Health Economics
Abstract
This report summarises the presentations and discussions at the Workshop on "Health Economics", held at the European Parliament in Brussels, on Wednesday 28 November 2012. The aim of the workshop was to exchange views on how to improve the efficiency and effectiveness of health systems. The workshop was hosted by MEP Alojz Peterle (SL, EPP) and MEP Glenis Willmott (UK, S&D), Co-chairs of the Health Working Group within the ENVI Committee.
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<tr>
<td><strong>DG ECFIN</strong></td>
<td>Directorate General for Economic and Financial Affairs</td>
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<td><strong>DG EMPL</strong></td>
<td>Directorate General for Employment</td>
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<td><strong>DG SANCO</strong></td>
<td>Directorate General for Health and Consumers</td>
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<td><strong>EC</strong></td>
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<td><strong>ENVI</strong></td>
<td>Committee on Environment, Public Health and Food Safety</td>
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<td><strong>EP</strong></td>
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<td><strong>EPC</strong></td>
<td>European Policy Centre</td>
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<td><strong>EU</strong></td>
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<td><strong>GDP</strong></td>
<td>Gross Domestic Product</td>
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<td><strong>HOPE</strong></td>
<td>European Hospital and Healthcare Federation</td>
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<td><strong>MEP</strong></td>
<td>Member of the European Parliament</td>
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<td><strong>MFF</strong></td>
<td>Multiannual Financial Framework</td>
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<td><strong>MoU</strong></td>
<td>Memorandum of Understanding</td>
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<td><strong>NGO</strong></td>
<td>Non-Governmental Organisation</td>
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<td><strong>NHS</strong></td>
<td>National Health Service</td>
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<td><strong>OECD</strong></td>
<td>Organisation for Economic Co-operation and Development</td>
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<td><strong>WHO</strong></td>
<td>World Health Organization</td>
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EXECUTIVE SUMMARY

On 28 November 2012, the Committee on Environment, Public Health and Food Safety (ENVI) of the European Parliament held a workshop on "Health Economics". The workshop was hosted by Mr Alojz Peterle (MEP) and Ms Glenis Willmott (MEP) Co-chairs of the Health Working Group within the ENVI Committee.

In his opening statement, Mr Peterle highlighted that the economic importance of health has been underestimated for a long time. This has changed in recent years, with EU Member States being increasingly confronted with the need to strike a balance between universal access to high-quality health services and budgetary constraints. Introducing the aims of the workshop, Mr Peterle stated that the focus of the discussion would be on how to ensure the sustainability and promote the efficiency of health care systems.

The first part of the workshop provided an overview of public health care reforms following the financial crisis. Prof. Pedro Pita Barros, Professor of Economics at the Nova University in Lisbon, presented the experience of Portugal, a country strongly hit by the crisis. As a result of the Memorandum of Understanding under the EU financial rescue plan, Portugal had to undertake a number of reforms including in the health care sector. In particular, he described the measures introduced to adjust user charges, i.e. by increasing their value on the one hand and by broadening the base of the population that is exempt from charges on the other. Further reforms concerned the pharmaceutical market, including the promotion of generic medicines and more rational prescriptions. However, Prof. Barros noted that changes in the management of Portugal’s National Health Service have been difficult to achieve so far and have mostly been postponed.

Ms Francesca Colombo, Senior Health Policy Analyst at the Organisation for Economic Cooperation and Development (OECD), addressed the issue of public medicine versus private medicine in the new reforms. In this context, she provided an overview of the impact of the financial crisis on health spending in the EU, highlighting that health expenditure growth dropped significantly in 2009-2010 in most EU countries. Although both public and private health care are affected, she noted that the public component of health spending is suffering the most from these cuts. This has a major impact on most member countries, as private health insurance plays a large role only in a few of them. Ms Colombo concluded her presentation by highlighting the trade-offs between public versus private health care. In particular, she stressed that shifting the provision of health care services to the private sector would mean that the poorest segments of the population may not be able to cover the costs of private fees. This would create inequalities in access to health care.

The following speaker, Mr Federico Paoli, provided the perspective of DG Health and Consumers on the issue of health care system reforms. He referred to Article 168 of the Treaty of the European Union1 to explain that the role of the EU is to support Member States’ coordination and exchange of best practices in this area. For this purpose, the EU has included the aim of supporting health care systems in the Health Strategy 2008-2013.

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Also, Council conclusions were adopted in the past two years to assess the performance of health care systems and to initiate a reflection process on the most effective ways of investing in health. The European Semester is another governance tool to promote health care reforms that are cost efficient and sustainable in the context of the Europe 2020 Strategy.

Dr Pascal Garel, Secretary General of the European Hospital and Healthcare Federation (HOPE) concluded the first part of the workshop explaining the role of NGOs in the reform process. Where systems fail, NGOs, such as Médecins Sans Frontières, tend to be effective in providing external health care assistance, especially in times of economic crisis. Within the system, NGOs are also playing an important role in promoting an acceleration of health care reforms. In particular, Dr Garel warned against the reduction in scope of essential services and population coverage. A more forward-looking approach should be taken with further emphasis on primary care and greater coordination across different parts of the health care system.

The second part of the workshop focussed on the cost of efficiency. Dr Tamás Evetovits, Senior Health Financing Specialist at World Health Organization (WHO) Europe, started his presentation by highlighting that efficiency gains can indeed help navigate through the crisis and represent an opportunity for better health care systems. However, he also stressed that efficiency gains will not be sufficient per se and have to be accompanied by the right instruments to minimise possible adverse effects on equity. To make his point clear, Dr Evetovits stated that balancing the budget is not a mere accounting exercise. In other words, ensuring stable and predictable revenues for health must go hand in hand with improving efficiency, without cutting back on services or penalising the poor. Finally, Dr Evetovits stressed that efficiency gains may not be immediate or easy to achieve, and must be accompanied by smart investments, including support from EU Structural Funds.

Mr Ivailo Kalfin (S&D, BG) MEP and Rapporteur on the Multiannual Financial Framework (MFF) for the years 2014-2020, provided an update on the MFF negotiations. In July 2011, the Commission proposed a new envelope for the Health for Growth programme, with only a slight increase in budget compared to the previous period. However, the current discussions in the European Council lean towards disproportionate cuts in a number of areas, including research, innovation, mobility, external action, and health within the citizens’ programme. Mr Kalfin stressed that the European Parliament should remain firm in defending key EU policies and in calling for a reform of the budget as a whole.

After that, Prof. Alicja Sobczak, Professor of Health Economics at Warsaw University, introduced a more theoretical framework to explain the notion of efficiency in health economics. She mentioned that efficiency is basically the relation between results or outcomes and resources or input. One can look at efficiency as a saving option, i.e. to minimise the resources used to achieve certain results, or as a productivity option, i.e. to maximise the outcome with given resources. Efficiency can also be seen as a result of both operational and distributional decisions aimed at reducing waste whilst ensuring the best allocation of resources. She concluded her presentation by highlighting the role of medical professionals to provide accurate measurements of the health gains and objective information, which are essential for efficiency research.
In conclusion to the workshop, Ms Ana Xavier introduced into the debate the point of view of DG Economic and Financial Affairs. In particular, she addressed the main policy challenges to improve the cost-effectiveness of health care systems, including the need to ensure a sustainable and equitable financing basis, to adjust cost-sharing while addressing equity, to improve the general governance of the system as well as data collection as a tool to inform better decision-making. She also stressed the importance of enhancing primary health care and hospital efficiency, while ensuring a cost-effective use of medicines (e.g. with the promotion of generics) and a more systematic use of health-technology assessments. Finally, she emphasised that health is more than just health care; hence health promotion and disease prevention should also be considered as key elements to improve the general health status of the EU population.
1. LEGAL AND POLICY BACKGROUND

Public spending on health absorbs a growing proportion of GDP and constitutes up to 15% of total government expenditure in some Member States. A rising demand is linked to a number of factors, including an ageing population and higher patient expectations towards the provision of better quality services. Over the last decades, EU Member States have achieved major improvements in population health with better access to care and quality of care. However, these developments have come at considerable financial costs, with health spending in European countries increasing at faster rate than the rest of the economy.

The beginning of the financial and economic crisis brought about what can be defined as a "health system shock", since many European countries had to reduce health spending as part of a broader effort to face budgetary constraints. As a result, growth in health spending per capita slowed or fell in 2010 in almost all European countries. The response to the crisis varied across the EU. A WHO Europe survey indicates that, in general, European countries have employed a mix of policy tools in response to the financial crisis. In some cases, the reform of the health care sector was already underway, and the economic crisis sped up the existing process. Although public expenditure remains the main source of health care financing almost everywhere in Europe, the economic crisis has affected the mix of public and private sources of funding.

The current economic and financial crisis has therefore created an even more pressing need to stimulate sound health care reforms and to improve the cost-effectiveness of health care systems. As such, technological and product innovation as well as the modernisation of health care could help reduce the costs and, at the same time, improve the quality of care. However, public health and health care spending should not be merely seen as a cost, but rather as an investment, since a healthy population is a prerequisite for increased productivity and prosperity. According to the Health for Growth Programme (the third multi-annual programme of EU action in the field of health for the period 2014-2020), health-related research and development has the potential to reach 0.3% of GDP and the health care sector is one of the largest in the EU, accounting for approximately 10% of the EU's GDP. Also, expenditure related to health promotion and prevention may bring about savings in curative treatment.

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6 Ibid.

7 Private sources of funding include out-of-pocket payments (i.e. the costs that private individuals must pay directly to the health care provider) and private health insurance.

According to Article 168 of the Treaty of the European Union\(^\text{10}\), the EU has a mandate to support Member States’ action and encourage cooperation to improve the complementarity of their health services. On this basis, the EU has taken a number of initiatives to promote more dynamic health systems and more effective ways of investing in health.

The EU Public Health Strategy 2008-2013\(^\text{11}\), under its Principle 2 "Health is the Greatest Wealth", encourages further understanding of the economic relationships between health status, health investment and economic growth. Health has also been integrated into other policy areas aimed at enhancing EU growth, employment and innovation, including research and regional policies.

Also, specific Council Conclusions have been adopted on modern, responsive and sustainable health systems\(^\text{12}\) as well as on the sustainability of public finances in the light of ageing populations\(^\text{13}\). On this basis, a reflection process has been launched to identify effective ways of investing in health, including measuring and monitoring the effectiveness of health investments, promoting integrated care models and better hospital management as well as the cost-effective use of medicines. Efforts for the modernisation and reform of health care systems aiming at cost-efficiency and sustainability are also promoted in the context of the European Semester for the implementation of the Europe 2020 strategy\(^\text{14}\).

The Health for Growth Programme\(^\text{15}\), which has been proposed by the European Commission as part of the Multiannual Financial Framework (MFF) 2014-2020\(^\text{16}\), is putting further emphasis on increasing the sustainability of health services and improving the health of the population, whilst encouraging innovation in health. With a proposed budget of EUR 446 million, the Health for Growth Programme aims to support and complement the work of Member States to achieve the following four objectives:

- Developing innovative and sustainable health systems;
- Increasing access to better and safer health care for citizens;
- Promoting health and preventing disease; and
- Protecting citizens from cross-border health threats.

The MFF, and the "health package" within it, is currently being discussed by the European Parliament and the Council. The negotiations are expected to be concluded by early 2013, which would allow the new MFF to enter into force in 2014, following adoption of the relevant legislation.


\(^{14}\) EUROPE 2020 A strategy for smart, sustainable and inclusive growth /* COM/2010/2020 final */.

\(^{15}\) Proposal for a REGULATION OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on establishing a Health for Growth Programme, the third multi-annual programme of EU action in the field of health for the period 2014-2020 /* COM/2011/0709 final - 2011/0339 (COD) */.

2. PROCEEDINGS OF THE WORKSHOP

2.1 Part I: Public Health Care Reforms Following the Financial Crisis

2.1.1 Welcome and opening – Alojz Peterle (MEP) and Glenis Willmott (MEP)

Mr Alojz Peterle, Member of the Environment, Public Health and Food Safety (ENVI) Committee and Co-chair of the Health Working Group, welcomed the attendees and the speakers to the workshop. In his introduction, he highlighted that health has been underestimated for a long time and it is now becoming a key political and economic issue. He reminded the audience of the EU principles on public health, i.e. health for all and in all policies. Health systems have been in trouble in some Member States already for a number of years, which means that policy-makers have had to take important decisions on necessary reforms. Mr Peterle noted that EU Member States have been increasingly confronted with the need to strike the right balance between providing universal access to high-quality health services and addressing budgetary constraints. Some countries have already had to cut their health budgets and others will follow. In this situation, understanding health economics is crucial to ensure the financial sustainability and promote the efficiency of health systems.

Finally, Mr Peterle reminded the audience of the aims of the workshop, i.e. to discuss the latest health care reforms and developments in health economics at EU and national levels. He then introduced the co-chair, Ms Glenis Willmott, who also thanked all experts and introduced the first speaker.

2.1.2 Reforms and efficiency in European health systems: the example of Portugal, Prof. Pedro Pita Barros (PT)

Prof. Pedro Pita Barros, Professor of Economics, Nova University Lisbon

In setting the context for his presentation, Prof. Barros mentioned that Portugal has been under a financial rescue plan since May 2011. Recent reforms are therefore related to the Memorandum of Understanding (MoU), which is part of the financial agreement. Prior to the current developments, however, there had been a first wave of reforms already in 2005. At that time, primary care was reorganised around "family health units" and the continued care network was introduced in the National Health Service (NHS).

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17 The Economic Adjustment Programme for Portugal was agreed in May 2011. It includes a joint financing package of €78 billion and covers the period 2011 to mid-2014. More information is available on the website of DG Economic and Financial Affairs: [http://ec.europa.eu/economy_finance/eu/countries/portugal_en.htm](http://ec.europa.eu/economy_finance/eu/countries/portugal_en.htm).
The "Master Financial Assistance Facility Agreement between European Financial Stability Facility, the Portuguese Republic as Beneficiary Member State and Banco de Portugal" is available at: [http://www.efsf.europa.eu/attachments/efsf_portugal_ffa.pdf](http://www.efsf.europa.eu/attachments/efsf_portugal_ffa.pdf).

Prof. Barros explained that, in the MoU, more than 50 measures have an impact on the health care sector. In particular, one of the measures that has caused growing public concern is the increase in user charges. To exemplify this increase, Prof. Barros presented a graph showing a huge leap in user charges (in real value) from 2011. However, this change corresponds to an increase in income-related user exemptions. Therefore, he concluded that what was taken away with one hand (i.e. higher user charges), was in fact given back with the other (i.e. income-related exemptions).

Another area that has been heavily targeted is the pharmaceutical market. Prof. Barros stated that this area alone would contribute to 30 - 40% of all savings in the public health care sector. Targets have been set for public spending in pharmaceuticals as well as for lower margins in retail and wholesale distribution. Generics and rational prescriptions have been promoted and there has been a change in international reference countries to get new drugs at lower prices. This has resulted in the use of cheaper generics - which has in turn impacted on lower margins for pharmacies - and in a payback agreement with the pharmaceutical industry if spending targets are exceeded.

The management of the Portuguese NHS has also experienced some changes. In the first place, it needed to recover arrears and to set procedures to avoid them in the future. By the end of 2011, the NHS owed the pharmaceutical industry EUR 3 billion – a huge amount taking into account that the initial budget in 2012 for the NHS was EUR 7.5 billion. As for other management issues, apart from having put in place a centralised purchasing and procurement plan, the NHS is lagging behind in terms of its proposed strategic plan. This plan is a benchmark system for hospital performance, reorganisation and rationalisation of the hospital network (to make 15% in cost savings), including a more efficient allocation of doctors and specialities. Measures that are effectively in place include medical guidelines and a feedback system for doctors for prescription patterns, a stronger role for primary care with more family health units, a reduction in fiscal benefits and increased competition among private providers.

Summarising the effects of the reforms and efficiency measures on health care use in Portugal, Prof. Barros highlighted that the cuts have generally been met with the resilience of health care professionals in hospitals. Also, there has been a decrease in emergency room use and in primary care as well as a slight increase in waiting times, although with more people treated. Finally, Portugal has experienced only a slight increase in suicides below the rate that could have been expected during an economic crisis.

2.1.3 Public medicine versus private medicine in the new reforms, Ms Francesca Colombo (OECD)

Ms Francesca Colombo, Senior Health Policy Analyst, Health Division

Ms Colombo began her presentation by explaining that she would be taking a broad view, i.e. not looking at individual countries but at the EU as a whole. She would be looking at both public and private sectors of health care and what has happened since the beginning of the financial crisis. In particular, she would focus on three main areas: the impact of the economic and financial crisis on health spending in the EU; the reforms following the crisis that affect public and private health care; and the important trade-offs to address between public and private health care.
On the first topic, i.e. the impact of the economic and financial crisis on health spending in the EU, she showed a graph on the annual average growth rate in health expenditure per capita, in real terms, from 1975 to 2010\(^{19}\). The graph clearly indicates that growth in health spending across the EU fell sharply since 2008 and has continued to fall. In fact, all (but two – Malta and Germany) EU countries have seen a slowdown or reversal in health expenditure growth. This slowdown has been even more substantial in the public component of health spending relative to the private one. Ms Colombo then showed another graph illustrating that health expenditure as a share of EU GDP came down slightly in 2010.

Regarding how the reforms following the crisis have affected public and private health care, Ms Colombo explained that cuts or slower growth took place in public spending across most sectors, including in-patient and out-patient care, long-term care, pharmaceuticals and prevention. This was due to budgetary and pricing measures, as well as changes in cost-sharing, i.e. in the public/private mix. Ms Colombo mentioned that many EU Member States have introduced co-payment measures. However, there has been no apparent change in overall benefit packages, as public health authorities have mainly cut on services and resources, not on benefits. All these reforms have resulted in a significant shift from public to private spending only in a few EU Member States, whereas in the majority of countries the public/private mix has not changed substantially. Other data show that private insurance coverage has grown in some Member States, but private health insurance plays a large role only in a few countries. On this topic, Ms Colombo remarked that out-of-pocket payments remains the largest private source of financing, accounting for 21 % of private insurance spending across the EU.

Finally, Ms Colombo looked at important trade-offs to address between public and private health care, as budget pressures raise questions about what and how much should be covered by public spending. She mentioned that cost-sharing reforms raise access challenges, but could be used to drive desirable health behaviours. She then looked at trade-offs between depth and breadth of coverage. Here the question is whether to cover all services but not well, or focus, for example, on specific issues such as in and out-patient care and not on issues such as the reimbursement of eyeglasses. She argued that shifting cost to the private sector to contain public cost raises trade-offs that could exacerbate some of the compromises inherent in the public-private mix, e.g. creating inequities in access for those unable to pay private fees.

In conclusion to her presentation, Ms Colombo stated that private health insurance is better than out-of-pocket payments, but should not be regarded as a "magic bullet" as it only covers marginal services. The bottom line for her is that there need to be efficiency gains in order to improve value for money from public health spending.

\(^{19}\) Source: OECD Health Data 2012. Available at: http://www.oecd.org/health/healthpoliciesanddata/oecdhealthdata2012.htm
2.1.4 Health systems reforms: the EU perspective, Mr Federico Paoli (European Commission)

Mr Federico Paoli, Policy Officer, Health care Systems, DG SANCO

The following speaker, Mr Federico Paoli, provided the perspective of DG Health and Consumers on the issue of health care system reforms. He referred to Article 168 of the Treaty of the European Union\(^{20}\) to explain that the role of the EU is to support Member States’ coordination and exchange of best practices in this area. For this purpose, the EU has included the aim of supporting health care systems in its Health Strategy “Together for health: a strategic approach for the EU 2008-2013”\(^{21}\). The Strategy has three main objectives: fostering good health in an ageing Europe; protecting citizens from health threats; and supporting dynamic health systems and new technologies. Also, Mr Paoli explained that Council Conclusions were adopted in the past two years to assess the performance of health care systems\(^{22}\) and to initiate a reflection process on the most effective ways of investing in health\(^{23}\). The Council also invited the European Commission and Member States to assess the performance of health care systems and implement sound and needed reforms to achieve both a more efficient use of limited public resources and the provision of high quality health care.

After introducing the broad policy framework, Mr Paoli went on to present how the EU is intervening in practice. He mentioned three main directions: the European Semester, the economic adjustment programmes and the reflection process on health systems. He then focussed on the former and the latter approaches during his presentation.

The European Semester\(^{24}\), which involves the European Commission, the Council of Ministers, the European Parliament, the European Council and Member States, is the governance tool in place since 2011 to promote health care reforms that are cost-efficient and sustainable in the context of the Europe 2020 strategy\(^{25}\). Operational targets for Member States and the EU as a whole are defined year by year on the basis of the Annual Growth Survey.

In this context, Mr Paoli summarised the main elements on health of the Annual Growth Survey for 2012, which included the modernisation and reform of health systems aiming for cost-efficiency and sustainability; the elimination of unjustified restrictions for health and social services; and the promotion of initiatives to facilitate the development of sectors with the highest employment potential, for example the health and social sectors. He then provided an overview of the country-specific recommendations issued in 2012 for the health sector, which were in some cases related to the implementation of MoUs (e.g. for Greece, Ireland, Portugal and Romania).

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\(^{24}\) For more information on the European Semester, please see: http://ec.europa.eu/europe2020/making-it-happen/index_en.htm

\(^{25}\) EUROPE 2020 A strategy for smart, sustainable and inclusive growth /* COM/2010/2020 final */.
As far as the reflection process is concerned, Mr Paoli explained that the Council invited Member States and the European Commission to identify effective ways of investing in health, so as to pursue modern, responsive and sustainable health systems. The process is based on five working groups that should achieve concrete progress by autumn 2013, e.g. on enhancing the representation of health in the framework of Europe 2020, on the cost-effective use of medicines and on measuring and monitoring the effectiveness of health investments.

Mr Paoli concluded his presentation by highlighting the ten main challenges ahead to contain costs and make health systems more effective, including sustainable financing, adjusting existing cost-sharing systems and improving the general governance of the health sector.

2.1.5 Reforming Health Systems: The role of NGOs, Dr Pascal Garel (HOPE)

Dr Pascal Garel, Secretary General, European Hospital and Healthcare Federation

At the beginning of his presentation, Dr Pascal Garel briefly introduced the European Hospital and Healthcare Federation (HOPE), which is an international non-profit organisation representing national public and private hospital associations as well as hospital owners - either federations of local and regional authorities or national health services.

Dr Garel explained that there are many types of different Non-Governmental Organisations (NGOs). In particular, he mentioned NGOs that are internal to health services (i.e. representing doctors or other health professionals), partially internal, (i.e. representing patients, carers and consumers) and NGOs that are external to the health system (i.e. those providing humanitarian aid).

He then gave some examples of where NGOs play a key role in health systems. Where systems fail to provide the necessary support, for example for homeless people or for migrants, NGOs (such as Médicins Sans Frontières and Medecins du Monde) tend to be effective by providing external health care assistance. NGOs can also be effective within health services, e.g. promoting the acceleration of health care reforms and enhancing patient empowerment. Looking at how integrated NGOs are in Europe, Dr Garel explained that the degree of integration varies depending on the country. In some countries, NGOs are not even consulted in the discussion of reforms or in the organisation of health care systems, whereas in other countries NGOs are actively engaged.

Focusing on the current economic downturn and crisis, Dr Garel explained that it is not easy to get a clear picture of reality. As indicated in a HOPE publication “The Crisis, Hospitals and Healthcare”26, health care systems are more affected in some countries and less in others. There is also a big diversity in the way reforms are enacted, including short-term reactions that are not necessarily the most efficient way to tackle problems in the health sector. The main message is that the crisis should not be automatically expected to represent a good time for structural reforms. Where countries are affected, the main consequences that are being witnessed include increased emergency activities (with the exception of Portugal), increased waiting times and no compensatory mechanisms for closure or reduced activity of hospitals.

26 European Hospital and Healthcare Federation (HOPE), The Crisis, Hospitals and Healthcare, April 2011.
Currently, humanitarian NGOs are not only warning on what is happening on the ground, but also providing care, as is the case in Greece. As for other non-humanitarian NGOs, their role does not seem to have changed substantially as a result of the crisis, and in most cases they are still not involved in the reform process.

In his prognosis for the future, Dr Garel highlighted that the signs are very worrying. In the past two years, policy tools have focused on a reduction in the scope of essential services and in population coverage, as well as on an increase in waiting times and the addition of user charges for essential services.

In conclusion to his presentation, Dr Garel stressed that a more forward-looking approach should be taken with further emphasis on primary care and greater coordination across different parts of the health care system.

2.1.6 First round of questions and answers

Ms Willmott then opened the floor for questions. A representative from Novartis addressed the first two presenters, Prof. Barros and Ms Colombo, asking about health care outputs or outcomes for patients in terms of morbidity, mortality, burden of disease and life expectancy. He said that we had heard a lot about inputs, measurements or parameters of health care systems, for example user charges, the pharmaceutical market, emergency rooms, primary care etc., and he was wondering about what was happening in terms of output.

Ms Colombo answered by saying that all countries have experienced increases in life expectancy. However, there has also been a general increase in chronic conditions, which has put further pressure on health systems as most of these systems are geared towards acute care. Therefore, the attention now needs to shift more on prevention, in particular on those preventative interventions that deal with chronic conditions and are cost effective. Although there may be some short-term cuts, it would not be advisable to pursue cuts in preventative measures as a long-term strategy. Prof. Barros added that he would welcome more outcome-oriented assessment. However, this type of measurement usually takes longer and is not always precise. In particular, morbidity is more difficult to measure in a given timeframe.

Another question was asked to Mr Federico Paoli about the next steps of the Health Strategy 2008-2013, which is due to expire next year. Mr Paoli answered that the current strategy is still very valid and will remain so for the years to come.

Finally, Mr Peterle asked the panellists if, rather than cuts in health budgets, any of them had seen more investment in prevention. Ms Colombo answered that she had not, despite the fact that just before the crisis there was some investment in prevention, e.g. in the vaccine for swine flu.
2.2 Part II: The Cost of Efficiency

2.2.1 How much can efficiency gains help navigate through the crisis? Dr Tamás Evetovits (WHO Europe)

Dr Tamás Evetovits, Senior Health Financing Specialist, Barcelona Office for Health Systems Strengthening, Division of Health Systems and Public Health

Dr Evetovits started his presentation by stating upfront that efficiency-enhancing measures should be used to reduce the adverse effects of the crisis. However, he stressed that efficiency gains alone would not be sufficient to navigate through the crisis. Equity is also an important objective, which makes the task more difficult as the distributional effect of efficiency measures is potentially huge on the poorer segment of the population.

The financial crisis has tested both governments’ commitment to health system objectives, in particular equity and solidarity, and health systems’ preparedness and resilience to deal with an economic shock. According to Dr Evetovits, it is important to have a strong health system that can deal with the challenge of adapting to a lower cost environment.

Dr Evetovits stressed that the choice of policy instruments used by governments to address the downturn plays a key role. So far, the instruments used have not impacted access to health care among the general population. However, when these instruments involve an increase in cost sharing, i.e. an increase in the portion of health care costs not covered by health insurance, there are negative financial implications, especially for the poorest segments of the population.

He also stated that balancing the budget is not a mere accounting exercise, but rather a matter of public policy priorities to minimise any adverse effects on equity and financial protection. He then looked at what he defined as the real measure of “priority”, i.e. government spending on health as a percentage of total government spending. In 2010, there was a big variation across countries in Europe, ranging from just over 5% for Cyprus to approaching 20% for the Netherlands and Germany. In response to the crisis, some of these countries have further reduced the share of public spending on health within their government budgets.

The World Health Organization (WHO) has recently produced an overview of health policy responses to the financial crisis. Dr Evetovits summarised the key findings of the survey, which concluded that health systems need predictable sources of revenues with counter-cyclical public spending and that the health sector itself can contribute to the economic recovery. Quoting Dr Margaret Chan, Director-General of WHO, he stated that "improving efficiency is a far better option than cutting back on services or imposing fees that punish the poor".

Dr Evetovits then listed the leading sources of inefficiency according to the WHO's World Health Report 2010, including the misuse of medicines, services and products. In his view, improving efficiency would reduce the adverse effects of the crisis and help secure popular and political support for more spending in the future. This could be achieved by eliminating ineffective and inappropriate services, improving rational drug use, allocating more resources to primary and outpatient specialist care at the expense of hospitals, investing in infrastructure that is less costly to run, and cutting the volume of the least cost-effective services.

Dr Evetovits further emphasized that the crisis presents opportunities not to be missed as well as potential failures to avoid. Short-term solutions are somehow necessary to keep the system running. However, efficiency gains should be pursued in a sustainable way, i.e. avoiding loss of human resources and bearing in mind that cost containment does not necessarily equal efficiency. He explained that there is also a limit to how far (and how fast) efficiency gains can be achieved. Efficiency savings may not be immediate and some inefficiencies may be harder to address than others. With health care systems already overstretched, what works well should be protected because re-building capacity may be more costly in the long run. Also, investments have to be smart to make health systems stronger and more resilient to future shocks.

In conclusion, financial sustainability is meaningless if it is not linked to public policy objectives that include equity and efficiency. Therefore, across the board cost cutting would not solve the problem. Dr Evetovits finished his presentation by mentioning Health 2020\textsuperscript{28}, the new European policy framework by WHO aiming for solidarity, fairness and sustainability.

\section*{2.2.2 European Parliament perspective, M. Ivailo Kalfin, MEP}

Mr Ivailo Kalfin, MEP and Rapporteur on the Multiannual Financial Framework (MFF) for the years 2014-2020

In his presentation, Mr Kalfin provided an update on the Multiannual Financial Framework (MFF) and the on-going MFF negotiations\textsuperscript{29}. He explained that in July 2011 the Commission proposed a new envelope for the Health for Growth Programme\textsuperscript{30}, with only a slight increase in funding compared to the previous period (from EUR 321 million to EUR 396 million). The Commission suggested freezing the expenditure for the next seven years to the level of 2013. However, Member States have expressed scepticism at financing the budget on these terms. As a matter of fact, the latest discussions in the Council lean towards decreasing even further the overall financing of the budget. In particular, among the Member States, the big contributors to the EU budget want deep cuts, whereas the so-called "friends of cohesion" are fighting to keep the current level of cohesion funds. Last but not least, the Member States in favour of a strong Common Agricultural Policy claim that agriculture policy should not be touched.

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\textsuperscript{30} Proposal for a REGULATION OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on establishing a Health for Growth Programme, the third multi-annual programme of EU action in the field of health for the period 2014-2020 /* COM/2011/0709 final - 2011/0339 (COD) */.
Mr Kalfin felt that negotiations in the Council were heading towards a relative preservation of funds for both cohesion and agriculture, which would mean deep cuts for other funds, including research, innovation, mobility, competitiveness, external action, as well as health within the Europe for Citizens Programme. The last proposal of the European Council President, Mr Van Rompuy, mentioned a slight decrease in the budget for health, but at this stage it is difficult to estimate how the different envelopes will be affected. Expectations are that in February 2013 the Member States will reconvene to find a compromise. Mr Kalfin expressed concerns that further, disproportionate cuts might be envisaged in that context.

In conclusion to his presentation, Mr Kalfin stressed that the European Parliament is not pleased with the current state of play. Even if the Council found an agreement, he highlighted that there might still be a disagreement in the Parliament. He implied that the Parliament should remain firm in defending key EU policies, such as health, and in calling for a reform of the budget as a whole.

2.2.3 The notion of efficiency in Health Economics, Prof. Alicja Sobczak (PL)

Prof. Alicja Sobczak, Professor of Health Economics, Warsaw University

In her presentation, Prof. Alicja Sobczak introduced a more theoretical framework to explain the notion of efficiency in health economics. She started with the definition of efficiency as a relation between results and the resources used to achieve them. In other words, efficiency can be defined as the relation between outputs/outcomes and inputs. Inefficiencies therefore occur when more results can be achieved from given resources or fewer resources may be needed for achieving given results.

When talking about efficiency, Prof. Sobczak went on to explain that there are two basic options: the "saving" option, with a minimisation of the resources used to achieve certain results; and the "productivity" option, with a maximisation of the results achieved from given resources. Introducing the different types of efficiency, Prof. Sobczak also spoke about "operational efficiency", i.e. focusing on how to produce a chosen result, and "allocative efficiency", i.e. focusing on how to allocate scarce resources between different goods. She sees improving overall efficiency as a joint result of operational and allocative decisions. In other words, resources have to be directed to the right combination of goods that are produced effectively in operational terms.

Prof. Sobczak then explained a variety of efficiency formulas where results and resources can be measured in terms of physical quantity or monetary cost. She also stressed that results and resources may be perceived differently from the point of view of different stakeholders, e.g. patients, health care professionals, politicians, owners of health care entities, managers, payers, etc. In this context, she considers efficiency in health care as a consequence of allocative decisions made by politicians, technocrats/bureaucrats, owners and managers of non-public and public institutions, as well as of operational decisions made by health providers. Looking at the different types of efficiency analyses expressing health gains, she mentioned the following: cost minimisation, which compares costs of equal medical technologies in terms of health gains as non-monetary outcomes; cost effectiveness, which looks at cost per unit of health gains; cost utility, which regards health gains as a joint measure of life duration and quality; and cost benefit, where health gains are expressed in monetary terms.
In conclusion, Prof. Sobczak stressed that efficiency is ultimately a joint effort of economists and clinicians: clinical effectiveness is critical for proper efficiency analyses and evidence-based medicine is essential for providing economists with objective and accurate information on clinical effectiveness. Finally, she highlighted that efficiency is not the main criterion when discussing health care, as health is a human right in the first place.

2.2.4 Cost-effectiveness use of drugs (medicines) and their spending in Member States, Ms Ana Xavier (European Commission)

Ms Ana Xavier, DG Economic and Financial Affairs (DG ECFIN)

The final speaker of the workshop introduced into the debate the point of view of DG Economic and Financial Affairs. First of all, Ms Xavier presented the main aspects of the 2010 Joint report by DG ECFIN and the European Policy Centre (EPC) on health care systems31.

The report, prepared in cooperation with DG SANCO and DG EMPL, started as a didactic exercise to identify determinants of expenditure as well as challenges and good practices to improve the cost effectiveness of health systems. In particular, it looked at how to contain spending pressures through efficiency gains, in order to ensure sustainable access to high-quality health services for all. The broad conclusion of the report was that the measures introduced by Member States in the last two decades should be re-assessed and intensified in the immediate future, in order to achieve the needed consolidation of public finances in Europe. The report also found that macro-type controls, e.g. cap on expenditure or expenditure growth, are not sufficient and should be associated with micro-type, incentive-based reforms.

Ms Xavier then elaborated on the policy challenges identified in the report as priorities. Specifically, the policy challenges to be addressed include the creation of a sustainable and equitable financing basis with pooling of risks and funds, and a reduction of tax deductions and resource allocation adjusted to the needs. Also, a cost-effective care path needs to be defined while addressing equity and access concerns. This should go hand in hand with an improvement in the general governance of health care systems, as in many Member States it is still unclear who decides on what. Data collection and the use of available information are also very important to support performance improvement. A reduction in the unnecessary use of specialist and hospital care should be achieved while improving primary health care. Additionally, there needs to be an increase in the use of day-care surgery and concentration of some hospital services; a cost-effective use of medicines; a balanced mix of staff skills; and a more systematic use of health-technology assessment to determine cost-effective treatment. In conclusion, Ms Xavier stressed that health is much more than just the health care system. Hence, more effective health promotion and disease prevention is also necessary.

Following on from the report, DG ECFIN has recently produced an Economic Paper on the cost-effective use of medicines. Ms Xavier explained that the paper recommends a greater use of generics, centralised public tendering, health–technology assessment, monitoring and controlling of prescription behaviour, risk-sharing arrangements with industry, as well as discounts and payback to control excess spending in agreement with the pharmaceutical industry.

### 2.2.5 Second round of questions and answers

Mr Peterle opened the floor for the second round of questions and answers. Ms Xavier asked the rest of the panel what the best way would be to move forward if efficiency gains were not sufficient to achieve set targets.

Dr Evetovits answered that even if efficiency gains could be used to achieve certain objectives, such gains would not be sufficient to maintain financial protection with the current economic downturn. Therefore, avoiding increased user charges is ultimately a question of priority given to health compared to other sectors. In his view, cuts in health systems across the board should be avoided. If any cuts are absolutely needed, these should be smart, i.e. aimed at improving efficiency rather than at downsizing health objectives.

Mr Peterle then asked for more clarification about prescription behaviours, specifically on antibiotics, which seem to vary a lot across the Member States. Mr Paoli mentioned that one possible solution would be to issue clinical guidelines to encourage proper treatment and to avoid the unnecessary prescription of antibiotics. However, Prof. Barros argued that, from his experience in Portugal, clinical guidelines might not be sufficient per se. To be effective, information on how the treatment has worked should also be provided. Ms Colombo added that there is a lot that can be done to educate patients and to involve them in the process.

Finally, Mr Peterle wondered if there are currently any endeavours to reform health systems using complementary or alternative medicine. Mr Marcelo Sosa Iudicissa said that indeed this should be taken seriously. Ms Colombo mentioned that so far there has been very little evaluation of the cost-effectiveness of alternative medicine, and therefore it is difficult to include it in the equation.

### 2.2.6 Conclusions

At the end of the workshop, Mr Peterle thanked the panellists and the audience. In her concluding remarks, Ms Willmott stressed that policy-makers need to consider the long-term consequences of the reforms. She also emphasized the importance of promoting cost-effective prevention to tackle issues such as tobacco, alcohol and obesity in order to bring down the cost of health care. Her view is that, in the current EU budget negotiations, cutting back on policies such as health, research and innovation is not acceptable.

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ANNEX 1: PROGRAMME

WORKSHOP ON
Health Economics

Wednesday, 28 November 2012 from 12.30 to 14.45
European Parliament, Paul-Henri Spaak Room P7C050, Brussels

Organised by the Policy Department A-Economy & Science
for the Committee on the Environment, Public Health and Food Safety (ENVI)

AGENDA

12.30 - 12.35
Welcome and opening by Co-chairs of the Health Working Group Alojz Peterle and Glenis Willmott, MEPs

Part 1 - Public Healthcare Reforms Following Financial Crisis

12.35 - 12.45
Reforms and efficiency in European health systems: the example of Portugal.
Prof. Pedro Pita Barros, Professor of Economics, Nova University Lisbon (PT)

12.45 - 12.55
Public medicine versus private medicine in the new reforms
Ms Francesca Colombo, Senior Health Policy Analyst, Health Division, OECD

12.55 - 13.05
Health systems reforms: a European perspective?
Ms Nathalie Chaze, Head of Unit, Health care Systems, DG SANCO, European Commission

13.05 - 13.15
Reforming Health Systems: The role of NGOs
Dr Pascal Garel, Secretary General, European Hospital and Healthcare Federation (HOPE)

13.15 - 13.30
Question Time

Part 2 - European Parliament Perspective

13.30 - 13.40
Mr Ivailo Kalfin, MEP, Rapporteur on Multiannual Financial Framework for the years 2014-2020
Part 3 - The Cost of Efficiency

13.40 - 13.50
How much can efficiency gains help navigate through the crisis?
Dr Tamás Evetovits, Senior Health Financing Specialist, Barcelona Office for Health Systems Strengthening, Division of Health Systems and Public Health, WHO Europe

13.50 - 14.00
The notion of efficiency in Health Economics
Prof. Alicja Sobczak, Professor of Health Economics, Warsaw University (PL)

14.00 - 14.10
Cost-effectiveness use of drugs (medicines) and their spending in Member States
Ms Ana Xavier, DG Economic and Financial Affairs, European Commission

14.10 - 14.40
General Discussion

14.40 - 14.45
Conclusions

14.45
Closing
ANNEX 2: SHORT BIOGRAPHIES OF EXPERTS

Prof. Pedro Pita Barros

Pedro Pita Barros is Professor of Economics at Universidade Nova de Lisboa where he teaches industrial organisation and health economics. He is also a research fellow at the Centre for Economic Policy Research (London). Prof. Barros’ research focuses on issues related to health economics, regulation and competition policy. His work covers different topics including: health expenditure determinants, waiting lists, bargaining in health care, competition policy in Portugal and in the European Union. The results of his research have been published in many academic journals (such as the Journal of Health Economics and Health Economics). Prof. Barros has contributed to several books, and has written two books on health economics (written in Portuguese).

He has served as Member of the Board of the Portuguese Energy Regulator (2005/2006) and on the Governmental Commission for the Financial Sustainability of the National Health Service (2006/2007). Over time he has acted as consultant for both private and public entities, in Portugal and at the European level, in the areas of health economics, competition policy and economic regulation. In June 2005, Prof. Barros was awarded by the President the "Grande-Oficial da Ordem do Infante D. Henrique".

Ms Francesca Colombo

Francesca Colombo has been with the Organisation for Economic Cooperation and Development (OECD) since 1999. As Senior Health Policy Analyst, Mrs Colombo has led policy projects on the performance of health systems, including on health financing, health-professionals’ migration and workforce, long-term care for frail and elderly people, and several country reviews. Currently, she is responsible for the OECD Health Care Quality Reviews project and for OECD work on long-term care.

Prior to joining the OECD, Mrs Colombo worked as acting Head at the Planning Unit of the Ministry of Health of Guyana, under the British Overseas Development Institute (ODI) Fellowship Scheme. She graduated from Bocconi University (Milan, Italy) and the London School of Economics (United Kingdom), and also spent part of her studies at the University of British Columbia (Canada) and Keio University (Japan).

Mr Pascal Garel

Since 2005, Mr Pascal Garel has been the Chief Executive of HOPE, the European Hospital and Healthcare Federation. During the past 20 years, Mr Garel has been actively involved in various health-care related decision-making processes, including those on research programmes, hospital management and human resources development.

His main professional background is healthcare management, with a twelve year experience at two French Teaching Hospital Centres, Nantes and Rouen. Prior to his present occupation, Mr Garel was the Director of the European and International Department of the French Hospital Federation and worked at the French Ministry of Health being in charge of cooperation with Central and Eastern European countries.
Mr Garel teaches as an associated lecturer at the University Paris Dauphine and at the Alexandria University Senghor in Egypt. Mr Garel holds a university degree in political sciences from the Institut d’Etudes Politiques de Paris (1986), and a European law degree (1992) from the University of Rennes and a hospital manager degree from the French National School of Public Health (1989).

Dr Tamás Evetovits

Dr. Tamás Evetovits is Senior Health Financing Specialist at the WHO Barcelona Office for Health Systems Strengthening. He is providing technical assistance on health financing to member states of the WHO European region. In particular, he is responsible for WHO’s country work in health financing policy in Bulgaria, Bosnia and Herzegovina, Estonia, Hungary, Latvia, Poland and Slovenia. His current focus of region-wide relevance is on the health policy responses to the financial and economic crisis in Europe and sustainability of health financing.

Prior to joining WHO he worked as Director of International Programs at the Health Services Management Training Centre at Semmelweis University, Budapest, where he was responsible for the World Bank Institute’s regional Flagship courses delivered jointly by the University, WBI and WHO Europe.

He has extensive experience in training and consultancy in the areas of health financing policy and capacity building in countries of Central and Eastern Europe. In particular, his main area of professional interest is in provider payment reforms and coordination of care across the vertical spectrum of health service provision. He is a medical doctor by training and holds two MSc degrees in the fields of health policy and management from Semmelweis University (Budapest) and the University of London.

Prof. Alicja Sobczak

Dr Alicja Teresa Sobczak, is an Associate Professor at the Management Faculty of the Warsaw University, being specialised in health management and health economics. She is the author of many publications and reports that she has prepared as an external consultant. Dr Sobczak’s doctoral dissertation was dedicated to health care management at district level.

She has been involved as an advisor to the Minister of Finance in the development of various health care related reforms since Poland’s democratic transition (1989). Moreover at the beginning of the 1990s she was the Polish task leader of the World Bank Project on health care reform.

Currently she is in charge of managing the Postgraduate Managerial Studies “Health Care Management” and the co-ordinator of the health care management specialisation at the Management Faculty of the Warsaw University. She also teaches healthcare management and economics within a postgraduate programme for physicians at the Medical Centre of Warsaw.
ANNEX 3: PRESENTATIONS

Presentation by Mr Pedro Pita Barros

Reforms and efficiency in European health systems: the example of Portugal

Pedro Pita Barros

Two waves

• Reforms of 2005:
  – Primary care reorganized around “family health units” – small multidisciplinary units, two regimes (with / without financial incentives/ P4P), low roll out
  – NHS continued care network (inexistent prior to 2005; makes use of non-profit institutions)
• Reforms of 2011/2012 – dictated by the MoU under financial rescue plan
MoU Reforms

- More than 50 measures, many areas
- User charges
  - Increase values, differentiation primary care – hospital emergency room
  - Revision of user charges exemptions
  - Revenue targets (double revenue value)
  - Status: done, both exemptions and values increased
  - Impact: unknown yet

<table>
<thead>
<tr>
<th>(residents in Portugal)</th>
<th>2006</th>
<th>2012 (predicted)</th>
<th>2012 (7 Nov)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income related*</td>
<td>1,900,055</td>
<td>5,189,209</td>
<td>2,926,279</td>
</tr>
<tr>
<td>Pregnant women &amp; children &lt; 13</td>
<td>1,501,210</td>
<td>925,961</td>
<td>1,411,086</td>
</tr>
<tr>
<td>Significant incapacity to work</td>
<td>3,861</td>
<td>81,711</td>
<td>97,313</td>
</tr>
<tr>
<td>Firemen</td>
<td>34,225</td>
<td>59,387</td>
<td>25,844</td>
</tr>
<tr>
<td>Blood donors</td>
<td>160,606</td>
<td>74,692</td>
<td>121,120</td>
</tr>
<tr>
<td>Other</td>
<td>50,000</td>
<td>5,934</td>
<td></td>
</tr>
<tr>
<td>Specific medical conditions</td>
<td>572,019</td>
<td>890,120</td>
<td>890,120</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4,196,737</td>
<td>7,271,080</td>
<td>5,477,696</td>
</tr>
</tbody>
</table>
Pharmaceutical market

- Targets for public spending with pharmaceuticals (1,25% GDP in 2012, 1% in 2013)
- Lower margins in retail and wholesale distribution
- Promote generic entry
- Promote rational prescription
- Change international reference countries
- Results: generics keep path to lower prices
- Results: pharmacies face difficulties in economic model
- Results: payback agreement with industry will meet targets
• NHS management
  – Recover arrears. Set procedures to avoid them in the future (3 b€/ NHS initial budget 2012 7.5b€)
  – centralized purchasing and procurement
  – strategic plan
  – benchmark system for hospital performance
  – Reorganisation and rationalisation of the hospital network (15% cost savings)
• Human resources
  – Planning, distribution over specialities and geography

• Prescription patterns – information and feedback
• Primary care
  – Stronger role to primary care, more family health units
• Health subsystem/civil servants
• Tax system – reduce fiscal benefits (initial: 30% of private expenditures deductible from taxes; target: change to 10%)
• Public private interface
  – Increase competition among private providers to the NHS
<table>
<thead>
<tr>
<th>Topic</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>User Charges</td>
<td>Done</td>
</tr>
<tr>
<td>Pharmaceutical market</td>
<td>Done</td>
</tr>
<tr>
<td>Prescription patterns</td>
<td>Mostly done</td>
</tr>
<tr>
<td>Management of NHS</td>
<td>Mostly postponed</td>
</tr>
<tr>
<td>Primary care</td>
<td>Delayed, slowly moving</td>
</tr>
<tr>
<td>Human capital/health professionals</td>
<td>Changed to ongoing</td>
</tr>
<tr>
<td>Health public subsystem/civil servants</td>
<td>create plan by the Summer 2012</td>
</tr>
<tr>
<td>Tax system adjustments</td>
<td>Done</td>
</tr>
<tr>
<td>Public – private interface</td>
<td>Partially done, part under watch</td>
</tr>
</tbody>
</table>

**Effects on health and health care use**

- Hospital activities: cuts have been met with resilience of health care professionals
- Decrease in emergency room use, but also in primary care
- Slight increase in waiting times, but more people were treated
- Slight increase in suicides, but below what could be expected during economic crisis
This presentation is about…

- Impact of the economic and financial crisis on health spending in the EU
- Reforms following the crisis that affect public and private health care
- Public versus private health care: important trade-offs to address
IMPACT OF THE ECONOMIC CRISIS ON HEALTH SPENDING

Growth in health spending across the EU fell in 2010

Annual average growth rate in health expenditure per capita, in real terms, EU average, 1975-2010

Sources: OECD Health Data 2012, Eurostat Statistics Database, WHO Global Health Expenditure Database
Note: Data for the six non-OECD EU member states are only included from 2000 onwards
All (but two) EU countries have seen a slow down or reversal in health expenditure growth

Annual average growth rates, real terms,

Source: OECD Health at a Glance Europe, 2012

More important slowdown/reduction for the public component of health spending

EU average growth rates, in real terms, 2007-2010

Source: OECD Health Data 2012; Eurostat Statistic Database, WHO Global Health Expenditure Databases
Health expenditure as a share of GDP came down slightly in 2010

Source: OECD Health at A Glance Europe, 2012

REFORMS AFFECTING PUBLIC AND PRIVATE HEALTH CARE
Cuts or slower growth in public spending across most sectors...

Public health spending and components,
EU average growth rates, in real terms

<table>
<thead>
<tr>
<th>Component</th>
<th>2008-2009</th>
<th>2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total, 3.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-patient, 3.0%</td>
<td>0.9%</td>
<td></td>
</tr>
<tr>
<td>Out-patient, 6.3%</td>
<td></td>
<td>-1.2%</td>
</tr>
<tr>
<td>LTC, 5.3%</td>
<td>3.3%</td>
<td></td>
</tr>
<tr>
<td>Pharmaceuticals, 2.4%</td>
<td></td>
<td>0.1%</td>
</tr>
<tr>
<td>Prevention, 5.5%</td>
<td></td>
<td>-3.3%</td>
</tr>
<tr>
<td>Administration, 1.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: OECD Health Data 2012; Eurostat Statistics Database, WHO Global Health Expenditure Database

...due to budgetary and pricing measures

- Many public sector cuts came from a combination of budgetary constraints and reduced prices/remuneration
  - **Health services**: cuts in wages and fees, or freezing on hiring (Greece, Ireland, Iceland, Czech Republic, Estonia, Slovenia)
  - **Pharmaceuticals**: cuts through negotiations over prices and other measures (Greece, Ireland)
  - 6-10% cuts in **administration** (Austria, Czech Republic, Finland and Spain)
  - Cuts in **public investment** (Estonia, Ireland, Iceland and Czech Republic)
  - **Prevention**: countries that reduced public spending made bigger cuts in prevention (e.g., Estonia, Hungary, Iceland; not Portugal); cuts also in Belgium and Finland.
… and changes in cost-sharing

- Many EU member states introduced co-payment measures (e.g., Czech Republic, Ireland, France)
- There has been no “apparent” change in overall benefit packages
  - Ireland make eligibility to public coverage for primary care services for patients aged above 70 means-tested
  - The Czech Republic tightened entitlement for foreigners and removed coverage for non-prescribed drugs
  - However public health care facilities may be cutting back on certain services
- All these reforms resulted in a significant shift from public to private spending but only in some EU member states (e.g., Ireland, Bulgaria and the Slovak Republic)

Financing from PHI has grown only slightly

Share of various health financing components, EU average 2008-10

<table>
<thead>
<tr>
<th>Component</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>21.5</td>
<td>21.3</td>
<td>21.5</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>73.1</td>
<td>72.8</td>
<td>72.6</td>
</tr>
<tr>
<td>Private insurance</td>
<td>1.9</td>
<td>3.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Other</td>
<td>3.6</td>
<td>3.6</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Sources: OECD Health Data 2012; Eurostat Statistics Database, WHO Global Health Expenditure Database
Coverage by private insurance has grown in some member States

Trends in “additional” private health insurance coverage, 2000 to 2010

But private health insurance plays a large role only in a few countries

- Coverage of « top-up » insurance (PHI)
  - Large in France (96%), Belgium (79%), Slovenia (71%), Luxembourg (55%) and Ireland (50%)
  - Small or insignificant in many other EU countries

- PHI financing
  - accounts for 4% of total health spending across the EU, compared to 21% for out-of-pocket spending (2010)
  - accounts for more than 10% of health spending in France, Ireland and Slovenia; less than 4% in 17 EU member States.

- And in relation to the crisis
  - Other than is Ireland, PHI plays a small role in all the EU member states most affected by the crisis
  - No major shifts from OOP to PHI (other than Ireland) and no major reform in PHI markets following the crisis
Out-of-pocket spending remains the largest private source of financing

In the past 10 years, OOP has grown especially in the Slovak Republic, Czech Republic, Bulgaria, Cyprus, Malta, and Romania.

PUBLIC VERSUS PRIVATE HEALTH CARE: TRADE OFFS
Budget pressures raise questions about what and how much should be covered

- The definition of "border-line" vs core activities does not always reflect rational decisions or cost effectiveness
  - Switzerland has cut coverage on eye products but added alternative medicine in the coverage
  - France decided to provide 100% coverage for Alzheimer drugs against the advice of the Transparency Commission

- Cost-sharing reforms raise access challenges, but could be used to drive desirable health behaviours
  - From 2009, in France, patients who do not follow the agreed medical pathway faces a 40% higher co-payment
  - Higher cost-sharing for patients preferring branded pharmaceuticals over generic bioequivalents (e.g., Switzerland)

Trade-offs between depth and breadth of coverage

Share of costs covered by basic public health insurance in selected EU countries

Source: Paris et al. (2010), OECD Health working paper No 50 (based on survey carried out in 2008-09)
Shifting cost to the private sector to contain public cost raises trade-offs

- It could exacerbate some of the trade-offs inherent in the public-private mix, for example:
  - Different prices across the public & private sectors (e.g., France, U.K., Germany) compensate providers for lower public-sector fees
  - But create inequities in access for those unable to pay private fees
- Private health insurance is better than out-of-pocket payments but should not been regarded as a magic bullet
  - PHI typically covers non essential services and choice of provider
  - PHI coverage of cost-sharing can improve access when co-pays are high, but also encourages health utilisation beyond need
- Seeking value for money from public health spending becomes a *sine-qua-non* option

If you want to know more…

- Health at A Glance: Europe 2012
- OECD Health Data 2012
- Value for Money in Health Spending 2010

http://www.oecd.org/health/
Health system efficiency and sustainability
the EU perspective

Federico Paoli – DG SANCO

Brussels, 28 November 2012

EU role in health issues

1. Lisbon Treaty (Treaty on the Functioning of the European Union)
   Art. 168 "Public health"

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.

   Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.
EU role in health issues

2. The Health Strategy “TOGETHER FOR HEALTH: A STRATEGIC APPROACH FOR THE EU 2008-2013”

objective 1: fostering good health in an ageing Europe
objective 2: protecting citizens from health threats
objective 3: supporting dynamic health systems and new technologies

(A clear Community framework will [...] support Member States in areas where coordinated action can bring added value to health systems)

EU role in health issues

Council conclusions: towards modern, responsive and sustainable health systems
(2011/C 202/04)

INVITES Member States and the Commission to:

— initiate a reflection process under the auspices of the Working Party on Public Health at Senior Level aiming to identify effective ways of investing in health, so as to pursue modern, responsive and sustainable health systems,
EU role in health issues

Council conclusions on the sustainability of public finances in the light of ageing populations
3167th ECONOMIC and FINANCIAL AFFAIRS Council meeting
Brussels, 15 May 2012

the Council, recalling its Conclusions of 7 December 2010, invites Member States to balance the need to provide universal health care and long-term care with an increasing demand related to an ageing population, technological development and growing patient expectations in the coming decades. This enhances the need to assess the performance of health care systems and implement sound and needed reforms to achieve both a more efficient use of limited public resources and the provision of high quality health care within the context of significant budgetary constraints resulting from the high government deficit and debt levels.

EU approaches

- European Semester
- Economic adjustment programmes
- Reflection process on health systems
European Semester

Europe 2020

“Europe 2020 is the EU’s growth strategy for the coming decade. In a changing world, we want the EU to become a smart, sustainable and inclusive economy. These three mutually reinforcing priorities should help the EU and the Member States deliver high levels of employment, productivity and social cohesion.”
European Semester

Annual Growth Survey 2012

Pursuing the reform and modernisation of pension systems, respecting national traditions of social dialogue to ensure the financial sustainability and adequacy of pensions, by aligning the retirement age with increasing life expectancy, restricting access to early retirement schemes, supporting longer working lives, equalising the pensionable age between men and women and supporting the development of complementary private savings to enhance retirement incomes. This modernisation should be coupled with a reform of health systems aiming at cost-efficiency and sustainability.

Enhancing competition and competitiveness in the retail sector, reducing barriers for the entry and exit of firms, and eliminating unjustified restrictions for business and professional services, legal professions, accounting or technical advice, health and social sectors.

Developing initiatives that facilitate the development of sectors with the highest employment potential, including in the low-carbon, resource-efficient economy (“green jobs”), health and social sectors (“white jobs”) and in the digital economy.

European Semester

Country-specific recommendations on health in 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>Implement concrete reforms to improve organisation, financing and efficiency of healthcare and education.</td>
</tr>
<tr>
<td>BE</td>
<td>Continue to improve long-term sustainability of public finances by curbing age-related expenditure, including health expenditure.</td>
</tr>
<tr>
<td>BG</td>
<td>Strengthen efforts to enhance the quality of public spending, particularly in the education and health sectors.</td>
</tr>
<tr>
<td>CY</td>
<td>Complete and implement the national healthcare system, ensuring its financial sustainability while providing universal coverage.</td>
</tr>
<tr>
<td>DE</td>
<td>Continue growth-friendly consolidation through additional efforts to enhance the efficiency of public spending on healthcare and long-term care.</td>
</tr>
<tr>
<td>EL</td>
<td>Implement the Memorandum of Understanding</td>
</tr>
<tr>
<td>IE</td>
<td>Implement the Memorandum of Understanding</td>
</tr>
<tr>
<td>NL</td>
<td>Implement the planned reform in long-term care and complement it with further measures to contain the increase in costs, in view of an ageing population.</td>
</tr>
<tr>
<td>PT</td>
<td>Implement the Memorandum of Understanding</td>
</tr>
<tr>
<td>RO</td>
<td>Implement the Memorandum of Understanding</td>
</tr>
</tbody>
</table>
Economic adjustment programmes

Greece

Ireland, Portugal

Hungary, Latvia, Romania (BoP)

Reflection process

Council invites MS and EC to initiate a reflection process under the auspices of the Working Party on Public Health at Senior Level aiming to identify effective ways of investing in health, so as to pursue modern, responsive and sustainable health systems
Reflection process, working groups:

1. Enhancing the adequate representation of health in the framework of Europe 2020 Strategy and in the process of the European Semester (EC)
2. Defining success factors for the effective use of Structural Funds for health investments (HU)
3. Cost-effective use of medicines (NL)
4. Integrated care models and better hospital management (PL)
5. Measuring and monitoring the effectiveness of health investments (SE)

EC/EPC Joint report on health systems

Main challenges ahead to contain costs and make the health systems more efficient

Main measures include:
1. sustainable financing basis to the sector, a good pooling of funds and a resource allocation that is not detrimental to more vulnerable regions;
2. adjusting existing cost-sharing systems to ensure that they encourage a cost-effective use of care;
3. a balanced mix of different staff skills and preparing for potential staff needs due to ageing;
4. improving and better distribute primary health care services and reducing the unnecessary use of specialist and hospital care;
5. increasing hospital efficiency;
6. cost-effective use of medicines while allowing for innovation in the health sector;
7. improving the general governance (coherence of decision-making and management) of the systems;
8. improving data collection and information channels and using available information to support performance improvement;
9. using health technology assessment more systematically to help decision-making processes;
10. improvement in life-styles and access to more effective health promotion and disease prevention.
Summary and conclusions

EU role: Lisbon Treaty, health strategy, Council conclusions on modern health systems and sustainability of public finances

EU approaches: EU 2020/European Semester, Economic assistance programmes, Reflection process on health systems

Thank you.

Federico.paoli@ec.europa.eu
Reforming Health Systems: The role of NGOs

Pascal Garel  European Parliament - 28/11/2012

HOPE membership:
An excellent example of the diversity of European healthcare system
A diversity reinforced by each new enlargement

HOPE activities:
Knowledge and exchange: Hospital and hc services compared
Influence and representation: European Union influence

Where does the crisis stand in HOPE activities?
Part of traditional activities: Review of policies and practices
Here, the impact of the crisis on European healthcare services.
New perspective with EC, ECB and IMF involvement (WB, OECD... )
NGOs?

- Internal to the health services
  - Professionals
  - Institutions

- Internal/external to the health services:
  - Patients, carers, families, volunteers
  - Consumers (tax payers, potential users...)

- External to the health services
  - Humanitarian aid

Why is it important?

- External to the health services
  - Where systems fail

- Internal to the health services
  - Hospitals as “professional bureaucracies”
  - Science and art...

- Internal/external to the health services:
  - Patient empowerment
  - Healthcare is only a part of the picture
**Are they considered?**

- Wide range: from none to a lot
- Diversity of health systems
- Numerous, different and conflicting (vested) interests

**In time of crisis?**

Update in the HOPE yearbook Hospital Healthcare Europe 2012
Update in the HOPE yearbook Hospital Healthcare Europe 2013
Main conclusions

Not so easy to picture reality

Diversity in being affected by the crisis
- in and out,
  - extensive reforms of the healthcare system:
    - reforms already under discussion
    - accelerated,
      - a response to the financial constraints
  - short term reactions

*Do not expect the crisis to be automatically a good time for structural reforms*

Main conclusions

- Increased emergency activities
- Increased waiting time and waiting lists
- No compensatory mechanisms for overcome closing hospitals or reduced activity: other sectors are not ready
- Could even almost stop elective care in hospitals
Involvement of NGOs

Humanitarian NGOs: warning signs

Other NGOs

- a few systems have reacted normally: NGOs no more no less involved

- most have not reacted normally: NGOs much less involved but this is true also for ministries of health...

Coming next, policy tools that risk undermining health system goals:

- reducing the scope of essential services covered;

- reducing population coverage;

- increases in waiting times for essential services;

- user charges for essential services;

- attrition of health workers caused by reductions in salaries.
Long term agenda taken into consideration?

- Payment systems to reward high-quality care and prevention, not just activity?
- Assess the cost-effectiveness of new treatments?
- Greater co-ordination of care across different parts of the health system?
- More emphasis on primary care and on patient satisfaction?

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Presentation by Mr Tamás Evetovits

How much can efficiency gains help navigate through the crisis?

Dr. Tamás Evetovits
Senior Health Financing Specialist
WHO Regional Office for Europe

Outline

- Dealing with the downturn
- Can efficiency gains help navigate through the crisis?
- Will efficiency gains be sufficient to navigate through the crisis?
- If equity was not an objective...
The financial crisis put governments and health systems to the test

- Testing governments’ commitment to health system objectives, in particular equity and solidarity

- Testing health systems’ preparedness and resilience to deal with an economic shock

Are we moving away from universal health coverage?

[Diagram showing coverage mechanisms, financial protection, and population coverage]
Balancing the budget

An accounting exercise or a matter of choice in public policy priorities and finding the right instruments to minimize adverse effects on equity and financial protection?

The real measure of “priority”: government spending on health as a % of total government spending (2010)

Huge variation across the European Region and within the EU

Source: WHO, 2011
Overview of health policy responses to the financial crisis in Europe

1. Health systems need predictable sources of revenues – counter-cyclical public spending
2. Health sector can contribute to economic recovery
3. Re-allocate within government budget
4. Re-allocate within health sector budget
5. Improve efficiency

Action is needed on both fronts

Stable, predictable revenues for health

- General taxation
- Payroll & other earmarked taxes
- User charges/co-payments

Improving efficiency/reducing waste

- Public health
- Primary care
- Hospitals
- Long-term care

Modified after Reinhardt 1984
“Improving efficiency is a far better option than cutting back on services or imposing fees that punish the poor”

Dr. Margaret Chan, Director-General
World Health Organization

Ten leading sources of inefficiency
World Health Report 2010, Chapter 4

<table>
<thead>
<tr>
<th>Medicines: under-use of generics and higher than necessary prices</th>
<th>Medicines: use of sub-standard and counterfeit medicines</th>
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</thead>
<tbody>
<tr>
<td>Medicines: in appropriate and ineffective use</td>
<td>Services: inappropriate hospital size (low use of infrastructure)</td>
</tr>
<tr>
<td>Services: medical errors and sub-optimal quality of care</td>
<td>Services: inappropriate hospital admissions and length of stay</td>
</tr>
<tr>
<td>Services &amp; products: oversupply and overuse of equipment, investigations and procedures</td>
<td>Health workers: inappropriate or costly staff mix, unmotivated workers</td>
</tr>
<tr>
<td>Interventions: inefficient mix / inappropriate level of strategies</td>
<td>Leakages: waste, corruption, fraud</td>
</tr>
</tbody>
</table>
**Improving efficiency** reduces adverse effects of the crisis and help secure popular and political support for more spending in the future...

- Eliminate ineffective and inappropriate services
- Improve rational drug use (including volume control)
- Allocate more to primary and outpatient specialist care at the expense of hospitals
- Invest in infrastructure that is less costly to run
- Cut the volume of least cost-effective services

Crisis presents opportunities not to be missed and potential failures to avoid
Short-term solutions are important to keep the system running, but proceed with care when looking for savings

- Aim for sustainable efficiency gains
- Avoid losing human resources
- Careful with shifting from public to private spending especially out-of-pocket expenditure
- Cost containment ≠ efficiency

There is a limit to how far (and how fast) efficiency gains can take us?

- Efficiency savings may not be immediate
- Some inefficiencies are harder to address: hospitals
- „It is easier to lose weight if one is fat to start with“
- But what if you are already very thin?

- Protect what works well because re-building capacity may be more costly in the long run
- Smart investments can make health systems stronger and more resilient to future shocks
Sustainability is meaningless if not linked to public policy objectives

- Financial sustainability should not be seen as a policy objective worth pursuing for its own sake
- If it was an objective, then across the board cost cutting would do the job...
- ...and both equity and efficiency would suffer.

Health 2020 builds on strong values

- Solidarity, fairness and sustainability
- A new European policy framework by WHO supporting action across government and society for health and well-being
**Definition**

- **Efficiency** = a relation between results (utilities, benefits, goods) and resources used for achieving them

  or

  between Outputs/outcomes and Inputs

- Inefficiency = more results are possible to be achieved from given resources or fewer resources may be used for achieving given results

- For judging efficiency one needs information on both sides of the relation
Two basic options

„Saving” option
- Result(s) is(are) defined in terms of quantity and quality
- Focus on minimization of resources used

„Productivity” option
- Resources are given (at disposal)
- Focus on maximizing results achieved from these resources

Types of efficiency

Operational efficiency
- Producer’s perspective
- Question – how to produce a chosen result;
- Technical decisions - what resources are needed in order to produce a good? How to minimize waste in production process?

Allocative efficiency
- User’s/buyer’s perspective
- Question – how to allocate scarce resources between different goods (applications) in order to get utility
- Distribution decisions – what to spend on, what combination of goods should be produced/bought?
Efficiency as a joint effort

- Improving overall efficiency of a system needs both types of decisions
- Operational efficiency is not enough if we devote resources on sub-optimal (in terms of utility) combination of goods
- Resources have to be directed to right combination of goods that are produced effectively in operational terms

Variety of efficiency formulas

- Results may be expressed as outputs or outcomes
- Results and resources can be measured in natural or monetary units (costs)
- Synthetic vs fragmented formulas
- Results and resources may be perceived differently from the point of view of different stakeholders, ex. patients, healthcare professionals, politicians, owners of healthcare entities, managers, payers, etc.
Efficiency in health care

A consequence of:

- distribution decisions made by politicians, technocrats/bureaucrats, owners and managers of non-public and public institutions as well as in health care providers
- operational decisions made by health providers

Levels and areas of application

- At micro, mezo and macro levels
- Expressing results as outputs (number of hospitalizations, consultancies, patients served, etc.) or as outcomes (health status and gains, degree of financial protection against ill-health, overall social satisfaction with health system)
Health and its improvement as the main outcome

- Very wide notion of health as 3-dimensional status
- Difficult to apply a single measure of health or ill-health
- Activity of health care providers – in terms of number and structure of health care services provided – is not a direct measure for judging outcomes

Types of efficiency analyses expressing health gains

- Cost minimisation (CMA) – comparing costs of equal medical technologies in terms of health gains as non-monetary outcomes
- Cost effectiveness (CEA) – cost per unit of health gains (ex., LYG)
- Cost utility (CUA) – health gains as a joint measure of life duration and quality (ex. QALY)
- Cost benefit (CBA) - health gains expressed in monetary terms
The role of research on clinical effectiveness

- Clinical effectiveness (CE) is critical for proper efficiency analyses
- The role of EBM providing economists with objective and accurate information on CE

Limits of efficiency criteria in health care

- Health as a human right
- State’s obligation to save life and protect health
- The role of human values and dignity
- Moral norms
- Professional norms
Ensuring cost-effective provision of health services in EU Member States

Workshop on "Health Economics"
European Parliament, Room ASP A5G-2
Brussels, 28 November 2012

Ana Xavier
Sustainability of Public Finances
DG Economic and Financial Affairs
European Commission

2010 Joint EPC – EC (DG ECFIN)
Report on Health Care Systems

- With Member States: understand determinants of expenditure, identify challenges and identify good practices to improve health systems’ cost-effectiveness

- How to contain spending pressures through efficiency gains, in order to ensure fiscally sustainable access for all to high-quality health services …

- Measures introduced in the last two decades need to be intensified in the immediate future to achieve the needed consolidation of public finances in Europe
How to improve cost-effectiveness of health care systems

- Macro-type controls (e.g. cap on exp or exp growth) need to be associated with micro-type incentives-based reforms
- General and Country specific challenges / recommendations
- 10 main policy challenges for EU Member States to address resolutely in coming years to contain spending in health care in an efficient and equitable manner.

10 policy challenges to be addressed:

1. sustainable and equitable financing basis with pooling of risks and funds, reduction of tax deductions and resource allocation adjusted to needs;
2. adjust cost-sharing to encourage a cost-effective care path, while addressing equity and access concerns;
3. Improve the general governance (decision-making, management, contracting systems) of the system;
4. Improve data collection and information channels and use available information to support performance improvement;
5. Reduce the unnecessary use of specialist and hospital care while improving primary health care services (and referral system);
10 policy challenges to be addressed:

6. Enhance hospitals’ efficiency through increasing use of day-case surgery and concentration of some hospital services;

7. Cost-effective use of medicines;

8. Ensuring a balanced mix of staff skills;

9. More systematic use of health-technology assessment (HTA) to determine cost-effective treatment to be financed publicly;

10. Promoting more effective health promotion and disease prevention to improve health status and reduce the demand for health services.

Cost-effective use of medicines

- Promote use of generics
  - Shorten time to entry and promote generic competition
  - Generic substitution
  - Use cost-sharing / reimbursement rates (internal ref price)
  - Prescription guidelines
  - Information to patients and physicians

- Centralised public tendering

- Health-technology assessment
  - Positive/negative lists

- Monitoring / controlling prescription behaviour

- Risk-sharing arrangements with industry

- Discounts/rebates and payback to control excess spending
Thank you!

Papers found at
and
POLICY DEPARTMENT
ECONOMIC AND SCIENTIFIC POLICY

Role
Policy departments are research units that provide specialised advice to committees, inter-parliamentary delegations and other parliamentary bodies.

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- Employment and Social Affairs
- Environment, Public Health and Food Safety
- Industry, Research and Energy
- Internal Market and Consumer Protection

Documents