



European  
Commission



Report of the  
**EXPERT PANEL ON EFFECTIVE WAYS  
OF INVESTING IN HEALTH (EXPH)**  
on  
**Typology of health policy reforms  
and framework for evaluating reform effects**





EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH  
(EXPH)

Typology of health policy reforms  
and framework for evaluating reform effects

The EXPH adopted this opinion at the 14<sup>th</sup> plenary meeting of 3 May 2016

### **About the Expert Panel on effective ways of investing in Health (EXPH)**

Sound and timely scientific advice is an essential requirement for the Commission to pursue modern, responsive and sustainable health systems. To this end, the Commission has set up a multidisciplinary and independent Expert Panel which provides advice on effective ways of investing in health ([Commission Decision 2012/C 198/06](#)).

The core element of the Expert Panel's mission is to provide the Commission with sound and independent advice in the form of opinions in response to questions (mandates) submitted by the Commission on matters related to health care modernisation, responsiveness, and sustainability. The advice does not bind the Commission.

The areas of competence of the Expert Panel include, and are not limited to, primary care, hospital care, pharmaceuticals, research and development, prevention and promotion, links with the social protection sector, cross-border issues, system financing, information systems and patient registers, health inequalities, etc.

#### **Expert Panel members**

Pedro Barros, Margaret Barry, Helmut Brand, Werner Brouwer, Jan De Maeseneer (Chair), Bengt Jönsson (Vice-Chair), Fernando Lamata, Lasse Lehtonen, Dorjan Marušič, Martin McKee, Walter Ricciardi, Sarah Thomson

#### **Contact**

European Commission  
DG Health & Food Safety  
Directorate B: Health systems, medical products and innovation  
Unit B1 – Performance of national health systems  
Office: B232 B-1049 Brussels

[SANTE-EXPERT-PANEL@ec.europa.eu](mailto:SANTE-EXPERT-PANEL@ec.europa.eu)

The opinions of the Expert Panel present the views of the independent scientists who are members of the Expert Panel. They do not necessarily reflect the views of the European Commission nor its services. The opinions are published by the European Union in their original language only.

### **ACKNOWLEDGMENTS**

Members of the Working Group are acknowledged for their valuable contribution to this opinion.

The members of the Working Group are:

#### **Expert Panel members**

Professor Walter Ricciardi	Chair
Dr Fernando Lamata	Rapporteur
Professor Lasse Lehtonen	
Dr Dorjan Marušič	
Professor Martin McKee	
Professor Pedro Pita Barros	

The declarations of the Working Group members are available at:  
[http://ec.europa.eu/health/expert\\_panel/experts/working\\_groups/index\\_en.htm](http://ec.europa.eu/health/expert_panel/experts/working_groups/index_en.htm)

### ABSTRACT

The purpose of this report is to develop a typology of reforms and a template for screening health policy effects to support ex-ante and ex-post evaluation. Thus, it is proposed a typology of reforms that can be used to review impact and progress in areas such as coverage, equity, efficiency, quality, resources and sustainability.

Moreover, the report discusses types of health reforms; stresses the need to address coherent reforms reinforcing the core values of universality, solidarity, equity and access to high quality services; analyses the factors influencing the reforms, and the various narratives and choices that are at the basis of reforms; and warns of the cost of inaction.

Then, the influence of the institutions of the European Union in health reforms in recent years is analysed, showing how the European Semester and the Country Specific Recommendations are creating opportunities to orient reforms.

The report also notes several factors that have to be taken into account when implementing reforms, in order to its feasibility.

Finally some conclusions and recommendations regarding the reform processes and the design and implementation of the template are presented.

**Keywords:** EXPH, Expert Panel on effective ways of investing in Health, health care reforms, typology, template, evaluation

**Opinion to be cited as:** Expert Panel on effective ways of investing in Health (EXPH), Report on Typology of health policy reforms and framework for evaluating reform effects, 3 May 2016

© European Union, 2016

ISSN 2315-1404  
doi:10.2875/858242

ISBN 978-92-79-57122-0  
EW-BA-16-004-EN-N

[http://ec.europa.eu/health/expert\\_panel/index\\_en.htm](http://ec.europa.eu/health/expert_panel/index_en.htm)

### TABLE OF CONTENTS

ACKNOWLEDGMENTS .....	3
ABSTRACT .....	4
TERMS OF REFERENCE .....	7
OPINION .....	9
1. EXECUTIVE SUMMARY .....	9
2. INTRODUCTION .....	13
3. HEALTH REFORMS: NARRATIVES AND CHOICES .....	19
3.1. COMPLEXITY OF HEALTH SYSTEMS .....	19
3.2. THE COST OF NON ACTION .....	21
3.3. REFORM OF HEALTH SYSTEMS.....	26
3.3.1. CONCEPT OF HEALTH REFORM .....	26
3.3.2. UNIVERSALITY: THE MAJOR HEALTH CARE REFORM I/T 20 <sup>th</sup> CENTURY	30
3.3.3. HEALTH EXPENDITURE AND TYPES OF HEALTH REFORMS .....	33
3.3.4. FACTORS INFLUENCING REFORMS .....	37
3.4. INFLUENCE OF THE INSTITUTIONS OF THE EUROPEAN UNION IN REFORMING HEALTH SYSTEMS.....	39
4. EXPLORING TYPOLOGIES AND TEMPLATES ON HEALTH REFORMS .....	43
4.1. TYPOLOGY OF RECENT REFORMS .....	43
4.2. PROPOSAL OF A TEMPLATE FOR EVALUATING REFORM EFFECTS.....	50
4.2.1. RATIONALE OF THE TEMPLATE.....	50
4.2.2. TEMPLATE TO GUIDE IMPLEMENTATION AND EVALUATION OF REFORM	51
4.3. SOME FACTORS TO TAKE INTO ACCOUNT WHEN IMPLEMENTING HEALTH CARE REFORMS: FEASIBILITY .....	62
5. CONCLUSIONS .....	73
6. RECOMMENDATIONS.....	77
LIST OF ABBREVIATIONS .....	79
REFERENCES .....	81
ANNEX 1. REFORMS / POLICIES AND MEASURES IMPLEMENTED OVER THE LAST YEARS IN EU MEMBER STATES .....	93

*[This page intentionally left blank]*



### **TERMS OF REFERENCE**

#### **BACKGROUND**

In recent years many EU Member States have responded to the challenges posed by the economic crisis facing their health systems by varying levels of financing and / or expenditure and by introducing measures designed to improve the performance of the system, seeking to generate greater outputs for the same amount of resources. However, there are still many gaps in the evidence as to how the crisis has impacted on health system performance. The proposal offers a means to categorize systematically types of reforms with a focus on those designed to enhance the sustainability of health systems over the long term.

Rationale: Strengthening of the evidence-based for best practices regarding health policy reforms and thereby support recommendations to Member States.

#### **PURPOSE**

To develop a typology of reforms and a template for screening health policies that can support ex-ante and ex-post evaluation. This should be applicable in all EU Member States, accounting for national specificities, and offer a basis for guiding policy evaluation and design.

To develop a framework for fiscal quantification of reform effects. This could help understanding which reforms, depending on the level of investment, can be expected to create benefits in terms of the desired health system goals.

#### **TYOLOGY**

Classification of policies based on dimensions of interest. This could include: target of reform; dimensions of time; system financing.

#### **RATIONALE OF A TEMPLATE**

Challenges in conducting such evaluation; limits / advantages of a template in terms of its application.

### **FIELDS OF THE TEMPLATE**

An assessment of which dimensions are useful for an evaluation. Which aspects have been implemented and obstacles to implementation; effects on access, quality of health care and its outcomes; intermediate outputs to measure when the effects of the policy are medium / long term; whether an appropriate level of resources has been invested; distribution of effects on different population groups; distribution of possible fiscal effects (upfront investment versus future savings); spillovers (guidance on possible effects not taken into account by the specific policy reform).

### **ISSUES WITH MEASURING AND MONITORING**

Which of the effects can be monitored using readily available data? What technical elements are required to enable a standard template for evaluating policy reforms to be applied?

### **POLICY MEASURES**

What is needed on the policy level (including policy processes and involvement of stakeholders) to apply this standard template? What conclusions can be drawn from looking at how and if policy effects of commonly applied health policy reforms are evaluated (properly or at all)?

### **EU ACTION**

Is there added-value of potential EU action?

### OPINION

#### 1. EXECUTIVE SUMMARY

This report seeks to guide policy evaluation and design in Member States, with the aim of ensuring that health reforms maximise the ability to achieve desired health system goals through continuous performance improvement.

A health reform is any change in any fiscal or structural policy designed to have a direct impact on the health system, in terms of the income (source of funds), expenditure, demand or supply of health care, and health outcomes. Health systems are constantly being reformed, in many ways, both large and small, reflecting the changing nature of disease, innovations in the ability to intervene, and changing expectations. Health reforms are policy choices, and these choices have to do with the diagnosis of the problem and the narratives that explain processes.

Health Systems in EU Member States are based on overarching values of universality, access to high-quality services, and equity and solidarity. Consequently, healthcare reforms should incorporate these values. It is, however, one thing to agree a set of values and another to implement them in practice. In recent years, Europe has experienced a deep economic crisis and many countries have chosen to implement wide-ranging austerity policies. As a consequence, the resources available for health care reform are limited, posing the challenge of how to ensure the realisation of these values at a time when such resources are scarce.

The first part of the report (Chapter 3) discusses the types of health reforms, the need to address reforms, the factors influencing the reforms, and the narratives and choices that are at the basis of reforms. Then, the influence of the institutions of the European Union in health reforms in recent years is analysed, showing how the European Semester and the Country Specific Recommendations are creating opportunities to orient reforms. The report stresses that present and future challenges imply that further reforms are needed to ensure that health systems are as effective and efficient as possible, without any sacrifice of coverage and quality. It is important to recognise that all aspects of a health system are interconnected, so that modifying one element will often have consequences for other elements.

There may also be changes outside the health system that affect its functioning (e.g. social policies, fiscal policies, etc.).

There seems to be agreement in considering that some measures / policies achieve desired results in promoting efficiency, while maintaining access and quality. These include, among others: disease prevention and health promotion; developing primary care; preventing over- prescription and over- treatment; more efficient pricing of medicines; excluding interventions that are ineffective from the list of benefits covered; increasing competition in purchasing goods (joint procurement, etc.).

After analysing different reforms implemented in recent years, the second part of the report (Chapter 4) proposes a typology of health policy reforms, with elements based on the main dimensions targeted / affected.

- Reforms designed to modify coverage (people covered; benefits covered; out-of-pocket payments; timely access to care).
- Reforms designed to modify equity (equity in financing; equity in delivery and use; equity in health outcomes).
- Reforms designed to modify efficiency (efficiency in delivery; efficiency in collection of funds).
- Reforms designed to modify quality of care.
- Reforms designed to modify availability of resources (human resources; financial resources, other resources).

A template for evaluating implementation and impact of health reforms is proposed, seeking to capture all the essential elements of the health system: a very complex mix of dimensions involving multiple trade offs. The idea of offering a global vision is important, because if measuring only one aspect, albeit a priority at the time, other impacts on the system, in the middle or long- term, including those that are unexpected and adverse, could be forgotten.

Any assessment of the impact of reforms must take account of the time scale of both the reform and its effects, recognising that measures adopted can have an

impact after one, two or more years (with different costs and benefits accruing over different timescales).

The template does not provide a “grade” or “score” for the reform, as different countries may face different trade-offs in objectives and resources constraints. The template intends to call attention to the main issues when discussing a reform in health care in a comprehensive yet simple way. Detailed analysis of particular issues may be triggered after use of the template.

The template includes the following contents:

- First, a description of how the reform fits into the vision for the health system. This requires a brief review of economic and political context; societal values; the problem to be solved; causes of the problem; and motivation for reform.
- Second, description of the reform: definition of the Reform / Policy / Measure to be adopted, and explicit targets to which the reform is aimed; legal and / or institutional changes; and political and managerial decisions (implemented, or to be implemented). Suggest alternative measures, including the possibility of non-action, pros and cons. Specify beneficiaries of the reform; main actors involved; ownership; and environmental factors.
- General overview: impact on benefits; impact on costs; fiscal impact.
- Detailed overview on the impact on particular health system dimensions.
- Feasibility: some policy considerations to take into account when implementing reforms (knowledge; coherence; timeframe; alliance of supporters; monitoring capacity; transparency and upfront investment).

This scheme offers the basis for discussion among interested parties (WPPHSL, DG SANTE, DG ECFIN, DG EMPL, SPC, EPC, etc.), about a common Template to guide implementation and evaluation of health reforms.

The template may be applied ex-ante (before a reform has been adopted) and ex-post (to assess the impact of a reform). The main difference is that, in the ex-ante analysis, alternative approaches to solve the problem identified can be considered and compared, with one of the options available ultimately being selected.

*[This page intentionally left blank]*

### 2. INTRODUCTION

*"The authorities always have choices in deciding what policy approaches to use and how measures are targeted – in other words, who should pay most" (Caritas Europa 2015).*

**Health systems are constantly being reformed**, in many ways, both large and small, reflecting the changing nature of disease, innovations in the ability to intervene, and changing expectations. The nature of these reforms varies greatly, both in scope and nature (McKee et al., 2009). Sometimes they are the consequence of explicit policies focused on the health system itself, while at other times they are a consequence of policies developed in other areas, such as reform of local government, the public sector more generally, or the rights of citizens. As organised health care inevitably involves the redistribution of resources, from healthy to ill, from rich to poor, and from those in working age to children and the elderly, health system reforms are inevitably political. They are also heavily influenced by the regional and national context within which they are embedded. This includes the historical development of institutions, such as health coverage linked to employment in the 19th and early 20th century, themselves a consequence of industrialisation, as well as expectations of the relationship between the individual and the state.

Nonetheless, within the European Union, all member states have committed to health systems that have certain common elements, the so-called European Union model, adopted in a set of Council Conclusions in June 2006. These Conclusions agreed a set of common values and principles that should underpin health systems based on overarching values of universality, access to high-quality services, equity and solidarity. **A key driver of reform in the EU ought to be the recognition that many member states fall short in terms of health system performance** and need to reform in order to do better in meeting the goals identified in the common values. In other words, the need for reform comes from failure to meet performance objectives.

In the same way, subsequent healthcare reforms should incorporate these values. It is, however, one thing to agree a set of values and another to implement them in

practice. Since the Council Conclusions were issued, Europe has experienced a deep economic crisis and many countries have chosen to, or in some cases been required to, implement wide-ranging austerity policies. As a consequence, the resources available for health care reform are limited, posing the challenge of how to ensure the realisation of these values at a time when such resources are scarce. **Financial sustainability cannot be understood in isolation from performance.** The policy question is not 'How to sustain the system?' but 'What level of health system performance can we sustain given current fiscal constraints or do we want to sustain in future?'

### **THE NEED FOR REFORMS**

The case for further reform has been set out clearly in a report on public finances in the Eurozone, published by ECFIN in 2013 (European Commission 2013-2). It noted how "Since the 2008-2009 crisis the focus of reforms has been on generating savings and improving the financing side, with few reforms aiming at improving the value for money of public health care. Emergency measures on the financing and cost-saving side may be a necessary condition to improve the fiscal positions of government in times of economic crisis. However, they are not a sufficient condition for securing long term sustainable improvements in the value for money of public health care services. **In view of future fiscal challenges related to rising health care costs, EU Member States will have to strengthen reform efforts in the coming years, and broaden their scope to cover also efficiency and quality issues**".

The message is clear, although it is not new. Thus, "Although it has been recognised for more than twenty years that the demand for health care is potentially unlimited, whereas resources are not, attempts to face this dilemma have until recent years concentrated on organisational, rather than behavioural, solutions. In the past five years however, the failure of such strategy, coupled with the deepening of an economic recession, has led to more specific attempts to contain the costs of health service delivery, in particular through the exploration of ways to define, measure, and improve the performance of health service organisations". This comment was made 30 years ago (Long A, Harrison S 1985).



**Further reforms are needed to ensure that health systems remain as effective and efficient as possible, without any sacrifice of coverage and quality.** Specifically, this does not call for a rolling back of health systems, but rather for further strengthening of them. A similar message was conveyed in the 2013 Annual Growth Survey of the European Commission, which noted that “in the context of the demographic challenges and the pressure on age-related expenditure, reforms of healthcare systems should be undertaken to ensure cost-effectiveness and sustainability, assessing the performance of these systems against the twin aim of a more efficient use of public resources and access to high quality healthcare”.

### **THE RIGHT REFORMS**

Notwithstanding the clear case for further reforms, concerns have been raised about the nature of those that have been adopted in response to the financial crisis. Commentators have noted a change in the nature of the discourse on healthcare reform. Prior to the crisis, there was an acceptance of the need for sustained investment, based on the extensive evidence relating better health to economic growth, for example by decreasing the burden of illness in the population and thus improving labour force retention and productivity, by exploiting innovations that reduce the cost of care, and by taking advantage of the increase in aggregate demand stimulated by expenditure on healthcare (the fiscal multiplier effect). This approach, which drew extensively on the earlier EU policy “health is wealth”, was adopted by Member States, under the auspices of the World Health Organization, in the Tallinn Charter.

Investment in health care was also seen as an important means of promoting the concept of a Europe of citizens, with measures such as the directive on Cross Border Care, the creation of European networks of Centres of Excellence, and related measures to strengthen patient’s rights. **Since the crisis, the narrative has been dominated by calls for reduced spending on health care, with several countries implementing significant reductions as well as related measures such as cost shifting to patients.**

Drawing on this evidence, the Parliamentary Assembly of the Council of Europe has observed that “inequalities in access to health care are growing” in Member States (Council of Europe 2013). They stated that “the crisis should be viewed as an opportunity to rethink health systems and be used to increase their efficiency, and not as an excuse for taking retrograde measures”.

In a similar vein, the European Policy Centre (Ahtonen A, 2013) warned that “many member states have already seen substantial cuts, especially to hospital services, pharmaceuticals and health staff salaries. The tendency has been to cut in areas which bring quick savings. However, cutting costs across the board without a comprehensive long-term vision fails to reward those stakeholders and sectors that have already carried out reforms and improved efficiency. **Radical cuts do not necessarily remove existing inefficiencies and can have serious negative consequences for people’s health and well-being if they undermine access to and quality of care.** They run the risk of increasing medium and long-term costs to society and the economy as people suffering from ill health put more pressure on healthcare systems, and tend to earn less and be less productive. People in ill health are less likely to invest in their education or save for retirement, and thus less likely to support the wider economy”.

These concerns have been reiterated more recently by the Council, which has drawn attention to the potential for reforms to impact adversely on access to health care (Council Conclusions on the economic crisis and healthcare, points 20-24, 2014). The EXPH Opinion on Access demonstrated how those concerns were justified, documenting the growing extent of unmet need for health care across Europe since the onset of the crisis (EXPH 2015).

### **THE NEED FOR EVALUATION**

Given the importance of health systems in the economies and social systems of member states, coupled with growing concerns about the potential gap between the rhetoric and reality of reform, **it is essential that those reforms that take place are adequately evaluated.** This aspiration was given force in the Council Conclusions on the “Reflection process on modern, responsive and sustainable health systems” (10 December 2013), in which the Council invited the Member States to assess the possible impact of health system reforms, and invited the

Commission and the Member States to improve the coordination on Health System Performance Assessment at European Union level.

Likewise, the Commission has highlighted the importance of health system performance assessment in its Communication on effective, accessible and resilient health systems (2014).

In this context, various initiatives have been developed at EU level to assess the performance of health systems; among others:

- The Council Working Party on Public Health at Senior Level has created an Expert Group on Health System Performance Assessment for analysing health policies and their impacts (Council 2014-2).
- The Social Protection Committee has continued to develop an assessment framework in the area of health based on the Joint Assessment Framework methodology (JAF health). In the Progress Report on the review of the JAF health (17 February 2015) it is discussed the utilization of this tool in the European Semester process.
- DG ECFIN has created a thematic framework assessment on health, and other analytical tools, related to the European Semester process.
- The EXPH Opinion related to Health System Performance Assessment included references to relevant dimensions of Health Systems, and indicators to measure them (EXPH 2014).

### **PURPOSE OF THIS REPORT**

The purpose of this report is to support the analysis of health care reforms in member states to ensure that they maximise the ability to achieve desired health system goals through continuous performance improvement. It proposes a typology of reforms that can be used to review progress in areas such as coverage, equity, efficiency, quality and resources. This typology in turn feeds into a template for assessing the implementation of reforms and their impacts. The mandate given to the EXPH specifies that this template should be applicable to all EU countries, accounting for national specificities.

*[This page intentionally left blank]*

### 3. HEALTH REFORMS: NARRATIVES AND CHOICES

#### 3.1. COMPLEXITY OF HEALTH SYSTEMS

Health systems are, by their nature, complex adaptive systems. This is manifested in many ways that have implications for reforms. One set of implications are derived from **complexity theory**. Thus, health systems are characterised by path dependency, whereby the starting conditions, such as the institutional structures that are in place in a particular country constrain what is possible. Thus, it will be very difficult to implement a social insurance system, based on a tripartite relationship between organised employers and labour representatives, such as trade unions, and governments, in a country where the first two groups do not exist, such as those that came late to industrialisation. They are also characterised by the existence of non-linear relationships and feedback loops, both positive and negative, whereby the implementation of a set of regulations or a package of incentives may have multiple unpredictable results.

A second set of implications are derived from **soft systems theory**. Thus, each health system is itself a collection of subsystems, each interacting with the others, and contributing to the operation of the overall system. Examples of subsystems include those elements that have been identified as the building blocks of the system, including financing, delivery, and governance. In addition, the health system exists within a larger social system. The boundaries of these systems will vary among countries. Thus, in one country, the formal boundaries of the health system may include elements of social care, medical education, or research and development while these may be considered to lie outside the health system in another country. These boundaries may change over time. For example, the United Kingdom government has pledged to protect the budget of the National Health Service (NHS) in England, but has done so in part by redefining its boundaries, with activities such as public health and training of health professionals now moved outside it, where their budgets have been cut substantially. These differences are important, especially as the definitional problems that arise pose significant problems for international comparisons.

Soft systems theory helps not only by making explicit the boundary of the health system being discussed but also by forcing those who are assessing reforms to identify and make explicit key elements of them (Checkland, 1981). These are

conventionally identified using the acronym CATWOE. This stands for customers, actors, transformations, Weltanschauung, or the vision necessary for the system to function, ownership and environment.

Consequently, it is necessary to determine which of the many possible transformations that take place within the health system are affected by those reforms. Thus, reforms may seek to change the method of gathering funds, pooling or redistributing them, or delivering care among many others. It also requires those who are assessing them to identify the customers of the reforms, in other words, the beneficiaries of the proposed changes (who may be patients but who also may be those delivering the service or some part of it), as well as the actors who are required to bring about transformation. It is necessary to specify the ultimate ownership of the system and who is in charge of it and of any reforms. This is conventionally defined as those who can make the system cease to exist, as a means of determining where the real power lies. This is important because, in many circumstances, those who are thought to be responsible for change may not have the authority to bring it about. The concept of Weltanschauung has been introduced as a means of capturing the culture that underpins the system, recognising that systems operate, and reforms succeed, where they are aligned with dominant value systems. Finally, the environment, which may include elements as diverse as the resources available, both financial and otherwise, and the geography of the country, must be taken into account when seeking to understand what is or is not possible in any reform.

Several issues flow from the application of these theories. First, the complexity of health systems means that unpredictable consequences may emerge after reforms. This does not mean that each reform will be a leap into the unknown. All else being equal, a reform that includes financial incentives designed to increase a certain activity is likely to achieve this goal at least in the short term, but it may also have perverse incentives that promote gaming or have effects that are unsustainable in the long term. Second, a failure to identify explicitly the actors involved in any reform, the transformation being sought, and the customers or beneficiaries risks creating confusion among those involved. Third, reforms are more likely to succeed where they take account of the dominant values and the environment within which the system is embedded.

### 3.2. THE COST OF NON ACTION

The goals of a health system were set out in the 2000 World Health Report. These are the improvement of population health, responsiveness to the legitimate expectations of the population, and financial protection, which is underpinned by solidarity (equity in financing). To achieve these goals, health systems must constantly adapt to the wider changes in society that influence each of them. A failure to do so threatens the sustainability of European health systems.

The achievement of all three goals is influenced by the changing composition of the population. **The European population is ageing.** Life expectancy at birth in the EU is projected to increase from 76.7 years in 2010 to 84.6 in 2060 for men and from 82.5 to 89.1 for women (European Commission, 2012). Birth rates have been falling, and while current projections envisage fertility rates in the EU climbing, from 1.58 births in 2012 to 1.71 in 2060, this is still well below replacement rate (European Commission, 2011). And the ethnic composition of Europe is changing, with large scale migration from other parts of the world.

Turning first to the **implications for health**, one of the main reasons why numbers of older people are increasing is the success of modern medicine, allowing people to survive, often in good health, following the onset of illnesses that might once have been fatal. In many cases, modern treatment allows the condition to be treated definitively, allowing them to return to good health. An example is treatment for acute appendicitis, a condition that was usually fatal before modern anaesthesia and aseptic surgery. Others will require long term, and often lifelong treatment, but will be restored to good health, albeit maintained in this condition by regular, and often inexpensive medication that is relatively free from side effects. Essential hypertension provides an example. For others, modern medicine may control the illness but the patients will remain disabled, to a greater or lesser extent. An example might be chronic obstructive airways disease. And finally, for some, the onset of illness will be the beginning of a relentless decline until death. Examples include an untreatable cancer or dementia. All of these conditions become more common with increasing age and, crucially, **as people age they accumulate disorders so multi-morbidity, perhaps involving seven or eight co-existing conditions, becomes increasingly common.**

The situation is complicated further as **the incidence of these conditions is also changing**. Thus, rates of acute coronary syndrome have fallen markedly in Europe in recent decades (Kuulasmaa et al., 2000), reflecting improvements in risk factors, both through lifestyle changes, such as a much reduced rate of smoking, and early detection and treatment. Smoking related cancers are similarly much less common (in males). Research in England has shown how the age specific prevalence of dementia has fallen markedly (Matthews et al., 2013) However, as these conditions become less common, others emerge to take their place. An obvious example is HIV/AIDS, unknown until just over three decades ago. Antibiotic resistant infections are another example of an emerging problem with major implications for health systems. In other cases, **changing risk factors are driving new patterns of disease**, as with growing rates of obesity, leading to increasing incidence of many cancers, musculoskeletal disorders, and cirrhosis. Other conditions may come to prominence because of changes in the composition of the population, such as the increase in sickle cell disease where there are growing numbers of migrants of African origin.

**The consequences of these changes are profound. The burden they place upon the health system is a function of their prevalence at different ages, the numbers of people in each age group, and their collective exposure to risk factors over their life time.** This complexity alone means that they will constantly change, although it is important to emphasise the word “change”, rather than “increase” because the same advances in medicine that are keeping people alive are also allowing them to remain in better health. The widespread assumption that the total disease burden will increase markedly in the future because of population ageing is over simplistic and takes no account of the increase in healthy ageing, whereby successive birth cohorts are in better health than those that came before them.

There is one other important implication. This is that if there are concerns about the future sustainability of health systems, **the most logical response is to implement policies that will increase the health of the population in the future**. Hence, **health system reforms must not be seen in isolation from what is termed “health in all policies”, whereby multi-sectoral responses are developed in response to emerging threats to health**. This explains why, for example, the National Health Service in England, responsible for the delivery of health care, has placed such a high priority on measures to reduce levels of



obesity, even though some argue that this lies outside its responsibility simply to treat those in need. Similarly, it seems difficult to reconcile concerns of some governments about the sustainability of the health system in the future if they have failed to adopt comprehensive anti-tobacco strategies, including steadily increasing cigarette taxes, bans on point of sales advertising, and standardised packaging, which together have been extremely successful in reducing smoking rates in Australia (Laverty et al. 2015).

The nature of the demands on health systems are also changing because of the **new opportunities to intervene** that are keeping people alive, whether in the form of new and safer medicines, improved diagnostics, or new surgical or minimally invasive techniques. Child health offers a good example (Wolfe et al., 2013). The hospital wards that, only a few decades ago, were filled with children suffering from respiratory and gastrointestinal infections are now empty. Instead, paediatricians care for premature babies who, in the past, would never have survived, for older children with complex disorders, both physical and mental, who in the past may also have died or, had they not, would have been hidden in institutions, and children with behavioural problems who, in the past, may have found themselves in the criminal justice system. Paediatric surgeons enable children with once fatal developmental disorders, such as congenital heart disease, to survive and in many cases live a normal life.

As noted previously, at older ages one of the greatest challenges is that of multi-morbidity, requiring health professionals that can offer holistic care to patients with multiple chronic disorders, avoiding interactions between their many medications, and avoiding the need for them to spend their days travelling from specialist to specialist.

Since 2001, the Economic Policy Committee and the European Commission have undertaken studies on the ageing of the population and, in 2009, they considered different scenarios and projections of future health care expenditure at European level (Przywara 2010). The Ageing Report (EC-EPC 2015) updates projections on health care expenditure, using a range of scenarios. As it notes, “balancing the health care needs of the European population with spending resources, as well as continuous efforts to increase the efficiency and quality of health service delivery, will continue to be high on the political and economic reform agenda of Member States”. Thus, the pace of change in the health needs of the European population

means that **health systems must both anticipate patterns of disease, where this is possible, and plan for contingencies where the situation is less predictable**. But in both cases, the changing disease burden will inevitably have implications for how services are delivered and, often, for the systems within which they are embedded, as when organisational structures or payment systems serve as a barrier to the multi-disciplinary and multi-agency responses required by an ageing population.

The second goal of a health system is to be **responsive to legitimate expectations**. These too are changing. For example, changing family compositions and work patterns give rise to an expectation that services will be available at times and in places that are most convenient for patients. However, they also pose challenges for those employed in health care, especially where irregular working patterns are not matched by adequate childcare provision, leading to the risk of discrimination on the grounds of gender, as in England. The changing ethnic composition of the population brings with it a need for culturally appropriate services.

The third goal is **financial protection**. This means ensuring no one faces financial hardship as a result of needing and using health services. Health systems provide good financial protection by keeping out-of-pocket payments to a minimum using a combination of strategies. Adequate and stable public funding for the health system plays a fundamental role in ensuring financial protection, but other policy choices are also important, especially efforts to protect poorer people and people who are vulnerable in other ways. EU member states vary substantially in the extent to which they meet this health system goal. The economic crisis has added to the challenge, with most countries experiencing an increase in levels of poverty in recent years.

In many countries, there are often concerns about the financial sustainability of health systems, expressed in terms of concerns about the economic impact of higher total spending on health (economic sustainability) or concerns about the impact on higher public spending on health on levels of total public spending (fiscal sustainability or fiscal balance) (Thomson et al 2009). As with predictions of the impact of ageing on disease burden, the impact of ageing on future health expenditures is an area where there are many over simplistic assumptions. First, many are based on projections of the old age dependency ratio, calculated using

the predicted numbers in the population aged over 65. Yet, as noted above, older people now are much healthier than in the past and many are still working, either in paid or unpaid employment. At a time when pension age in many countries is above 65, this simplistic figure is obsolete. However, **more challenging for some health systems, especially those heavily reliant on employment-based financing, is the decline in the traditional model of employment, requiring increasing contributions from various other forms of taxation.** The extent to which this is equitable will depend on how the taxes are levied, with those on incomes and capital gains progressive while those on consumption, such as value added tax, are regressive. However, again, as the population and its characteristics change, reforms to the health financing system may be needed. Second, **the impact of ageing on health expenditures is in general small when compared to the impact of changes in health technology.**

For all these reasons, health systems cannot stand still, and indeed they have not done so. The 2000 World Health Report also identified the importance of the stewardship role, whereby governments would engage in forecasting, anticipating changing needs while planning for uncertainty. In some cases reforms have done so, although often at the level of sub-systems within the overall health system. An example would be the introduction of an organised screening programme, requiring new payment systems and governance structures. In reality, in many countries the stewardship function is weak or fragmented. Moreover, as noted above, given that organised health care is a form of redistribution of resources, the main driver for major reform is frequently political, with changes to the health system a side effect of wider changes, such as a redistribution of power between central and regional governments, or differing views on the role of the market in public services. In such cases, the extent to which the reforms will promote the goals of the health system set out above are secondary to other considerations. As this section has argued, **health systems must adapt to changing circumstances. The “cost” of doing nothing will be high. But the reforms must be for a purpose –to improve the performance of the health system- and not merely for the sake of change.** If that purpose is the adoption of a political ideology, it should be explicit, and the implications for the health systems goals set out above should be spelled out.

### 3.3. REFORM OF HEALTH SYSTEMS

#### 3.3.1. CONCEPT OF HEALTH REFORM

*A health reform is any change in any fiscal or structural policy aiming at having a direct impact on the health system, in terms of the income (source of funds), expenditure, demand or supply of health care, and health outcomes.*

As noted above, it is important to achieve clarity about the objectives of health reforms, distinguishing those whose primary objective is to improve health, health system responsiveness, or fairness of financing, from those where the primary objective is political, such as redefining the role of the state and the individual, or opening up provision to competition. In practice, of course, these are often conflated, with the stated objectives being, for example, to improve health, while the true objectives reflect the prevailing ideology. It is also important to differentiate those where the focus of the reform is on the health system itself, and its institutions, and those where the health system reforms are secondary to changes directed at other sectors, such as the degree of centralisation or decentralisation in government, or the labour or education sectors.

In this report we focus on reforms of health care systems: structures and programmes whose main objective is to prevent and treat illness (usually under the aegis of health ministries or health insurance institutions). However, as noted above, health system reforms should proceed in tandem with public health measures, making health in all policies a reality.

Reforms comprise a set of changes that seek to improve the existing situation. They may change structures, processes, or both. As noted above, as living organisms, health systems are changing constantly and can be considered to be in constant reform. As an example, van Ginneken refers to health care reform in the Netherlands as a “perennial” reform (van Ginneken 2015). Similar examples can be seen in almost every member state.

When talking about health system reforms, several types of process can be observed: those based on scale, either partial or global reforms, or on timing, either incremental or discrete (big-bang) reforms. Partial reforms (day-to day operational changes, evolutionary, incremental) seek to change one aspect of the

system. Global structural reforms try to reshape the system. Partial reforms are continuously being implemented in response to changing situations (demography, economy, technology, epidemiology, public opinion, etc.). The sum of partial reforms in several significant elements of the system can lead to a global, comprehensive reform. For example, when analysing Italian health policy, Fanelli and Zangrandi observed that, since its creation in 1978, the Italian National Health Service has been characterised by a series of reforms that have modified its functioning substantially (Fanelli and Zangrandi 2015).

Global reforms are often a result of major changes that have occurred in society (including demographic, political, ideological, social, economic, technological, and cultural changes, both individually and collectively). Countries vary greatly in the frequency with which they have implemented global reforms of their health systems, to a considerable extent reflecting the speed at which their legislative process operates, including the extent of checks and balances on the executive. Thus, the United Kingdom and, until the introduction of voting based on proportional representation, New Zealand, have stood out internationally for undergoing frequent and repeated reform while the USA, with its separation of powers between the President and Congress and the States and the federal government, with a rigid and detailed constitution upheld by a powerful Supreme Court, has found it extremely difficult to implement reform.

But when can it be said that a package of changes constitute a “reform”? Berman argued that, for reform to occur, changes must aim to achieve a series of policy objectives explicitly formulated, and be sustained (Berman P 1995). Jönsson argues that there must be a specific regulation or law establishing the reform (Jönsson 1997). Other authors argue that there must be structural and institutional changes (OECD 1994, Saltman 1997, Lamata 1998).

Global reforms are complex processes that require: a) an explicit formulation to be published (a law, decree, government declaration, etc.); b) a set of measures explicitly related to the reform to be applied; c) there must be changes to important structural dimensions affected by the reform process (coverage, adequacy or level of expenditure; package of benefits, quality, health outcomes, equity in financing, efficiency, etc.); d) institutional changes to be implemented (governance).

### HEALTH REFORM PROCESSES UNDER WAY

The 2016 Country Reports (European Commission 2016), and other documents, report health reform processes under way in several member countries:

- Austria: Health System Reform 2013-2016.
- Czech Republic: Government's Manifesto and National Strategy for Health 2020; Diagnosis-related group Project (January 2015).
- Finland: The main elements of healthcare and social services reform have been agreed, consequent upon a wider reform of local government. A legislative proposal is foreseen at the end of 2016. The stated goals of the reform are to ensure quality, effectiveness and availability of services and to support the stability and sustainability of municipal economies. The reform seeks to integrate both primary care and hospital services and health care and social services.
- France: Health care Law of 26 January 2016.
- Germany: Several laws on healthcare have been adopted in recent months, aimed at containing costs and enhancing cost-effectiveness, but also at expanding care services: hospital care, provision of healthcare to undersupplied regions (rural areas); disease prevention and health promotion; palliative care; long-term care.
- Ireland: Future Health Strategy (2012), Activity Based Funding Implementation Plan 2015-2017.
- Portugal: Comprehensive Hospital Reform being implemented since 2012.
- Slovenia: National Health Care Resolution Plan 2016-2025, approved by the government on December 2015. The Health Care and Insurance Act could be approved by the Parliament at the end of 2016.
- Spain: Royal Decree Law 16 / 2012 and other measures at national and regional level that have impacted on health care expenditure, coverage, co-payments, workforce remuneration, and prices of medicines. Some Autonomous Communities have maintained population coverage, undertaking re-organization of services.
- United Kingdom (England): Although the NHS in England underwent a major reform in 2012, with the enactment of the Health and Social Care Act, the resulting challenges have led to the adoption of a wide range of alternative local solutions, including devolution of responsibility to groups of local government bodies and so-called vanguard projects, some seeking to roll back aspects of the competitive market envisaged in the Act.

It is important to recognise, as noted in the section on complexity, that **all aspects of a health system are interconnected, so that modifying one element will**

**often have consequences, many unanticipated, for other elements.** There may also be changes outside the health system that affect its functioning (e.g. social policies, fiscal policies, etc.).

In this report we use the term “reform” for both global and partial reforms.

### **LONG TERM CARE AND HEALTH SYSTEM REFORMS**

Long Term Care (LTC) is defined as a range of services required by persons with reduced functional capacity and who are dependent for an extended period of time on help with basic and / or instrumental activities. Traditionally, this help had been provided by the family (informal care), and by using formal services privately funded. However, progressively, European countries have developed public funded benefits to help dependent people (through services “in kind”, or “cash benefits”). It can be noted that, if there are variations between Member States in health expenditure for curative services, the differences in public expenditure dedicated to LTC are huge (10 to 20 times, as a share of GDP). Recently, the economic crisis affected negatively long-term care services.

The dependency is caused by ageing, but is due mainly to sickness or frailty. For that reason, **health and social care for people in situations of dependency must be well coordinated to provide a comprehensive and continuing care, focusing on the needs of people.**

Indeed, many policies of prevention, health promotion, primary care, and rehabilitation, as well as the approach to health in all policies, have a long-term perspective. These strategies are no response to acute situations but to protracted situations. Thus, health care reforms must be designed having in mind the role of LTC resources and programmes.

### **3.3.2. UNIVERSALITY: THE MAJOR HEALTH CARE REFORM IN THE 20<sup>th</sup> CENTURY**

Throughout the 20<sup>th</sup> century, European governments have progressively moved towards universal health coverage (defined as ensuring all people can use needed health services of good quality without financial hardship). This evolution was not spontaneous, it was the result of tensions, and the pressure of social movements that were demanding access to human rights (health, education, pensions, etc.). Access to these rights required public funding, and for that, establish the collection of social contributions, and establish or increase taxes on wealth and higher incomes were necessary conditions. It should be noted that, before the financial and economic crisis there were important differences across EU countries in universal health coverage, and since the onset of the financial crisis there have been some important reversals. Notwithstanding this recent setback, for the first time in the human history, the right for all people to have access to the same level of health services, publicly funded, was recognised, with funding based on the principle of solidarity.

However, it is important not to take this progress for granted. Moreover, there are constant voices arguing that universal health care systems are unsustainable, frequently invoking some of the misleading arguments, such as the impact of ageing populations, discussed above. It is important to note that these calls are not new. Over three decades ago (September 1982), in the United Kingdom, a confidential memorandum of the Central Policy Review Staff to Margaret Thatcher argued that:

*"It is therefore worth considering aiming over a period to end the state provision of healthcare for the bulk of the population, so that medical facilities would be privately owned and run, and those seeking healthcare would be required to pay for it... Those who could not afford to pay would then have their charges met by the state, via some form of rebating or reimbursement". The only exceptions might be the long-term institutional care of the "mentally handicapped, elderly" whom the authors conceded "clearly could not afford to pay" (Travis A, 2012).*

These arguments hark back to an earlier age when health care was considered a private issue, albeit allowing a role for charity. Those who seek to resurrect this view argue that health care is a service that must be purchased just like any other one. People should work and save for their medicines or their treatments, or buy a



private insurance scheme. If they go bankrupt, then charities will take care of them, if needed.

However, there are strong arguments against this view:

People do not choose to get ill. It is a risk that affects everybody.

People do not choose when to get ill.

People do not choose what kind of illness they are going to suffer.

People do not choose how much to spend in health care this year, in the same way they decide how much they will spend in consumer goods. The cost of treatment is unforeseeable, will depend of the illness, and can be unaffordable for them as individuals.

Moreover, those more in need of care are often poor, reflecting the influence of the social determinants of disease, and even if not poor when they fall ill, may become so if they lose the ability to work and receive earnings (Himmelstein D et al 2009; Emami S 2010). In this respect, the following testimony is relevant: Joe Biden, Vice President of the USA, told CNN that if his son were forced to step down of his position as Dealware's attorney general, and lose his income because of the cancer (that ultimately killed him), the Vice President and his wife would have to sell their home to help with expenses. He reported how President Obama told him not to do that. "He said "I'll give you the money. Whatever you need, I'll give you the money"" (Mufson S, 2016; Liptak K 2016).

For these reasons, European governments have repeatedly confirmed their commitment to universal health care, funded through solidarity mechanisms like progressive taxation. Thus, following the Second World War, the signatories to the Constitution of the World Health Organization proclaimed the right to health for all, recognising "...the highest attainable standard of health as a fundamental right of every human being."

In 1966 the States Parties to the International Covenant on Economic, Social and Cultural Rights in 1966 confirmed the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. They stated that "Health is a fundamental human right indispensable for the exercise of other human Rights. **Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life with dignity**" (CESCR 2010).

There are different aspects that contribute to the right to health (education, food,

housing, potable water, sanitation, working conditions, etc.). One of these conditions is access to health services: prevention, health promotion, treatment, care, palliative care, etc. Universal health care is a necessary means to promote the right to health.

The health systems put in place in the post war period functioned well. They offered a broad package of benefits, at a reasonable cost for the society, increasing equity in access while contributing to the economy and to social stability. Deaths from conditions amenable to health care fell markedly. But, this debate is not closed and can be seen as a sub-text in any health reforms, although it is rarely discussed openly. Instead, as noted above, it is often framed in terms of concerns about the sustainability of the system, although the emphasis is typically on perceived rising demands placed on the system rather than the problem of falling tax revenues, as the increasing share of national income going to the top 1% becomes increasingly difficult to tax (Oxfam 2016).

The “soft” way to introduce these changes is reducing progressive taxation (with increases in the shadow economy and regressive taxation), reducing public healthcare expenditure, encouraging private insurance, increasing cost-sharing, reducing the benefits package and the quality of services, and reducing access. This has the consequence of reversing the progress made towards universal health care *de facto*. This is a political choice.

A key issue for those supporting this approach is the level of taxation, and the extent to which they contribute through taxes. Yet, it is unarguable that **universal health services require a taxation mechanism. Societies have to decide what proportion of income and wealth should be transferred from individuals and corporations to public institutions. They must also decide the degree of progressivity** (Murphy R 2015). **There are no rights without taxation** . *“Fair tax regimes are vital to finance well-functioning and efficient states and to enable governments to fulfil their obligations to uphold citizens’ rights to essential services such as healthcare and education”* (Oxfam 2016).

When analysing health systems reforms it is important to consider the fairness and efficiency of the taxation system as this is the basis on which health services are built. The share of taxes and contributions in relation to GDP, and the priorities for

expenditure (e.g. bank bailouts versus social expenditure) are key political and moral decisions that affect the sustainability of health systems.

### 3.3.3. HEALTH EXPENDITURE AND TYPES OF HEALTH REFORMS

#### Trends in publicly funded health expenditure

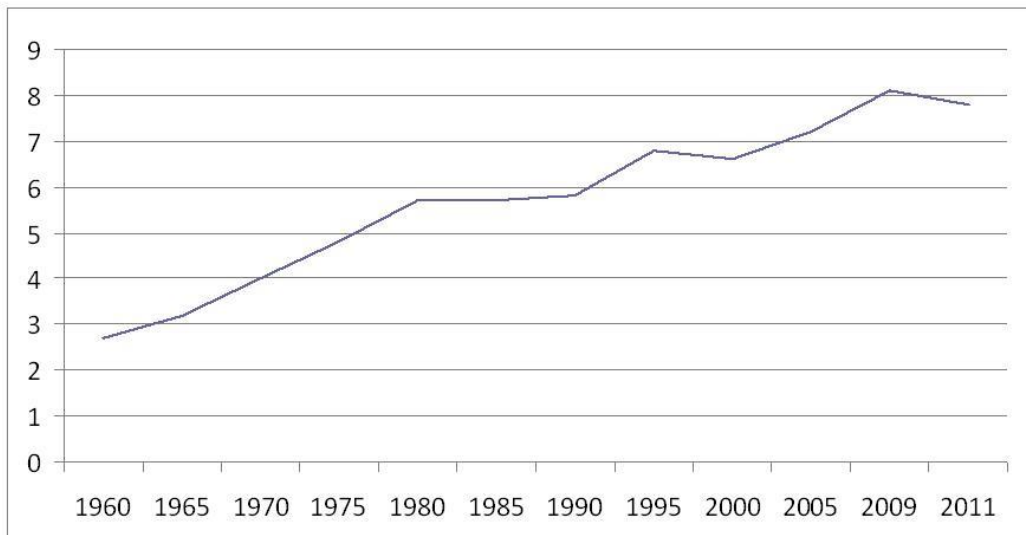
From the beginning of the 20<sup>th</sup> century three processes can be discerned in the move towards universal health coverage. First, the **share of the population covered increased**, reaching almost 100% in most European countries. Second, the **benefits package expanded** and the quality of services improved. Third, the **contribution made directly by patients** (out-of-pocket payments) **reduced**. Thus, in the 1960s, public health spending in EU countries grew by 1.3 percentage points of GDP, and in the 1970s by another 1.7 percentage points (European Commission 2013-2). These changes reflected a commitment to solidarity, shaped by the experience of the inter war period, coupled with a sense of optimism about the potential benefits of advances in medicine. It was at this time that many of the so-called block-buster drugs were being introduced, extending the length and quality of life for millions. However, this was accompanied by a growing recognition that the benefits were not being enjoyed by all, with some groups facing difficulties in accessing high quality health services.

By the 1980s, the discourse was changing. Now the discourse was dominated by concerns about the sustainability of the “welfare state” and the perceived need for **“budgetary consolidation”** and control of spending (OECD 1992; OECD 1996; Nolan 1996; Cutler 2001; EC 2013). In the UK and USA, under Margaret Thatcher and Ronald Reagan, free market think-tanks became extremely influential, shaping the global debate. As a result, in the 1980s, health expenditure in EU countries grew by only 0.1 percentage points of GDP (public expenditure on health grew from 5.7% to 5.8% of GDP). (Figure 1)

In the first part of the 1990s growth in public health expenditure increased again, from 5.8% in 1990 to 6.8% in 1995. At this time reforms focused on **micro-management and efficiency** (Jönsson 1996; Dunning 1996). However, at the same time, some countries sought to improve access (reducing waiting times), increasing patient choice and upgrading infrastructure, or trying to introduce

market mechanisms (contracting, outsourcing, changing payment methods). Some of these measures contributed to the increased health spending. Countries that had relied more on regulation sought to “open” their systems to competition, while countries with less regulation tried to limit some options (convergence). From 1995 to 2000, public health expenditure stabilized (6.6% of GDP). However, after 2000, demand for **higher quality services, more patient choice, new technologies, and increased use of services** by an ageing population led again to an increase of health expenditure, reaching 8.1% of GDP in 2009.

FIGURE 1. Evolution of public expenditure on health as a share of GDP in the EU, 1960-2011



Source: European Commission. Report on Public Finances in EMU 2013

The financial crisis caused by deregulation of the financial system exploded in 2007-2008, impacting European economies severely and provoking a new wave of health care reforms, focused mainly on **cost-containing measures**. Since 2009, public spending on health in the EU has decreased from 8.1% of GDP to 7.8 % in 2011 (European Commission 2013-2). According to the OECD, average health spending growth across the EU members of the OECD climbed just above zero in 2013 after three successive years of reductions (OECD 2015-4).

### Typologies for analysing health reforms

Many different frameworks have been proposed to analyse health reforms. The OECD has undertaken important work in identifying different dimensions of reforms and characterising them. In particular, they have focused on **health expenditure and cost-containment**. Moreno-Serra studied the impact of different reforms on health expenditure (Moreno-Serra R 2013; OECD 2015). He differentiated policies aimed at the supply side, the demand side, and those oriented to public management, co-ordination and financing reforms, while exploring the impact on cost-containment of different approaches.

Other experts and institutions have analysed reforms on **governance** (decentralisation; payment / contracting / funding; integration of subsystems; patient empowerment, etc). Some studies have focused on the **sectors** that have been reformed (pharmaceutical, hospital, primary care, mental health, etc.).

In the 1990s, Saltman and Figueras identified four integrating themes around which different processes of reform could be analysed: the **changing roles in the market and the state** in health care; **decentralisation** to lower levels of the public sector or to the private sector; **greater choice** for and empowerment of patients; the evolving role of **public health** (Saltman and Figueras 1997).

The IMF (2010) analysed health care reforms using a typology developed by Oxley and MacFarlane (1995): macro-level controls (budget caps, price controls, etc.); micro-level reforms (coordination, contracting, etc.); demand-side reforms (cost-sharing).

In the context of the recent economic crisis, the European Observatory on Health Systems and Policies surveyed health policy responses to austerity, presenting a framework for analysing policies and their impact on health system performance (Mladovsky et al 2012). They classified the different types of policies into three categories: policies intended to reduce the **level of contributions for publicly financed health care** (cuts in health budget; user charges...); policies intended to affect the **volume and quality** of publicly financed health care (benefits package; entitlement; public health measures; taxes on alcohol and cigarettes...); policies intended to affect the **cost** of publicly financed health care (prices of medical goods, improve the rational use of medicines, salaries, payment systems,

restructuring of ministries of Health, restructuring the hospital sector, investing in primary care...). The authors identified some measures as more suitable for furthering the objectives of health systems while others measures could jeopardize these objectives.

The European Observatory and the Andalusian School of Public Health has also developed the "Health & Financial Crisis Monitor", summarising evidence on the impact of the crisis and policy responses. The Observatory provides extensive information in its "Health Systems and Policy Monitor", a platform that provides detailed descriptions of health systems (Health in Transition reports) and provides up to date information on reforms.

In its Report on Public Finances (2013), the European Commission grouped public health policy responses to economic crisis into four categories (WHO scheme): **finance adjustment**; changing health **coverage** (reduced / increased population coverage; benefits package; user charges); generating **savings** (reducing salaries, pharmaceutical policy, reducing capital investments, etc.); improving **efficiency** (primary care, e-health, HTA etc.).

More recently, the European Observatory and the WHO Regional Office for Europe, carried out a second study of health system responses to the crisis (Thomson S et al 2014), mapping and analysing policy responses across Europe from late 2008 to the middle of 2013. The authors discussed changes in three areas: **public funding** of the health system; health **coverage**; and **planning, purchasing and delivery** of health services. In assessing the impact of changes on health system costs, the study distinguished between savings and efficiency gains, identifying four potential outcomes:

- doing the same or more with fewer resources, leading to savings and efficiency gains
- doing more with the same or more resources, leading to efficiency gains without (immediate) savings
- doing less with fewer resources, leading to savings, without efficiency gains
- doing less with the same or more resources, leading neither savings nor efficiency gains

### 3.3.4. FACTORS INFLUENCING REFORMS

#### **Caution when analysing reforms**

When comparing and assessing the impact of different policies, certain precautions must be taken. The impact of a policy depends on the situation in which it is applied; for example, hospital payment based on DRGs can reduce costs, compared to unconstrained fees for each element of the treatment, but both methods, based on activity, can increase costs compared to a fixed annual budget, whether based on physical capacity, human resources, or some other measure. Unfortunately, many analyses used to support particular policies have been funded or undertaken by those with vested interests, or used questionable methodology. It is also important to recognise that reforms are often accompanied by other changes, or have multiple components, so there is a need for caution in attributing any observed effect to a specific policy.

Much work is still needed to develop capacity for independent research to assess health reforms objectively, using appropriate methodologies.

#### **Motivation for health reform, narratives and choices**

One important issue to be considered is the motivation for reform. As noted above, in recent years a major objective of many health reforms in Europe has been reducing expenditure (“fiscal consolidation”, “cost-saving” measures). Often, this emphasis on reduced spending has failed to consider the impact on access, quality or health outcomes, or on social cohesion, productivity and the economy (Caritas 2015). As Thomson and colleagues noted, “if fiscal balance is taken as an independent objective, then the impact of spending cuts on other objectives may be less important than their success in aligning (public) expenditure and revenue. In this case, the main technical criterion guiding policy is the potential for coverage reduction to lower public expenditure on health care. If, however, the objective is to maximize the attainment of health system goals within a fiscal constraint, the technical criterion guiding policy will be slightly different. The potential for coverage reduction to lower public expenditure on health care remains a consideration, but the overriding aim is to achieve this in ways that are least likely to undermine other objectives” (Thomson et al, 2009).

In other cases the motivation has been to create markets to attract private investors and provide economic benefits to for-profit providers (Reynolds L, McKee M 2012).

Health reforms are often an expression of the balance of power between different actors: citizens (users, taxpayers), health professionals, health institutions, managers, officials, politicians, industry, insurance companies, financial institutions and investment funds. Consequently, it is wrong to view most reforms as strictly technical processes. **Reforms inevitably have an important political component, where social rights and economic interests have to be balanced. This is a moral issue (about values) and a political one (about priorities).**

At the same time, reforms should, as far as possible, be based on evidence. **The diagnosis, the narrative, and the global framework in which health reforms are implemented all influence the assessment of a certain measure as positive or negative in relation to the main goals pursued.** During the economic crisis, health care reforms have been influenced by the narrative of the deficit and, consequently reducing health costs (Lamata F, Oñorbe M, 2014). Thus, the lack of emphasis on the social implications of the measures taken was something evidenced in an analysis of the language used in the documents related to financial assistance by the Troika (Sapir et al, 2014).

Mr Juncker explains the difference between technical and political questions: *"Because it is not a technical question whether you increase VAT not only on restaurants, but also on processed food. It is a political and social question. It is not a technical question, but a deeply political question, whether you increase VAT on medicines in a country where 30% of the population is no longer covered by the public health system as a result of the crisis. Or whether you cut military expenditure instead – in a country that continues to have one of the highest military expenditures in the EU... It is certainly not a technical question whether you reduce the pensions of the poorest in society or the minimum wage; or if you instead levy a tax on Greek ship owners"* (Juncker 2015).

If the main motive of health reform is to contribute to fiscal consolidation, reduction of the public deficit, and reduction of public debt, then the measures will be



oriented to reduction of health expenditure (reducing personnel, salaries, package of benefits, coverage, etc). If the motive of health reform is to improve health of the population, and contribute to inclusive economic growth, then investing in health, increasing access and quality of health care could be appropriate measures. Usually, as the causes of the problems are complex, the objectives of the reforms so to should combine different approaches, trying to maximize efficiency and stability.

### **3.4. INFLUENCE OF THE INSTITUTIONS OF THE EUROPEAN UNION IN REFORMING HEALTH SYSTEMS**

The European Union has had an important role in the development of the health care systems through various institutions and programmes: European Agencies; EU "health for growth" programme; cohesion and structural funds; research and innovation programs; joint actions; legislation (for example, Directive 2011/24/EU on patients' rights in cross-border healthcare); prevention and health promotion initiatives; European Reference Networks; e-health, m-health and ICT solutions; partnerships; expert panels; reports, etc. (A good review of European Union health policies in Greer S et al, 2014).

Historically, it was accepted that health care planning, managing, and funding is a competence reserved to Member States, a principle that is stated in the Treaties and reiterated in successive rulings of the European Court of Justice. However, **the Stability and Growth Pact, and the European Semester process has led to an important change, whereby the European Institutions have made Country Specific Recommendations (CSR) related to health care.** The CSRs make certain assumptions about what policies should be pursued (for example, reforms in pharmaceutical policies, in the hospital sector, in the pricing of health services, in out-patient care and primary care, or recommending maintaining and improving access to care). The CSRs emerge from consultations between the member states, the Commission and the Council.

During the recent financial crisis, Economic Adjustment Programmes (EAP) were adopted for various member states. These programmes and their Memorandum of Understanding (MoU) contained health policy measures. Thus, national Health Reforms have received guidance from the EU institutions in the last years.

In recent years almost all member states received CSRs issued by the European Council (EPHA 2014; EC 2014-2). Thus, in practice, the European Semester having a direct impact on health system reforms. As Azzopardi-Muscat and colleagues have noted, most CSRs tended to be framed within the discourse on sustainability of public finances rather than on social inclusion and investing in health. Most of the recommendations have been aimed at reduction of the health budget, with less attention given to access and quality (Azzopardi-Muscat 2015; Caritas Europa 2015). This is understandable having in mind that one of the main purposes of this process was to control public deficit and public debt. However, since 2013, recommendations included also issues on quality and on access.

The EU is playing, and can play a stronger role in promoting effectiveness and efficiency of health systems, and the European Semester gives the EU greater scope to act in this regard (Ahtonen 2013). CSRs offer potential to encourage those health system reforms that prioritize investment in health as a means to achieve inclusive growth, coupled with mechanisms to ensure adequate funding to guarantee long-term financial equilibrium.

In any case, this is a very important change in the EU's role in health care: the EU is influencing in defining and orienting national health reforms. And this change requires the reinforcement of their technical resources and an open debate on objectives, policies and results in the main dimensions of health care. This is an opportunity to reinforce the vision of an EU more socially responsive that guarantees the right to health and health care for all citizens in all EU Member States.

There is another (parallel) discussion needed about the legitimacy of these interventions, and the possible democratic deficit of these processes (Fisher-Lescano 2014; Karger 2014; Fazi 2014). It is important that policy decisions are made based on solid information, and taking into account long term impacts, and the views of citizens and of civil society organisations (Caritas Europa 2015).

When analysing the 2014 CSR the European Public Health Alliance concluded: "The potential for the recommendations to improve the health and well-being of Europeans rests not only upon uptake and implementation by the member states, but also upon the inclusion of health actors, civil society and social partners in the drafting of the CSRs... The legitimacy, effectiveness and success of the CSRs is

dependent upon the involvement of these stakeholders and though some progress has been made in this respect, there remains considerable scope for improvement” (EPHA 2014).

In its Conclusions on the economic crisis and healthcare, the Council invited the member states and the Commission to reinforce cooperation and improve coordination between the Social Protection Committee (SPC) and the Working Party on Public Health at Senior Level (WPPHSL) so that Ministries of Health can actively contribute within the framework of the European Semester (Council 2014). Likewise, **the working programme of the WPPHSL foresees greater involvement in the European Semester process** (Council 2014-3). This involvement should include regional health authorities responsible for health care management.

In addition to the EU institutions, other international institutions have influenced, and are influencing, health policies, such as WHO and the IMF and, in the past, the Council of Europe.

The World Health Organization (WHO) has played also an important role in supporting actions to improve the health and well-being of populations, reducing inequities, strengthening public health and ensuring people-centred health systems that are universal, equitable, sustainable and of high quality. Health 2020 was adopted as the new European health policy framework in 2012 by the 53 Member States. Seven targets were defined: reduce premature mortality; increase life expectancy; reduce inequities; enhance the well-being of the European population; universal coverage and the right to health; and National targets/goals set by Member States. The European Health Report 2015 assesses the extent to which progress has been made towards the defined targets (WHO 2015).

The IMF has historically encouraged reductions in social protection spending, and increasing co-payments for care (Reeves A et al 2014). Tax revenue falls and exposure to lending from IMF could determine priorities of health reforms. What is clear is that economic conditions are very important to develop health systems, and also that there are different policy options to cope with economic constraints. IMF, as a member of the “troika” (EC, ECB, IMF) has participated also in the orientation of health reforms in various EU countries through Economic Adjustment Programmes and their corresponding MoU.

## **Typology of health policy reforms**

---

The Council of Europe has promoted social rights, equal access to health care, and the improvement of health care systems, through different recommendations and resolutions (see Council of Europe 2012; 2013; 2015).

### 4. EXPLORING TYPOLOGIES AND TEMPLATES ON HEALTH REFORMS

#### 4.1. TYPOLOGY OF RECENT REFORMS

Reforms can be classified according to the dimensions targeted / affected. After analysing different reforms implemented over the last years, it is suggested the following typology, according to the main set of dimensions affected.

Reforms designed to modify **coverage** (people covered; benefits covered; financial protection).

Reforms designed to modify **equity** (equity in financing; equity in delivery and use of health services; equity in health).

Reforms designed to modify **efficiency** (efficiency in delivery; efficiency in funds origination).

Reforms designed to modify **quality**.

Reforms designed to modify availability of **resources** (human resources; financial resources; other resources).

Over the last years there have been implemented different health reforms in European countries. The study of implemented reforms permits to obtain certain information about possible impacts of different reforms. It has to be noted that it is not easy to attribute one specific result as consequence of one specific reform. The same policy could have a different effect depending on the context, and the way in which it is implemented. Moreover, different measures can be implemented simultaneously, and the effects can be mixed.

Careful evaluation should help to answer the question about which of these measures / policies / reforms, enhances the performance of health systems in the short term and over the long term.

### EXAMPLES OF EUROPEAN UNION RECOMMENDATIONS

The Commission and the Council have proposed Specific Country Recommendations to some European Countries, suggesting a certain orientation for their health reforms. For example:

#### Improve Coverage

- Providing universal coverage

#### Improve Equity in financing

- Take decisive measures to improve, and increase tax collection
- Address the shadow economy

#### Improve Equity in distribution and use of health services

- Increase accessibility for disadvantaged people, vulnerable groups, and remote and isolated communities

#### Improve Efficiency

- Cost-effective use of medicines
- Reviewing the pricing of healthcare
- Reducing spending on patented medicines
- Gradually implementing adequate prescription practices
- Rationalise (reduce) hospital pharmaceutical spending
- Encourage the provision of and access to effective primary health care services
- Strengthening primary healthcare
- Better public procurement
- Improve integration of care
- Strengthening outpatient care
- Establishment of a Gate-keeper GP structure

## Typology of health policy reforms

---

- Improving the management of hospital care
- Assess the relative effectiveness of health technologies
- Improve the governance of the healthcare sector
- Encourage health promotion and disease prevention
- Stronger focus on rehabilitation and independent living
- Implementing reforms aimed at improving efficiency of healthcare
- Linking hospital financing to outcomes, DRGs,...
- Reduce inappropriate length of stay in hospitals
- Increasing co-payments

### Improve quality

- Improve Quality of health care services

### Improve Availability of resources

- Create a sustainable financing basis
- Tackle the fiscal risks in healthcare
- Remedy low funding
- Strengthen the national budgetary framework by aligning legislative, administrative, revenue-raising and spending responsibilities across the different levels of government, in particular in the area of healthcare
- Develop financially sustainable model
- Restructuring the hospital network

The Annual Growth Survey 2016 defines the following priorities:

Regarding health care and long-term care systems, reforms need to continue to enhance their cost-effectiveness and to ensure adequate access. The demographic challenge affects not only pensions but also health care and long-term care related expenditure. A healthier population will also improve labour market participation and labour productivity. Member States need to introduce measures to ensure a sustainable financing basis, encourage the provision of and access to effective

primary health care services, the cost-effective use of medicines, better public procurement, improve integration of care through up to date information channels (such as e-health), assess the relative effectiveness of health technologies and to encourage health promotion and disease prevention.

Reviewing different policies that have been applied (or recommended) during the last years, and comparing observed impacts and opinions by different authors and institutions, it can be said that some of them get more general agreement about the positive, or negative impact on health system values.

Thus, there seems to be agreement in considering that some measures / policies achieve good results in efficiency, while maintaining access and quality. For example: disease prevention and health promotion; developing primary care; preventing over- prescription and over- treatment; reducing medicines' prices; excluding from the list of covered benefits the ones that are ineffective; increasing competition for purchasing goods (joint procurement, etc.).

There also seems to be agreement that some measures / policies can generate short-term savings for public budgets, but can affect negatively access and / or quality. For example: reducing population coverage; increase cost-sharing; reducing package of effective benefits; reducing salaries.

However, there is more controversy in relation to other policies. For example: methods for payment to providers (physicians, hospitals, etc.), like DRG, or linking hospital financing to performance mechanisms; these reforms may increase efficiency at hospital level (more activity, reducing ALOS, orienting services to high priced procedures) and transparency at system level, but can create inefficiencies at health system level, increasing public expenditure without increasing health outcomes. Another example is increased competition in health care; the effects will depend on the kind of products; it is not the same applied to goods, like pharmaceutical or medical products, or when applied to services; it will depend on the context, management, control, etc. (EXPH 2015-3).

The health system is a balance, and the positive / negative impact of a measure depends on the starting point, and of other political, economic and social processes (the history and the context). That means that a certain measure could be globally positive (in relation to access, quality, efficiency and sustainability) in a certain



context and negative in other context. We must highlight that no recipe is valid for every country at every time. Each country has to define its process of health system reform according to their needs and conditions.

### **SOME POLICIES THAT MIGHT IMPROVE THE SUSTAINABILITY OF THE HEALTH SYSTEM**

A list of policies and measures adopted in recent years, selected from different sources, is included in Annex 1.

Among the policies that can help to sustain and improve health system performance, maintaining access and quality and improving cost-effectiveness we have selected the following:

1- Effectively, efficiently and equitably invest in Public Health, based on the concept of Health in all Policies, at national and EU level (TFEU). There is extensive evidence on the cost-effectiveness of many (although not all) types of prevention, often leading to savings in cost of treatment or long-term care. Knowing that there are effective public health interventions that can avoid unnecessary illness and pain, these interventions should feature prominently in health policies. Investments in national health strategies that achieve public health goals are an important means of promoting sustainability of health systems.

2- Link levels of public spending to population health needs. Each country should ensure that there are adequate resources to guarantee the right to health, taking account of the principle of progressive realisation according to the national economic context. Health Systems should offer access to high quality, safety and cost-effective interventions to address health needs.

3- Control growth in care expenditure. As resources are limited, cost-effectiveness in the use of available resources is essential.

4- Adopt quality improvement as a driving force for change. Doing things right first time is cost-effective (EXPH 2014-2).

5- Better health system governance. Develop appropriate governance structures, with an appropriate balance between centralization and decentralization of functions (consistent with the national political context). Ensure that operational information systems and arrangements for accountability align with organisational structures. Develop mechanisms to disseminate good practices within the health system. Stimulate communication and other interchanges between policy makers at regional and national level.

6- Encourage the provision of and access to effective primary health care services. Primary care, adequately funded, can address the majority of health problems affecting patients and populations. Investing effectively, efficiently and equitably in Primary Care is highly cost-effective, especially when based on well-equipped multidisciplinary Primary Care centres (EXPH 2014-3).

7- Invest in integration of services: primary care, hospital care, home care and social services (funding, insurance, provision, processes, information channels). Development of e-health/m-health where this can be shown to be cost-effective.

8- Policies to increase the cost-effective use of medicines. Identify more efficient ways to fund R&D, linked to lower prices of new medicines. Increase the use of generics and biosimilars. Improve public / joint procurement. Encourage rational prescribing and dispensing of medicines, medical products and diagnostic tests. Avoid over-medicalization.

9- Actively manage investment in facilities, infrastructure and equipment. Reduce fragmentation, with hospitals and other facilities organised in networks.

10- Continually assess the benefit package, linked to health technology assessment (including medicines) as a basis for reimbursement decisions. Ensure that the publicly financed benefits package covers the full spectrum of essential services, reflecting population health needs in an equitable fashion. Put in place systematic priority-setting processed to support decisions about coverage of both new and existing technologies in ways that are HTA-informed and cost-effective.

11- Reduce unnecessary use of health care services. The wide variations in use of medicines, hospital admissions, diagnostic procedures, etc., between and within EU countries suggest possibilities for improvement.

12- Improve mechanisms to raise revenue: including action on tax havens; combating tax fraud; and minimising tax evasion and avoidance. Ensure that taxation systems are progressive.

13- Reduce / eliminate informal payments. Guarantee an adequate system of remuneration, so as to ensure appropriate motivation of health personnel.

14- Shift care from inpatient to day-case or ambulatory care. Encourage home care and care at the workplace (when appropriate), using e-health, m-health, and task shifting where this can be shown cost-effective.

15- Adequate training and support to deliver services in line with evidence. Active and engaged patients / citizens should stimulate a new vision of partnership and shared decision-making with health workers.

16- Improve motivation and working conditions of health personnel. The key element to improve efficiency and quality is high quality performance of health personnel. In this complex, personalized service, where more than 50% of total expenditure corresponds to remuneration of personnel (personnel intensive), adequate personnel policies are essential. This requires a shared vision, with attractive working conditions, effective participation, continuing professional development, and adequate support.

17- Develop and support self-management of health conditions. The role of engaged patients / citizens can be facilitated and reinforced with appropriately structured information and training programmes. There is a need for adequate support by the health team (at home, in schools and the workplace, etc.), coordinating their efforts with other networks (social, education, etc.), making effective use of m-health and e-health tools.

18- Improve health system performance assessment. A basic step to improve efficiency and sustainability of health systems is to know what is happening. Evaluate the impact of measures being adopted. Implement systems that generate the knowledge needed to reorient policies in the appropriate direction. Support countries to identify actionable indicators for performance assessment and support to interpret the results of monitoring.

### 4.2. PROPOSAL OF A TEMPLATE FOR EVALUATING REFORM EFFECTS

#### 4.2.1. RATIONALE OF THE TEMPLATE

The Template must try to capture all the essential elements of the health system: a very complex mix of dimensions and trade offs. The idea of **offering a global vision** is important, because if you measure only one aspect, albeit a priority at the time, we could forget other negative impacts on the system, in the middle or long-term.

On the one hand, the **dimensions relating to the common values of health systems should be part of the template**. Universality, access to high quality services and equity (in distribution), and solidarity (equity in financing) are key aspects of European health systems.

Fiscal sustainability has to be analysed from the expenditure perspective, but it has also to take account of the revenue side. Equity (tax progressivity) and efficiency of fiscal systems are an essential component of public services, and of course of health systems.

The Template has to consider the inputs (resources), and the expected results.

Finally, the Template for analysing health reforms should offer some key information about the context (socio-economic situation), and about the political agenda, including political sustainability (for example, associated with concentration/ dispersion of costs and benefits) timeframes, cost of the measures, public support, etc.

In order to assess the impact of reforms, an analysis of time profile of the reform is important, knowing that the measures adopted can have an impact after one, two or more years (costs and benefits over time).

*The template does not provide a "grade" or "score" for the reform, as different countries may face different trade-offs in objectives and resources constraints. The template intends to call attention to the main issues when discussing a reform in*

*health care in a comprehensive yet simple way. Detailed analysis of particular issues may be triggered, a desirable, after use of the template.*

### **4.2.2. TEMPLATE TO GUIDE IMPLEMENTATION AND EVALUATION OF REFORM**

The proposed Template includes the following contents:

- First, a description of how the reform fits into the vision for the health system. This requires a brief review of economic and political context; societal values; problem to be solved; root causes of the problem; motivation for reform.
- Second, description of the reform: definition of the Reform / Policy / Measure to be adopted, and explicit targets at which the reform is aimed; legal and / or institutional changes; and political and managerial decisions (implemented, or to be implemented). Alternative measures, including the possibility of non-action; pros and cons should be suggested. Specify beneficiaries of the reform; main actors involved; ownership; and environmental factors.
- General overview: impact on benefits; impact on costs; fiscal impact.
- Detailed overview on the impact on particular health system dimensions.
- Feasibility: some policy considerations to take into account when implementing reforms.

The following scheme could be the basis for discussion among interested parties (WPPHSL, DG SANTE, DG ECFIN, DG EMPL, SPC, etc.), in order to develop a common Template to guide implementation and evaluation of health reforms.

*The Template may be applied ex-ante (before a reform has been adopted) and ex-post (to assess the impact of a reform).* The main difference is that under the ex-ante analysis, alternative approaches to solve the problem identified for intervention can be considered and compared, with ultimately one of the options available being selected.

## **Typology of health policy reforms**

---

The template entries were defined after the review of main policies (and their objectives) adopted in the recent past in European countries. As a general tool it is not exhaustive and for some policies analysts should add specific entries to the template. The template is proposed as the minimum set of aspects that should be addressed. Two examples illustrate when further entries may become desirable. One example is the split of "socio-economic equity" into cultural, linguistic, and ethnic aspects when looking at policies targeted at migrant populations. Another example is the inclusion of specific aspects of quality of care, such as user experience, responsiveness of the health system and governance.

### DESCRIPTION OF THE TEMPLATE

*Reform title:*

*Vision* (a description of how the reform fits into the vision for the health system. This requires a brief review of economic and political context):

*Environment* (resources available; other constraints):

*Agents / actors:*

*Beneficiaries / customers:*

*Ownership* (who is in charge of the system and who is charge of carrying out the reform?):

*Problem to be solved:* (It should be stated clearly, first, which health system goal(s) the reform aims to address – what is the performance problem to be addressed – and second the specific objective of the reform, as precisely as possible, i.e. decrease mortality by cardiovascular disease instead of improve longevity).

*Root causes of the problem* (diagnosis): (this requires careful analysis to identify the problem, provide the available evidence on the problem, and determine its likely root causes. Note that often correlation is confused with causation)

*Available options/instruments to solve the problem:* (In the presence of a problem, usually several options are available to tackle it, including a “doing nothing” option. The several options may have some that are strictly dominated in its effects (costs and benefits) by others, while comparing some of the options may involve trade-offs between objectives of health systems. These trade-offs and the values involved in their resolution should be clear)

*Chosen reform instrument description* (transformations):

*Evidence on relevance:* (show how the selected option solves the problem and why it is the best option. When a particular option or instrument for health policy reform is adopted, it should be described and explained why it was selected)

*Feasibility* (detail how it needs to be implemented; see 4.3):

**GENERAL OVERVIEW:**

	Short run (0-1 years)	Medium-run (2-5 years)	Long run (6+ years)	Total impact
Impact on benefits				
Impact on costs				
Fiscal impact				

Note: use qualitative analysis (positive/neutral/negative) in addition to available quantitative analysis.

The impact on benefits and costs should describe the anticipated (or expected) effect of the reform on the aspects of interest in a way suited for verification later in time. While the more natural unit to measure costs is monetary, it does not need to be the case in all circumstances (i.e. when the cost is to unprotect citizens or residents from health insurance coverage). Benefits will often prove to be difficult to be measured in monetary terms. Nonetheless, they should be expressed in a clear way.

The general overview should provide a quick assessment of the likely cost-effectiveness of the health policy reform as well as a view on the time profile of the reform (are there quick wins with benefits concentrated in the first years and cost dissipated over future years? Are benefits gained in the long run with upfront costs mainly?)



**IMPACT ON KEY DIMENSIONS OF HEALTH SYSTEM**

**PROBLEM TO BE SOLVED:**

**EVIDENCE ON THE PROBLEM:**

	Improves	Does not change	Decreases	Assumptions/ conditions  Critical issues
<b>Coverage</b>				
Universality (population covered)				
Range of benefits covered				
Out-of-pocket payments				
Timely access to care				
<b>Equity</b>				
Equity in financing				
Equity in delivery and use				

## Typology of health policy reforms

	Improves	Does not change	Decreases	Assumptions/ conditions  Critical issues
Geographic equity				
Socio-economic equity				
Equity in health outcomes				
Geographic equity				
Socio-economic Equity *				
<b>Efficiency</b>				
Efficiency in delivery of care				
lowers costs for same results				
increases benefits for same cost				
introduction of new models of work				
Efficiency in collection of funds				
<b>Quality of care</b>				

## Typology of health policy reforms

	Improves	Does not change	Decreases	Assumptions/ conditions  Critical issues
<b>Availability of resources</b>				
Human resources				
Financial resources				
Other resources				
Fiscal impact on Government budget				
Distributional impact				
Sustainability / long term financial equilibrium of public accounts				

Note: \* Socio-economic Equity includes considerations of age, gender, social class, education, language, sexuality, ethnicity, and culture.

The different dimensions of health systems performance are directly linked to the expressed values to health systems, as discussed earlier.

**The quick appraisal of impact on key dimensions to the health system aims to provide a check list of likely effects.** The ones deemed to be more relevant in each health policy reform can then be assessed in further detail. The check-list just requires a sense of the direction of change implied by the reform. We suggest a qualitative scale to be used when a change is expected, whatever the direction (a lot/some or strong/mild qualification should be provided). The last column asks for a brief justification or for unveiling the underlying assumptions. An explanation of critical issues preventing progress in specific areas (public perception, law

## Typology of health policy reforms

---

enforceability, etc) could be included here. This may help formalise whether the reform, as it's built is too, or too little ambitious and balanced.

All these elements together will keep focus on the dimensions that need to be addressed in detail but without neglecting (or ignoring) likely effects on other dimensions relevant to the global assessment of the health system.

**Based on the screening of effects addressed in the template, a more detailed analysis of some aspects can be addressed.** Additional to the identification of impacts on the health system (both positive and negative), a necessary next step is to consider the costs of reforms. In particular, its impact on public finances, both expenditure and revenue sides.

### FISCAL SUSTAINABILITY AND HEALTH POLICY REFORMS

*The focus in this section is on impacts for the public sector in terms of both expenditure and revenues. It addresses directly the concern about the effect on public finances from health policy reforms. Obviously, this concern does not exhaust the (potentially) relevant effects of health policy reforms on the public sector (for example, need for organizational changes that do not imply change in public expenditure and public revenues) or across society.*

### COST OF THE REFORM (UPFRONT INVESTMENT)

Before adopting the reform there should be made estimates on the cost of the reform. For example, legislation on tobacco is a very low-cost reform, and positive health outcomes can be expected. On the other hand, there are policies that require upfront investment in personnel (for example to improve access, reduce waiting lists, etc., it would be necessary to incorporate more personnel); other policies could require new equipment (electronic health records, e-prescription), or new facilities.

#### Total public health care expenditure of the measure (to be) adopted:

Cost	Year t	Year t+1	Year t+2	Year t+3	Year t+4
Personnel					
Pharmaceuticals					
Equipment, MD, ICT					
Facilities, infrastructure					
Other					
Total					

**FISCAL IMPACT OF REFORM**

Some reforms could increase expenditure at the beginning of implementation, but will reduce expenditure in the following years. Other reforms can reduce expenditure at the beginning and then can have a boomerang effect.

Total public revenue includes revenue from taxes and contributions. One should have a comprehensive perspective (expenditure and revenue) when looking at fiscal balance.

In publicly financed health care, revenues normally come from general taxation mechanisms, or from social contributions. Many times they are not specifically related to health care. But it is important to know the foreseen evolution of public revenue, and the impact of different measures on the taxation system.

**Public health expenditure and public revenue**

<b>Annual figures</b>	Year t	Year t+1	Year t+2	Year t+3	Year t+4	Year t+5
<b>Total public expenditure on health</b>						
Personnel						
Pharmaceuticals						
Equipment, MD, ICT						
Facilities, infrastructure						
Other						
Total						
<b>Total public revenue</b>						

**Public health expenditure and public revenue variation**

<b>Annual Variation (%)</b>	Year t	Year t+1	Year t+2	Year t+3	Year t+4	Year t+5
Personnel						
Pharmaceuticals						
Equipment, MD, ICT						
Facilities, infrastructure						
Other						
Total						
<b>Total public revenue</b>						

### **4.3. SOME FACTORS TO TAKE INTO ACCOUNT WHEN IMPLEMENTING HEALTH CARE REFORMS: FEASIBILITY**

Health care systems are highly path dependent. They are large and complex, and they have evolved in very specific ways in different national contexts. Health sector reform is best described as a process with certain recognizable characteristics, including a focus on fundamental change that is well-conceived and endures. Health sector reform is underway or under consideration in countries throughout the world and at all levels of income. While it is difficult to define precisely what constitutes a true reform, there is widespread consensus that reform is a process of change involving the what, who, and how of health sector action.

There is a considerable debate about the relative of a swift and radical reform compared with more incremental approaches. The ability to introduce rapid reforms depends mainly on the configuration of the governance structure and on political will, but it is also influenced by contextual circumstances such as the state of the economy and the degree of support from key stakeholder. Radical changes based on ideology may not be politically and technically sustainable in long term. In long run, an incremental approach may lead to more socially sustainable policies than the wholesale changes introduced in "big-bang" reforms. The best approach depends on country particular circumstances, but flexibility is recommended to be built into implementation process. For example, combine "big-bang" approach politically for the passage of the legislation, with steady implementation inside health sector institutions. Flexibility to modify the strategy when some aspects are going wrong is essential role of the health ministry. Two different situations may occur. The first one is when an initial impetus triggers a snowball effect, making it easier to progress through the reform. The 'big-bang' approach implicitly assumes that a big initial effort will make the reform successful in terms of implementation. The second situation is when upon start of a policy reform, barriers and obstacles begin to mount. In this case, persistence is the key to implementing the reform. Instead of a 'big-bang', a continuous reform effort, with increasing force put into it, is necessary. To distinguish which approach is more adequate to each health policy reform is crucial to its implementation.



It has been shown that, when acknowledged leaders accept innovation, other follows. The success of the implementation will depend on identifying strategies that help to change behaviour, having codes of practice that establish expected standards of service provision, and inventing incentives for change.

OECD experts have dedicated important efforts to analyse reform processes finding some common traits (OECD 2010): sound public finances are strongly associated with reform progress; it is important to have an electoral mandate for reform; effective communication is essential; policy design must be underpinned by solid research and analysis; appropriate institutions are needed to make the transition from decision to implementation; successful structural reforms take time; leadership is critical; successful reform often requires several attempts; it usually pays to engage opponents of reform rather than simply trying to override their opposition; the question of whether, when and how to compensate the losers from reform requires careful consideration.

Similarly, Thomson et al discussed requirements for effective policy implementation (Thomson 2014). These requirements were: ensure reforms are underpinned by capacity, investment and realistic timeframes; ensure reforms are in line with national policy goals, values and priorities; ensure transparency in communicating the rationale for reform and anticipate resistance to changes that challenge vested interests; improve information systems to enable timely monitoring, evaluation and the sharing of best practice; foster strong governance and leadership at national and international levels; address gaps in coverage; strengthen health financing policy design; invest in measures to promote efficiency.

**Review of experience in the field of policy reform does not yield any one-size-fits-all “toolkit” for reformers, or even suggest that such a toolkit exists.** On the other hand there are some recommendations for the implementation process of health reforms.

There are three general considerations to keep in mind.

First, **the process of thinking about reform should begin from a deep understanding of the context and the starting point.** What is the situation in the country at the moment?, what are the identified weaknesses (and strengths) in terms of health system performance?, what are the root causes of health system

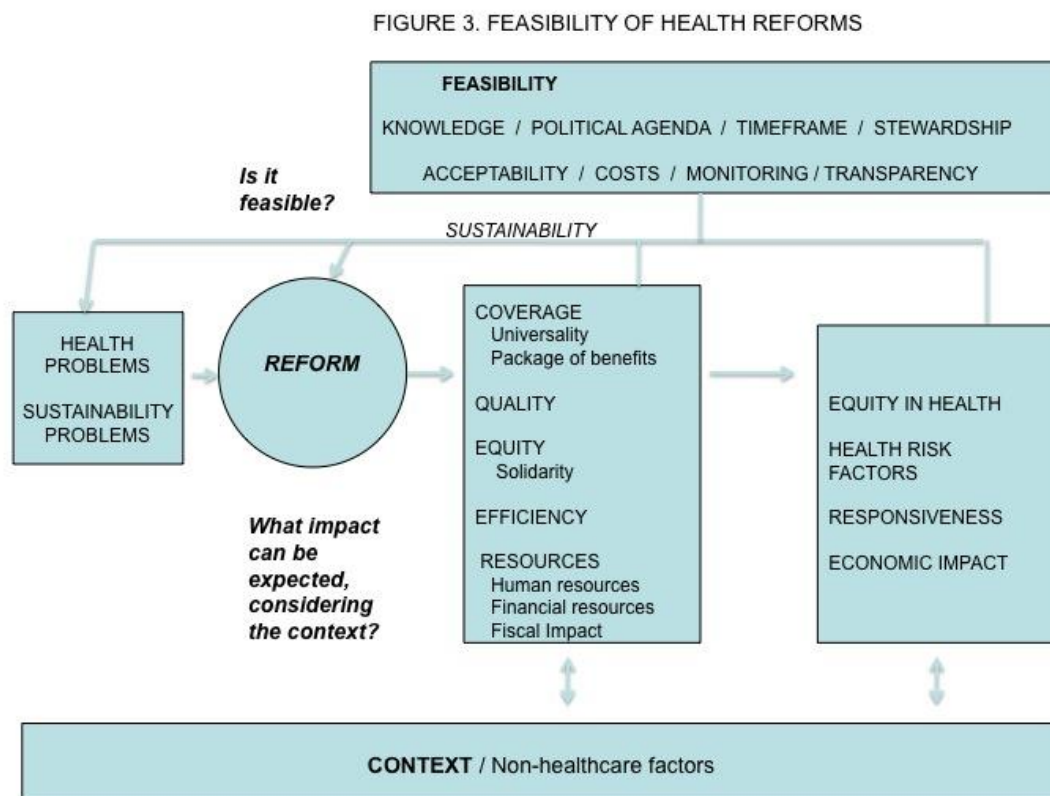
## Typology of health policy reforms

problems (often not obvious)? Deep and context-specific policy analysis is required to make the connection between what the indicators are telling us and what is appropriate in terms of policy responses.

Second, **understanding what is feasible politically and in terms of prevailing societal values, and the economic context.** Consider trade-offs, and look at fiscal sustainability as a constraint (not as a goal in itself). Some reforms may be desirable from a technical perspective, but inappropriate given the economic context or simply because they are not in line with underlying values in society.

Third, consider the question of **how to build a consensus** for achieve real transformation. Bringing about positive change or genuine transformation require developing alliances. Successful reforms cannot be dictated from above.

*In order to analyse feasibility of reforms, let us look in more detail to some of these aspects (Figure 3).*



### **KNOWLEDGE, CAPACITY**

The evidence suggests that cross-national studies and international policy dialogue can speed up the process of “policy learning”, enabling governments to learn from one another and thus avoid repeating others’ errors. Based on internationally comparable data, sharing knowledge and evidence analysis can be performed. Even where common problems can be identified in different countries, the specific features of the constitutional order, the political conjuncture, the policy process and other facets of the context for reform mean that simple, unaltered “transplants” of policies and institutions from one environment to another rarely take root. Some degree of adaptation is usually required.

Given global interest, the importance of health sector reform in development strategies, and significant existing knowledge and experience, country level analysis and action should proceed vigorously.

Governments are increasingly aware that inappropriate incentives built into the existing arrangements for organising and paying for health-care services have contributed importantly to current problems. An evidence-based and analytically sound case for reform serves both to improve the quality of policy and to enhance prospects for reform adoption.

The prerequisite for a successful health care system reform is knowledge of the key personnel included in the reform process and detailed analyses of the focused on the historical changes of the system. Through the preparation on proper positions at different stakeholders can build up experience and knowledge for the leaders of the reform. The absence of an independent administrative service often means that, as the parties in power change, the administrative machinery replicate the inbred inefficiency of the former system.

The foregoing challenges, in turn, are more likely to be met where appropriate institutions exist, capable of supporting reform from decision to implementation. The impact of economic analysis, in particular, depends to a significant extent on the source: research presented by an authoritative, impartial institution that commands trust across the political spectrum appears to have a far greater impact.

Yet institutions capable of providing expertise and advice are not all that is needed. Effective institutions are often required to guide and monitor implementation.

Besides negotiating skills, at least an understanding of political culture should be built up. Unfortunately, on average the mandate of ministers teams do not last long enough to create capacities. There should be an appropriate system of education personnel in the period when parties are in opposition, not in power, period for policy analysis and decision-making preparation for future.

### **POLITICAL AGENDA, COHERENCE**

Important constrain of health system reforms has been the position of health ministries, being accorded a comparatively low position in the political hierarchy. Sometimes, resources of ministries of health are weak in comparison with social security or health insurance agencies. Consequently health policy has ranked low on the reform agenda.

Political will is a significant factor affecting policy implementation, firm governmental commitment for changes is essential aspect of success. The evidence suggests that an electoral mandate appears to be most important in respect of reforms. It is not enough to win an election or command a parliamentary majority: it also matters a great deal if the government has made the case for reform to the voters ahead of an election.

Passing appropriate legislation in the early stages of the process can significantly facilitate reform, although having legislation in place does not guarantee automatic implementation. Successful reforms have usually been accompanied by consistent co-ordinated efforts to persuade voters and stakeholders of the need for reform and, in particular, to communicate the costs of non-reform.

Real engagement with stakeholders also involves listening to their concerns, and may well result in some modification of reform proposals.

### **TIMEFRAME, IMPLEMENTATION TIME, REACTION TIME**

Choosing the most appropriate time to reform, such as when there are appropriate or specific circumstances that favour change, is a key factor in determining success. Even more than when to execute, time and timing are crucial also for how to execute changes. The survey for political, social and economic environment is important to identify those circumstances that will facilitate launching and implementation of the reform.

A governmental mandate is not infinitely long. The skeleton of the reform should be launched as soon as possible, even better if the health care reform would represent the main content of the pre-election period. The period spend on analyses at the beginning of the mandate would only affect and prolong the D day of the reform.

Successful structural reforms take time in several attempts, successful reforms generally took several years to prepare and adopt, and they often took far longer to implement. By contrast, many of the least successful reform attempts were undertaken in haste, often in response to immediate pressures: when it comes to policy reform, more haste can indeed make for less speed.

### **STEWARDSHIP, GOVERNANCE, LEADERSHIP**

Governmental understanding of the values system is of paramount importance in order to develop reform policies that are acceptable and workable. The main goals should be necessarily inserted into the Governmental political agenda, agreed and full supported by the Ministry of Finance. Strong leadership is critical in winning consent rather than securing compliance. Leadership should not be read as endorsing a top-down approach to reform or a preference for unilateral action by the executive. Some political leaders have only general idea of their objectives.

In a political vacuum, a variety of agencies, organizations and groups will seek to push the reform agenda towards changes that are more acceptable to themselves. Multiple approaches to policy formulation and implementation can lead to inaction or even fully reflection of partial interests of particular groups of stakeholders, such as insurance companies.

### **ACCEPTABILITY, SUPPORT, OPPOSITION, OBSTACLES**

The inclusive and collaborative approach to the reform is recommended from the beginning: the bottom up approach, and building up achievements with mind set on predefined goals.

A key to successful implementation is maximizing the potential of “policy friend” by establishing alliance of supporters, individuals, organizations, agencies, of the reform to oppose the influence of opposition or even invite them in confrontation with each other on proposed changes. It is necessary a positive balance to overcome opposition because if not it will fail (see Hillary Clinton health reform failure).

In all studies emerges the key question of whether, when and how to compensate those who will lose out of a result of reform. Concessions to potential losers need not compromise the essentials of the reform: it is often possible to improve the prospects of particular groups that will be affected by a reform without contradicting its overall aims. Failure to compensate may reinforce opposition to reform, but excessive compensation may be costly or may simply blunt the effects of the reform. The most common compensation strategies involve “grandfathering” rents and long transition periods. Concessions in the form of “side payments”, such as policies in other domains that might offset the cost of reform for some groups, are employed less frequently (see Obamacare reform, and the role of the pharmaceutical sector and the health insurance sector).

The general population is a particular set of stakeholders that can influence change. Persuading the citizens of the need for reform can have an important enabling effect. This is especially true when the reform being implemented lead to a growing conflict between social and market values. Broad public support for reform can be an effective catalyst for change, just as lack of it can be a major barrier.

### **MONITORING CAPACITY, INDICATORS, INFORMATION SYSTEM**

There is little agreement about what constitutes “best practice”. In some policy domains, one can identify a broad consensus on certain essential elements of a

sound policy framework. In health care, however, there is no such model of best practice against which to assess individual policy regimes.

There is no consensus about how to assess outcomes in health care. This is partly due to the complex mix of goals to be pursued, but it also reflects the difficulty to set appropriate indicators (see discussion and proposals for quality and access indicators in EXPH 2015 and 2016 reports). Evidence-based reform is difficult where the evidence is either lacking or contested. That is why work by national or international organisations to generate reliable, credible evidence on policy outcomes can be very valuable in clarifying the terms of debate.

Good information system and technical skills together with the managerial and technical skills have been shown as an important guarantee for a progress of the health systems reforms and an effective monitoring and evaluation of the whole process.

### **TRANSPARENCY**

The process should be transparent. Symbolism can be supportive in presenting reforms; media can often be effective in promoting reforms and in seeking public support. By ensuring the transparency in communicating the rationale for reform, resistance to changes can be anticipated. This is even more important when cuts and other measures directly threaten the incomes of patients, health workers, providers and the suppliers of drugs, devices and equipment.

### **COST, FINANCING THE REFORM, UPFRONT INVESTMENT, RESOURCES NEEDED**

Policy-makers should be prepared to invest additional resources to achieve particular objectives. The availability of financial resources is critical in implementing reform. Even when reform measures are aimed at containing costs or generating savings, their results are not likely to be felt in the short term. In most cases, financial commitment is required. Very often additional costs are needed for information system, management training, new personnel, equipment, or changes in organizational structures.

A careful analysis of these needs is required, as well as a thorough evaluation of impact (as pointed out in the proposed template).

### **THE RATIONALE AND STEPS APPLYING HEALTH CARE REFORM**

- In health care system, beside the reform, there is a need of regularly upgrading in solving the priority problems.
- Electoral mandate appears to be most important in respect of reforms; the case for reform has to be presented to the voters ahead of an election.
- Governmental understanding the values system is a paramount to develop reform policies that are acceptable and workable. Strong health minister position and high position in the political hierarchy has to be assured before launching the health system reform. The main health reform goals should be inserted into the Governmental political agenda, agreed and full supported by the minister of finance and the Prime Minister.
- Healthcare reform could be expensive. It is expected to help contain costs over time, but it often involves expensive concessions in the short term and additional funds are needed for information system, management training, changes in organizational structures, etc.
- The prerequisite for a successful health care system reform is knowledge. Detailed country level analysis focused on the historical changes of the system should be performed. An evidence-based sound case for reform serves to improve the quality of policy and to enhance prospects for reform adoption. Cross-national studies and international policy dialogue can speed up the process of “policy learning”.
- The survey for political, social and economic environment is important to identify those circumstances that will facilitate launching and implementation of the reform. Passing appropriate legislation in the early stages of the process can significantly facilitate the implementation of the reform.



## Typology of health policy reforms

---

- Successful structural reforms take time, generally took several years to prepare and adopt, and they often took far longer to implement. Choosing the most appropriate time when there are appropriate or specific circumstances that favour change, is a key factor in determining success.
- The inclusive and collaborative approach to the reform is recommended from the beginning. Real engagement with (a majority of) stakeholders most directly affected by reform involves listening to their concerns. Negotiation and special efforts in direct communications with the public and other stakeholders can reduce the potential resistance more effectively.
- Clear and effective communication of the long-term objectives of reform is important. By ensuring the transparency in communicating the rationale for reform and the resistance to changes can be anticipated.
- Good information system and technical skills together with the managerial and technical skills have been shown as an important guarantee for a progress of the health systems reforms and an effective monitoring and evaluation of the whole process. Effective institutions are required to guide, monitor and evaluate the reform implementation.

*[This page intentionally left blank]*

### 5. CONCLUSIONS

- European Union countries are committed to guarantee the human right to health. Health systems that are universal, equitable, accessible, and funded through solidarity mechanisms, are a key element to guarantee the right to health.
- Health systems are very complex organisations that require a continuous process of reform. Reforms are not only a technical issue; they are a political one. They reflect choices, values, and priorities.
- During the last 6 years, as a consequence of the financial crisis, different packages of measures were adopted in the health sector.
- The choices that are made have to do with the diagnosis of the problems, and the narratives that are chosen to explain processes and issues. Language generates behaviour.
- The analysis of the causes of the crisis requires more reflection.
- In considering reforms, the revenue side of the equation of sustainability has to be included together with the expenditure (cost-containment) side.
- The European Semester process and the Economic Adjustment Programmes have incorporated the debate about health reforms, and led to an annual discussion of health policies between MS and EU bodies, including specific recommendations for reforms.
- In the context of the crisis, the majority of EU recommendations have been designed to control spending (fiscal consolidation). Some access and quality considerations have been included more recently.
- Some attention has also been paid to efficiency improvement (excessive prices of medicines, unnecessary interventions, adverse drug reactions, waste of resources, etc.).

- The cost of no action is unacceptable. There are not only crisis-related reasons to make reforms. Structural conditions (demographical, epidemiological, technological, cultural, etc.) require strong responses in order to be able to maintain and improve health systems. It is necessary to continue the process of reform prioritising public health approaches and health in all policies approach (health promotion, disease prevention, etc.).
- Although some countries and EU Institutions have developed instruments for analysing health reforms, the evaluation of the impact of health reform has been insufficient. There have been used different set of data, and dashboards. We have therefore drawn up a template designed to analyse the implementation and impact of health reforms in EU Member States.
- Many times, when frameworks, dashboards or templates are used to analyse health policies or reforms, benchmarks are used implicitly, without an explicit justification of why some attract better or worse rankings.

### **PRE-REQUISITES AT THE POLICY LEVEL FOR THE USE OF A STANDARD TEMPLATE**

It is well-recognised that health policy makers face many challenges and constraints, with urgent issues often displacing longer term reflection, for example when emergencies (epidemics, strikes, internal conflicts, etc.) arise that require immediate attention. Frequently there are other challenges, including availability of data, and technical capacity. The following paragraphs set out some pre-requisites for the effective use of a template for assessing health policy.

### *-Demand:*

First of all, policy-makers must demand evaluations.

The utilisation of these tools takes time and effort. Policy-makers must value the results and understand why they are important.

The European Semester process is a strong motivation for undertaking such evaluations. The use of these templates could be part of this process. As we have seen, the EU Institutions are using different tools for analysis. Agreement on a common template would encourage the Member States to apply it.

A template also offers a potentially valuable resource for Member States engaged in Health System Performance Assessment, especially where this is linked to health reforms.

### *-Training:*

Having decided to use the template, there is a need to learn how to use it. This is not in the sense of how to complete the data but rather in how to use it. This may be facilitated by systems to enhance data visualisation, for example using software to create dashboards, etc. Different levels of complexity could be presented for different users (Ministries, Regional authorities, General Directors, top civil servants, etc.).

### *-Implementation:*

Introducing the template into decision-making processes requires a proactive approach, in which the European Commission could play a part, for example by supporting mechanisms for exchange of practical experience and good practice.

*[This page intentionally left blank]*

### 6. RECOMMENDATIONS

- It is appropriate to analyse the effect of health reforms in relation to access, efficiency, equity, quality, and sustainability and not only “cost-savings” (meaning reductions in publicly funded services, especially where this transfers the cost to individuals). It is also important to identify violations of the human right to health, in order to prevent and correct them.
- The European Semester process could be an opportunity to undertake an annual review of health reforms, structured in such a way as to encourage international comparisons, while including country specific recommendations.
- There is a potential to apply a common tool (template), which could be agreed by SPC, ECFIN, DG SANTE, and WPPHSL, supported by a range of appropriate tools. These tools should generate evidence that can be the basis for discussion of health policies within the European Semester process (and similar discussions). The template should be comprehensive, enabling policy-makers to evaluate the impact of reform on coverage, equity (in financing, in delivery and use, and in health outcomes), quality, efficiency, and availability of resources.
- If the template / dashboard includes a benchmark, or a goal, this should be explicit and reasoned.
- Information systems should provide appropriate data for elaborating the indicators in order to monitor reforms.
- There should be careful consideration of the feasibility of reforms. Some practical steps are recommended in the report.
- Communication between policy-makers at different levels is needed in order to ensure a shared vision of the goals and direction of health reforms, the means of implementation, and their impacts (using seminars, workshops, and other networking opportunities).
- Certain policies can be identified as priorities:

Some are identified in the 2016 Annual Growth Survey, which includes certain priorities related to health sector.

Reforms to health and long-term care systems must continue to emphasise cost-effectiveness and to adequate access. Health and long term care both face significant demographic challenges, albeit often misrepresented. Reforms should take account of the evidence that a healthier population contributes to economic growth, through greater labour market participation and labour productivity. Member States should also ensure that they have systems to ensure a sustainable financing base, encourage the provision of and access to effective primary health care services, the cost-effective use of medicines, improved public procurement, greater integration of care, using new information systems such as e-health, where appropriate, assess the relative effectiveness of health technologies and to encourage health promotion and disease prevention.

These areas provide a useful starting point for reforms, setting out a series of measures that have been shown to work in different settings, while recognising the need to adapt to differing contexts and measuring their impact in practice.



### LIST OF ABBREVIATIONS

AGS	Annual Growth Survey
AMR	Alert Mechanism Report
AWG	Ageing Working Group
COPD	Chronic obstructive pulmonary disease
CSR	Country Specific Recommendation
DALY	Disability-adjusted life year
DG ECFIN	Directorate General for Economic and Financial Affairs
DG EMPL	Directorate General for Employment, Social Affairs & Inclusion
DG SANTE	Directorate General for Health and Food Safety
EAP	Economic Adjustment Programme
ECB	European Central Bank
EPC	Economic Policy Committee
EU	European Union
GDP	Gross domestic product
ICT	Information and Communications Technology
IMF	International Monetary Fund
JAF	Joint Assessment Framework
MD	Medical Devices
MoU	Memorandum of Understanding
NCDs	Non-communicable diseases
OECD	Organisation for Economic Co-operation and Development
SPC	Social Protection Committee
TFEU	Treaty on the Functioning of the European Union
USA	United States of America

## Typology of health policy reforms

---

WHO

World Health Organisation

WPPHSL

Working Party on Public Health as Senior Level

### REFERENCES

- Abel Smith B (1986). Cost Containment in 12 European Countries. *World Health Statistics Quarterly* Vol 37 (4): 351-63
- Abel Smith B (1992). Cost Containment and new priorities in the European community. *The Milbank Quarterly* 1992; 70(3):393-416
- Abel Smith B, Figueras J, Holland W, McKee M, Mossialos E (1995). Choices in health policy. An agenda for the European Union. Office for Official Publications of the European Communities. Darmouth 1995
- Abel Smith B (1996) The escalation of health care costs: how did we get there? In: *Health Care Reforms. The will to change. OECD Health Policy Studies N°8.* Paris,1996
- Ahtonen A (2013). Economic governance: helping European healthcare systems to deliver better health and wealth? European Policy Centre. Policy Brief 2 May 2013 [http://www.epc.eu/documents/uploads/pub\\_3497\\_economic\\_governance.pdf](http://www.epc.eu/documents/uploads/pub_3497_economic_governance.pdf)
- Azzopardi-Muscat N, Clemens T, Stoner D, Brand H (2015) EU Country Specific Recommendations for health systems in the European Semester process: Trends, discourse and predictions. *Health Policy* 119 (2015) 375-383.
- Berman P (1995). Health sector reform: making health development sustainable. *Health policy*, 32:3-13.
- Blumenthal D, Hsiao W (2015). Lessons from the East. China's Rapidly Evolving Health Care System. *N Eng J Med* 372;14: 1281-1285, April 2, 2015.
- Borst-Eiler E. (1997): Progress report of the Minister of Health to the Chairman of the National Assembly on Medical Technology Assessment and Quality Assurance in Medical care. National Assembly, The Hague.
- Busse R, Blümel M, Scheller-Kreinsen D, Zentner A (2010) Tackling chronic disease In Europe. Strategies, interventions and challenges. *Observatory Studies Series No. 20.* WHO 2010.
- Caritas Europa (2015). Poverty and Inequalities on the rise. Just social models needed as the solution! *Crisis Monitoring Report 2015*, prepared by Ann Leahy, Seán Healy, Michelle Murphy)
- Carone G, Schwierz Ch, Xavier A (2012). Cost-containment policies in public health pharmaceutical spending in the EU. *European Economy. Economic papers* 461, September 2012
- CESCR (2010) UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: <http://www.refworld.org/docid/4538838d0.html> [accessed 9 January 2016]
- Checkland P (1981). *Systems Thinking, Systems Practice.* Chichester: John Wiley & Sons.

Christie W (1996) Keynote Address. In: Health Care Reforms. The will to change. OECD Health Policy Studies N°8, Paris 1996.

Cooper M (1994) Jumping on the spot. Health Reform New Zealand Style. Health Economics 1994, 3: 69-72

Correia de Campos A (1989). The Political and Policy-Making Perspective. In: Culyer A J et al. Perspectives on the Future of Health Care in Europe. Centre for Health Economics. University of York, 1989, page 17-36.

Council (2006). Council conclusions on common values and principles in European Union Health Systems (2006/C 146/01)

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF>

Council (2011). Council conclusions Towards modern, responsive and sustainable health systems. June 2011.

Council (2012). Council Conclusions on the sustainability of public finances in the light of ageing populations (3167<sup>th</sup> ECOFIN Council meeting, 15 May 2012):

[http://www.consilium.europa.eu/uedocs/cms\\_data/docs/pressdata/en/ecofin/130261.pdf](http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ecofin/130261.pdf)

Council (2014). Council conclusions on the economic crisis and healthcare. (2014/C 217/02).

Council (2014-2). Health System Performance Assessment (HSPA). Terms of reference for an expert group. General Secretariat of the Council. Brussels 9 Sept 2014. 12945/14

Council (2014-3). Three years work programme of the Working Party on Public Health at Senior Level. General Secretariat of the Council. 9/6/2014; 11262/14

Council of Europe (2012). Austerity measures: a danger for democracy and social rights. Parliamentary Assembly. Resolution 1884 (2012). Text adopted by the Assembly on 26 June 2012.

Council of Europe (2013). Equal access to health care. Parliamentary Assembly. Resolution 1946 (2013). Text adopted by the Assembly on 26 June 2013.

Council of Europe (2015). Public health and the interests of the pharmaceutical industry: how to guarantee the primacy of public health interests? Parliamentary Assembly. Rapporteur: Ms Liliana Maury Pasquier. Doc 13869. 14 Sept 2015

Cutler DM (1994). A guide to health care reform. J Econ Perspect. Vol8 N°3:13-29.

Cutler D (2001) The Third Wave in Health Care Reform. Aging Issues in the United States and Japan. Edited by Seiritsu Ogura, Toshiaki Tachibamaki and David Wise. University of Chicago Press, 169-186.

Dunning AJ (1996). Reconciling Macro and Micro concerns: objectives and priorities in healthcare. In: Health Care Reforms. The will to change. Health Policy Studies. N°8, Paris.1996.

Ekman I et al (2016). Health-care improvements in a financially constrained environment. [www.thelancet.com](http://www.thelancet.com) Vol 387 February 13, 2016: 646-647

Emami S (2010) Consumer over-indebtedness and health care costs: how to approach the question from a global perspective. Health systems financing. The path to universal coverage. WHO 2010.

European Commission (2008) Strengthening pharmacovigilance to reduce adverse effects of medicines. Memo / 08 / 782. Press Release, Brussels, 10 December November 2008.

[http://europa.eu/rapid/press-release MEMO-08-782\\_en.htm?locale=en](http://europa.eu/rapid/press-release_MEMO-08-782_en.htm?locale=en)

European Commission, EPC (2010). Joint Report on Health Systems. European Commission and the Economic Policy Committee (together with the Ageing Working Group). European economy. Occasional papers 74

[http://ec.europa.eu/economy\\_finance/publications/occasional\\_paper/2010/pdf/ocp\\_74\\_en.pdf](http://ec.europa.eu/economy_finance/publications/occasional_paper/2010/pdf/ocp_74_en.pdf)

European Commission (2011). The 2012 Ageing Report: Underlying Assumptions and Projection Methodologies. European Economy 4/2011.

European Commission (2012). Analysing structural reforms and EU policies. Ageing report: Europe needs to prepare for growing older.

European Commission (2013). Investing in Health. Commission Staff working document. Brussels, 20.2.2013. SWD (2013a) 43 final.

European Commission (2013-2). Public expenditure on health: its growing importance, drivers and policy reforms to curb it down. In: Report on Public finances in EMU 2013. European economy 4 / 2013 (Joao Medeiros, Christoph Schwierz, Ana Xavier)

[http://ec.europa.eu/economy\\_finance/publications/european\\_economy/2013/pdf/e-2013-4-04.pdf](http://ec.europa.eu/economy_finance/publications/european_economy/2013/pdf/e-2013-4-04.pdf)

European Commission (2014). Communication from the Commission on effective, accessible and resilient health systems. Brussels 4.4.2014, COM(2014)215 final

European Commission (2014-2). Identifying fiscal sustainability challenges in the areas of pension, health care and long-term care policies. DG ECFIN. European Economy. Occasional Papers 201. October 2014.

[http://ec.europa.eu/economy\\_finance/publications/occasional\\_paper/2014/pdf/ocp\\_201\\_en.pdf](http://ec.europa.eu/economy_finance/publications/occasional_paper/2014/pdf/ocp_201_en.pdf)

European Commission (2014-3). Competition. State Aid Scoreboard 2014. Aid in the context of the financial and economic crisis. Financial Crisis Aid. State Aid used 2008-2013.

[http://ec.europa.eu/competition/state\\_aid/scoreboard/financial\\_economic\\_crisis\\_aid\\_en.html](http://ec.europa.eu/competition/state_aid/scoreboard/financial_economic_crisis_aid_en.html)

European Commission (2014-4). Annual Growth Survey 2015. Communication from the Commission COM (2014) 902 final. Brussels 28.11.2014

European Commission, EPC (2015). The 2015 Ageing Report. Economic and budgetary projections for the 28 EU Member States (2013-2060). Economic Policy Committee (Ageing Working Group), DG ECFIN. European Economy 3/2015.

## Typology of health policy reforms

---

[http://ec.europa.eu/economy\\_finance/publications/european\\_economy/2015/pdf/e3\\_en.pdf](http://ec.europa.eu/economy_finance/publications/european_economy/2015/pdf/e3_en.pdf)

European Commission (2015) Annual Growth Survey 2016. Strengthening the recovery and fostering convergence. COM (2015) 690 final. Brussels, 26/11/2015

European Commission (2015-2) Communication from the Commission to the European Parliament and the Council on tax transparency to fight tax evasion and avoidance. Brussels 18.3.2015. COM (2015) 136 final.

European Commission (2015-3) Communication from the Commission to the European Parliament and the Council on A fair and efficient Corporate Tax System in the European Union: 5 Key Areas for Action. Brussels 17.6.2015. COM (2015) 302 final.

European Commission (2016). Country Reports on Member States. Commission Staff Working Documents.

[http://ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/index\\_en.htm](http://ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/index_en.htm)

European Parliament (2011). Differences in Cost of and Access to Pharmaceutical Products in the EU. Directorate General for Internal Policies. Policy Department A: Economic and Scientific Policy.

EPHA (2013). Country Specific Recommendations. EPHA analysis 2013. September 2013.

[http://www.eph.org/IMG/pdf/EPHA\\_paper\\_-\\_Country\\_Specific\\_Recommendations\\_-\\_Sept-2013\\_.pdf](http://www.eph.org/IMG/pdf/EPHA_paper_-_Country_Specific_Recommendations_-_Sept-2013_.pdf)

EPHA (2013-2). Briefing document on Access to medicines in Europe in times of austerity. May 2013.

EPHA (2014). The 2014 Country Specific Recommendations. EPHA analysis July 2014.

[http://www.eph.org/IMG/pdf/2014CSRsAnalysis\\_final.pdf](http://www.eph.org/IMG/pdf/2014CSRsAnalysis_final.pdf)

EUAFR (2015) Cost of exclusion from healthcare. The case of migrants in an irregular situation. European Union Agency for Fundamental Rights. Luxembourg 2015.

[http://fra.europa.eu/sites/default/files/fra\\_uploads/fra-2015-cost-healthcare\\_en.pdf](http://fra.europa.eu/sites/default/files/fra_uploads/fra-2015-cost-healthcare_en.pdf)

European Parliament (2013) Resolution of 21 May 2013 on Fight against Tax Fraud, Tax Evasion and Tax Havens; 2013/20160 (INI).

Eurostat (2015). Tax revenue statistics.

[http://ec.europa.eu/eurostat/statistics-explained/index.php/Tax\\_revenue\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Tax_revenue_statistics)

EXPH (2014). Expert Panel on effective ways of investing in Health (EXPH), Definition and endorsement of criteria to identify priority areas when assessing the performance of health systems, 27 February 1014

[http://ec.europa.eu/health/expert\\_panel/opinions/docs/002\\_criteriaperformancehealthsystems\\_en.pdf](http://ec.europa.eu/health/expert_panel/opinions/docs/002_criteriaperformancehealthsystems_en.pdf)

EXPH (2014-2) Expert Panel on effective ways of investing in Health (EXPH), Future EU Agenda on quality of health care with a special emphasis on patient safety , 9 October 2014

[http://ec.europa.eu/health/expert\\_panel/opinions/docs/006\\_safety\\_quality\\_of\\_care\\_en.pdf](http://ec.europa.eu/health/expert_panel/opinions/docs/006_safety_quality_of_care_en.pdf)

EXPH (2014-3) Expert Panel on effective ways of investing in Health (EXPH), Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems, 10 July 2014

[http://ec.europa.eu/health/expert\\_panel/opinions/docs/004\\_definitionprimarycare\\_en.pdf](http://ec.europa.eu/health/expert_panel/opinions/docs/004_definitionprimarycare_en.pdf)

EXPH (2015) Expert Panel on effective ways of investing in Health (EXPH), Preliminary report on Access to health services in the European Union, 25 September 2015

[http://ec.europa.eu/health/expert\\_panel/opinions/docs/010\\_access\\_healthcare\\_en.pdf](http://ec.europa.eu/health/expert_panel/opinions/docs/010_access_healthcare_en.pdf)

EXPH (2015-2) Expert Panel on effective ways of investing in Health (EXPH), Disruptive Innovation. Considerations for health and health care in Europe, 29 February 2016

[http://ec.europa.eu/health/expert\\_panel/opinions/docs/012\\_disruptive\\_innovation\\_en.pdf](http://ec.europa.eu/health/expert_panel/opinions/docs/012_disruptive_innovation_en.pdf)

EXPH (2015-3) Expert Panel on effective ways of investing in Health (EXPH), Competition among health care providers. Investigating policy options in the European Union, 7 May 2015

[http://ec.europa.eu/health/expert\\_panel/opinions/docs/008\\_competition\\_healthcare\\_providers\\_en.pdf](http://ec.europa.eu/health/expert_panel/opinions/docs/008_competition_healthcare_providers_en.pdf)

Fanelli S, Zangrandi A (2015). Centralizzazione o Regionalizzazione della politiche sanitarie? Italian Health Policy Brief. Anno V, N°4: 1-4, 2015.

Fazi, 2014. It's Time to Stand up to the Troika Austerity (Part II). 'Social Europe Journal'. [Online] Available at <http://www.social-europe.eu/2014/06/time-stand-troika-austerity-part-ii/>

Figueras J, Lessof S, McKee M et al (2009). Health Systems for Health, Wealth and Societal Well-Being. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Figueras J, McKee M, eds (2012). Health Systems, Health, Wealth and Societal Well-being. Maidenhead: Open University Press, 2012.

Fischer-Lescano, A., 2014. Human Rights in Times of Austerity Policy: The EU institutions and the conclusion of Memoranda of Understanding. Legal opinion commissioned by the Chamber of Labour Vienna. Bremen, 17 February.

Greer S et al (2014). Everything you always wanted to know about European Union health policies but were afraid to ask. European Observatory on health systems and policies. Observatory Studies Series 34. WHO 2014.

Hall J (2015). Australian Health Care. The Challenge of Reform in a Fragmented System. *N Eng J Med* 373;6:493-497. August 6, 2015.

Himmelstein D, Thorne D, Warren E, Woolhandler S (2009). Medical Bankruptcy in the United States, 2007: Results of a National Study. *Am J Med* 2009 Aug; 122 (8): 741-6  
<http://www.ncbi.nlm.nih.gov/pubmed/19501347>

Hurst J (2010) Effective ways to realise policy reforms in health systems. OECD Health Working Papers, Nº 51, OECD Publishing, Paris.

Hoefman RJ, van Exel NJA, Brouwer WBF (2013). How to include informal care in economic evaluations. *PharmacoEconomics* 2013; 31(12): 1105-1119

IMF (2010). Macro-Fiscal Implications of Health Care Reform in Advanced and Emerging Economies. Prepared by the Fiscal Affairs Department. Approved by Carlo Cottarelli (this paper was prepared by a team led by B Clements and D Coady, and overseen by S Gupta). International Monetary Fund, December 28, 2010.

Jamison DT et al. (2013) Global Health 2035: a world converging within a generation. *Lancet* 2013; 382:1898-955. [http://dx.doi.org/10.1016/S0140-6736\(13\)62105-4](http://dx.doi.org/10.1016/S0140-6736(13)62105-4)

Jönsson B (1996) Making sense of health care reform. In: *Health Care Reforms, the will to change*. OECD, Health Policy Studies Nº8, Paris 1996

Jönsson B (1997) La reforma sanitaria en Suecia: haciéndolo mejor y sintiéndose peor. In: *La modernización de la sanidad pública en el mundo*. Arthur Andersen, Madrid 1997.

Joumard I, André Ch, Nicq Ch (2010) Health Care Systems: Efficiency and Institutions. Economics Department. OECD Working Papers Nº 769.

Juncker JC (2015) State of the Union 2015: Time for Honesty, Unity, Solidarity. Strasbourg, 9 September 2015.

Karger, H., 2014. 'The Bitter Pill: Austerity, Debt and the Attack on Europe's Welfare States. *Journal of Sociology & Social Welfare* June 2014, Vol XLI, Number 2.

Krol HM, Rutten FFH, Brouwer WBF (2013). Productivity costs: past, present, future. *PharmacoEconomics* 2013;31(7):537-549

Kuulasmaa K, Tunstall-Pedoe H, Dobson A, Fortmann S, Sans S, Tolonen H, Evans A, Ferrario M, Tuomilehto J (2000). Estimation of contribution of changes in classic risk factors to trends in coronary-events rates across the WHO MONICA Project populations. *Lancet*; 355: 675-87

Lamata F (1998) *Manual de Administración y Gestión Sanitaria*. Díaz de Santos, Madrid, 1998.

Lamata F y Oñorbe M (2014). *Crisis (esta crisis) y Salud (nuestra salud)*. Bubok. Madrid, 2014.



Laverty AA, Diethelm P, Hopkinson NS, Watt HC, McKee M. Use and abuse of statistics in tobacco industry funded research on standardised packaging. *Tob Control* 2015; 24: 422-4

Liptak K (2016). Biden says Obama offered financial help amid son's illness. *CNN politics*, January 12 2016.  
<http://edition.cnn.com/2016/01/11/politics/joe-biden-barack-obama-financial-help/>

Long A, Harrison F (1985). *Health Services Performance. Effectiveness and Efficiency*. Croom Helm. Kent, 1985.

Marengo A et al (2015) Economic crisis, health systems and health in Europe. Country experiences. *Observatory Studies Series 41*. WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Mathers CD, Loncar D (2006). Projections of Global Mortality and Burden of Disease from 2002 to 2030. *PLoS Medicine*. 11: 2011-2030.

Matthews FE, Arthur A, Barnes LE, Bond J, Jagger C, Robinson L, Brayne C; Medical Research Council Cognitive Function and Ageing Collaboration (2013). A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. *Lancet*; 382: 1405-12.

McKee M, Nolte E, Figueras J (2009). Strategies for health services. In: Beaglehole R, Detels R, Lansang MA, Gulliford M (eds). *Oxford Textbook of Public Health*, 5th edition. Oxford: Oxford University Press. pp 1668-1681.

McKee M, Suhrcke M, Nolte E et al (2009). Health systems, health, and wealth: a European perspective. *Lancet* 373: 349-51.

Medeiros J, Schwierz Ch (2013) Estimating the drivers and projecting long-term public health expenditures in the European Union: Baumol's "cost-disease" revisited. *European Economy. Economic Papers* 507/ Oct 2013

Medeiros J and Schwierz Ch (2015). Efficiency estimates of health care systems. *Economic Papers* 549. *European Economy*. June 2015.

Mladovsky Ph et al (2012). Health policy responses to the financial crisis in Europe. *European Observatory on health systems and policies*. WHO 2012.

Moreno-Serra R (2014), "The impact of cost-containment policies on health expenditure: Evidence from recent OECD experiences", *OECD Journal on Budgeting*, Vol. 13/3. DOI: <http://dx.doi.org/10.1787/budget-13-5jxx2wl6lp9p>

Mufson S (2016). Vice President Biden: Obama offered financial help when his son was ill with cancer. *The Washington Post*. January 12, 2016.

Murphy R (2012) *Closing the European Tax Gap*. A report for Group of the Progressive Alliance of Socialist & Democrats in the European Parliament. Tax Research LLP, 10 February 2012.

Murphy R (2015) *The Joy of Tax*. Bantam Press, London, 2015.

## Typology of health policy reforms

---

OECD (1992). The reform of health care. A comparative analysis of seven OECD countries. Paris 1992.

OECD (1994). The reform of health care systems: a review of seventeen OECD countries. Health Policy Studies, N°5. Paris 1994.

OECD (2007). The health BASKET project: comparison of international treatment costs. Employment, Labour and Social Affairs Directorate. Health Division. OECD June 2007.

OECD (2010). Making Reform Happen. Structural priorities in Times of Crisis. OECD, May 2010.

OECD (2013), Action Plan on Base Erosion and Profit Shifting, OECD Publishing. <http://dx.doi.org/10.1787/9789264202719-en>

OECD (2013-2). Definitions for Health Care Quality Indicators 2012-2013. HCQI Data Collection.

OECD (2013-3). Public spending on health and long-term care: a new set of projections. OECD Economic Policy Papers. N°6.

OECD (2015). Fiscal sustainability of health systems. Bridging health and financial perspectives. OECD 24 Sep 2015. doi:10.1787/9789264233386-en

OECD (2015-2) Health at a Glance 2015. OECD Indicators. OECD Publishing, Paris. [http://dx.doi.org/10.1787/health\\_glance-2015-en](http://dx.doi.org/10.1787/health_glance-2015-en)

OECD (2015-3). OECD webpage 3 / 12 / 2015  
<http://www.oecd.org/tax/corporate-tax-revenues-falling-putting-higher-burdens-on-individuals.htm>

OECD (2015-4). Focus on Health Spending. OECD Health Statistics 2015.  
<https://www.oecd.org/health/health-systems/Focus-Health-Spending-2015.pdf>

Ortun V (1994) Prólogo. In: San José P, Reformas Sanitarias. Europa y la elección del usuario. Díaz de Santos. Madrid. 1994.

Oxfam (2016). An economy for the 1%. 210 Oxfam briefing paper. 18 January 2016.

Oxley H, MacFarlan M (1995). Health Care Reform: Controlling Spending and Increasing Efficiency. OECD Economic Studies N°24, 1995/I

Paris V, Deaux M, Wei L (2010). Health Systems Institutional Characteristics: A Survey of 29 OECD Countries. OECD Health Working Papers N°50, OECD Publishing  
<http://dx.doi.org/10.1787/5kmfxfq9qbnr-en>

Pita P (2007) The slow and unintended changes in the funding mix (Editorial). Health Econ 16: 437-440, 2007  
<http://onlinelibrary.wiley.com/doi/10.1002/hec.1241/pdf>

Przywara B (2010). Projecting future healthcare expenditure at European level: drivers, methodology and main results. Economic Papers 417/ July 2010

- Rechel B, Thomson S, van Ginneken E (2010). Health Systems in Transition: Template for authors. WHO Europe on behalf of the European Observatory on Health Systems and Policies.
- Reeves A, McKee M, Basu S, Stuckler D (2014). The political economy of austerity and healthcare: Cross-national analysis of expenditure changes in 27 European nations 1995-2011. *Health Policy* 115(2014) 1-8
- Reich M, Shibuya K (2015) The future of Japan's health system. Sustaining good health with equity and low cost. *N Eng J Med* 373;19: 1793-1797, Nov 5 2015.
- Reynolds L, McKee M (2012) Opening the oyster: the 2010-11 NHS reforms in England. *Clinical Medicine* 2012; Vol 12 (2): 128-32.
- SALAR (2008). A comparison of Cost-Effectiveness in 17 Countries. In: *The Swedish System: How Does It Compare with Other EU Countries, the United States and Norway?* Swedish Association of Local Authorities and Regions (2008).
- Saltman R, Figueras J (1997). European health care reforms. Analysis of current strategies. WHO Regional Publications, European Series N°72. WHO Regional Office for Europe, 1997.
- Saltman R, Cahn Z (2013) Restructuring health systems for an era of prolonged austerity: an essay by Richard B Saltman and Zachary Cahn. *BMJ* 2013; 346: f3972.  
doi:<http://dx.doi.org/10.1136/bmj.f3972> (Published 24 June 2013)
- Sapir A et al (2014). The Troika and Financial Assistance in the Euro-Area: Successes and Failures. European Parliament. Study on the request of the Economic and Monetary Affairs Committee
- Scheiber N, Cohen P (2015). By Molding Tax System, Wealthiest Save Billions. *The New York Times*, December 30, 2015; page A1.
- Schneider F et al (2015) Shadow economy and tax evasion in the EU. *Journal of Money Laundering Control*, 2015, Vol 18; 1: 34-51 DOI 10.1108/JMLC-09-2014-0027  
<http://www.econ.jku.at/members/Schneider/files/publications/2015/JournalofMoneyLaunderingControl.pdf>
- Smith P, Papanicolas I (2012). Health system performance comparison: an agenda for policy, information and research. WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.
- SPC (2015) Towards a Joint Assessment Framework in the Area of Health. Work in progress: 2014 update. Indicators' Sub-group. The Social Protection Committee. 17 February 2015.
- SPC (2015-2) Progress Report on the review of the Joint Assessment Framework in the Area of Health. 17 February 2015.
- Sommers B (2015). Health Care reform's unfinished work. Remaining barriers to coverage and access. *N Eng J Med*. Downloaded from [nejm.org](http://nejm.org) on December 7, 2015.

Stuckler D (2008). Population causes and consequences of leading chronic diseases: a comparative analysis of prevailing explanations. *Milbank Quarterly*. 86:273–326.

Suhrcke M, Arce RS, McKee M, Rocco L (2012). Economic costs of ill health in European Region. In: Figueras J, McKee M, eds. *Health Systems, Health, Wealth and Societal Well-being*. Maidenhead: Open University Press, 2012.

The Guardian (2016). The Guardian view on public health: confronting the National Sickness Industry. Editorial. 24 January 2016.

Thomson S et al (2009). Addressing financial sustainability in health systems. WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Thomson S et al (2014). Economic crisis, health systems and health in Europe: impact and implications for policy. European Observatory on health systems and policies. WHO 2014.

Travis A (2012). Margaret Thatcher's role in plan to dismantle welfare state revealed. *The Guardian* 28 Dec 2012.  
<http://www.theguardian.com/politics/2012/dec/28/margaret-thatcher-role-plan-to-dismantle-welfare-state-revealed>

TFEU (2012) Consolidated version of the Treaty on the Functioning of the European Union. Official Journal of the European Union C 326 / 47; 26.10.2012

United Nations (2013) World Population Ageing: 1950-2050. Magnitude and speed of population ageing.

United Nations (2015). World Population Prospects. The 2015 Revision. Key Findings and Advance Tables.

United Nations Development Programme (2013). *Humanity Divided: Confronting Inequality in Developing Countries*.

Usher D (1973). An imputation to the measure of economic growth for changes in life expectancy. In: Moss M ed. *The measurement of economic and social performance*. New York. Columbia University Press for National Bureau of Economic Research. 1973.

van Ginneken E (2015). Perennial Health Care Reform. The long Dutch quest for cost control and quality improvement. *N Eng J Med* 373;10: 885-889. Sep 3 2015.

Vogler et al (2011). Pharmaceutical policies in European Countries in response to global financial crisis. *South Med Rev* 2011; 4 (2) : 69-79.

Wolfe I, Thompson M, Gill P, Tamburlini G, Blair M, van den Bruel A, Ehrich J, Pettoello-Mantovani J, Janson S, Karanikolos M, McKee M. Health services for children in western Europe. *Lancet* 2013; 381: 1224–34

WPPHSL (2013). Measuring and monitoring the effectiveness of health investment. Report by the Sub-group 5 of the Working Party on Public Health at Senior Level. October 2013.

## Typology of health policy reforms

---

World Bank (2015). The World Bank webpage. Data. Indicators.

<http://data.worldbank.org/indicator>

World Economic Forum (2013). Sustainable Health Systems. Visions, Strategies, Critical Uncertainties and Scenarios. A report from the World Economic Forum Prepared in collaboration with McKinsey & Company.

WHO (2000) The world health report 2000: health systems: improving performance. Geneva, World Health Organization, 2000. Available at:

[http://www.who.int/whr/2000/en/whr00\\_en.pdf](http://www.who.int/whr/2000/en/whr00_en.pdf)

WHO (2008) The Tallinn Charter: Health Systems for Health and Wealth.

Copenhagen, WHO Regional Office for Europe, 2008, available at:

[http://www.euro.who.int/\\_data/assets/pdf\\_file/0008/88613/E91438.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0008/88613/E91438.pdf?ua=1)

World Health Organization (2008). Social determinants of health. World Health Organization Report.

World Health Organization (2014). Noncommunicable Diseases Country Profiles 2014. Geneva.

WHO (2015). The European Health Report 2015. Targets and beyond-reaching new frontiers in evidence. Regional Office for Europe.

*[This page intentionally left blank]*

### **ANNEX 1. REFORMS / POLICIES AND MEASURES IMPLEMENTED OVER THE LAST YEARS IN EU MEMBER STATES**

Examples of reforms, policies and measures adopted in the last years have been obtained from the following sources:

Public Expenditure on Health, in: Report on Public Finances (EC 2013); Communication from the Commission on effective, accessible and resilient health systems (EC 2014); Annual Growth Survey 2015(EC 2014-4); Annual Growth Survey 2016 (EC 2015); Country Specific Recommendations 2014 and 2015; Thomson et al (WHO 2014); Mladovsky et al (WHO 2013); Joint Report European Commission and the Economic Policy Committee (together with the Ageing Working Group) (EC EPC 2010); OECD (Joumard 2010, Moreno Serra 2014, Health at a Glance 2015), and recommendations from the EXPH' reports on Quality, Access, and HSPA. In some cases, these reports include an assessment of the impact of the measures, according to the available experience.

Reforms have been classified according to their main impact in different aspects of the health system: coverage, equity, efficiency, quality or availability of resources. These constitute main areas included in the template.

#### COVERAGE / ACCESS

Within this general heading, three different aspects are to be covered: universality (population covered), package of benefits (breadth of protection), and financial protection. For each, we list below elements found in several reviews and evaluations of policies and reforms. These are illustrations of how past policies and reforms are related to the template proposed, by listing them under the heading where most impact is expected to take place.

## Typology of health policy reforms

---

### UNIVERSALITY

<b>Reform, policy, measure</b>
Increase coverage
Reduce coverage
Basing entitlement in factors other than residence
Broaden the basis for entitlement to encompass everyone living in a country

### PACKAGE OF BENEFITS

<b>Reform, policy, measure</b>
Increase, not based on HTA
Decrease, not based on HTA
Increase, based on HTA
Decrease, based on HTA
Ensure the public financed benefits package covers the full spectrum of essential services, is correlated with population health needs, and does not result in inequity by disease
Put in place systematic priority-setting processes to enable HTA-informed, cost-effective coverage decisions for both new and existing technologies
Define the publicly financed benefits package
Define quality standards to reduce variation



## Typology of health policy reforms

---

### *FINANCIAL PROTECTION OF CITIZENS / AFFORDABILITY*

<b>Reform, policy, measure</b>
Reducing cost-sharing
Patient has not to pay before reimbursement
Ensure most health system funding comes from public rather than private sources
Increasing cost-sharing
Improve user-charges so they do not create financial barriers to cost-effective services or undermine financial protection
Reducing / eliminate informal payments
Identify and close gaps in publicly financed coverage of cost-effective services

EQUITY

*EQUITY IN FINANCING*

<b>Reform, policy, measure</b>
Reducing public health care expenditure as a share of total health care expenditure
Increasing proportion of public health care expenditure in countries with low levels of public expenditure on health
Fiscal policies to expand public revenue base (raising contribution rates and ceilings, broadening the revenue base, including new taxes)
Increase tax progressivity
Reduce subsidies to Voluntary Health Insurance
Conduct systematic review of the tax system
Improve tax compliance and fight tax evasion by increasing the efficiency of tax administration
Financing through taxes vs social insurance

*EQUITY IN DELIVERY*

The impacts of policies and reforms on equity in delivery can take along two main dimensions, geographic equity and socio-economic equity.

<b>Reform, policy, measure</b>
Increase waiting time for essential services
Protective measures for vulnerable groups
Specify and adhere to maximum waiting times; provide reliable information
Ensure unmet need is accounted for in CSR
Introduce and improve sub-national resource allocation formulas

## Typology of health policy reforms

---

### *EQUITY IN HEALTH*

The impacts of policies and reforms on equity in health can take along two main dimensions, geographic equity and socio-economic equity.

<b>Reform, policy, measure</b>
Link levels of public spending to population health needs

## Typology of health policy reforms

---

### EFFICIENCY

#### *EFFICIENCY IN DELIVERING CARE*

*Lower cost for same result*

<b>Reform, policy, measure</b>
Increase public health, prevention, health education, early detection
Hospital closures, merging and specialisation. Optimising hospital network.
Take steps to avoid over-medicalisation
Reducing administrative costs; restructuring MoH
Reducing prices of medicines; use of generics and biosimilars
Rationalising hospital pharmaceutical expenditure
Identify more efficient ways to fund R&D, linked to lower prices of new medicines
Provider competition
Increase of HTA to select / include Technologies
Increase HTA to de-list Technologies
Trying to reduce unnecessary / duplicated services; avoid waste
Reduce unnecessary admissions

*Increase benefits for same cost*

<b>Reform, policy, measure</b>
Increase public health, prevention, health education, early detection
Raising taxes on tobacco, alcohol, food and drinks containing high levels of sugar or fat
National health strategies
Controlling spending through capacity planning
Introduction / improvement of Gate-keeping
Reduce corruption; reduce fraud.

## Typology of health policy reforms

---

### *Introduction of new models of work*

<b>Reform, policy, measure</b>
Increase primary care
Shifting care from inpatient to day-case or ambulatory care
Increasing hospital efficiency
Integration and coordination of services / networks, primary care, hospital care, social services
At home care; moving care out of hospitals; ehealth; mhealth
Improve referrals for specialist examination
Care coordination role (outpatient, inpatient)
Joint procurement; strategic purchasing
Priority setting
Payment to health centres
Payment to health professionals
Complement payment linked to inputs with payment linked to performance
Budget caps, global budgets
Reduce fragmentation of the system
Decentralization with clear definition of responsibility, common goals (benefits package), effective and fair financing mechanisms
Simplification of health insurance system
Consistent assignment of responsibilities across levels of government. Centralization / decentralization
Increase patient safety
Review utilization and results
Develop (independent, publicly funded) clinical guidelines; adapt guidelines to meet the needs of people with multiple morbidities and monitor adherence to guidelines
Develop appropriate governance structures. Leadership and consensus building in

## Typology of health policy reforms

---

governance
------------

Ensure operational information systems and accountability
---

Disseminate good practices. Encourage communication between managers of different management areas (at regional, national and international level)
--

### *EFFICIENCY IN FUNDING*

<b>Reform, policy, measure</b>
--------------------------------

Simplification of the health insurance system
---

Merging health insurance funds
--------------------------------

Reduce subsidies to voluntary health insurance
--

QUALITY OF CARE

<b>Reform, policy, measure</b>
Self-management of health conditions (supported by health professionals)
Ensure all patients have Access to adequate information about treatment options and outcomes
Strengthen the development of culturally sensitive and appropriate services
Encourage rational prescribing
Improve the communication skills of health personnel
Conduct regular national surveys of user experience of the health system
Patient choice
Training and evaluation of managers
Improving data collection and information systems to support performance
Develop secure systems of record linkage, including unique patient identifiers
Establish information systems to identify (and publicly report on) practice variations and patient outcomes, and to support effective decision making by health professionals and patients
Benchmarking
Health System Performance Assessment

## Typology of health policy reforms

---

### AVAILABILITY OF RESOURCES

#### *HUMAN RESOURCES*

<b>Reform, policy, measure</b>
Reduce number of health workers below requirements
Reduce salaries, reimbursement
Increase / reduce working hours (same wages)
Reduce extra (paid) hours
Reduce inflated salaries, unnecessary personnel
Adequate number and mix
Adequate training and support to deliver services in line with evidence
Increase participation
Improve motivation and working conditions
Payment systems (incentives for effective use of resources; performance based)

#### *FINANCIAL RESOURCES*

<b>Reform, policy, measure</b>
Reducing public health spending, non selective cuts
Reducing public health spending, selective cuts (e.g. excess capacity)
Introduce and improve sub-national resource allocation formulas
Ensure public health spending is used effectively, rather than simply driving up the prices



## Typology of health policy reforms

---

### *EQUIPMENT, MEDICAL DEVICES, FACILITIES*

<b>Reform, policy, measure</b>
Reorient (hospital) infrastructures
Reduce excess capacity
Control investment for health infrastructure and expensive equipment; mapping
Define national policies on Medical Devices
Use HTA to inform listing / delisting
Engage in area-level planning to create networks of facilities
Well-equipped, multidisciplinary primary care centres
Develop mechanisms to facilitate the transport of patients to health facilities, or of health professionals to patients
In the absence of geographical responsibility for health, instruments such as certificates of need for advanced medical technology can be used
Make existing (and new) services more easily accessible to the general population and to meet the needs of people with disabilities

## Typology of health policy reforms

---

### FISCAL IMPACT

<b>Reform, policy, measure</b>
Introducing automatic stabilisers, countercyclical measures
Annual health care spending targets

### SUSTAINABILITY

<b>Reform, policy, measure</b>
Reduce the amount of government arrears
Control health care expenditure growth



