or quality of services provided (outputs).

The bulk of government expenditure (52% in 2012) pays for inpatient medical services, with only a relatively small proportion going to outpatient services and public health. Ukraine has an extensive health care infrastructure despite a rapid reduction in the number of beds in 1995–1998 in response to a severe fiscal crisis. Reductions in the number of hospitals were achieved largely by closing rural facilities rather than rationalisation of provision in urban areas. Ukraine has also retained a large number of facilities in parallel health systems. The number of acute care hospital beds in Ukraine is high by international standards but despite this, operating indicators show that utilisation remains quite high and, once admitted, patients on average stay for ten days. The high utilisation and long length of stay highlight the inefficiency of financing hospitals based on their capacity. Research has shown that almost a third (32.9%) of hospitalisations in Ukraine are unnecessary.<sup>1</sup> Consequently, operating indicators remain high despite the development of day care and other schemes that could potentially substitute inpatient care.

Traditionally, primary health care in Ukraine has been provided within an integrated system by therapeutic specialists – district internists and paediatricians employed by state polyclinics. In 2000, the transition to a new model of primary care based on the principles of family medicine began. Family doctors/general practitioners (GPs) now make up more than half (57.2%) of all primary care physicians; they work at family medicine polyclinics or in appropriate polyclinic departments. Some movement towards reforming the health system started in 2010, but lacked overall strategic planning and implementation.

### Recent changes

While no fundamental reforms of health system financing have yet taken place, various changes have been initiated and sometimes realised since independence; the most recent package of reforms were introduced from 2010. Three phases of the reforms were to be implemented through a World Bank funded project in a few selected regions (oblasts) over a four-year period (2010–2014). They started with changes to health financing mechanisms which sought to reduce fragmentation in funding flows, prioritise primary care and strengthen emergency services. Phase two was to pilot the programme in four regions (Donetsk, Dnipropetrovsk, Vinnitsya regions and Kyiv city), where provider payment systems would be based on outputs rather than inputs, i.e. the volume of services provided rather than capacity criteria such as bed numbers or staffing levels. In phase three, the pilot regions were then due to deepen the reforms, and the successes would be rolled out nationwide, but these plans were not fully implemented, and so did not impact on the health system and did not result in fundamental reform. The political and humanitarian situation from late 2013 has made it even harder to continue. By 2014, these reform projects were abandoned.

Useful lessons have emerged from this most recent reform effort, particularly around the importance of communication strategies to explain why such changes were being made.<sup>2</sup> Strengthening primary and emergency care, rationalising hospitals and transforming the model of health care financing are ambitious aims in health care reform, and ones which often face strong resistance from patients and existing power structures. Fundamental issues re-emerged, such as numerous institutional barriers which have hampered reform efforts in the past, including constitutional blocks on reducing the number of state-owned health facilities. However, in this instance, conflict and political instability have proven the greatest barrier to reform implementation. More recently, governments in Ukraine have necessarily concentrated on more pressing humanitarian concerns.

## Conflict and health care

Health services were therefore overstretched even prior to the current crisis in Ukraine, but conflict has increased humanitarian and health-related needs. A severe lack of vaccines, medicines, and medical supplies in the conflict affected territories and the inability to provide services for many of the internally displaced persons (IDPs), their absorbing communities, the wounded and those who reside in fighting zones represent additional burdens. Consequently, WHO, UNICEF, the Red Cross and other health partners are working together to fill the gaps. About 5 million people are directly affected by the humanitarian crisis in Eastern Ukraine. More than 1.2 million IDPs have been registered, of whom about 15% are children and about 60% pensioners. Since mid-April 2014, more than 6,200 people have been killed and more than 15,500 people have been wounded. The conflict is also likely to have increased the mental health needs of the affected population.

It is estimated that 77 out of 350 and 26 out of 250 health care facilities (eg. polyclinics, outpatient departments and hospitals) have been damaged or destroyed in Donetsk and Luhansk regions, respectively. Many clinics and hospitals are closed or only partially operational due to shortages of medicines, medical supplies and personnel. Many have run out of basic supplies such as antibiotics, intravenous fluids, gloves and disinfection tools. Around 1.4 million people require health assistance and primary health care centres and hospitals are struggling to treat the war wounded. Some of the health staff have not been paid, and some have become IDPs; 30–70% of health workers have fled the conflict affected areas or been killed.

WHO has been filling gaps in provision with a network of Mobile Emergency Primary Health Care Units (MEPUs) and Emergency Primary Health Care Posts (EPPs). However, the cities of Donetsk and Luhansk, which have been foci in the conflict, hosted the tertiary level specialised medical services for their respective regional populations. Due to travel and other restrictions on

the movement of people around the two regions, patients who require specialist services cannot access these hospitals.

## Communicable disease control

Communicable diseases are reportedly on the rise in the conflict affected areas, due to economic isolation, deteriorating water and sanitation conditions, and limited access to adequate health services. Ukraine already has the lowest immunisation coverage in Europe – in 2012 only 79.2% of children were inoculated against measles, and only 73.5% of infants were immunised against polio.<sup>2</sup> This was an improvement on previous years (in 2010 just 56.1% were immunised against measles, 57.3% against polio) but was still way below the level required to ensure herd immunity. However, as a result of multiple factors, such as lack of funds, poor forecasting and planning and a general weak national medicines management system, no vaccines have been procured for Ukraine's immunisation programme since the end of 2014. The fact that millions of children have not been fully immunised makes the risk of severe outbreaks of vaccine-preventable diseases extremely high.

A complicating factor in this is that public health services in Ukraine have recently undergone substantial changes. In 2014, the Government abolished the State Sanitary and Epidemiological Services (SES), which was part of the original Semashko model health system and which was there to maintain some basic population health surveillance and health protection functions. The central and regional SES network had a number of problems. These included overcapacity in some areas of health protection and inspection which was determined by a complex institutional network of labs and inefficient, out-dated and duplicated infrastructures; the provision of services to private entities; and a high level of under-recorded for-profit activities. Nevertheless, despite the shortcomings of the SES system, it served as the baseline system enabling the delivery of some essential public health operations in Ukraine, including the monitoring of immunisation programmes. The abolition of the SES has left the country without the ability to

provide essential public health functions that are so needed, especially in times of crisis.

The government requested WHO to provide support in the assessment of essential public health operations to restore their delivery, and which are centred on surveillance, monitoring and emergency response, and health protection. These services need to be restored also in view of deteriorating access to essential medical services, including medicines and vaccines supply and an increasing prevalence and risk of communicable diseases outbreaks and the weak early warning system.

## Conclusion

The Ukrainian Ministry of Health, together with WHO and the donor community, are aware that, paradoxically, the crisis may provide a window of opportunity to steer Ukraine into modernising its health system, in all its functions. For example, there is new impetus for transforming and strengthening disease prevention services to tackle non-communicable diseases alongside other public health functions. The draft Health Strategy for 2015–2020 is one of the documents where this impetus for change is presented.<sup>3</sup> The document also highlights the fragmentation of financial pooling, the inadequate protection of the population from catastrophic health care costs, the strong bias in the system towards inpatient services, the need to rationalise hospital stock, and the need to strengthen primary care and public health services. The Strategy, if adequately planned, could turn into a reform programme which would hopefully bring Ukraine back to the path of universal health coverage. This undertaking is ambitious and will require sustained government commitment with technical and financial support from the international community. It is important to avoid further reductions in state health expenditure, which accounted for a modest 4.2% of GDP in 2013.<sup>4</sup> Improving efficiency, quality and access to health services that are people-centred is a great challenge, even more so at a time of financial, political and humanitarian crisis.

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# CHALLENGES TO UNIVERSAL COVERAGE IN UZBEKISTAN

By: Mohir Ahmedov, Ravshan Azimov, Zulkhumor Mutalova, Shahin Huseynov, Elena Tsoyi, Asmus Hammerich and Bernd Rechel

**Summary:** Health expenditure in Uzbekistan is comparatively low when compared to the rest of the European region. In recent years, the government has increased public expenditure on health, but private expenditure remains substantial, resulting in equity and access problems. The government has implemented a basic benefits package, but for most people this often does not include secondary or tertiary care and outpatient pharmaceuticals. A recent shift towards formal user fees for selected providers of secondary and tertiary care might aggravate problems of financial protection. Future reforms in health financing should aim to extend coverage, reduce duplication, reform payment mechanisms and acknowledge the challenge of informal payments.

**Keywords:** *Uzbekistan, Health System, Financing, Coverage, Financial Protection*

## Introduction

Uzbekistan is a former Soviet country in central Asia that became independent in 1991 with the break-up of the Soviet Union. In 2013, it had a population of 30.2 million, about half of whom lived in rural areas. Its size is similar to that of Sweden and, at 67.5 people per km<sup>2</sup>, it has the highest population density in central Asia. The country has 14 administrative divisions: 12 regions (*viloyats*), one autonomous republic (Karakalpakstan, at the north-western end of the country), and one administrative city, the capital Tashkent. The subordinate local administrative levels are *tumans* (*rayon*

in Russian, district in English) and cities. The state-run health system consists of three distinct hierarchical layers: the national (republican) level, the *viloyat* (regional) level, and the local level made up of rural *tumans* (districts) or cities, with a relatively small private sector.

Uzbekistan faces the double burden of high communicable and non-communicable diseases. Life expectancy at birth in 2012 was recorded in official statistics at 70.7 years for males and 75.5 years for females. However, international estimates (taking account of survey data for infant mortality) are lower,

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suggesting a male life expectancy at birth of 64.8 years and a female life expectancy of 71.5 years.<sup>1</sup> These are some of the lowest estimated life expectancies in the WHO European region.<sup>2</sup>

“an increasing reliance on user fees

### Recent reforms

Since the country's independence, Uzbekistan has embarked on several major health reforms,<sup>3</sup> including in the areas of primary care (initially in rural areas), secondary and tertiary care, and emergency care. Primary care in rural areas has been changed to a two-tiered system (consisting of rural physician posts and outpatient clinics of central district hospitals), while specialised polyclinics in urban areas are being transformed into general polyclinics covering all groups of the urban population. The government has aimed to ensure a more efficient use of resources, scaling back the extensive hospital sector and restructuring the primary health care system, with a gradually increasing role of general practitioners and primary care nurses. There are also efforts to introduce new approaches to maternal and child health, public health, non-communicable disease prevention and control, and monitoring and evaluation. Slowly, new mechanisms for the payment of health care providers are also being introduced, in particular capitation payments for primary health care.

In secondary and tertiary care, capacities have been scaled back and new governance and financing arrangements for pilot tertiary care facilities introduced, which are now expected to fund themselves predominantly through official user fees. Reforms of medical education have also been initiated. Attempts to improve allocative efficiency through increased allocation of resources to primary health care (as opposed to secondary and tertiary

care) are also being undertaken, but there is much scope for further progress. Quality of care is another area that is receiving more attention, with efforts to update treatment protocols and to revise medical education, continuous professional development and quality assurance and improvement frameworks.

Nevertheless, the health system also retains some of the more problematic features of the Soviet period. Payment of hospitals is still largely based on inputs (number of beds and staff) rather than outputs and quality of care. For specialised outpatient and inpatient care, there has been increasing reliance on user fees, but this might have negative repercussions for access to and quality of care.

### Health financing

In terms of health expenditure, Uzbekistan spent an estimated 5.9% of its gross domestic product (GDP) on health in 2012. This compares favourably with the other central Asian countries Kazakhstan, Tajikistan, and Turkmenistan, but was lower than in Kyrgyzstan. The average of the WHO European region in 2012 was 8.3%, and that of the central Asian republics was 5.2%.<sup>4</sup>

Although Uzbekistan is now classified by the World Bank as a lower-middle income country, it is still one of the poorest countries in the European region, so total health expenditure (THE) per capita is comparatively low, amounting to US\$ 221 purchasing power parity (PPP) per capita in 2012, although per capita expenditure was even lower in the neighbouring countries Turkmenistan (209), Kyrgyzstan (175) and Tajikistan (129). Furthermore, there are large variations in per capita government expenditure across the country's regions. Richer regions generally spend more per capita than poorer regions.

In terms of resource generation, slightly more than half of total health financing in Uzbekistan comes from public sources, accounting for 53.1% of THE in 2012, an increase from 44.6% in 2005. Among its central Asian neighbours, only Tajikistan, at 29.7%, recorded a lower share of public

sector health expenditure in that year. Most government expenditure on health is raised through taxes.

When looking at pooling and purchasing, the government pools and allocates public funding for health care and most government funds flow into public facilities. So far, no formal split between purchaser and provider has been introduced. There is a distinct divide between national (republican) and sub-national (regional, district or city) governments with regard to health financing. The national government is responsible for the financing of specialised medical centres, research institutes, emergency care centres, and national-level hospitals. Regional and local governments are responsible for expenditures related to other hospitals, primary care units, sanitary-epidemiological units, and ambulance services.

As mentioned, some reforms to provider payment mechanisms have been implemented in recent years. Primary care in rural areas is now financed on a capitation basis and primary care in urban areas is expected to follow in 2015. Specialised outpatient and inpatient care is financed on the basis of past expenditures and inputs, as well as, increasingly, through “self-financing”. The selected providers of secondary and tertiary care that have moved towards “self-financing” are now expected to cover most of their expenses through charging user fees (although they get reimbursed by the government for exempted patient and population categories).

Health workers in the public sector are salaried employees and paid according to strict state guidelines. However, there are efforts to increase the flexibility of health care providers in reimbursing health professionals. Salaries of physicians in the public sector ranged from US\$ 300 to US\$ 600 (about €270 to €540) per month in 2014 (according to the official exchange rate; 30% less in reality). These salary levels are considered insufficient to cover the cost of living (although some providers on the “self-financing” schemes are able to pay substantially better salaries), resulting in requests for informal payments.

## The basic benefits package

The 1996 Law on Health Protection introduced a basic benefits package paid for by the state. It clarified which services need to be covered from other sources of funding. The breadth of coverage is wide, covering all citizens of the country. However, there are major limitations in the scope of coverage, i.e. the range of benefits covered. The basic benefits package guaranteed by the government includes primary care, emergency care, care for “socially significant and hazardous” conditions (in particular major communicable diseases, plus some non-communicable conditions such as poor mental health and cancer), and specialised (secondary and tertiary) care for groups of the population classified by the government as vulnerable (e.g. veterans of the Second World War or single pensioners registered with support agencies). It thus excludes the full costs of secondary and tertiary care for significant parts of the population. Pharmaceuticals for both inpatient and outpatient care that forms part of the basic benefits package include only drugs for emergency care as well as drugs for 13 vulnerable population categories such as veterans of the Second World War, HIV/AIDS and TB patients, patients with diabetes or cancer, and single pensioners registered by support agencies.

## How is the gap in universal health coverage filled?

The narrow scope of the basic benefits package means that there remain major gaps in health financing, which are mostly filled by private out-of-pocket (OOP) payments. While the share of public sector expenditure has increased in recent years, private expenditure remains substantial. In 2012, 46.9% of THE came from private sources, mostly in the form of OOP expenditure. Voluntary health insurance does not play a major role.

Payments for health services are both formal and informal. Formal payments have been increasingly introduced and now account for a major share of revenue, in particular for health facilities that are expected to finance themselves largely through user fees rather than allocations from the state budget (the “self-financing” scheme). This approach

is being increasingly encouraged for secondary and tertiary care facilities. There is also anecdotal and survey evidence of informal payments, part of a large informal sector. These payments are particularly common for secondary and tertiary care, but the government has so far not fully acknowledged the scope of this problem. Other sources of funds include technical assistance programmes by multilateral and bilateral agencies. There are also still parallel health systems run by other ministries and state agencies, but information on the share of financing devoted to them is not available.

As mentioned, the limited scope of the benefits package relies on substantial private health expenditure. This in turn is likely to result in inequities and catastrophic expenditure for households. While the share of public expenditure is slowly increasing, financial protection thus remains an area of concern. Although primary care forms part of the benefits package, outpatient pharmaceuticals do not, and this may deter patients from seeking care in the first place. Free emergency care, on the other hand, may lead to an over-utilisation of emergency services.

The increasing shift to formal user fees for secondary and tertiary services is likely to aggravate problems in accessing services for poorer groups of the population. It also encourages the inappropriate use of health services, leading to a waste of limited resources. Furthermore, each facility is left to fight for its own survival, and the wider health system perspective is lost. Despite the use of formal payments, informal payments seem to persist, partly due to the low salaries of health workers.

## Conclusion

It is clear that Uzbekistan is still far from achieving universal coverage. The current move towards the “self-financing” schemes, which rely on OOP payments by patients, is likely to aggravate problems in access and equity and to result in catastrophic health expenditure. Further reforms in health financing would be one prerequisite for broadening the coverage of publicly funded health services. There are many inefficiencies built into the ways

that health care is financed and addressing them, if the resulting savings were to be ring-fenced, could help to broaden the scope of the benefits package. This might include the introduction of a benefits package for outpatient pharmaceuticals, as is being done in some other former Soviet countries.<sup>4</sup>

“ narrow  
scope of the  
basic benefits  
package

Establishing a unified information system and an analysis of the flow of funds could be a very important starting point towards better strategic governance in health financing. Such evidence-informed governance could help in reducing duplication (as in the existing parallel health systems), allocating a higher share of public resources to primary health care, reforming payment mechanisms to providers of specialised and inpatient care (with payment linked to outcomes and quality of care rather than inputs), and introducing clearer patient pathways and referral mechanisms. It will also be necessary to acknowledge the problem of informal payments, in order to initiate a multifaceted strategy for reducing them.

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# LUXEMBOURG PRESIDENCY HEALTH PRIORITIES: MEDICAL DEVICES, PERSONALISED MEDICINE, DEMENTIA, CROSS-BORDER CARE AND HEALTH SECURITY

By: Anne Calteux

**Summary:** Against the background of a Commission agenda dictated by the “less is more” principle, the health priorities of the upcoming Luxembourg European Union Presidency will focus on innovative and patient centred health care. These two objectives will guide the work on the revision of legislation in the field of medical devices and medical devices *in vitro*. They will also steer the reflections on how to facilitate patients’ access to Personalised Medicine, in accordance with the principle of universal and equal access to high quality health care. Patients will again be at the centre of discussions on innovative care models in the context of dementia, as well as on the implementation of the cross-border health care directive.

**Keywords:** *Medical Devices, Personalised Medicine, Dementia, European Presidency, Luxembourg*

## Introduction

The setting of the upcoming Luxembourg European Union (EU) Presidency differs substantially from the context of its last Presidency back in 2005, exactly ten years ago. The decision making process has changed. The accession since 2004 of many new Member States has led to a fundamental renewal of the traditional relationship of strengths within the Council and the European Parliament takes its role as co-legislator more seriously than ever. Furthermore, with the Juncker Commission taking office at a particularly challenging time for the

EU, the agenda setting has undergone a change of direction. The willingness to make a new start and to address shortcomings in the field of jobs and growth has had a direct impact on the role and responsibilities of the different European Commissioners and has led to the definition of new priorities articulated around the principle of “less is more”.

In particular, the Commissioner in charge of Public Health and Food Safety, Vytenis Andriukaitis, will now contribute to initiatives steered and coordinated by the Vice-President for Jobs, Growth and Competitiveness; a “partnership”

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which may raise questions as to whether the objectives of public health policies systematically follow the same logic as the one underlying the portfolio of the Vice-President.

In the field of public health, the focus will be on the clearly delineated mandate of Commissioner Andriukaitis: support to the EU's capacity to respond to crisis situations in food safety and pandemics; review of the decision making process in the field of Genetically Modified Organisms (GMOs); and performance assessment of health systems, in line with the European semester.

At the beginning of the Presidency Trio in which Luxembourg is involved, along with Italy and Latvia, the priorities of Commissioner Andriukaitis were yet to be defined. This is no longer the case since their announcement to the ministers of health during the Informal Council in April in Riga. The health agenda will be defined around the three "Ps": prevention, promotion and protection.

### Presidency priorities

The upcoming Luxembourg Presidency will focus its priorities in the field of public health around the objective of enhancing the protection of citizens' health while contributing to the sustainability of public health systems and to an innovative European Union. This objective will be addressed in various ways by topics which lie at the heart of societal debate, always putting patients at the centre of discussions.

#### Medical devices

Patients and their security, in particular, is one of the main aims of the revision of current legislation on *medical devices and medical devices in vitro*. So far, the Council has failed to agree on a common position for this proposal since its presentation in 2012. Luxembourg will, on the basis of the excellent progress achieved during the Latvian Presidency, make all necessary efforts to enable the implementation of a solid regulatory framework, allowing quick access for European citizens to products of high quality and security without hampering the competitiveness of the innovative

European market. Negotiations will be brought to a new level once the trilogues\* with the European Parliament have been launched.

#### Personalised medicine

Another subject high on the political agenda of the Luxembourg Presidency is *Personalised Medicine*, a theme which has recently received much media attention. A High Level Conference will trigger discussions on how to make access to innovative medical interventions, tailored to the specific needs of individual patients, available to a larger number of patients, thus providing what has previously been called "better treatment and preventing undesirable adverse reactions while fostering a more efficient and cost-effective healthcare system".<sup>■</sup>

Personalised medicine starts with the patient. It features ambitious potential for improving the health of many patients and can help to ensure better outcomes for health system efficiency and transparency. Yet, its integration into clinical practice and daily care is proving difficult given the many barriers and challenges to targeted health care efforts. If personalised medicine is to be in line with the EU principle of universal and equal access to high quality health care, then clearly it must be made available to many more citizens than it is now. What is requested is a long-term approach to innovation to ensure the translation of new therapies from laboratories to patients. Recent initiatives in the UK and US, among other countries, have put this innovative method of diagnosing and treating patients in the spotlight while demonstrating that it is necessary to build frameworks that allow the delivery of the right treatment to the right patient at the right time, in accordance with the principle of equal and universal access to high quality health care.

Incorporating patients' perspectives into the regulatory process will help address their unmet medical needs. Moreover, in times of budgetary constraints, facilitating better-targeted and more cost-efficient

treatment – to a potential 500 million patients in 28 EU Member States – is in line with the *Europe 2020* strategy and the aims of the Juncker Commission.

The High Level Conference is expected to contribute to the definition of a patient-centred strategy involving EU decision makers and regulators in the arena of public health, to enable the EU and Member States to contribute to integrating personalised medicine into clinical practice while enabling much-greater access for patients. The conference's main findings will feed into Council Conclusions to be adopted by the 28 health ministers during the Council of Health Ministers in December 2015.

#### Dementia

*Dementia* will be another health priority of the Luxembourg Presidency. We know that the prevalence of dementia will rise. Dementia is more than a mere medical or social care issue. Dementia also concerns partners, relatives and friends and is a common challenge for our communities. A cross-sectorial and comprehensive view on the multifaceted challenges of dementia should guide further actions at national and at European level.

“ putting patients at the centre of discussions

Contributing to healthy ageing in general should be a key policy goal. Besides the necessity to establish quality care for all people depending on care and especially dementia patients with their special needs, it is important to intervene at the earliest possible stage. This is the reason why during the Luxembourg Presidency, prevention – especially at primary and secondary level – as well as early diagnosis and post-diagnostic support will be more specifically addressed.

The discussions will focus on a comprehensive approach allowing not only adequate standards on timely diagnosis,

\* Trilogues are informal tripartite meetings attended by representatives of the European Parliament, the Council and the Commission.

but also multi-dimensional secondary dementia prevention programmes (post-diagnostic support) with advice on health related issues and additional counselling on social issues, general disease information, life-style related issues, family and financial matters, legal aspects and other related issues. Evaluation of these programmes will help us to also enhance primary prevention measures and can serve as best practice examples for other EU Member States.

Many EU countries are dealing with an ageing population, the increase of age-related diseases like dementia and the vulnerability of health care services. In order to achieve progress and make innovations possible and sustainable, it is necessary to collaborate in an international framework. Dementia will not only be a priority of the Luxembourg Presidency but it has also been addressed recently under the Italian Presidency and will be followed on by the Presidency of the Netherlands, starting 1st of January 2016 and hopefully thereafter.

#### *Cross-border health care*

During the Informal Council in September 2015, health ministers will take stock of the implementation of the cross-border health care Directive, two years

after the transposition deadline. Although cross-border health care concerns only a minority of EU citizens, this milestone text has the potential to contribute in the long term to better access and better quality in health care for a large number of patients. The provisions on Member States' cooperation will be of particular relevance in this respect. The first progress report which will be presented by the European Commission during the next few months will be a key opportunity to assess whether the Directive has actually been of added value for patients and Member States, and to highlight its strengths but also potential barriers in implementation, and new rights compared to existing ones.

The Commission report is expected to focus on various aspects such as information on patient flows, the financial dimension of patient mobility, the implementation of the provisions on reimbursement and prior authorisation, cooperation between neighbouring Member States, as well as the functioning of national contact points.

#### *Health security*

Finally, during the Luxembourg Presidency, the time will be ripe to evaluate how the Ebola crisis has been addressed. Luxembourg will be closely

associated with the organisation by DG SANTE of a conference on "Ebola lessons learned". After the recent commitments made by the World Health Organization (WHO) in relation to this issue, it is now up to the European actors to undertake the same exercise as in 2010 after the outbreak of the influenza A/H1N1 pandemic.

The conference will bring together many actors to ensure a cross-sectoral discussion on various themes, such as new strategies for treatment and prevention, including protection of health care workers, medical evacuation, diagnostic methods and vaccines, but also communication, inter-sectoral cooperation, preparedness activities and global health security. The reflections will take into account the work done by WHO in this field and their results will feed into the agenda of the December 2015 Council.

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## Trends in health systems in the former Soviet countries

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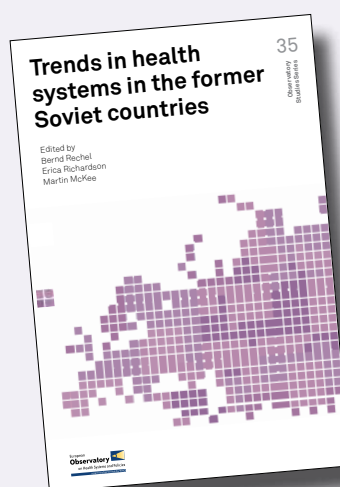
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After the break-up of the Soviet Union in 1991, the countries that emerged from it faced myriad challenges, including the need to reorganise the organisation, financing and provision of health services. Over two decades later, this book analyses the progress that twelve of these countries have made in reforming their health systems.

Building on the health system reviews of the European Observatory on Health Systems and Policies (the HiT series),



it illustrates the benefits of international comparisons of health systems, describing the often markedly different paths taken and evaluating the consequences of these choices. This book will be an important resource for those with an interest in health systems and policies in the post-Soviet countries, but also for those interested in health systems in general. It will be of particular use to governments in central

and eastern Europe and the former Soviet countries (and those advising them), to international and non-governmental organisations active in the region, and to researchers of health systems and policies.



# NEW STRATEGIES FOR THE CARE OF OLDER PEOPLE IN DENMARK AND NORWAY

By: Richard B. Saltman, Terje P. Hagen and Karsten Vrangbaek

**Summary:** Facing growing pressure from increasing numbers of chronically ill older people, national policy-makers in both Denmark and Norway have introduced an inter-linked series of structural, financial, and care coordination reforms. Municipalities have received financial incentives to reduce unnecessary hospital referrals by caring for chronically ill older people at the primary care level, and have established local acute care coordination units inside hospitals. Importantly, at a national governmental level, there has been substantial new investment in rural primary care and encouragement for hospital consolidation. While these new measures remain un-evaluated, they represent an aggressive multi-pronged effort to efficiently and effectively deal with the growing number of elderly patients.

**Keywords:** Long-term Care Reform, Norwegian Health Reform, Danish Health Reform, Nordic Health Reform, Denmark, Norway

## Introduction

The provision of care services for older people has become an increasingly pressing concern for European policy-makers. Growing numbers of older people (in both relative as well as absolute terms),<sup>1</sup> structural difficulties in coordinating hospital, primary medical and long term residential levels of care,<sup>2</sup> and unrelenting budget pressures following the 2008 financial crisis,<sup>3 4 5</sup> have made this policy task particularly difficult. Existing strategies for providing older people with clinical and curative services are often segmented and expensive, with outcomes that tend to be less than optimal.<sup>6</sup>

A wide range of potential alternative strategies have been put forward.<sup>7 8</sup> Among other measures, governments are seeking to structurally combine primary and social care services, to contract out more services to integrated private sector providers, to give older people virtual budgets with which to purchase home care services (the Netherlands and England), and to introduce a wide array of internet and mobile phone based monitoring technologies.<sup>9</sup>

This article examines the national programme of structural, financial and programmatic measures that Denmark and Norway have recently put in place.

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It reviews relevant structural reforms as well as service related changes. While many of these measures are as yet un-evaluated, the overall pattern of structural innovation and programmatic change may be useful for policy-makers in other countries as well as for interested researchers.

## Structural reforms

*Norway:* Beginning in January 2002, the Norwegian central government took over all public hospitals and other specialist care institutions from the county governments. Hospitals were reorganised as local hospital trusts within five (later four) regional health authorities (RHAs). Unlike the county councils the RHAs could not tax, and were completely dependent on state allocations for their funding. The local hospital trusts, supervised by these new regions, were grouped together at the former county level as semi-autonomous managerial units under a board of trustees responsible for their overall performance. The reform represented an attempt by the central government to resolve what were viewed as major problems in the Norwegian health care system: namely long waiting lists for elective treatment and a lack of financial responsibility and transparency that led to a blame-game between the counties and the state.<sup>9 10</sup>

Following the reform there was a reduction in waiting times but also an increased understanding of the fact that more weight needed to be placed on prevention and treatment of chronic conditions in primary care, which in Norway is the responsibility of the municipalities. This led to the implementation of the Coordination Reform; a reform that was strongly inspired by structural changes that meanwhile had taken place in Denmark.

*Denmark:* The Danish health care system underwent a major structural reform in 2007.<sup>11</sup> The previous (fourteen) county councils were consolidated into five elected regional councils. Similar to prior arrangements with the county councils, responsibility for operating hospitals and writing primary care physician contracts

(most Danish primary care physicians are in private practice) was shifted to the new regional level governments.

Simultaneously, the country's 271 municipalities were merged into 97 and received responsibility for prevention, health promotion, and rehabilitation (extensive home care and some health centres/clinics without medical personnel).

“improve  
coordination and  
service quality”

## Economic incentives for the municipalities

*Denmark:* As part of the Structural Reform, funding responsibilities for hospitals were taken away from the regional level—which no longer has the right to levy taxes—and split between the national government and the municipalities. State block grants (based on socio-demographic criteria) provide 77% of operating costs with activity based funding providing an additional 3%. The municipalities, in a major shift which has important implications for care of older people, now pay the remaining 20% of the cost of medical care provided by the Region. This is broken down as 34% of the diagnosis-related group (DRG) rate for hospital care, 30% of the rate for general and specialist practice, and 70% of the rate for rehabilitation in hospitals. This new fiscal responsibility is seen as giving the municipalities a strong incentive to keep frail and/or chronically ill older people from unnecessary use of physician, hospital, or rehabilitation services.

*Norway:* Funding of acute hospitals was split between 60% risk adjusted capitation where the risk adjusters were demographic, socioeconomic and health related criteria, and 40% activity based financing based on the DRG-system. From 2012, 20% municipal co-financing of all patient treatment in internal medicine and outpatient departments was initiated. Like in Denmark, the objective of this

measure is to encourage the municipalities to intervene before older people require hospital visits. The co-funding is somewhat less sophisticated than in Denmark, as the rate in Norway is similar across the types of services that patients require. Through the implementation of the Coordination Reform, Norway also introduced municipal responsibility for patients ready for discharge. A daily fee of 4000 NOK (about €450) is paid to the hospital by the municipalities if the patient stays in the hospital after being declared ready for discharge.

## Measures aimed at coordinating care

Concurrent with these structural and fiscal reforms, both countries also have introduced a variety of additional operating and management measures that are intended to improve coordination and service quality while reducing service demand, especially from frail and/or chronically ill older people. Among recently introduced measures are the following:

- 1) Each municipality must negotiate a written agreement every four years with its regional government, detailing how they will cooperate together to improve public health and reduce hospital utilisation. These agreements must be approved by the national government, which has established national guidelines and standards, and uses statistical indicators to confirm performance. Current statistical indicators in Denmark include: readmissions/preventable readmissions; acute medical short term admissions; patients waiting for discharge after treatment; and waiting time for rehabilitation.

In both countries, the municipal-regional agreements cover admission, discharge, rehabilitation, and patient communication. They also incorporate follow-up and accountability procedures, and there are additionally sections on prevention, staff training and health IT.

It is noteworthy that in Denmark when the requirement to negotiate these agreements was first put in place, the Ministry of Health rejected many of the initial versions as inadequate,

forcing municipalities and regions to forge more comprehensive agreements. In Norway, the Directorate of Health and the Norwegian Association of Municipalities cooperated in composing a proposal that later was implemented locally with only small variations.

- 2) As part of these municipal-regional agreements, some municipalities in both countries have chosen to have their own units embedded within the local area hospital to better coordinate patient care. In Denmark, these units range from several nurses to an entire entity, e.g. staffed by primary care physicians as well.
- 3) In both countries, the national government has established models for Patient Pathway Programmes for cross-sectoral care to supplement the already established pathway descriptions at the hospital level. In Denmark this is a generic model; in Norway the national government has started out with implementation of pathways for cancer care. The regions and municipalities in both countries have subsequently developed pathway descriptions for a range of cross-sectoral conditions including diabetes, chronic obstructive pulmonary disease (COPD), heart conditions, back and lower back conditions, dementia, schizophrenia, cancer rehabilitation and brain damage. The pathway descriptions integrate clinical guidelines and available evidence, and define the responsibilities for municipalities, hospitals and general practitioners (GPs) with regard to specific disease areas. Experiments with different types of “pathway coordinators” are currently underway at regional and municipal levels.
- 4) In both countries, municipalities have established home-focused rehabilitation programmes, to help older people regain functionality within their own living environment and tailored to individual needs, supported both by medical devices and by personal care.
- 5) In both countries, many municipalities work with civic volunteers, to create opportunities for healthier older people to participate in physical exercise programs and a range of social

activities, with an eye toward slowing the process of cognitive or physical decline.

### Local acute units

*Norway:* Each municipality is required to set up or cooperate with other municipalities in establishing a so-called “MAU” or municipal acute bed unit. A MAU can be a separate intermediate care unit or a community hospital. All municipalities are expected to have these units by 2016, with their operating costs funded partly by a matching grant from the central state and partly by transfers of resources from the regional health authorities to the municipalities. These MAUs are designed to treat stable patients with known diagnosis where the main problem was an acute disease that could be evaluated and treated by primary care methods, or stable patients with unknown diagnosis in need of observation and medical evaluation. Typical patients expected to be admitted to the MAUs were older people with pneumonia, urinary tract infections, other infections, gastroenteritis, COPD, heart failure, and dehydration.

“structural,  
financial and  
programmatic  
measures

*Denmark:* Municipalities have introduced local observational facilities attached to nursing homes, and staffed by nursing home personnel. These have a few beds, and serve as temporary treatment centres for elderly patients who have less severe medical issues (dehydration, medication-caused dizziness) and thus keeping them from making unnecessary emergency room visits. These observational facilities are also being used as step-down beds when these patients are discharged, making it possible for them to leave their (more expensive) hospital bed sooner. In Denmark, new municipal health centres are being built, especially in rural areas where access to primary care doctors and

follow-up has been more difficult. Some of these centres are being established in buildings being freed up by smaller hospitals, which the regions are merging and/or closing. These centres are funded jointly by regions and municipalities and with initial support from the state as part of a conscious strategy to improve access to primary care in less populated parts of the country. The development of municipal health care services should be seen in the light of an extensive (42 billion DKK, about €5.6 billion) state/regional investment plan to centralise hospital care and further encourage rapid and highly intensive hospital treatment.

### Patient choice and e-health

In both countries, patients have free choice of public hospitals upon referral. In Norway the choice also includes publicly funded treatment at private for profit hospitals on contract with the RHAs. In Denmark an “extended free choice” scheme allows access to private hospitals paid by public money if waiting times for diagnostic procedures exceed four weeks in the public system. Once a diagnosis is established, a new guarantee of four or eight weeks (depending on the severity of the condition) enters into force.

In both countries, integrated e-health portals ([www.sundhed.dk/](http://www.sundhed.dk/) and [www.frittsykehusvalg.no](http://www.frittsykehusvalg.no)) have been established, enabling every patient to see waiting times in every hospital in the country. In Denmark the portal also includes selected quality measures for procedures and access for patients and health care professionals to prescription data and personal medical records from GPs and hospitals.

### Conclusions

Both the Danish and Norwegian national strategies have taken important new steps within their tax-funded health systems to improve access, quality, and the integration of clinical and long term residential services for older people. They also have sought new organisational and fiscal techniques to shift utilisation to local, less expensive providers. Both countries have pursued these objectives by leveraging major structural reforms to the

regional level of their public health care systems – e.g. the shift from decentralised county councils to fewer, more centrally steered regions. As part of this structural reform, the two national strategies seek to increase the capacity of the public system to provide needed care, as well as heightening the direct financial interest of local municipal governments to provide more effective primary care and home care services.

Thus, both countries have embarked on substantial new investment in primary and long term care to increase the public health system's overall ability to meet the changing care needs in the population. Moreover, both strategies have sought to harness existing and new private sector providers, as well as expanding capacity among publicly paid and operated primary and long term care facilities. Both systems are combining elements of choice and hierarchical planning to achieve changes that are comprehensive, systematic and responsive to local and individual needs. Importantly, both national strategies include new mechanisms that require individualised care and coordination. Lastly, both countries are using statistical reporting to monitor progress, and written agreements to ensure that better collaboration remains an administrative priority at both regional and municipal levels.

The individual and/or combined impact of these new approaches has not as yet been adequately evaluated. However, it may well turn out that it is precisely in their combined impact that these structural, financial and programmatic measures might well be most successful in changing ingrained institutional behaviour in the public sector. They represent the type of comprehensive change that numerous health policy analysts in Europe have called for, and can provide a useful example of possible policy options as other countries seek ways to deal with a similar set of policy challenges.

One of the potential stumbling blocks for success in this new environment in Denmark is the status of GPs. Many of the municipal and cross-sectoral activities depend on support from GPs. However, their organisation as

independent businesses – which has been very successful in the past – creates difficulties in enforcing integration, particularly in a situation with a shortage of young GPs willing to invest in clinics. Regional efforts to impose integration through changes in the national level agreement with GPs led to a major conflict in 2012–2013.

Potential problems in Norway are first and foremost the country's small municipalities. While Denmark chose to merge the municipalities as part of the Structural Reforms in 2007, Norway still (2014) has 428 municipalities with a mean size of approximately 10 000 inhabitants, but 200 municipalities have less than 5000 inhabitants. However, the current national government has initiated a reform process that is expected to lead to an amalgamation of the municipalities from 2017.

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# OUT-OF-POCKET PAYMENTS IN THE NETHERLANDS: EXPECTED EFFECTS ARE HIGH, ACTUAL EFFECTS LIMITED

By: Margreet Reitsma-van Rooijen and Judith D. de Jong

**Summary:** Out-of-pocket (OOP) payments are often introduced to reduce health care expenditures. The assumption is that OOP payments result in less health care use, therefore lower expenditure. However, the effects of OOP payments appear to be limited and they have adverse effects. Variants of OOP payments are being considered by several governments in order to address these problems; however, in the Netherlands the current OOP payment system has limited effect. This is possibly due to a lack of knowledge, the limited influence people have on their health care use, and the fact that people rarely judge this use as unnecessary.

**Keywords:** Health Care Costs, Out-of-pocket Payments, Public Expectations, the Netherlands

## Growing health care expenditures; the problem and solutions

In many countries health care expenditures are rising faster than resources.<sup>1</sup> There are different factors which play a role in this development, including technological progress, an ageing population, and consumer expectations.<sup>2</sup> If no action is taken to limit these expenditures, then by 2060, the combined public health and long-term care costs for OECD countries will more than double as a share of gross domestic product (GDP).<sup>3</sup> In addition, the current financial crisis that started in 2007, makes growing health care expenditures an even more urgent problem,<sup>4</sup> as it has a large impact on health systems.<sup>5</sup>

In order to be able to provide high quality, accessible and affordable health care in the

future, health care expenditure needs to be controlled. Therefore, different countries have implemented a wide range of policy tools to reduce these expenditures and to respond to the financial crisis.<sup>6</sup> Some policies are designed to affect the volume and quality of publicly financed health care – for example, by reducing the coverage of the insurance package. Other policies aim to cut the cost of publicly financed health care – for example by reducing overhead costs.<sup>7</sup> Policies have also been introduced that aim to raise the level of contributions for publicly financed health care, for example, by increasing or introducing out-of-pocket (OOP) payments.<sup>8</sup> In this article the focus is on OOP payments as a tool for reducing health care expenditures.

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**Table 1:** Means (95% CI) for the degree to which participants agreed with the statements

	<i>Public expectations*</i>		
	<i>Cost consciousness</i>	<i>Cost conscious behaviour</i>	<i>Health care use</i>
Compulsory deductible	3.20 (3.11–3.28)	3.40 (3.33–3.47)	3.76 (3.68–3.83)
Shifted obliged deductible	3.01 (2.93–3.09)	3.08 (3.01–3.15)	3.15 (3.07–3.23)
Income dependent deductible	2.99 (2.92–3.07)	3.03 (2.96–3.10)	2.95 (2.87–3.02)
Charge per service	2.97 (2.90–3.05)	3.20 (3.13–3.27)	3.19 (3.11–3.27)

Source: <sup>11</sup> \* Scale running from 1 (completely disagree) to 5 (completely agree).

Note: Number of respondents between 662 and 686.

## OOP payments

With OOP payments the insured have to pay the costs, in whole or part, of the health care they use. This is assumed to lead to a reduction of health care expenditures in two ways. First, OOP payments will lead to a so-called funding shift,<sup>12</sup> since people have to pay for their health care use themselves. Therefore, collective costs will decrease. Second, OOP payments are assumed to lead to a decrease of health care use and thus to a reduction of health care expenditures.<sup>13</sup> Many countries, such as Austria, Belgium, France, Germany, Luxembourg, the United States, Switzerland and the Netherlands, have some form of health insurance system. In such systems, health care users often do not face the whole costs of their health care use, since these are paid partly or entirely by their health insurance company, to which they pay a premium (or a ‘contribution’ based on their income). Therefore, the insured lack a direct association between health care use and costs. As a consequence, health care users may demand treatment inefficiently, in the sense that the costs exceed the benefits. This might lead to excessive use of health care, also known as moral hazard<sup>14</sup> – and, consequently, to growing health care expenditures.<sup>15</sup> OOP payments, however, might help reduce excessive use of health care. The assumption is that OOP payments lead to higher cost consciousness which is assumed to lead to cost conscious behaviour and thus to less health care use. This might reduce health care expenditures.

Whether OOP payments lead to a decrease in health care use has been the subject of many studies in different

countries. These show that the effects of OOP payments on health care use are limited.<sup>16</sup> <sup>17</sup> This is the case for the current OOP payment, the compulsory deductible, in the Netherlands where health care consumers have to pay the first part of their health care use themselves before insurance coverage begins. The limited effect of this deductible might be due to the fact that this deductible has a maximum. If health care users reach the maximum (€375 in 2015), or know that they will reach the maximum, they will behave as fully insured, which will possibly lead to higher health care use. Besides these limited effects, there are indications that OOP payments disproportionately affect the lower income groups,<sup>18</sup> which leads to inequalities in health status between groups.<sup>19</sup>

## Variants of OOP payments

Variants of OOP payments also have been considered by governments, including the Netherlands, in an attempt to address the question of their limited effects and to overcome the problem of creating inequalities between groups.<sup>20</sup> One of these variants is to increase the level of the compulsory deductible so that it takes longer before the maximum is reached. Therefore, a higher compulsory deductible will have a more prolonged limiting effect on health care use. A RAND-study,<sup>21</sup> which focused on younger people and on healthy populations, showed that the higher the OOP payment, the stronger the effect. However, increasing the level of the compulsory deductible will have a significant impact on people with a low income, leading to differences in the financial accessibility of health

care. A compulsory deductible, which is income-dependent, is one option which could address this issue. If the compulsory deductible is income-dependent, it will be lower for people with a low income compared to people with a high income. The effect of the OOP payment on health care use will then be similar for all income groups.

Another option is a shifted compulsory deductible. Here, the level of the compulsory deductible is the same for everybody, but it will only apply when the costs of health care use exceed a certain amount. This amount is not the same for everybody, but depends upon risk-characteristics of an individual, for example age, since older people have a higher risk that they need health care than younger people. The older people are, the higher the level of health care costs before the compulsory deductible will apply. A shifted compulsory deductible increases the chance of low OOP payments, which in turn, increases the incentive for adequate health care use, possibly leading to a larger behavioural effect, in particular for chronically ill and older people.

However, for all these variants of the compulsory deductible, once the maximum has been reached there is no longer any limiting effect. A charge per service (a co-payment) will therefore probably have a stronger effect on reducing health care use.

## Public expectations of OOP payments in The Netherlands

Public expectations about the effects of OOP payments shed light on the acceptance of such policy measures,<sup>22</sup> and therefore on its legitimacy.<sup>23</sup> Public acceptance is an important factor for their success<sup>24</sup> and legitimacy is a crucial basis for such measures.<sup>25</sup> Therefore, it is important to gain more insight into the expected effects of these variants of OOP payments on the people whom these measures affect.<sup>26</sup>

In The Netherlands, public expectations of different variants of OOP payments were measured using a mixed-mode questionnaire dependent on the member’s preference. The questionnaire was sent out in November 2013 to 1,500 members of

the Dutch Health Care Consumer Panel, run by the Netherlands Institute for Health Services Research.<sup>[1]</sup> This sample was representative of the Dutch population aged eighteen years and older with regard to age and gender. The questionnaire was returned by 698 panel members (response 47%).

Four different types of OOP payments were presented to the respondents: The compulsory deductible; a shifted compulsory deductible that is dependent on age; an income dependent deductible; and a charge per service. After a short introduction, we measured public expectations for each on a 5-point Likert scale (1 = completely disagree, 5 = completely agree) together with statements that measured cost consciousness, cost conscious behaviour and less health care use. The mean score for the statements that measured public expectations is almost 3 or higher (see Table 1), indicating that health care users expect all these variants of OOP payments to be effective.

### The behavioural effects of OOP payments

In the Netherlands, there seems to be public acceptance for these forms of OOP payments as health care users expect all four variants to have some effect. Public expectations about the effects shed light on the acceptance of these OOP payments, and therefore on their legitimacy. Public acceptance is an important factor for their success<sup>[2]</sup> and legitimacy is a crucial basis for such measures.<sup>[3]</sup> However, this acknowledgment of effect may not result in an automatic effect on behaviour, as demonstrated by other evidence. For example, in a previous survey in October 2012, we asked 1,500 members from the Dutch Health Care Consumer Panel (845 respondents, response 56%) whether they had used less health care in 2012 due to the existing compulsory deductible. Only 9% of the respondents answered yes.<sup>[4]</sup> In addition, from other studies, we know that the behavioural effect of the compulsory deductible in the Netherlands is limited.<sup>[5]</sup> So, the effectiveness of the compulsory deductible is small, despite the expectations of the public (in our 2013 survey) that this will lead to less health care use. There

are several possible explanations for the limited effect. These include: a lack of knowledge about the OOP payment; the lack of opportunities people have to influence their health care use; and that health care users rarely judge their health care use as unnecessary.

Knowledge about the compulsory deductible seems to be limited. When asking the respondents how they actually made less use of health care due to the compulsory deductible, visiting the general practitioner (GP) less often was mentioned most frequently.<sup>[6]</sup> However, the compulsory deductible is not applicable to GP consultations. Health care users seem unaware of this. Based on another study among 1,559 members of the Dutch Health Care Consumer Panel in 2009 (1056 respondents, response 68%), we found that a quarter of the health care users thought that the compulsory deductible was applicable to GP consultations.<sup>[7]</sup> Thus, limited knowledge of the compulsory deductible might explain its limited effect on health consumption.

Another prerequisite for a policy to work is that people should have the opportunity to exert influence on their behaviour. One might question whether people can influence their health care use. If people are ill, they often need health care. In the Netherlands, due to the gate keeper system, the first step is usually to visit the GP. People can decide whether or not to go to the GP, but in general the GP decides whether or not further steps, such as visiting a medical specialist are needed. The compulsory deductible applies to these other levels of health care. Therefore, this gate keeper system limits the influence individual health care users have on their health care use.

Moreover, one could question whether health care users are able to decide whether or not their health care use is necessary. OOP payments have been introduced to reduce the use of unnecessary health care. Studies on the effects of OOP payments show that they also reduce the use of necessary health care.<sup>[8]</sup> If people decide not to make use of health care, whereas they should do so, this may result in even higher costs in the longer term. Results from a study among members of the Dutch Health Care

Consumer Panel in 2011<sup>[9]</sup> showed that the majority of respondents judged their own health care use to be necessary. Only 4% of respondents indicated that they used health care when it was unnecessary. However, when asked if others made use of health care when it is unnecessary, 38% agreed or completely agreed. This might explain why public expectations of the effectiveness of OOP payments are high, while actual effects are limited.

### Conclusion

Several countries increased or introduced OOP payments in response to the economic crisis,<sup>[10]</sup> although evidence of the actual effects are limited. It is questionable whether OOP payments are a valid means of limiting health care expenditures, particularly as the distribution of health care expenditures across the population is highly concentrated. Thus, a policy tool such as OOP payments, aimed at the 90% of the population that collectively accounts for less than one third of total health care expenditures, may have a limited effect on costs in the Netherlands as well as in other OECD countries.<sup>[11]</sup> It is also questionable to what extent people can influence their health care use, and to what extent they are able to make good decisions on whether or not to make use of health care. Yet, policy-makers still see OOP payments as a possible solution to reduce health care expenditures. Other solutions, however, might be more effective in reducing health care costs. These costs are more influenced by the way in which health care is provided rather than by the extent to which use is initiated by patients.<sup>[12]</sup>

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# ACCESS TO LONG-TERM CARE SERVICES IN SPAIN REMAINS INEQUITABLE

By: Pilar García-Gómez, Cristina Hernández-Quevedo, Dolores Jiménez-Rubio and Juan Oliva-Moreno

**Summary:** Population ageing poses challenges not only for access to health care systems but also to long-term care (LTC) services. Spain's Dependency Act (2006) provides universal access to LTC for those with certain levels of dependency. However, evidence suggests horizontal inequity favouring the well-off, especially for those with severe needs. These findings are particularly relevant for countries which, like Spain, have not yet fully developed national LTC services. Investing now in health policy efforts to improve longer life expectancy in good health appears to be the best way forward but requires complex coordination between social and health services.

**Keywords:** Disability, Dependency, Long-term Care, Unmet Need, Equity, Spain

## Introduction

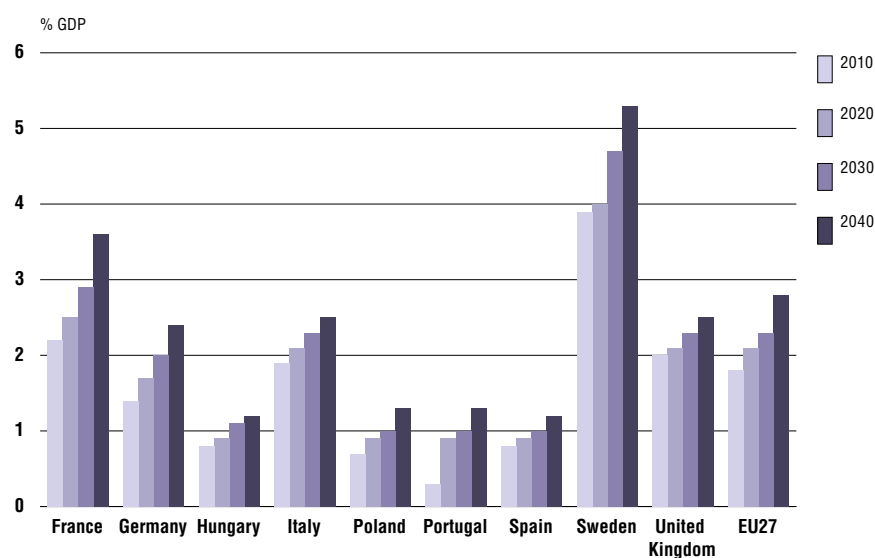
European countries present large differences in the way long-term care (LTC) is organised, as well as in spending: while half of the EU-27 countries spent less than 1% of their Gross Domestic Product (GDP) on LTC in 2010, Nordic countries and the Netherlands spent more than a 3% in that year.<sup>1</sup> These figures probably will increase sharply in the next decades (see Figure 1). Although the baseline is very different between countries and there is a degree of uncertainty in the way the health status of their populations will evolve in the near future, ageing of the population will not only challenge the organisation of health care systems but will also imply a redefinition of LTC systems in the years to come. LTC expenditures will

be affected not only by the percentage of the population over 65 years and their relative health, but also by the institutional characteristics of the LTC system, including its organisation, the trade-off between formal and informal care and the availability of support for the latter type of care. In this context, Spain is not an exception, with 3.85 million people living in households reporting a disability or limitation, which implies a rate of 85.5 per 1000 inhabitants.<sup>2</sup>

Moreover, the egalitarian objective defined as “equal access for equal need” for basic services is part of the policy agenda for most European countries. This implies that, for the same level of need, there should not be differences in the access to health care services by socioeconomic conditions, race or sex. The World Health



**Figure 1:** Total public spending on LTC as a % of GDP (2010 – 2040 projections in Spain, EU 27 average and selected countries)



Source: <sup>3</sup>

Organization defines horizontal equity in the access to health care services as an instrumental tool to achieve health improvement, as well as to favour the reduction of inequalities in health by socioeconomic status.<sup>3</sup>

A wide range of studies provide evidence on equity in access to health care services in the adult population within and across European countries, measured in terms of use of health care services and unmet needs of health-related services.<sup>3</sup> However, the level of equity in the use of health and LTC services by older and disabled people still remains a “black box”, even if those individuals are the greatest consumers of care services and possibly, those who face more difficulties in accessing them.

### Is access to LTC services equitable?

A crucial issue facing health policy-makers in Europe is to understand how access to LTC services is distributed across socioeconomic groups among the impaired population. Moreover, it is likely that barriers are not distributed equally among socioeconomic groups, so people with high levels of education and financial safety may experience a lower level of entry barriers to LTC services than those with low levels of education and income. Among other reasons, this could be related to an inequitable geographic

distribution of LTC services, to differences in the treatment of patients on the basis of socioeconomic status, or to the existence of differences in the demand for health and social care services among patients with different levels of income and education.

Spain provides an interesting context to investigate potential inequities in access to LTC services. In 2006, a new Dependency Act was approved, recognising the universal right of the dependent population to receive services. The implementation of the new system was designed to be progressive, although at the time of writing, only the population with the highest level of dependency is entitled to receive public LTC. While expenditure on LTC has been estimated to increase over time (see Figure 1), the percentage of GDP spent on LTC in Spain is much smaller than in other European Member States. The most recent data for Spain show that spending on LTC accounted for 0.8% of GDP in 2010 (Figure 1), with strong regional disparities.<sup>3</sup>

### The Spanish context

The Spanish National Health Service (NHS) provides universal coverage, with some minor geographical differences in the benefits package. Health competences were totally transferred to the 17 autonomous regions in 2002.<sup>3</sup> Health expenditure in Spain

reached US\$ 2987 purchasing power parity (PPP) per capita and 9.3% of GDP in 2012. Most health expenditure (71.7%) is derived from public sources (mainly from taxation) and predominantly operates within the public sector.<sup>3</sup>

In contrast, at the start of the new century, Spanish levels of social protection expenditure on LTC were extremely low compared to the rest of Europe.<sup>3</sup> Coverage was not universal; a large share of LTC expenditure was funded directly by households (dependent person and his/her family), with a high level of co-payments and a larger role for informal care. Informal caregivers only received a very low (almost non-existent) formal remuneration, and social protection was weak. The role of the family in this context was highly significant, being the main safety net to cover the needs of people in situations of dependency. Public social services were provided in very specific circumstances, including: when the family did not exist or was no longer available due to the large burden accumulated by caregivers, and when economic capacity was not sufficient to pay for formal professional care. However, demographic projections, coupled with social changes that have occurred in recent decades (e.g. reduction in family size and increasing participation of women in the labour market) seriously threatens the future sustainability of this system.

In this context, at the end of 2006, a new National System for Autonomy and Assistance for Situations of Dependency (SAAD) was established through the approval of the Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency Act (Act 39/2006 of 14th December). Social benefits are recognised by the Act under equal conditions for all disabled people, including older people who fall within this group, and who need help carrying out basic daily living activities. The autonomous regions are responsible for the provision of benefits and services established by the Dependency Act. The Ministry of Health, Social Policies and Equality sets a threshold of minimum services and benefits that should be allocated to eligible people, depending on their degree of dependence. Additional

resources can be provided by each region to complement the contributions made by the national government.

The degree and level of dependency establish the level of coverage and the timing of service delivery. Three degrees of dependency (moderate, severe and major) and two levels of dependency (levels 1 and 2, with 2 being the highest) were defined by the Dependency Act with citizens who apply for coverage being ranked according to an official scale. This includes objective criteria for assessing the degree of autonomy of individuals, capturing the ability to perform basic tasks of daily living and need for support and supervision for people with intellectual disabilities and mental illness. The assessment is based on a questionnaire and there is direct observation of the person who is assessed by a qualified and properly trained professional.

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evidence of  
horizontal  
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access to LTC  
services

The implementation of SAAD was designed to be gradual. According to the schedule in the Act, from 1st January 2007 only those with the highest dependency degree (major dependence) of both levels 1 and 2 would receive the corresponding services. From 1st January 2008, only level 2 severe dependents would become eligible, with level 1 severe dependents covered from 1st January 2009. From 1st January 2011, level 2 moderate dependents would be covered, with level 1 moderate dependents included from 1st January 2013. Given the large number of delays in undertaking assessments and implementing effective service delivery or financial assistance, only those with the highest degree of dependence (major) have been, in practice, covered by the Act since 2007. This does

not mean that other people with less severe levels of dependency have not been receiving LTC, either because they were receiving them from social services before the enactment of the Act, or because these services were privately financed. According to data for March 2015, there are 742,813 individuals receiving some type of aid (either monetary or through in kind services), with moderate dependents still excluded from universal coverage as the implementation of SAAD has been delayed due to a lack of resources during the economic crisis. However, 880,186 impaired individuals are entitled to receive some sort of aid. This gap is known as “dependency limbo” and has persisted since the application of the Dependency Act.

### What does the evidence tell us?

A first attempt to evaluate the level of income-related inequity in the access to LTC services (rather than health care) in Spain has been recently published, based on 2008 data.<sup>10</sup> Findings are not very encouraging, suggesting the existence of horizontal inequity in access to LTC services, both in terms of use and unmet needs across socioeconomic groups for LTC. In particular, formal care appears to be disproportionately concentrated among the rich, while unmet needs and intensive use of informal care services (at least four hours per day of informal care) seems to be concentrated among the relatively less well-off. Moreover, beneficiaries of LTC services (those with major dependency) seemed to experience relatively higher pro-rich inequity in the use of formal services in 2008. This implies that, despite universal LTC services, those who are well-off and have major dependency are more likely to access LTC formal services than their peers who are worse-off.

Analysis of the distribution of utilisation and unmet needs across socioeconomic groups for LTC services shows that there is evidence of horizontal inequity in access to LTC services. In particular, high levels of pro-rich inequity are found for the use of community care services and for home care services, including privately provided services. This may be related to the existence of access barriers for poorer individuals in terms of both

availability (e.g., waiting lists) and the costs associated with these services.<sup>10</sup> Evidence also suggests that the intensive use of informal care services appears to be disproportionately concentrated on the worse-off, with families acting as safety nets.

### Some conclusions and challenges ahead

While the current evidence is useful as a first step to understand the association between income and the use of several LTC services and unmet needs, caution is needed when generalising the results to other LTC systems. Differences in public and private spending for LTC are related to the use of formal and informal services provided in different European countries. These differences depend on the income per capita of the countries as well as on organisational, social and cultural elements surrounding the concept of care and on whether the family or the state is responsible for LTC and how it should be financed. However, current results may be relevant for European countries which have not yet established comprehensive national programmes in LTC. Italy in Southern Europe and Poland and Hungary in Central Europe may also have important access barriers to LTC that are similar to those found in Spain, which might be particularly driven by the role of private funding in LTC for these countries.

Within the next few decades, the population of Europe will contain a much greater share of older people. In particular, the proportion of the population over 65 years will double in the next 40 years as a consequence of the late baby boomer generation soon reaching retirement age. In addition, the proportion of the very old (over 80 years) in the total population, who constitute the main consumers of LTC, will rise from 4.1% in 2005 to 6.3% in 2025 and to 11.4% in 2050.<sup>11</sup>

Currently, there is no conclusive evidence on whether people will age in good or bad health in the future. The large baby boom cohorts will push up social services spending, but the extent and amount of such spending growth will depend on whether or not there will be a compression

of morbidity and disability in older people.<sup>9</sup> This implies that for future generations, it is worth investing now in health policy efforts focused on children, youth and adults to enjoy a longer life expectancy in good health, involving the development of health policies beyond the health care arena and focusing on other sectors (education, employment, housing, environment, etc.) But it also means that research on LTC must fill information gaps, and that coordination of formal (health and social care) and informal care should be improved to enhance efficiency and equity in the joint provision of these services.

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## Paying for performance in health care

Implications for health system performance and accountability

**Edited by:** C Cashin, Y-L Chi, P Smith, M Borowitz, S Thomson

**Published by:** Open University Press, 2014

**Number of pages:** xxi + 312 pages, **ISBN:** 978 033526438 4

**Freely available for download at:** [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0020/271073/Paying-for-Performance-in-Health-Care.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0020/271073/Paying-for-Performance-in-Health-Care.pdf?ua=1)

Health spending continues to outstrip the economic growth of most member countries of the Organisation for Economic Co-operation and Development (OECD). Pay for performance (P4P) has been identified as an innovative tool to improve the efficiency of health systems but evidence that it increases value for money, boosts quality or improves health outcomes is limited.

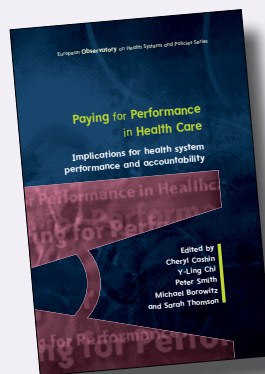
Using a set of case studies from 12 OECD countries (including Estonia, France, Germany, Turkey and the United Kingdom), this book explores whether the potential power of P4P has been over-sold, or whether the disappointing results to date are more likely to be rooted in problems of design and

implementation or inadequate monitoring and evaluation.

Each case study analyses the design and implementation of decisions, including the role of stakeholders; critically assesses objectives versus results; and examines the “net” impacts, including positive spillover effects and unintended consequences.

With experiences from both high and middle-income countries,

in primary and acute care settings, and both national and pilot programmes, these studies provide health finance policy-makers in diverse settings with a nuanced assessment of P4P programmes and their potential impact on the performance of health systems.



# NEW PUBLICATIONS

## Assessing chronic disease management in European health systems: country reports

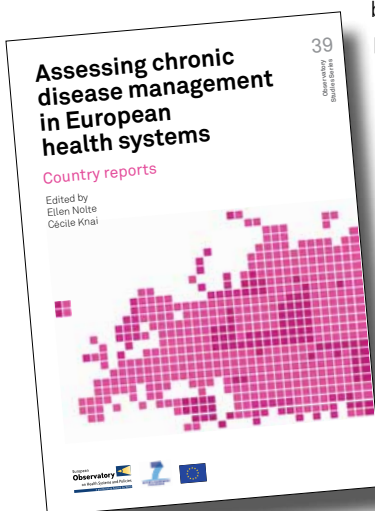
**Edited by:** E Nolte and C Knai

**Copenhagen:** World Health Organization 2015, Observatory Studies Series No. 39

**Number of pages:** 140; **ISBN** 978 92 890 5032 6

**Freely available for download at:** [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/277939/Assessing-chronic-disease-management.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0010/277939/Assessing-chronic-disease-management.pdf?ua=1)

Many countries are exploring innovative approaches to redesign delivery systems to provide appropriate support to people with long-standing health problems. Central to these efforts to enhance chronic care are approaches that seek to better bridge the



boundaries between professions, providers and institutions, but, as this study clearly demonstrates, countries have adopted differing strategies to design and implement such approaches.

This book systematically examines experiences of 12 countries in Europe, using an explicit comparative approach and a unified framework for assessment to better understand the diverse range of

contexts in which new approaches to chronic care are being implemented, and to evaluate the outcomes of these initiatives. It complements the previous study, *Assessing Chronic Disease Management in European Health Systems*.

The study focuses in on the content of these new models, which are frequently applied from different disciplinary and professional perspectives and associated with different goals and does so through analysing approaches to self-management support, service delivery design and decision-support strategies, financing, availability and access. Significantly, it also illustrates the challenges faced by individual patients as they pass through the system.

## Building primary care in a changing Europe: case studies

**Edited by:** DS Kringos, WGW Boerma, A Hutchinson and RD Saltman

**Copenhagen:** World Health Organization 2015, Observatory Studies Series No. 40

**Number of pages:** 304; **ISBN** 978 92 890 50 333

**Freely available for download at:** [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0011/277940/Building-primary-care-changing-Europe-case-studies.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0011/277940/Building-primary-care-changing-Europe-case-studies.pdf?ua=1)

This new volume consists of structured case studies summarising the state of primary care in 31 European countries. It complements the previous study, *Building primary care in a changing Europe* which provided an overview of the state of primary care across the



continent, including aspects of governance, financing, workforce and details of service profiles.

These case studies establish the context of primary care in each country; the key governance and economic conditions; the development of the primary care workforce; how primary care services are delivered; and an assessment of the quality and efficiency of the primary-care system.

The studies exemplify the broad national variations in accessibility, continuity and coordination of primary care in Europe today, something which complicates the assessment of primary care's role in contributing to the overall performance of the health system despite growing evidence of the added value of a strong primary care sector.

# NEWS

## International

### New Eurobarometer: Modest decline in tobacco use

Smoking remains the most significant cause of avoidable death in Europe, responsible for around 700,000 deaths per year. A new Eurobarometer survey on the attitudes towards tobacco of 27,801 respondents in all 28 EU Member States reveals that tobacco use is down by two percentage points since 2012, but that 26% of Europeans are still smokers. The age category that saw the biggest drop (4%) was young people aged 15 to 24 (25% vs 29%). There are still notable variations in tobacco consumption, with the lowest rates seen in Sweden (11%) and Finland (19%) and the highest in Greece (38%), Bulgaria (35%), Croatia (33%) and France (32%). 59% of smokers had tried to give up, with 19% having tried in the past 12 months. 12% of Europeans have used e-cigarettes, with 13% of 15–24 years olds having tried them compared with just 3% of people aged 55+. 21% of smokers were able to cut down with these products and 4% were able to stop smoking. 73% of workers in Europe are now rarely or never exposed to smoke indoors in their workplaces.

Vytėnė Andriukaitis, European Commissioner for Health and Food Safety, stated that the figures show that the fight against tobacco is not won, particularly amongst the young. The Commissioner went on to highlight strong measures in the Tobacco Products Directive (2014/40/EU) with rules on the manufacture, presentation and sale of tobacco and related products that will apply in Member States from May 2016. The products covered include cigarettes, smokeless tobacco, electronic cigarettes and cigars. The Directive includes a ban on flavours that mask tobacco, the introduction of combined (picture and text) health warnings covering 65% of the front and back of cigarette and roll-your-own tobacco packages, a ban on all promotional and misleading elements on tobacco products, and EU-wide tracking and tracing to combat illicit trade of tobacco products.

**The Eurobarometer is available at:** [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_429\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_429_en.pdf)

### World Health Assembly: Chancellor Merkel calls for a new plan to deal with catastrophes

At the opening session of the 68th World Health Assembly in Geneva German Chancellor Angela Merkel led calls for a new World Health Organization led plan to deal with “catastrophes”, such as the recent Ebola outbreak. More than 27,000 cases of Ebola Virus Disease (EVD) have now been reported in Guinea, Liberia and Sierra Leone, with over 11,130 reported deaths, marking it as one of the worst pandemics in modern times. *“The struggle (against Ebola) is only won if there are no new cases and if we have learned the lessons from this crisis: we should have reacted earlier,”* the Chancellor said.

She highlighted the critical need for urgent, collaborative action in emergencies, and the importance of having efficient structures in place, while paying tribute to all those working to safeguard human health worldwide, urging them to *“work together”*. She also pledged that, under Germany’s presidency, the Group of 7 (G7) would focus on fighting antimicrobial resistance and neglected tropical diseases. She emphasised the need for all countries to have strong health systems and highlighted the key role of health in sustainable development.

Later that day, WHO Director-General Dr Margaret Chan outlined her plans to create a single new WHO programme for health emergencies, uniting outbreak and emergency resources across the three levels (headquarters, regional and country offices) of the Organization. “I have heard what the world expects from WHO,” said Dr Chan. “And we will deliver”.

World Health Assembly delegates made a series of decisions stemming from the 2014 EVD outbreak. These now give the WHO Secretariat the go-ahead to carry out structural reforms so it can prepare for and respond rapidly, flexibly and effectively to

emergencies and disease outbreaks. These include setting out clear and effective command and control mechanisms across all three levels of the organisation. At the same time, WHO will establish an emergency programme, which will be guided by an all-hazards health emergency approach that emphasises adaptability, flexibility and accountability, humanitarian principles, predictability, timeliness and country-ownership. It will also set up a US\$ 100-million contingency fund to provide financing for in-field operations for up to three months. The contingency fund will run initially as a two-year pilot and will then be evaluated.

**More information on the outcomes of the World Health Assembly at:** <http://www.who.int/mediacentre/events/2015/wha68/en/>

## Country News

### United Kingdom: David Cameron calls for ‘wake-up to the threat from disease outbreaks’

UK Prime Minister, David Cameron, used the G7 summit in Germany to outline how the UK will step up its efforts to combat the outbreak and spread of deadly viruses with a new plan that will include more research and development and an improvement in how international health agencies respond on the ground. In a stark warning to other G7 leaders the Prime Minister said that the world must be far better prepared for future health pandemics that could be more aggressive and harder to contain than the recent Ebola outbreak.

While the number of new cases has fallen drastically, experts have warned that lessons must be learnt from what happened. A more virulent disease in future – transmitted by coughing, like the flu or measles for example – would have a much more devastating impact if a better approach is not put in place.

Mr Cameron said that *“despite the high number of deaths and devastation to the region, we got on the right side of it this time thanks to the tireless efforts of local*

and international health workers. But the reality is that we will face an outbreak like Ebola again and that virus could be more aggressive and more difficult to contain. As a world we must be far better prepared with better research, more drug development and a faster and more comprehensive approach to how we fight these things when they hit”.

The UK has also announced the creation of a rapid reaction unit of six to ten expert staff – mainly epidemiologists, infection control specialists and infection control doctors – who will be on permanent standby, ready to deploy to help countries respond to disease outbreaks. When deployed, the team will act as ‘disease detectives’, to understand what the disease is; how it is spreading; how fast it is spreading; and what response is required. A ‘reservist force’, including hundreds of doctors, nurses and public health experts, will be ready for call-up if the outbreak is not contained at an early stage.

### Germany: Nursing care industry reluctant to recruit foreign workers

A new study commissioned by German foundation, Bertelsmann Stiftung, reports that Germany’s nursing care industry is very reluctant to recruit nursing care staff from outside the country, despite a very high rate of staff shortages. 61% of nursing-care facilities have job vacancies, with an average of 4.3 unfilled places per firm. However, only one-sixth of all nursing-care operations have recruited skilled workers from abroad.

The study, carried out by Holger Bonin and Angelika Ganserer from the Centre for European Economic Research (ZEW) and Grit Braeseke from the European Institute for Health Care Research and Social Economy (IEGUS) investigated the practice of international recruitment of skilled workers in the German nursing-care industry. It is based on a survey of nearly 600 human-resources managers. In order to render its conclusions representative, the results of the survey were extrapolated to the full population of businesses in the German nursing-care sector by TNS Emnid, using the Mannheim Enterprise Panel dataset. In addition, interviews with selected experts and

industry practitioners helped deepen and enrich the survey’s findings.

Three out of four nursing-care organisations with job vacancies described the search for suitable skilled employees as difficult. Foreign recruitment ranked last on a list of strategies used by the care industry to address worker shortage, with only 16% of companies pursuing this option. Companies were more likely to headhunt competitors’ staff (20%) or try to reduce sickness-related absence (83%).

59% of nursing organisations that lack international-recruiting experience say it is not seen as an option for the future. They claim the process is too complex, expensive and entails too many legal hurdles. 83% of companies that have recruited skilled workers from abroad have run into bureaucratic obstacles, while 67% have encountered problems with recognition of qualifications. 60% have had difficulties related to immigration permits for non-EU nationals.

Jörg Dräger, a Bertelsmann Stiftung executive board member said *“it is clear how far Germany is from a pro-active and labour-market-oriented immigration policy”*. Companies want a reduction in regulatory barriers (67%), better language and integration courses (87%), and better information on potential recruits (73%). Small and medium-sized enterprises in particular need additional support. Despite these challenges, the survey also indicated that 60% of companies were satisfied or very satisfied with their foreign nursing staff. 61% of all German nursing-care companies who have hired foreign staff in the last three years have recruited from Spain; this is followed by Poland (19%), Croatia (16%), Romania (14%), Italy (13%) and Greece (12%).

#### The report (in German) is available at:

<http://tinyurl.com/opuyrh2>

### Italy: Non prescription on-line medicine sales from 1 July 2015

The Italian Ministry of Health has announced that from 1 July 2015 the provisions introduced by Legislative Decree No. 17 of 19 February 2014, transposing EU Directive 2011/62 concerning counterfeit medications, will

go into effect, permitting the on-line sale of non-prescription medicines by pharmacies and “para-pharmacies”. In order to proceed with on-line sales, pharmacies and para-pharmacies must obtain an authorisation from the competent region or autonomous territory, upon penalty of possible imprisonment for six months up to two years and a fine of up to €18,000. Online sales of prescription medicines remain prohibited, and subject to a penalty of imprisonment of up to one year and a fine of up to €10,000. The minimum contents of internet sites dedicated to on-line sales, including the details of the authorisation, weblinks to the website of the Ministry of Health, and the “common logo” identifying each sales site, are governed by Article 112-quarter of the Pharmacy Code.

### France: New report published on steps to create national public health agency

On 2nd June, François Bourdillon, Director General of Health Monitoring Institute (InVS) and the National Prevention and Health Education Institute (INPES) presented Marisol Touraine, Minister of Social Affairs, Health and Rights of Women, with his report setting out steps necessary to establish a new National Public Health Agency – Public Health France. Once established the new agency will amalgamate existing structures to bring together all public health missions including prevention, health promotion, population health surveillance, monitoring and warning, preparedness and response to health crises. Minister Touraine has stressed the need for the new body to be independent, providing transparent and clear advice. The new agency is expected to come into operation in 2016.

#### More information on the Bourdillon report

at: <http://www.sante.gouv.fr/rapport-de-prefiguration-agence-nationale-de-sante-publique.html>

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## SECURING HEALTH IN EUROPE

Balancing priorities, sharing responsibilities

Public health security remains high on the agenda,  
but effective health systems also need to engage  
with issues that lie beyond the health sector.