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European Observatory on Health Systems and Policies

New Eurohealth on governing public hospitals

22-03-2013

This issue's Eurohealth Observer section looks at governing public hospitals. The overview article discusses innovative strategies in governing public hospitals. Four case study articles are then presented focusing on autonomous hospitals in Spain, governance arrangements in the Netherlands, legal forms of hospitals in the Czech Republic, and decentralisation in Norway.

Other articles include: A nudge in the wrong direction; Addressing critical health workforce challenges; Pay-for-performance in FYR Macedonia; Reform in the Bulgarian pharmaceutical sector; and Eurohealth Monitor.

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› Governing public hospitals

- Innovative strategies
- Spain's hospital autonomy
- Hospital governance in the Netherlands and Norway
- Legal forms of hospitals in the Czech Republic
- Nudging approaches in public health
- Addressing health workforce challenges
- Pay-for-performance in the former Yugoslav Republic of Macedonia
- Balancing pharmaceutical policies in Bulgaria

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EDITORIAL

While public ownership is a common feature in the European hospital sector, the last few decades have seen a change in the way such institutions are governed, with greater flexibility in terms of the legal form they can take and in the level of autonomy that management and supervisory boards can exercise when making institutional-level decisions. Such features often, but not exclusively, reflect developments in private-sector management practices and associated incentive structures.

At the same time, the over-riding objective of making changes to hospital governance structures is to ensure that service quality remains high or improves, that services meet the needs of the catchment population and that resources are used efficiently. This issue of *Eurohealth* looks at some recent developments in this area.

The first article in the **Eurohealth Observer** section explores the central elements of governance theory that are applicable to publicly operated hospitals, and then maps some of the innovative hospital governance models that are being pursued in selected countries of the European region, where the development of 'semi-autonomous', rather than fully autonomous institutions, is an identifiable trend. Four case studies follow, looking specifically at: the evolution of various models of autonomous hospitals in Spain; governance arrangements for general hospitals in the Netherlands, which are mainly based on formal self-regulation; whether the legal form of hospital matters for good governance in Czech hospitals; and the current debate on the level of centralisation in hospital sector governance in Norway.

In this issue's **Eurohealth International** section, Christopher Bonell reflects on the use of nudge theory as a technique for encouraging behaviour change, suggesting that more work on both its theoretical framework and evidence of effect is required. Paul Giepmans and colleagues discuss the European Commission's *Action Plan for the EU Health Workforce* setting out challenges for the future. These include a need to address imbalances in skill mix and in recruiting and retaining a sufficient number of workers with the right qualifications.

In the **Eurohealth Systems and Policies** section, one article reports on a survey of physicians' reactions in the former Yugoslav Republic of Macedonia to the introduction of a pay-for-performance system for hospital doctors. Reforms to the Bulgarian pharmaceutical sector, including distinguishing ownership from management of pharmacies, establishing a positive drug list and introducing reference pricing, are explored in an article by Rohova and colleagues.

Finally, the **Eurohealth Monitor** section draws attention to two new books, entitled *Home care across Europe* and *Building European reference networks in health care,* with up to date developments in health policy, both nationally and internationally, highlighted in our news section.

As we always, we hope that you enjoy this issue and feedback to the editors is most welcome.

Sherry Merkur, Editor
Anna Maresso, Editor
David McDaid, Editor

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INNOVATIVE STRATEGIES IN GOVERNING PUBLIC HOSPITALS

By: Antonio Durán and Richard B. Saltman

Summary: European public hospitals have undergone a process of change by which they remain publicly-owned but use incentives and follow practices similar to those in the private sector. Governance theory explains the crowded policy process and complex mosaic of decision-making relationships among different actors within the hospital sector, often with blurred boundaries. A central element in those reforms has been establishing some autonomy, which is necessary to confront challenges and to restrain the interference of local and regional political actors in decision-making. Institutional, financial and accountability arrangements as well as decision-making capacity versus responsibility are core variables that capture semi-autonomous governance.

Keywords: *Hospital Governance, Hospital Autonomy, Europe, Czech Republic, England, Estonia, Israel, Netherlands, Norway, Portugal, Spain*

In this article we consider the central elements of governance theory that can be applied to publicly operated hospitals, and then map innovative hospital governance models in selected countries of the World Health Organization (WHO) European region. Like other English language terms (e.g. stewardship and accountability), *governance* does not readily translate into different national contexts; it designates the blurring of the boundaries between the public and private sectors and the receding capacity of government (national, regional and local) to directly manage provider institutions as the number of actors in various policy arenas has multiplied. In our recent study[1] *hospital* governance was defined as:

> *A set of processes and tools related to decision-making in steering the totality of its institutional activity, influencing most major aspects of organisational behaviour and recognising the complex relationships between multiple stakeholders. Its scope ranges from normative values (equity, ethics) to access, quality, patient responsiveness and patient safety dimensions. It also incorporates political, financial, managerial, as well as daily operational issues.*

Three factors drive change in public hospital governance: (i) technological improvement in clinical and informational capacity among hospitals; (ii) growing patient expectations regarding quality, safety, responsiveness and choice of providers; and (iii) growing political pressures on public authorities to restructure traditional command and control models.[1]

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Note: This article is based on a study completed in 2011[1].

Institutional evolution of hospitals

Twentieth century European health systems concentrated medical resources and professionals in purpose-specific buildings looking for: (i) economies of scale; (ii) economies of reach/scope; and (iii) facilitated professional training and the diffusion of technological knowledge.[2] Hospitals operated within the prevailing Weberian bureaucratic model of public administration; as typical administrative arms of government, their staff were public employees and received their funding from public budgets, having to return any operating surplus at the end of the year.

> A central element has been establishing some degree of institutional autonomy

More flexible models of hospital governance appeared in the late 1980s, in line with "New Public Administration" models that transferred some decision-making control to provider organisations through a "planned market" based on "public competition",[3] creating a new "internal market" in the hospital sector,[4] or by introducing a "quasi-market".[5] Efficiency and quality concerns along with patient demands combined to produce less rigid governance strategies within tax-funded health care systems.[6]

The impact of the electronic revolution and globalisation on European companies' finances (and, via revenue from taxes, on the financial capacity of governmental owners of public hospitals) has now altered the fiscal picture. As these structural changes have taken hold, public hospitals in both western and central Europe have undergone a process of "autonomisation and corporatisation".[7]

These hospitals remain publicly-owned but, like private companies, use incentive systems and have quasi-independent supervisory boards that do not require direct political approval. Doctors and nurses are hired on short term contracts, as are managers with professional skills (particularly in northern European models). Although hospitals still receive their funding from public revenue, some form of purchaser–provider split separates the public funder from public providers, and funding follows a case-based formula (typically adjusted diagnosis-related groups – DRGs). Capital is sometimes raised through the private sector.

A framework for assessing governance in modern hospitals

Government, boards, staff and patient groups create a complex mosaic of decision-making relationships among and between different actors, often linked to decisions devolved to regional or local governments or transferred upwards to European Union level institutions.

Hospital governance aims at ensuring high levels of service quality and responsiveness while maximising the return from available resources within a given regulatory framework (frequently related to national history, culture and context). In practice, a specific institutional-level linkage of governance strategies to clinical, financial and patient-related outcomes remains highly qualitative in nature. While useful quantitative performance measures are currently being developed, they are at an early stage of refinement.[8]

A central element in recent hospital reforms has been establishing some degree of institutional autonomy which is necessary to confront challenges and to restrain the interference of local and regional political actors. For all practical purposes, of course, no publicly-owned hospital is, or can ever expect to be, fully autonomous. The most that public hospitals can aspire to be is semi-autonomous, as a recognised, legitimate status granted by the owners to make institutional-level decisions, even if this may not be legally guaranteed and could be changed should the political environment shift. Semi-autonomy is thus different from informal hospital efforts to evade constraining and/or unpleasant formal controls.

The argument in favour of creating semi-autonomous hospitals has been exhaustively documented.[9,10] Semi-autonomous governance can be captured through four core variables:

a. *Institutional arrangements* (legal form and objectives, room for decisions, relations with stakeholders). Foundations, corporatised public companies, public entities with delegated management and other "new" types of institution include mechanisms and tools to help hospitals strive for a desired set of objectives (economic, social, political, etc.) with unions, professional organisations, patient organisations, citizen groups participating in decisions regarding clinical services, locations, incentives/sanctions, and so on.

b. *Financial arrangements* (sources, constraints, conditions of capital investments and operational expenses, ability to retain surpluses and incur debt). European publicly-owned hospitals need space in their decisions in terms of finding additional sources of funds and arranging loans to respond to the demands relating to patient needs, professional preferences and the concerns of other stakeholders.

c. *Accountability arrangements* (role, size, composition, appointments, citizen and patient involvement and participation, reporting). Financial, performance and political/democratic accountability make governance more complicated than traditional management in a context of improved "intelligence" and more robust information systems. Political bodies and authorities also play a complex role here.

d. *Decision-making capacity versus responsibility* (room to adjust to unexpected trends, freedom from political interference, power sharing with clinicians, flexibility in internal monitoring, follow-up and evaluation). The acid test in setting up new power relationships is to what extent the high-level goals and politics give hospitals

sufficient room to adjust to unexpected events, free from undue political interference at ground level.

Mapping new governance models

Hospitals in the Czech Republic, England, Estonia, Israel, Norway, Portugal and Spain have redesigned publicly-owned hospital governance models with a considerable degree of decision-making autonomy.[1] While ownership of public hospitals in the Netherlands was transformed to non-profit-making foundations in 1991, they serve as a reference point for evaluating the public models (while remaining socially and politically accountable). A spectrum of new configurations can be seen (**see Table 1**).

Table 1: New public hospital governance models

Country	Hospital governance model
Czech Republic	Limited liability companies Joint-stock companies
England	Self-governing trusts Foundation trusts
Estonia	Joint-stock companies Foundations
The Netherlands	Hospital Governance model: Foundations *(Stichting)*
Norway	State enterprises
Portugal	Public enterprise entity hospitals (PEEHs)
Spain	Public Health Care Foundations Public Health Care Companies *(Empresas Públicas Sanitarias)* Public Health Care Foundations *(Fundaciones Públicas Sanitarias)* Consortia *(Consorcios)* Foundations *(Fundaciones)* Administrative Concessions *(Concesiones Administrativas)*
Sweden	Public-stock corporations

Source: [1]

In terms of the four variables of semi-autonomous governance, the following observations may be made.

Institutional dimension

Public hospitals usually become semi-autonomous as part of a governmental decision, typically national, but in some cases regional (e.g. Spain). Models in northern and central Europe range from "trusts" to "foundations", "state enterprises" and "joint-stock companies". There are six Iberian models with differing degrees of autonomy. The legal status in the Netherlands is seen to be not entirely stable. In Israel, public hospitals have *de facto* rather than institutional autonomy: a national government agreement allows outpatient clinics to operate as "Health Corporations".

There is also variation in "ownership". In all countries except the Netherlands, owners are typically national, regional or municipal governments (in Estonia, a combination of national and municipal governments). Dutch hospitals are owned by a domestically chartered foundation. In Israel, one private non-profit-making hospital is owned by a New York foundation and another by an Israeli non-profit-making sickness fund (now called "health funds").

Governments often reserve the right to intervene as they believe appropriate. Managers make decisions regarding structural parameters (service configuration, size, degree of focus on outpatient services) yet for major questions, regional (Norway, Spain and England) or central governments typically maintain leverage to various degrees. For example, in the Netherlands, the Minister of Health, Welfare and Sport intervened when one hospital approached bankruptcy, despite its private status, out of concern for patients' continuity of care. For decisions relating to the level of clinical services offered (district/secondary/tertiary), there is additional input by insurers whenever sickness funds play an important role in financing (Czech Republic and sickness fund-owned hospitals in Israel).

Medical specialists are mostly salaried, with pay levels either controlled by national agreement (government and sickness fund-owned hospitals; private non-profit hospitals in Israel) or subject to additional negotiation at hospital level (several models in Spain). Some models do shift physicians to independent contractors, with pay negotiated for each specialist (limited liability and joint-stock companies in Estonia and the Czech Republic; sickness fund-owned private hospitals in Israel; private non-profit institutions in the Netherlands). Labour unions remain relatively important in England, Norway, Portugal and Spain, are less significant in Israel and have little leverage in the Czech Republic, Estonia or the Netherlands.

Financing dimension

Investment capital-related decisions are still dominated by centralised models. For large equipment, renovations and new buildings, capital comes from owner investments and/or national government, hospital funds and/or bank loans. EU grants (Estonia, Portugal) and charities (government and sickness fund-owned hospitals in Israel) play significant roles. In hospitals with sickness funds as major owners, shareholders also provide funds. The process of capital investment is usually initiated by the Management Board and then approved by the Supervisory Board (and sometimes by the government). In Portuguese PEEHs national government approval is needed for amounts beyond 2% of the hospital's statutory capital.

For operating capital (day-to-day expenses: staff payroll, supplies and overheads such as heat and light), activity-based state financing (Portugal, Norway, Foundations in Spain), and insurance companies when applicable (Czech Republic) are key. The board generally has a prominent role. Hospitals are moving away from

global budgets towards case-mix-based funding. In England, Foundation Trust hospitals have more control over assets, a certain ability to raise finances and more accountability. The situation could become more complex if hospitals are allowed to attract investment partners, property agencies or private companies in new partnerships, similar to the Private Finance Initiative (PFI) in the United Kingdom, or the Alzira Hospital model in Spain.

> Many models set performance-related incentives

In the Netherlands, price competition for operating income is complemented by "yardstick competition", using maximum tariffs centrally set for specific services, allowing efficient hospitals and independent treatment centres (ITCs) to retain surplus revenue. Norwegian Regional Health Enterprises and all Estonian semi-autonomous hospitals also retain financial surpluses while Czech semi-budgetary organisations and Spanish Public Health Care Companies *(Empresa Pública Sanitaria)* cannot. Other hospitals may retain surpluses, conditional upon the decision of the owner (Israeli sickness fund-owned hospitals) or regional governments (joint-stock companies and limited liability companies in the Czech Republic). Administrative Concession hospitals in Spain can retain surpluses up to a 7.5% annual profit rate. England's Self-Governing Trusts can retain surpluses but are expected to break even over a three-year period.

Accountability framework

In most new models, appointment to the Supervisory Board is carried out by political authorities, at local municipal (Estonia), regional (Spain, Czech Republic) or national (Norway, England, Portugal) level. In the Netherlands, the Supervisory Board is self-renewing and without political input. English Foundation Trusts vote for governors, who in turn appoint the head of the Supervisory Board. The few privatised hospitals in the Czech Republic, several new for-profit hospitals recently established in Estonia, and ministry-owned hospitals in Israel, have no board–they are managed by CEOs. Non-profit private, sickness fund-owned and profit-making hospitals have boards not appointed by politicians.

Supervisory Board size varies between five and six members (semi-budgetary organisations in the Czech Republic, Dutch boards, PEEHs in Portugal, Public Health Care Companies in Spain) to ten or more (England, Norway) with variable physician presence. Politicians are typically placed in several models to speak for the interests of the body they represent. In the Public Health Care Company model in Andalusia, one board member represents the Regional Ministry of Health and a second the Regional Ministry of Finance, whereas in Estonia the politician members represent local government. The Supervisory Board works through the hospital's senior managers, often appointing and supervising the Management/Executive Board (in Estonian Foundations, only its head, who then appoints other members). Most Supervisory Boards typically provide guidance on budget, finance, new investment and capital issues and approve the strategic and operating proposals put forward by the hospital's Executive Board and/or the hospital CEO. Quality of care, patient safety, responsiveness and patient satisfaction, as well as monitoring and evaluation, are more the concern of CEOs and the Executive Boards.

Management Boards/Boards of Directors set missions and strategy, advise on management, evaluate performance, exercise oversight and control, and obtain community support/resources. Although direct citizen participation is restricted, members of English Foundation Trusts can vote for representatives on the Board of Governors. Several models include ombudsmen and spokespersons, and/or publishing minutes of board meetings, which must be open in the Norwegian model and in Self-governing Trusts in England. In the sickness fund-owned hospitals in Israel, sickness fund members and Labour Federation members have an indirect voice through their organisations.

Decision-making capacity on operational issues

All hospitals in this study hire and fire employees (the only exception being the Dutch private non-profit-making hospitals, which have self-employed physicians working on contract). Management can also make decisions on numbers and functions of chiefs of service (again with the exception of the Netherlands). Inclusion of new treatments and the setting up of clinical trials depend on different combinations of decisions by hospital boards, individual physicians and departments, as well as governments.

Many models (except Norwegian hospitals, where most employees are salaried) set performance-related incentives affecting staff income beyond labour union veto powers. English hospitals are entirely (Foundation Trusts) or partly (Self-governing Trusts) free to set such incentives. Outside England, Estonia has the largest share of income affected by incentivisation (25%), above 8% for Portuguese PEEHs and Spanish *Consortia* and 15% in Spanish Public Health Care Companies for clinical staff, although for administrative staff it may be up to 40% of their salary. In Czech semi-budgetary organisations, governmental decrees set basic salary but hospitals can allocate bonuses.

Incentive systems are defined by consensus (Portuguese PEEHs, Israeli private non-profit-making hospitals), or agreed with the individual staff members (Israeli government-owned hospitals).

Data collection requirements for national/regional governments are minimal, such as patient flows (all Israeli hospitals), monthly reporting on waiting lists and three-monthly financial situation reporting (*Consortia* hospitals in Spain). Management/Executive Boards decide on evaluation of achievements, with an important role for department heads, especially in the Netherlands and in all but the private Israeli models. However, performance indicators in Israel and

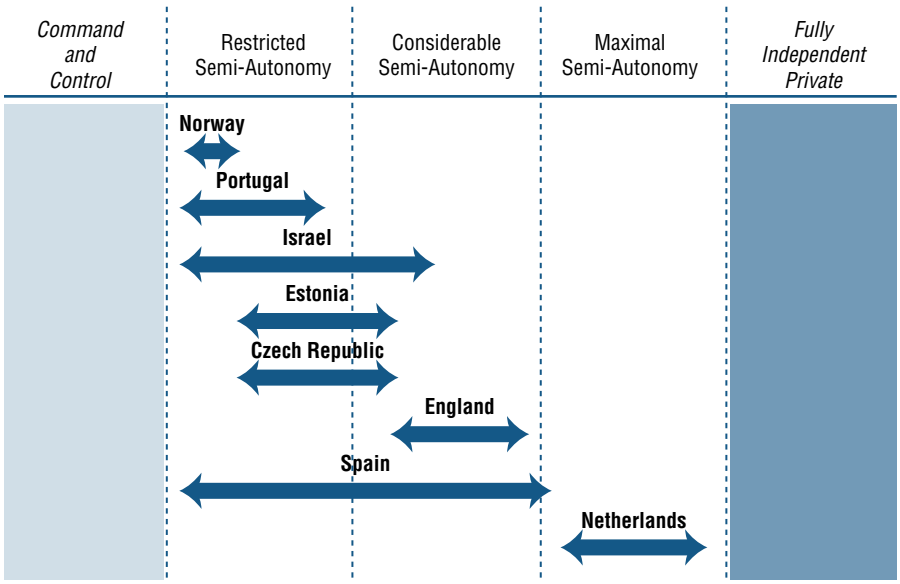
England remain unpublished and are not shared internally while Estonian joint-stock companies and foundations share performance data and apply them voluntarily for payment purposes. In Spain, Public Health Care Companies apply them for payment purposes and Czech limited liability companies use them through full-fledged internal benchmarking systems.

What can and cannot be concluded

What are the advantages and disadvantages of developing these new hospital governance processes and tools? Several observations can be made.

First, a continuum of hospital semi-autonomy in practice can be constructed (**see Figure 1**).

Figure 1: Continuum of hospital governance strategies



Source: [1].

Although all hospitals, private and publicly-owned, must follow a substantial number of nationally established clinical, environmental, labour-related, financial and also political policies,[11] private institutions typically do have considerable decision-making autonomy with regard to operational issues. However, ample studies appear to demonstrate that profit-making hospitals are not more clinically effective than their non-profit-making private counterparts.[12] In contrast, a United Kingdom review[13] argues that public hospitals have significantly worse management practices than private hospitals, although ratings among publicly-owned hospitals were relatively high for Foundation Trusts (hospitals with greater autonomy), larger hospitals, and in settings with more clinically expert managers.

Overall, the boundaries between the public and private health sectors in Europe have become increasingly blurred. The critical question of how to find the correct balance between decision-making autonomy and political accountability is not easy to define. The answer lies obscured beneath the weight of academic evidence and experience, the expectations of the patient population, the nature of the new model and, of course, the expectations, behaviour and fiscal situation within the municipal, regional or national governments concerned. The challenge in governance is to establish "clear loci of responsibility, enough information and appropriate sanctions".[14]

Semi-autonomous hospitals are popular with patients, and there is no concerted move by political actors to abolish them. The degree of decision-making autonomy, as well as the tipping point at which governments begin to regret such grants and reassert their central authority, inevitably differ based on national political conditions and the prevailing cultural expectations within each country. For example, in Andalusia, Spain, Public Health Care Company hospitals are no longer allowed (since 2008) to retain surpluses while in Norway, efforts by hospital management to close a rural satellite hospital centre (Roros) were blocked by the Ministry of Health.

The considerable variation between (and within) countries provides a natural laboratory to assess the overall benefits of different models. In this context, the most recent changes in hospital maps in Europe are mostly mergers and organisational re-structuring, such as the Helsinki and Uusimaa University Hospital (merging 23 hospitals), the merging of the campuses of Huddinge University Hospital and Karolinska Hospital in Stockholm or the Sheffield Teaching Hospital (merging five hospitals). This pattern of institutional consolidation ratifies our conviction that existing institutional arrangements will continue to undergo major changes.

Practically speaking, the process of defining and steering autonomy in public hospitals operates in a terrain of complex incentives that can create a treacherous environment for the design and implementation of effective reforms. Given the likelihood that in twenty years hospitals will differ considerably from the institutions of today, efforts to formally restructure governance arrangements towards a "public firm" or other more autonomous arrangements should not reduce the ability of these institutions to respond appropriately to their changing environment.

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SPAIN'S HOSPITAL AUTONOMY: MUDDLING THROUGH THE ECONOMIC CRISIS

By: Arturo Álvarez and Antonio Durán

Summary: The evolution of the various models of autonomous hospitals in Spain (public health care companies, public health care foundations, foundations, consortia and administrative concessions) under conditions of severe economic recession and drastic public spending cuts, has been uneven. While the sustainability of the health care system has entered public debate, it seems that many innovative features of hospital self-governance models have been gradually eroded by centralising forces at regional level. The model that has attracted most interest is the Alzira-type of Administrative Concession, perhaps given that the political party that introduced it is currently in power. The most remarkable finding overall, however, is the near absence of systematic comparisons of hospital performance, an issue that instead, is obscured by ideological discussions (the information exists but it is not made public).

Keywords: *Hospital Governance, Spain, Hospital Autonomy, Economic Crisis, Alzira*

Five characters… without a script

Historically, the development of various hospital governance models in Spain has been the result of societal and state realignments under post-Franco politics.[4] The transition from a dictatorship to a democratic regime, configured in the 1978 Constitution, established a decentralised state with a great deal of power devolved to the seventeen autonomous communities (ACs), each with its own regional legislative and executive institutions. While some elements of this "State of Autonomies" was left intentionally open, reforms included the granting of various degrees of autonomy to hospitals in an effort to address the problems inherited in the health sector and to accommodate the aspirations of new stakeholders – notably the newly empowered regions.

The resulting approaches and models stemmed from addressing a set of incremental needs without a preconceived plan, and were themselves incremental in nature, combining national decisions and decisions by the brand-new regional structures. While the absence of a

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definitive final model became increasingly evident, the results were essentially interesting in their diversity.

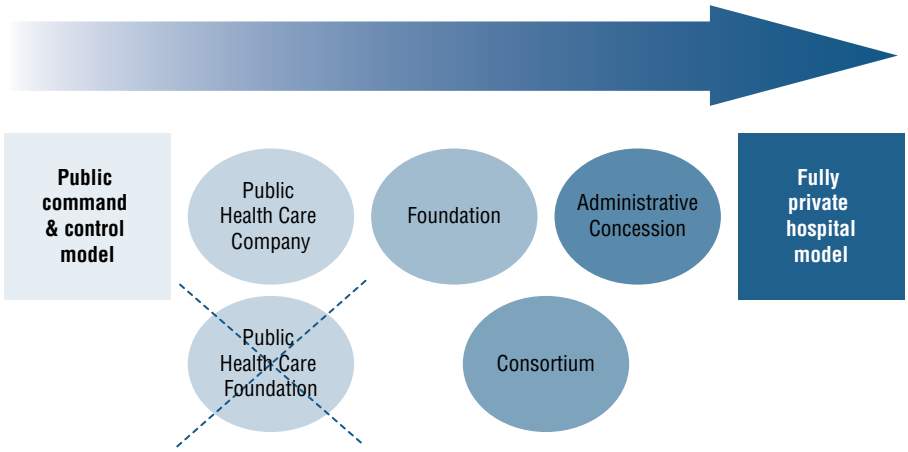
"Consortia" *(Consorcios)* are legal entities resulting from merging resources from more than one public authority, usually the regional government and a lower local one. They have been used in the Spanish health sector since the 1980s, in particular in Catalonia. Staff are not statutory employees (i.e. not civil servants) and hospital management typically enjoys autonomy to lease or buy equipment and decide on the basket of services to offer, often supplementing a public basket with extra services (usually restricted to ambulatory care) provided to public patients covered by private health insurance and to fully private patients.

In 1992, the Andalusian government, ruled by the Socialist Party, introduced the "public health care companies" model (*Empresas Públicas Sanitarias,* EPS). Major features are non-statutory staff instead of civil servants (with clinicians under a performance-related payment scheme) and substantial political intervention (the regional health minister chairs the Supervisory Board).

"Foundations" *(Fundaciones),* are not-for-profit organisations regulated by private law and have a greater capacity to decide the basket of services that they provide. Introduced in 1994, again under the Socialist Party, Foundations have non-statutory health care professional staff and autonomy to choose where to invest and whether to lease or buy equipment. They are also free to manage their own cash-flows and to pay their providers directly (which allows them to negotiate better deals).

Two years later, the conservative *Partido Popular* (People's Party) introduced legislation to allow for the use of various governance models to manage those hospitals that had not yet been devolved to ACs at the time. In 1998, instead of making use of the Foundation model already in place, the government introduced "public health care foundations" *(Fundaciones Públicas Sanitarias, FPS)* amidst fears of open conflict with the powerful trade unions.

Figure 1: Hospital autonomy and self-governance, Spain, 2013



Source: the authors. Note: The cross in dotted lines indicates that there is no current example of this legal model; the last hospital of this type was transformed back into the traditional model in December 2012.

Like the EPS, an FPS is a public entity, but staffed by statutory personnel. The governing body, which is responsible for appointing the hospital CEO, is usually made up of representatives from the regional health department and local authorities.

Finally, in 1999, the "administrative concession" *(Concesión Administrativa, CA)* model was established in Valencia, which also was governed by conservatives. Under this model, a private concessionary company (usually a joint venture between private health insurers, health groups, building societies, or banks) receives the tender to build a hospital and – in contrast to the Private Finance Initiative (PFI) model seen in the UK – to manage it as well, including providing clinical and non-clinical services, usually with non-statutory staff. The model was trialled with the *Hospital de la Ribera* in Alzira, where in fact, the existing statutory staff were given a choice on whether or not to convert to non-statutory status. One controversial aspect of CAs, at least in the eyes of opponents, is whether the company itself should be allowed to keep any surpluses (should they occur) or whether some or all should be repaid to the regional department of health since public funds are used in the capitation formula to pay the company for providing and managing ambulatory services and for the reimbursement of hospital services.

In terms of autonomy, the five self-governed hospital models can be configured along a continuum, measured from less to more autonomous, as shown in Figure 1, from the EPS to the FPS, then the Foundations, then the Consortia and finally the CA.

A changing context: weathering the storm

The development of these models took place initially in a favourable context, with real gross domestic product (GDP) growth above the European Union (EU) average, fiscal surpluses and declining unemployment. National and regional administrations were increasing government (health) spending, often in a rather uncontrolled way, involving debatable facility-building decisions and rather generous staffing. Then in 2008 the Spanish economy started to crumble. An extraordinarily mistaken handling of the situation by the government of the day only made things worse. Currently, Spain is immersed in a severe economic recession, with unemployment above 25% of the working-age population, the highest level since 1976.

Despite abundant academic and technical discussion, measures to ensure the fiscal sustainability of the National Health Service (*Sistema Nacional de Salud,* SNS) were limited in scope[2] even after the crisis started, aiming at reducing costs and improving efficiency across the board.

Many targeted pharmaceutical expenditure by imposing drug price reductions. Health care staff salaries were cut (as were the salaries of all civil service staff) and infrastructure development slowed down. When a new national government was elected in November 2011, it was revealed that the SNS owed health care providers €15 billion. By September 2012, some additional €4.87 billion in debts had been accumulated. Under pressure from the EU, overall drastic cuts and reforms were launched. The national government gave a loan of €17.25 billion to regional governments (all but four took it) and AC governments were requested to substantially slash expenses, including health budgets, with Catalonia leading the way. In this context, the sustainability of the health care system has suddenly entered the sphere of public discussion at national level (often as a claim against an alleged "privatisation of health"), with opposition parties questioning the government's policies in every forum, and nationwide newspapers interviewing opinion leaders, economists, doctors and nurses' representatives, patients' associations, etc.

Given the situation, has the economic crisis brought about a real erosion of hospital autonomy? What other relevant effects has the crisis had on the overall governance of Spanish hospitals? In practice, the evolution of the five models has been uneven. While there is an absence of systematic comparisons of hospital performance, anecdotal evidence would indicate that many innovative features of hospital self-governance models have been gradually eroded by centralising forces at regional level, perhaps with the exception of Consortia.

In the case of EPS, self-governing capacity, including the ability to retain surpluses, has been curtailed over the years and decisions on capital investment are now placed under public procurement law. Moreover, the model has not been replicated elsewhere within or outside Andalucia. The FPS model always faced political interference and its achievements – in the sense of their being different from the traditional public sector management model – have been disappointing. Actually, the last example of this kind of hospital, the *Hospital Comarcal de Inca,* in Baleares, was transformed back into the traditional public management model in December 2012. Regarding Foundations, the regional government of La Rioja has announced that the management of the *Hospital de Calahorra* will be contracted out to a private company, effectively ending its Foundation status and converting it to a new hybrid, a kind of publicly-owned CA.

> Supporters emphasise that new governance models are more efficient

The CA is the model that has attracted most interest, even while the concessionary company of the Alzira Hospital was undergoing major shareholding changes, due to, among other things, restructuring of the banking sector in Spain. When regional elections on 22 May 2011 gave the conservative People's Party power in eleven of the seventeen ACs and coalition-governments in another three regions, a number of lobbyists were quick to endorse a very ideology-loaded version of public-private partnerships – which was almost a euphemism for transferring portions of the public health sector network to the private sector,[3] perhaps expecting greater opportunities. The new regional governments of Castilla-la Mancha, la Rioja and Extremadura also soon sought out the CA model. Castilla-la Mancha is planning to transform four hospitals (three of them just built by the previous Socialist government) into the fullest version of the CA model–that is, including the private management of both the hospital and the primary care centres ascribed to it.

However, the most extreme political battle has been set in the Madrid Region. Until recently, four hospitals there were already under the CA formula and another seven new hospitals were functioning as PFIs, with only the management of non-clinical services contracted out. Now, the government plan for 2013 includes the adoption of the CA model in six of the seven hospitals and in 27 health centres. The plan has faced great opposition, with a regional strike in the health sector and the resignation of primary care managers as well as members of hospital clinical committees. In addition, PFIs are being attempted in Galicia, Extremadura, Baleares and Castilla-León – although in these cases changes mainly affect the management of non-clinical services, not the governance of the hospital proper.

No systematic comparisons

The conditions for consolidating semi-autonomous hospital arrangements in Spain have become tougher than ever imagined. Much of the story of 2012 was about the possibility of Spain requesting a financial rescue plan from the EU. The economic crisis has increased political conflicts and exacerbated nationalist tensions over recent months. A remarkable finding in this highly tense political environment is the absence of systematic comparisons of hospital performance, specifically regarding semi-autonomous arrangements. Moreover, the scarce analyses are limited in their scope and/or suffer from insufficient information, obvious technical limitations, or bias.

In particular, there have been few studies on the relative performance of centralised managed hospitals vis-a-vis each of the innovative models or among these. This is remarkable given that in CAs, for example, in principle a strong accountability regime is implemented by a regional health ministry delegate located in the actual hospital and supported by information, quality control and finance units directly under his/her command, with capacity to control, inspect, and impose sanctions. In other words, the information exists but it is just not made public.

Supporters emphasise that new governance models are more efficient in using resources (beds) and in maximising the use of ambulatory care alternatives, with an average cost per unit of production

that is 30% lower and adjusted human resources activity that is 37% higher.[4] This finding is hardly surprising given that new hospitals tend to be smaller in size and staff numbers (no bigger than 300 beds), and have a simpler case-mix than hospitals under traditional management. In addition, an English NHS Confederation study trip to the *Hospital de la Ribera* in Alzira in 2011 assessed its performance positively, using data provided by the hospital, and comparing these to that of the Valencia region hospitals under traditional management. Alzira had higher patient satisfaction rates, lower staff absenteeism numbers, shorter average lengths of stay, lower waiting times and lower capitation costs.[5] Nevertheless, another study counters that Alzira might not be showing the totality of its numbers and, if the contract had not been renegotiated (with the consequent loss for the regional government), the original project would never have been viable.[6] Even less autonomous models of hospital governance, like the EPS, seem to achieve some positive results when compared with traditional management models. In Andalucia, the parliamentary auditing body compared an EPS (348 beds and a population of 373,000) with a 555-bed hospital (providing services to 349,000 people) and concluded that the former had lower operational costs and staff absenteeism.[7]

On the other hand, critics claim that costs are much higher in CAs or PFI hospitals than in publicly-managed hospitals. A recent study by the largest health trade union in Madrid argued that a CA or PFI bed costs €1,660 per day, while in a public hospital the daily cost is €955.[8] One of the few technically sound evaluations concludes that in general, no overwhelming superiority of any model has been proven across all measures and that each legal form probably has specific advantages and disadvantages.[9]

Conclusion

In summary, the analysis of the Spanish case confirms three factors. First, hospital autonomy, far from being a one-off technical solution, becomes embedded in powerful political and social structures which can both limit or enhance the hospital's capacity for change – in other words, context and politics matter. Second, old models of command and control, public administration or even private-sector management styles are no longer useful, even if the governance model that implies using new tools in response to changes in state-society relationships have receded with the crisis. Third, but by no means least, political tensions make it difficult to conduct the kind of scientific evaluation of innovative governance that is required. Under such circumstances different stakeholders tend to show only the evidence favouring their preferred option instead of accepting all impartially produced evidence.

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HOSPITAL GOVERNANCE IN THE NETHERLANDS

By: Hans Maarse

Summary: Governance arrangements for general hospitals in the Netherlands are based on their status as private entities with high degrees of institutional autonomy. Instead of a formal regulatory framework, a voluntary *Health Care Code* describes the structure of relations, tasks, conflicts of interests, competences and accountability of the executive and supervisory boards of publicly-funded provider organisations such as hospitals. The Code is a product of self-regulation; while not legally binding, in practice, it has acquired a quasi-binding status. However, for some issues, such as how public hospitals may utilise budget surpluses, it is expected that a more binding regulatory framework based on legislation may be established in the future while for other issues, such as imposing a cap on the remuneration of hospital executives, legislative provisions have recently replaced self-regulation.

Keywords: *Hospital Governance, Netherlands, Health Care Code*

General hospitals in the Netherlands are private organisations. Gradually, all former public hospitals have been converted into private entities with a high degree of institutional autonomy. In addition, due to a legal ban on for-profit hospital care in health legislation, hospitals have a not-for-profit status.[1] The Health Insurance Act *(Zorgverzekeringswet),* which came into force in 2006 and integrated the former sickness fund scheme and private health insurance arrangements into a single mandatory scheme covering all legal residents,[2] pays for the bulk of hospital care. Thus, private provision of hospital care is combined with public funding.

Most general hospitals have the legal structure of a foundation *(stichting)* and because of their private status, they are not hierarchically subordinated to the Minister of Health or any other public authority. As a consequence, public authorities are not involved in the appointment (or discharge) of the members of the hospital's executive and supervisory board. The situation is different for university medical centres. Here, with the exception of two centres, the Minister for Education is formally charged with the appointment of the members of the supervisory boards, which in turn appoints the members of its executive board.

Scant regulatory framework

There is hardly any regulatory framework for hospital governance. Legislation only requires general hospitals to

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have an appropriate administrative structure. To fill the 'regulatory gap', the representative associations of health care providers (executives and supervisors) agreed in 2005 upon a *Health Care Code* (hereafter, the code) describing the structure of relations, tasks, conflicts of interests, and competences and accountability of the executive and supervisory boards of publicly-funded provider organisations such as hospitals, nursing homes and others facilities for planned and residential care.

The code, which was renewed in 2010, can be regarded as the product of self-regulation. It is not legally binding, but provider organisations are expected to adhere to it (i.e. 'play or explain'). In practice, the code has acquired a quasi-binding status, as provider organisations which do not respect the code cannot be a member of any representative organisation which has signed it. Furthermore, insurers increasingly require provider organisations to adhere to the code as a precondition for contracting. In addition, the national association of university medical centres adopted its own code in 2008. It draws to a great extent upon the *Health Care Code,* but nevertheless deviates from it in some respects because of differences in the regulatory framework of university medical centres and hospitals respectively.

Why a code?

The adoption of the code cannot be considered separately from the fundamental changes currently taking place in Dutch hospital care. As a consequence of the introduction of regulated competition, hospitals are seen as enterprises with a social purpose which must act in an increasingly competitive environment. Nowadays, they are also much more at risk than they were in the recent past. Furthermore, hospitals are held increasingly accountable to the general public on their performance, in particular with regard to quality of care. Quality measurement and quality reporting are currently being embedded as new elements in health care. These developments make the professionalisation of hospital governance increasingly indispensable as the renewed code explicitly identifies quality and safety of care as central elements of hospital governance.

> "the code can be seen as an attempt to restore public trust

The revision of the code in 2010 was not only based upon an evaluation of the 2005 code. The near bankruptcy of some hospitals and the occurrence of a number of significant failures in quality management had undermined public trust in the quality of hospital governance. Thus, the renewed code can be seen as an attempt to restore public trust. It aims to offer hospitals a common reference framework for the structuring and evaluation of hospital governance.

Accountability

Unlike in many other countries, the local or regional community, including local or regional public authorities, is not directly involved in hospital governance. At the same time, however, hospitals are publicly funded enterprises which are held accountable to the community. For this reason, the code requires hospitals to publish an annual document in which the executive and supervisory boards give a full account of their activities. Furthermore, hospitals are obliged to make clear whom they see as their stakeholders, how they organise consultation with these stakeholders and how they plan to inform them. The code also includes a list of topics about which hospitals must inform and/or consult their stakeholders – for example, changes in their mission or strategic objectives, planned mergers and acquisitions, and expansion or contraction of working areas. As yet, the impact of these obligations on hospital governance is unclear.

Executive Board

The basic assumption underpinning the code is that hospitals should be governed by an executive board which is supervised by a fully independent supervisory board. The executive and supervisory boards together form the nucleus of hospital governance. This assumption draws upon a practice that has evolved over the last two decades in Dutch health care. Thus, the code in fact codified common practice. Its main objective is to translate this practice into a proper and clear regulatory framework to strengthen the effectiveness of hospital governance.

The executive board *(Raad van Bestuur)* is a relatively new actor in hospital governance. Until the early 1980s many hospitals still had a medical superintendent who combined – usually on a 50/50 basis – his or her practice with the hospital directorship.[9] Currently, each hospital has an executive board of between one and three members who are recruited on the basis of their assumed expertise. There is no compulsory requirement that a person with a medical background should be the chairman of the board; its members may also be recruited from outside the medical profession. They are appointed by the supervisory board, after consultation with the employees' council and the clients' council. It is common to also ask the medical staff for its opinion.

The code charges the executive board with full responsibility for the strategic and operational management of the hospital as well as the hospital's relationship with the 'outside world' (e.g. with the Minister of Health, insurers, financial agencies and, last but not least, the media). In theory, the board can make unilateral decisions but in practice this does not work well. To be successful, it must continuously build a sufficient level of support for its decisions within the organisation. For a set of specific decisions, it also needs the formal approval of the medical staff and the employee's council. The decisions for which formal approval of the medical staff applies are formulated in the *Medical Staff Document* which was given legal basis by the *Integration Act,* 2000. This regulatory framework conceptualised the hospital as an 'integrated medical specialist enterprise'.

An important task of the executive board is to inform the supervisory board about matters in a timely and adequate manner. In practice, this appears to be a delicate issue. To reinforce its position, the supervisory board is formally permitted to acquire extra information from hospital employees or external advisors. The 2010 Code also includes an arrangement for whistle blowing. Whistle blowers are legally protected if they inform the executive board about alleged misconduct. If these problems concern a member of the executive board, the whistle blower reports to the chairman of the supervisory board.

> quality of care and patient safety are explicit topics for supervision

Supervisory Board

The code requires each hospital to have a supervisory board *(Raad van Toezicht)* which appoints and discharges the members of the executive board and supervises the functioning of the executive board and its individual members. Furthermore, it must approve a number of specific decisions and documents by the executive board, including the annual budget estimate, strategic and investment plans and decisions relating to property transactions and decisions on consolidations. Quality of care and patient safety are explicitly mentioned as topics for supervision. Finally, the supervisory board is in charge of the remuneration of the members of the executive board.

There are no formal rules regarding the number of board members. In practice, the number has tended to be smaller than in the past and most boards now have only five to seven members. The supervisory board appoints its own members (co-optation). For a long time, board members were not selected because of their expertise but for their position in the upper echelons of the local community. Now, because of the need for professionalisation, the code obligates the supervisory board to follow a formal selection procedure with an explicit description of the expertise required, with the objective of having a variety of expertise on board.

The code contains only minimal regulation regarding the number of annual meetings of the supervisory board. It requires the board to discuss, at least once a year, the strategy of the hospital, the most important risks the organisation is facing and the effectiveness of internal control systems. The average number of annual meetings can be estimated at about six while specific circumstances (e.g. mergers, crises) increase the frequency of meetings.

The supervisory board is not in charge of hospital management, but functions – apart from its formal competences – as a sounding board to the executive board. Strategic and operational management is the exclusive responsibility of the executive board. Hence, the supervisory board must operate at a distance from the executive board. However, there is no clear answer regarding what operating 'at a distance' means in practice. Supervision remains a subtle matter, requiring much expertise and a sensitive antenna. It is also a matter of trust in the executive board, but that trust should be permanently deserved. The code prescribes that the supervisory board must regularly assess its own functioning as well as the interplay with the executive board.

This model of the supervisory board has some weaknesses. A first weakness concerns its position relative to the executive board. Can the supervisory board function as an effective countervailing power which is able to intervene in a timely and effective manner when needed? Of course, the answer to this question depends to a great extent upon the professional capacity of the supervisory board. But it remains a delicate issue in spite of the regulations in the code to strengthen its position relative to the executive board by obligating the latter to inform it fully and punctually so that it may fulfil its role properly.

A second weakness concerns the question of who supervises the supervisor. This question arises because of the problem of ownership. As mentioned earlier, hospitals are not owned by public authorities or private investors (although there are now a few exceptions), but by a foundation which has no owner(s) itself.* A foundation also lacks a general assembly which has ultimate power. Therefore, what does the accountability of the supervisory board concretely mean if a hospital fails to function properly? The general trend is to hold the board and its members (co-) accountable for mismanagement. In case of manifest failure, members may be held personally liable – membership of a supervisory board has indeed become a job of great responsibility!

Medical staff and other stakeholders

The code does not regulate the relationship between the executive board and medical staff. It only holds the executive board responsible for the functioning of the hospital in its entirety, thus including the quality and safety of care provided by its doctors. Yet, hospital governance cannot be well understood without taking the role of the medical staff into account. Employed and self-employed specialists have usually organised themselves into the association of medical specialists which elects a medical staff board from among its members. The medical staff board frequently interacts with the executive board on strategic and operational issues, but most of the time it does so without a general mandate from the medical staff. As a consequence, the medical staff board must consult its constituency for approval of agreements with the executive board. The relationship between medical staff and executive boards may be tense, which explains why so many executives have had to leave the organisation prematurely.[4] The relative strength of the medical staff vis-à-vis the executive board is great.

The Law on Employees' Councils regulates which management decisions the council has the right to give advice on and over which ones it has the right of approval. In the latter case, if the

* Foundations may be established by a parent foundation but this does not solve the weakness raised here. It only displaces the structural weakness to the parent foundation.

employees' council formally withholds its approval, the hospital's executive board may ask the court to annul the council's decision, but it cannot implement its decision during this procedure. Hospitals are also required by law to have a client council representing patients' interests in hospital governance.

> surpluses must be reinvested in the hospital

New developments

Since a hospital can only function as a private not-for-profit agency, if it manages to achieve a budget surplus, then it can either reinvest the surplus or add it to its reserves. This arrangement also applies to the few hospitals which are presently owned by a commercial corporation. In all cases, hospitals cannot pay their owner(s) a return on investment. However, there are some legal constructions which make it possible for a hospital to act as the (co-) owner of for-profit entities and the code addresses this problem by stipulating that in such a situation a return on investment must be in accordance with the hospital's social purpose, which in concrete terms means that any surpluses must be reinvested in the hospital. It is likely that on this issue of surpluses, self-regulation by the code will be replaced with a binding regulatory framework. The new government in office (a coalition of the Liberal Party and the Labour party) recently announced that it plans to lift the ban on for-profit hospital care, but the new arrangement will include strict conditions to keep 'unwelcome' investors out and avoid hospitals evolving into profit-maximising enterprises. Nevertheless, it remains to be seen how the new legislation will be drafted: for-profit hospital care has always been a politically sensitive topic in Dutch health care.

Another new development focuses on the remuneration of the executive board. The code charges the supervisory board with managing the remuneration of the executive board. At the request of the government, the national representative organisations of supervisors and executives introduced a remuneration code which contained criteria for how to determinate a fair remuneration. This code, in force since 2009, was another piece of self-regulation. It was complemented by state legislation obligating provider organisations to publicly report, at the individual level and in detail, on the remuneration of supervisory and executive board members. The assumption underlying this regulation was that transparency would induce moderation. However, the regulation had a counterproductive 'escalating' effect as in practice, members of the executive board claimed better remuneration by referring to what other provider organisations were paying their executive boards.

Currently, remuneration of hospital executives has become a political issue. The general public tends to believe that they (and many other executives and top-level officials in the public sector) are heavily overpaid, and this is seen as an adverse effect of market competition. To address this problem, the remuneration code has been replaced with new legislation, in force from 2013, which limits the maximum yearly remuneration of chief executives in the public sector to 130% of the so-called 'Balkenende norm' of about €180 000 (Balkenende was Prime Minister from 2002–2011). The law is disputed by the national representative bodies of hospital executives and supervisors on practical grounds and in principle. At the practical level, the representative bodies object to the fact that a remuneration cap will be increasingly applied (as it is a legal requirement) while the in-principle objection springs from their contention that hospitals do not form part of the public sector, even though hospital care is largely publicly funded. The latter view contrasts with the government's view which sees hospitals as part of the public sector. The National Association of Hospital Executives started a legal process contesting the state regulation on remuneration, but lost its case.

Although the new state regulation on executive payment levels must be viewed within the context of some past remuneration scandals which received a lot of media attention, it nevertheless remains a somewhat curious measure. On the one hand, the state views hospitals as enterprises which can decide on their own capital investments and which incur significant financial risks. On the other hand, the new regulation expresses a stronger state influence over hospital governance. Is this another hybrid in Dutch hospital care?

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DOES THE LEGAL FORM OF HOSPITAL MATTER FOR GOOD GOVERNANCE IN THE CZECH REPUBLIC?

By: Tomas Roubal and Pavel Hrobon

Summary: Three main governance requirements for the successful running of a hospital include managerial organisation with clear responsibilities and duties; transparency in accounting and economic results; and effective oversight using incentives and sanctions. In practice, other micro factors crucial for success include strong leadership and managerial know-how. Generally speaking, a change in legal status, in and of itself, has not led to many changes in hospital governance or performance in the two Czech hospitals studied. It is extremely difficult to separate the impact of changes in legal form from other local or countrywide influences, but one lesson learnt is that even under unfavourable conditions it is possible to improve hospital governance with effective management accountability.

Keywords: *Hospital Governance, Czech Republic, Leadership*

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Currently, the main players in the Czech hospital market are the Ministry of Health, regional governments and some private providers. The Ministry of Health (and other ministries) own 24 hospitals, accounting for nearly 30% of all beds. These are usually university hospitals that have a legal status known as semi-budgetary organisations *(příspěvková organizace)*, a concept which we explain later in this article. Regional governments directly own 23 hospitals with the same legal form and a further 42 hospitals that are joint stock or limited liability companies. Altogether, regional governments control over 43% of hospital beds. Only a few hospitals are owned by municipalities or churches. The remaining 20% of beds are in private hospitals. Since the majority of hospitals are government owned, this article will focus on changes in the system of governance of public hospitals, in particular on smaller, regional hospitals.

Historical background

Huge changes occurred in the Czech hospital sector during the transition from a communist to capitalist political and economic system when the traditional Semashko system of health system organisation and governance was transformed into a social health insurance

system, with a largely privatised pool of providers. In 1989, all hospitals were publicly owned by central authorities and effectively run by district councils; the most specialised hospitals, mainly teaching hospitals, were owned by the Ministries of Health, Defence or Justice. All hospital budgets were provided by the state. In 1992, the first health insurance fund was established (the General Health Insurance Fund, VZP). This fund, which is now the largest, with around 60% of citizens as members, historically contracted with all hospitals. The Fund's regional structure and disinclination to shrink its network of providers allowed many local alliances that prevented strategic contracting. In fact, health insurance still plays a decisive role in the contracting of hospitals as over 90% of hospitals' revenues come from health insurance funds.

The Czech health care system was based on a pyramidal structure where hospital care played a crucial role. The organisation of care was set up around a hospital in every district and thus the number of beds was enormous. A variety of measures were taken by the Czech central government in the 1990s to address this situation, including closing small, redundant inpatient facilities or restructuring them into long-term care facilities. These early measures were generally successful, leading to a rapid fall in the number of acute-care beds, as well as to a sharp rise in the acute-care bed occupancy rate between 1992 and 2000.[1] During this time only a limited number of hospitals were privatised and changed their legal form to that of a commercial company.

Changes in legal status

In 1998, the Czech Republic began a far-reaching process of decentralising public administration. Over the course of five years, executive power was gradually devolved from state-administered districts to fourteen newly formed regions (with between 500,000 and one million inhabitants). This public administration reform and the transfer of former district hospitals to regional ownership provided the main contextual conditions for many hospitals to change their legal form. Regional governments, which were novice owners, became concerned about the financial condition of these facilities and the possible negative consequences for regional budgets. In particular, it emerged that many hospitals' budgetary deficits made them unable to fulfil their financial obligations towards suppliers and in late 2002 pharmaceutical distributors threatened to stop supplies.

> ensure better management responsibility and greater transparency

As a result, improving the efficiency of these hospitals became a central task for their new regional owners. The central government paid more than CZK 5.7 billion (€226 million) to cover hospitals' debts and reimbursement rates from health insurance funds also were raised in order to try and cover losses. However, these measures were not adequate[2] and in response, many regions decided to transform hospitals into joint stock companies with full ownership remaining in the hands of the region. The goal was to ensure better management responsibility and greater transparency in accounting processes for hospital owners. In each region, the decision on what legal form a hospital should take was based on its previous experience and the local political situation. Overall, the main issues to be addressed were the hospital's managerial structure, as defined by its legal form; accounting rules; and appropriate leadership roles vis-à-vis relations with hospital employees. Another difference between the two legal forms is that for employees of semi-budgetary organisation hospitals, government regulations on salary levels apply.

Due to general improvements in hospital management in the years that followed, it is very difficult to directly ascribe any improvements to changes in hospitals' legal form or to other external or internal influences. In order to identify some decisive factors, we look at two similar district-level hospitals that have taken two different paths: one changed its legal status from a semi-budgetary organisation to a limited liability company, while the other remained a semi-budgetary organisation. Both hospitals are owned by municipalities with close connections to the local political scene.

Traditional hospital structure and other factors

First though, let us look generally at the primary legal form from which all hospitals in the Czech Republic started and which to a greater or lesser extent, influences their corporate culture. A semi-budgetary organisation is a unique Czech form of legal entity that can be established by a governmental body. This legal form of ownership was established in the 1960s when the main rationale for creating these organisations was that they performed various tasks in the public interest (museums, libraries, schools, etc.). So these organisations are partially independent but their budgets are linked to their owner, who can provide subsidies. Other revenue streams are allowed–hence the term 'semi-budgetary' organisation. Since all hospitals were originally owned by the districts they all had this legal form.

From a governance point of view, there are three major disadvantages with this sort of organisation – and changes in legal status have sought to overcome some of these problems. The first is its management structure and lack of strong accountability processes. The director of a semi-budgetary organisation is the only managerial or control body defined by law. Even though some hospitals have set up managerial boards, they have no legal status or responsibility. The director's status is that of an employee; that is, the selection process for choosing a director is in the hands of the owner (the regional government or the relevant ministry). The director is solely responsible for deciding on how to run the organisation, its structure, and how its obligations and responsibilities are set up.

The second disadvantage relates to the organisation's accounting rules which are not transparent and provide a high degree of freedom to conceal management and budgetary problems. Furthermore, capital investments can be covered only from the depreciation of assets and there are many other accounting-related limitations that make it very difficult to manage hospitals under current market conditions.[3] The third disadvantage relates to the relative lack of nuanced tools to either reward performance or punish misconduct. Directors of semi-budgetary organisations can be sanctioned by penalties of up to three months' salary. In addition, as only the director and not the members of boards (if these have been set up) is responsible for the hospital's financial performance, the only real "stick" over the management is the dismissal of the director. As a counterbalance, there are no "carrots" to reward good work.

In contrast, joint-stock company or limited liability company hospitals are new legal forms in the Czech environment and have gone through rapid and often painful development. The Commercial Code was fine-tuned during the privatisation process in the 1990s and now these standard legal forms incorporate accountable management boards and obligations to fulfil robust accounting rules, including published audits. The ownership structure of these types of hospitals also allows for incentives for management.

The functioning and performance of all hospitals is also very much influenced by changes in the developing social health insurance system and the way that hospitals are reimbursed for the services they supply. In fact, a comparison of improvements in hospitals with different legal forms is hindered substantially by the historically non-transparent financial arrangements between hospitals and health insurance funds. Under these circumstances, the general incentives acting on hospital managers are evident. Directors are highly dependent on the local political climate which leads to a very cautious managerial style. Higher hospital revenues were possible when a good relationship with local health insurance funds was established or when a director succeeded in receiving government grants (or transfers from European Union Structural Funds)*. In fact, there are huge historical differences in the prices of acute inpatient care, as has been highlighted recently when the Diagnosis Related Group payments system was implemented in 2010.[4] The base rates differ from CZK 25,000 to CZK 45,000 (€990 to €1800) in various hospitals.

Two hospitals

For the purposes of this article we have briefly looked at developments in two hospitals with different legal forms, one (Hospital SBO) is a semi-budgetary organisation while the other (Hospital LLC) is a limited liability company. The change in this hospital's legal form was mainly a political decision by its municipal owner, which had had a bad experience with semi-budgetary organisations and changed all its organisations into limited liability companies. Although we do not provide a complete overview of the performance of all Czech hospitals, the experience of our selected hospitals should help us to understand the importance of leadership, managerial skills and transparent economic conditions for a hospital to work efficiently rather than the impact of a hospital's formal legal status, per se.

Although the two legal forms of the hospitals we looked at are quite different, the directors of both have significant scope in terms of governance. They bear full responsibility for their actions and are accountable to the hospitals' owners. They both also have the power to decide on matters relating to structural and internal administrative matters. Moreover, in both the hospitals the directors have created a motivated team of managers who help them with their day-to-day decisions. In this respect, the most challenging task for management has been to change the mind-set of employees who were used to working under the old conditions of command and control and where middle management was not aware of the costs and revenues generated by their hospital departments (even as late as the 1990s). In addition, managers' salaries are not dependent on the economic situation of the hospital.

One major difference is that the management of Hospital SBO (which remained a semi-budgetary organization) introduced an internal market and divided the hospital into departments, which now act as individual producers and sellers within the hospital. Management provides every department with a financial and health care plan for the coming year and available bonuses are dependent on successfully fulfilling the plan. This has proven to be a good motivating factor in the efficient production and delivery of services. Three times a year the management team holds a discussion and presents results and feedback to every hospital department.

Hospital LLC also prepares budgetary plans for each of its departments and carries out benchmarking of its performance within and outside the hospital. A special team in every ward meets weekly to discuss and assess all expensive or atypical cases, looking for inefficiencies and identifying best practices.

Concluding remarks

In short, the main message emerging from our case study is that in terms of hospital efficiency and good governance, success lies with the people charged with delivering results and the legal form is just a secondary factor that can make things easier or harder. Even in the complex conditions of a country such as the Czech Republic, whose health system is still in a process of transition, hospital management can build effective managerial systems. Such systems must contain transparent accounting processes, incentives for employees and middle management, smart contracting of supplies, and an internal culture favouring learning and innovation. The leadership role and technical know-how of the hospital management team seem to be the crucial ingredients for the success of hospitals regardless of their legal form.

* The social health insurance funds have been consolidated into fewer funds and thus it is now harder to build regional alliances. Also since the new system of hospital payment is based on centrally set DRG prices, it is harder to establish beneficial price alliances.

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HOSPITAL SECTOR GOVERNANCE IN NORWAY: DECENTRALISATION AND THE DISTRIBUTION OF TASKS

By: Jon Magnussen

Summary: Specialist health care and the hospital sector in Norway are the responsibility of the central government. Hospital care is delivered by local trusts, owned and governed by regional health authorities, who again are owned and governed by the state. There is an ongoing debate in Norway about the role of the administrative decision-making levels versus the role of the national (political) level, effectively reigniting the debate on the desirability of greater centralisation. Thus, the regional health authorities are, by some, viewed as an unnecessary administrative buffer between politicians and hospitals. It is not clear, however, what type of decisions should be "politicised" at the national level.

Keywords: *Hospital Care, Governance, National Stewardship, Decentralisation, Norway*

Structure of specialised health care

In the Nordic countries, health care is an integral part of the welfare state. Thus, health care is generally a public responsibility, funded by taxes, with universal access, negligible user fees and a strong focus on equity. The governance structure of the hospital sector is decentralised in the tradition of the Nordic health care model.[1] However, a difference between Norway and the other Nordic countries is that responsibility for primary and specialised health care services lies within different government levels. Thus, while responsibility for primary care is devolved to 428 municipalities, the state assumes responsibility for specialised health care, within a model of administrative decentralisation to four state-owned regional health authorities (RHAs).

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Each RHA is governed by a board of trustees appointed by the Minister of Health and Care Services. Board members are a mix of (appointed) politicians and other representatives. The state executes its strategic and operational governance through the Ministry of Health and Care Services, more specifically through the Department of Hospital Ownership within the ministry. This department prepares annual governing documents, known as "task documents", to signal that the central authorities primarily are concerned with strategic rather than operational governance. In addition to the task documents, there is an annual enterprise meeting – similar to the annual shareholders meeting in private firms.

The RHAs own the hospitals, and the latter are organised as independent health trusts. Therefore, health trusts explicitly are independent legal persons with governing bodies (hospital boards) appointed by the RHA; these boards have the same mix of politicians and other representatives as the regional boards. The strategic and operational governance of the health trusts is undertaken – as at the regional level – through task documents and annual enterprise meetings.

> politicians may intervene in quite detailed matters

Thus, there is a seemingly thought-through division of responsibilities and tasks between the political level (state), the RHAs and the local health trusts. The RHAs are regulated by a set of statutes that clearly defines their responsibility to coordinate the activity and division of tasks between the local health trusts in such a way that it is appropriate and efficient.* Furthermore, the local health trusts also operate under a set of statues regulating, among other things, tasks and investment decisions.

Strategic governance and national stewardship

The role of the central government is mainly one of strategic governance and stewardship at the national level. The current policy debate is very much related to how this role should be executed. Critics claim that important decisions that ought to be made at the national (political) level are now instead made at the regional administrative level. Thus, important health policy issues are removed from the political arena. The solution, the critics say, is to abolish the RHAs, and replace them with a centralised health administration in combination with a more detailed national health plan.[2]

Proponents of the existing model argue that it gives sufficient room for political decision-making. Some modifications have been made to the law regulating the RHAs, describing in more detail areas where it is important that RHAs consult the national Ministry of Health before making decisions. Political governance is undertaken, proponents argue, through the financial and organisational framework, as well as active political participation in structural discussions. The existing model is also flexible, in the sense that politicians may intervene in quite detailed matters if they feel this is necessary.

What does this mean in practical terms? Two issues can serve as an illustration–the regional hospital structure and the level of investment.

As noted, the *structural framework* of hospitals is – in principle – determined by the RHA. Thus, the RHA will make decisions about the broad distribution of clinical services between the local health trusts in the region. The same will, in the case of investment decisions, apply to the location and size of the facilities. In a sparsely populated country such as Norway, however, hospital structure and the distribution of tasks has emerged as a major political issue. Investment as well as location decisions increase the tension, both between the local health trusts and the RHA and between the RHA and the state. Thus, in some cases, the Ministry of Health and Care Services will have views on what is the appropriate structure and will directly influence the decisions made by the regional and/or local boards.

A full analysis of which factors trigger RHA and/or Ministry interference is beyond the scope of this article. In practice, we see that what constitutes a strategic or operational issue is open to interpretation. Thus, decisions that by some are viewed as "operational" (e.g. the merging of maternity wards in two closely located hospitals in order to optimise quality and cost efficiency) is by others viewed as "strategic" (e.g. should all acute care hospitals include a maternity ward?)

Local political pressure, sometimes in combination with resistance from unions, tends to increase the likelihood that decisions viewed as operational by the board (regional or local) will be elevated to the national political arena. Once this is the case, the Minister of Health finds it increasingly hard to refer to the decisions as "operational", and thus redirects attention to the regional or local administrative level. A recent example is the merger of three large hospitals in the national capital, Oslo, where the process formally is the responsibility of the RHA, but where the minister was put under increased political pressure to "redefine" it as a political and strategic decision. In this case, the RHA is viewed by some as an unnecessary buffer between the national (political) and local (administrative) level. Thus, further centralisation, i.e. removing the regional level, is considered a better alternative.

Another example is the funding of capital. Capital costs are included in hospital accounting and the transfer of funds to RHAs includes funds for investments. Formally, however, the state does not distinguish between funds for investment and funds for operating costs; RHAs are therefore free to invest as long as they can cover the costs within their budgetary framework. Since RHAs can only finance their investments from general funds and loans from the state, however, the level of investments is limited by the availability of loans.

For large investments, RHAs can obtain state loans (they are not permitted to

* Author's translation of statute provision.

take loans from the private sector) for up to 50% of total investment costs. The remaining 50% has to come from accumulated surpluses in the RHA. The interesting implication of this is that an investment (say, replacing an old building with a new one) that is cost-efficient in the sense that the increase in capital costs will be offset by a reduction in labour costs will not be realised unless the RHA can provide 50% of the investment costs. While this may seem puzzling, it reflects the substantial degree of uncertainty attached to the cost-effectiveness analysis of large health care investments, as well as the inherent scepticism at the central level that potential efficiency gains will in fact be realised. Again, there is increased focus on the role of the RHA, the alternative being a central body responsible for large investments.

Hospital autonomy

Turning now to the relationship between the RHAs and the local health trusts, one question is to what extent the hospital management team is allowed to organise its own internal operational structures (i.e. architecture and routines – operational methodology, processes mapping, benchmarks/best practice standards, etc.)

The task document given to the local health trusts describes goals related to a number of broadly defined patient-related activities. Still, it is fair to say that the most important goals when it comes to practical stewardship from the RHA are related to the level of activity and the financial result. However, within the explicit boundaries imposed by the budget and the (more implicit) distribution of functions to hospitals, regional authority provides few limits or boundaries on the management of a hospital.

For local trusts, however, the distinction between operational and strategic (policy) decisions is sometimes unclear. In principle, the Ministry of Health may (through the correct channels) interfere in any decision. In principle, this will be done by a communication from the Ministry of Health via the board of the RHA to the board of the local trust, and finally to local management. In practice, the channels are more direct.

Thus, local trusts will have substantial freedom to manage their hospitals within the boundaries laid out in the governing task document and under the assumptions that the hospital board will sanction the chosen model. It is also worth noting that this seems to be uncontroversial. One question that is raised, however, is the necessity of having local boards. Thus, an alternative would be for the RHAs to govern the local trusts directly, and not via the board.

> “local trusts have substantial freedom

One reason for this is that the concept of “departmentalisation”, i.e. the division of tasks within a local trust becomes more controversial when departments are created across physical structures, or even across different geographical locations. It is often accentuated by the composition of the local boards, where local politicians will often look out for the interests of their own constituency rather than the interest of the health trust as a whole. Again, the challenge is determining which decisions could be administratively decentralised and which should be politically centralised. Thus, an argument could be made that removing the local board would make operational governance easier, while preserving the need for political governance via the RHAs.

Summary of key dilemmas

The discussion in the previous sections highlights some of the key features of the Norwegian model of hospital sector governance; a three-level model with a high degree of decentralisation but within some (often not explicitly stated) political boundaries. Within this structure there are, however, some key dilemmas.

First, we note that there is a dilemma between models based on centralised ownership and decentralised management justified by a perception of better and more professional management. Thus, the Norwegian model is formally quasi-autonomous in the sense that RHAs are given a lot of autonomy and the state is meant to govern primarily through the financial and structural framework. Still, there seems to be a perception between both regional and local health authorities that the degree of central regulation in some cases overrides the possibility to make wise local decisions.

This dilemma also translates to the relationship between the RHAs and the local hospital trust. While the statutes of the RHAs clearly state that they are responsible for making decisions that obviously affect the local health trusts (i.e. division of tasks, financing system, large investment decisions), the intention of the model is still to leave the local hospital trusts with autonomy to run their operations within the framework provided by the RHA. In this case, it seems fair to say that local health trusts are autonomous when it comes to internal institutional arrangements, internal financial arrangements and, to some extent, accountability arrangements.

This conclusion, however, requires an interpretation of “autonomous” as “within a centrally-set, broad structural and financial framework.” Thus, local health trusts are not free to introduce new services or discard old services, but they are (mostly) free to organise the delivery of those services that are laid upon them by the RHA. Moreover, while they cannot determine the mechanism that generates income, or the size of the budget, they are free to organise their internal flow of funds, and internal resource allocation mechanisms.

Conclusions

The present Norwegian model is more than ten years old (having been introduced in 2002) and is supported by the present government, but there is an open question as to whether it will survive the next general election in September 2013. All political parties currently in opposition, as well as two out of three coalition partners in government, would like to abolish the regional level. What would come in its place would be a more centralised

model. Local health trusts would then relate directly to the central government. In this case, structural issues, including issues related to investment levels, would be more centralised than they are today. On the other hand, it is difficult to see how a centralised administration (e.g. a national directorate of health) would be able to govern local health trusts in detail. Thus, one might expect the level of local autonomy to rise.

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A NUDGE IN THE WRONG DIRECTION: PROBLEMS WITH "LIBERTARIAN-PATERNALISTIC" APPROACHES TO PUBLIC HEALTH

By: Christopher Bonell

Summary: Nudges aim to change behaviour by altering the "choice architecture" surrounding actions which are neither conscious nor rational. This idea has been taken up by some governments, for example informing public-health strategy in England. Here, a 'responsibility deal' aims to ensure industry supports public health via voluntary agreements rather than regulation. As well as being a vague and poorly-evidenced approach, nudge has been misrepresented, for example by the UK Coalition government, which has sought to conflate regulation of industry with coercion of citizens and to suggest that nudging offers a better way than legislation of addressing environment influences on health.

Keywords: *Public health, health behaviour, regulation, health inequalities, industry*

A nudge in the wrong direction: problems with "libertarian-paternalistic" approaches to public health.

What are nudges?

The concept of nudging was popularised by Richard Thaler and Cass Sunstein,[1] respectively an economist and a law academic. Based on the intentionally oxymoronic concept of "libertarian paternalism," nudgers aim to change behaviour not by compulsion or rational persuasion but by changing the "choice architecture" within which decisions are made. Nudging recognises that people's decisions are often automatic or habitual rather than conscious and rational.

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Modifying the "choice architecture" might involve: subconscious cues (such as painted targets in urinals to improve accuracy); harnessing the power of social norms (such as telling us that most people do not drink excessively); introducing minor costs for some decisions (such as people who quit smoking being paid money that they would have spent on their habit, but only if they test as nicotine free); altering the profile of different choices (such as the prominence of unhealthy food in supermarkets); or changing which options are the default (such as having to opt out of rather than into health insurance).

The idea of nudging has been influential on governments, particularly in the English-speaking world. Cass Sunstein has been advising Obama on regulation while Richard Thaler has contributed to the UK government's 'Behavioural Insight Team'. Nudge theory has also informed work by the French Prime Minister's Centre for Strategic Analysis. Nudge theory has influenced public health policy in England under the Coalition government.[2] A 'Responsibility Deal' has been initiated whereby the government works with industry to develop pledges on food, alcohol, physical activity, health at work and behaviour change, encouraging industries to support rather than harm public health.[3] The idea is that voluntary agreements, for example to reduce salt in some foods, reduce the prominence of alcohol in some supermarkets, or reduce the strength of some beers, can be instituted more quickly and efficiently via voluntary action than through government regulation.

What's wrong with nudging?

The first big problem with nudging is that it is not a very clear concept. Beyond offering the hazy concepts of "libertarian paternalism" and "choice architecture", the idea of nudging has been conveyed more through examples than a theoretical framework. This is a problem because it is then not clear how nudging really differs from or adds value to existing public health approaches, such as social marketing. It also causes confusion because some of Thaler and Sunstein's own examples of nudges don't appear to fit with the minimal conceptual definition that is offered. One example they cite is legislation requiring cigarette packets to include information on the risks of smoking; which is surely an example of presenting the sort of factual 'health education' information which nudging is meant to transcend. Another example they cite is a conditional cash transfer programme paying a "dollar a day" to teenage mothers if they have no further pregnancies; which surely exacts a financial penalty which is not 'trivial' to these women, again contradicting their definitions.

> nudgers aim to change the "choice architecture" within which decisions are made

The second big problem lies not with nudging itself but with how some politicians have misrepresented the concept to serve their own ideological ends. The UK government's strategy for public health in England presents its own nudge-informed approach as contrasting with "Whitehall diktat", "nannying", and "banning". It argues for voluntary partnership with, rather than regulation of, industry.[3] In other words, the government has misleadingly conflated regulation of corporations with coercion of individuals. The previous Health Secretary, Andrew Lansley, presented his public health strategy in Parliament, arguing that: "rather than nannying people, we will nudge them by working with industry to make healthier lifestyles easier."[4]

But this is a gross misrepresentation of the nudge approach. Thaler and Sunstein provide many examples of nudges which require government regulating industry; such as cap-and-trade systems to limit pollution; and directives requiring businesses to inform consumers about the harms arising from cigarettes and pesticides. Indeed Thaler and Sunstein go as far to suggest that when "consumers have a less than fully rational belief, firms often have more incentive to cater to that belief than to eradicate it".[1] Citizens might harm themselves through non-rational decisions which subtle nudges might counteract. Business decisions, however, are highly unlikely to be unconscious or irrational. When corporations harm consumers, this is likely to be the result of their rationally serving their own commercial interests. Nudging would surely be an inadequate means of countering such tendencies.

But the misrepresentation does not stop there. Although the government's public health strategy acknowledges health inequalities, it makes few proposals about how these should be addressed. Another recent government report[5] makes the bizarre argument that the need to challenge health inequalities via addressing their upstream causes means that regulation and legislation will not be effective tools: "The lifestyle factors that impact upon people's health and wellbeing are often deeply entwined in the fabric of our everyday lives. In these areas, passing an Act of Parliament is unlikely to have the desired effect. Strong-armed regulation is not the answer to rebalancing our diets, changing our desire to drink too much alcohol on a Friday night, or making our lives more active." Thus, reference to nudging might also function as a smokescreen for inaction on addressing the socio-ecological factors that like behind health inequalities. At a superficial level, nudging appears to call attention to environmental influences on health. However, whereas addressing health inequalities is widely recognised to require action to address factors such as poverty, unemployment, neighbourhood deprivation and stress in the workplace, nudging actually focuses on 'downstream' factors such as how individuals process information and make choices. Rather than challenging poverty and injustice, nudgers can only hope to compensate for these by nudging the poor a bit more firmly and frequently. But how can one nudge away

the barriers to health experienced by those living in poverty? Could an earlier generation of public health workers have nudged away the problems associated with poor sanitation, over-crowded housing and dangerous work environments?

> nudging has been conveyed more through examples than a theoretical framework

The final problem with nudging is that there is currently minimal evidence for its effectiveness. Few 'nudges' have been evaluated and those which have provide patchy evidence of effectiveness. For example, an intervention which aimed to correct misconceptions about normal levels of alcohol intake was found to be effective when delivered to individuals by a practitioner, but ineffective when delivered via mass communication approaches.[6] Furthermore, there is no evidence that responsibility deals are faster or more efficient to deploy than regulation. One analysis[7] in fact suggests that: sign-up to the various 'pledges' by industry has been patchy; some pledges merely reflect existing standards; some major corporations have not signed up at all or not to pledges that would critically affect their business; and some pledges have been tokenistic and irrelevant (for example a tea manufacturer pledging to eliminate trans-fats from its products!). In contrast, there is considerable evidence for the effectiveness of various forms of industry regulation in curbing health risks.[8]

Conclusions

The concept of nudging individuals to adopt healthier behaviours is not inherently problematic; unless one regards such unconscious manipulation as unethical. I would contend that such manipulation is ethical as long as it falls short of compulsion and does not infringe fundamental rights (the right to grab chocolate at a supermarket check-out for example does not meet this standard). However, if nudging is to become a useful element within public health strategies, it first would require clearer theoretical formulation and second the development of an evidence base through empirical evaluation. Neither is currently available. Coming as it does from the USA, the concept of 'libertarian paternalism' can be read as a liberal (in the American sense) defence of (limited) state intervention. Nudge should not perversely become a fig leaf used by right-wing governments in Europe for reduced government regulation of health-harming industries in Europe.

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MANAGING A SCARCE RESOURCE: ADDRESSING **CRITICAL HEALTH WORKFORCE CHALLENGES**

By: Paul Giepmans, Gilles Dussault, Ronald Batenburg, Jan Frich, Roel Olivers and Walter Sermeus

Summary: With health care services significantly changing, the challenge is to initiate innovative, situational and integrated workforce forecasting and planning. Many health systems require a shift in mindset to move to the planning of skill mixes for health care professionals. This implies great challenges for complex processes involving different groups of actors in the health system. This article also discusses organisational challenges, specifically concerning the recruitment and retention of health care professionals, requiring (human resource) managers to have new capacities, supported by organisational strategies, in order to build and maintain a workforce that can ensure the quality and continuity of health services.

Keywords: *Health Workforce; Recruitment and Retention; Health Workforce Forecasting and Planning*

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In April 2012, the European Commission (EC) launched an *Employment Package* to stimulate the creation of jobs towards aiding the recovery of the European economy. It includes an *Action Plan for the Health Workforce*[1] which takes stock of current trends in the health labour market and sets out a programme for addressing future challenges. It proposes actions to identify the skills needed of the future health workforce, and to forecast how many and what types of workers will have to be trained, recruited and, above all, retained to meet service needs.

The European Health Management Association's work on the health workforce, and in particular its efforts to improve recruitment and retention resulted in the formation of a 'Workforce Taskforce' to support the implementation of the *Action Plan*. The Workforce Taskforce held a workshop in Budapest on 27–28 November 2012, with discussions focusing primarily on the current state-of-play of health workforce planning and policy on recruitment and retention issues. Participating policy-makers, managers and researchers took stock of available evidence on changes affecting the health workforce in the European Union (EU), as documented by recent research funded by the EC*, and by information collected through a series of policy dialogues convened by the European Observatory on Health Systems and Policies, which produced evidence for

* Results of the MoHPROF, RN4Cast and HEALTH PROMeTHEUS studies are available online or in several scientific journals.

the debate on what the Organisation for Economic Cooperation and Development (OECD) has called "the health workforce looming crisis".[2] The next phase of work began in January 2013 with a *Joint Action on health workforce planning and forecasting*†, led by the Belgian Federal Public Service: Health, Food Chain Safety and Environment, to address these issues in practice, and to engage stakeholders in better managing this critical, but scarce, resource for health care systems.

> stakeholders need to connect and start cooperating

In this article, we will highlight the challenges that national health systems, as well as public, private and non-governmental organisations now face in the recruitment and retention of health professionals. We will also identify some of the policy implications which EU Member States will need to address, but begin by briefly indicating how these challenges have emerged from a changing health system landscape.

Changing health systems and demand

With health needs and requisite health care services significantly changing, the *Action Plan for the EU Health Workforce* is a timely initiative. The ageing population requires chronic and multiple disease management; lifestyle trends are resulting in new challenges (e.g. obesity) for the public health community, with a greater emphasis now being placed on prevention and health promotion. Patients also have higher expectations about the quality and costs of health services, while health problems that previously have been neglected are increasingly being recognised (e.g. mental, occupational and environmental health concerns). Consequently, a shift in the organisation of delivery systems is needed. In a context of technological advances and economic austerity, the demand for more decentralisation and improved coordination and integration go hand-in-hand with calls for greater patient involvement, tighter quality assurance, and more and better continuity between primary and secondary care services.

To make sure that the health workforce can respond to these changes now and in the longer term, there is an immediate need to identify and plan services that will be required over the coming decades. Based on this analysis, the required corresponding skills can be recognised and informed decisions made on the training needs of different professional groups. For many countries and health care systems, this implies a shift in mindset: from planning for separate groups of health care workers (i.e. nurses, paramedics, doctors, specialists), to planning *skill mixes* of health care professionals. This puts a great weight of responsibility on the complex task of health workforce planning. Hence, different groups of actors in the health system will need to be involved in this process. In view of the expected time lag between decisions on changes and their actual impact (due to different types of 'institutional inertia' such as the duration of training, review/redesign of education programmes, negotiation of changes between different stakeholders), the challenge is to initiate innovative context-specific and integrated health workforce forecasting and planning.[3] And clearly, considering the current pace of rising financial pressures on health budgets and labour market tensions, this has to start now.

Workforce planning and building platforms for cooperation

With its general objective of creating a platform for collaboration and exchange between EU Member States on how to better plan and produce an adequate health workforce, the *Joint Action* provides the opportunity to kick-start a systems approach to workforce challenges for all countries. Not only does the *Joint Action* seek to increase quantitative and qualitative forecasting capacity and to produce methodological guidelines, it also seeks to promote cooperation between Member States in sharing good practice to help improve the effectiveness of policies and decision-making. This is essential, as effective use of forecasting results for workforce planning requires their full integration within a well-functioning policy structure. Within this structure different stakeholders (e.g. professional associations, social partners and ministries of health and education) need to engage in balancing the supply and demand of newly trained professional groups with different skill sets.

An inspiring example of what this may look like is the model developed in the Netherlands where a simulation model for the workforce planning of doctors has been successfully in place since 1999.[4] This model matches a stock-and-flow capacity model with a needs-based demand forecasting model, generating policy advice to determine the 'optimal' annual training inflow into the medical professions for the next ten to fifteen years. As advanced as this simulation model and forecasting system is, it has no value without the support of professional medical associations, medical training institutes, health insurers and the ministries of health and education. Hence, it takes both a technical and institutional planning structure to make health workforce planning feasible and effective in the first place. The United Kingdom provides another example of how forecasting seeks to include methodologies for 'horizon scanning' to identify future workforce needs while taking likely future developments into account. The results of these exercises are used to discuss and negotiate student intakes and funding scenarios for different professional groups.[5] The *Joint Action* seeks to transfer this knowledge and methodologies to other participating Member States – more in-depth information is available on the website of the Centre for Workforce Intelligence (http://www.cfwi.org.uk).

Member States and actors involved in workforce planning need to connect and start cooperating now, and the *Joint Action* has started just in time to support these

† A temporary website outlining the goals of the Joint Action is available at: http:www.euhwforce.eu.

inter-country processes. In doing so, the goal is not to define 'one' best practice, or 'the' most successful system or model for health workforce planning and forecasting. Rather, the aim is to define the best fit: what type of health workforce planning and forecasting better fits with what type of health care system? This question is not easy to answer, but it should stimulate planners and policy-makers to explore different types of systems and adjust them to their specific features and conditions.

> the health workforce is changing significantly

Recruitment, retention and management of health workers

Most EU Member States already face, or will soon face, the challenge of recruiting and retaining a sufficient number of workers with the right qualifications. Old practices will not be appropriate as the health workforce itself is changing significantly. Firstly, its age structure is that of an ageing population and replacement needs will be high in the coming five to fifteen years. In addition, this workforce is highly feminised which implies new working patterns and needs. For example, female medical doctors are known to spend more time with their patients and to prefer to work in certain specialties. They also have different expectations to their male counterparts with regard to work-life balance as women still carry the major part of family responsibilities.[6]

The new generation of workers is accustomed to new technologies, social networking, and high mobility, including working in other countries. They expect flexible working conditions, a participative management environment in which they feel trusted, and the opportunity to participate in continuing professional development. If health sector employers do not meet these requirements, young people will look in other sectors for a career.

Rather than 'one health labour market', different professional groups also now have their own national and international markets. This has important consequences and adds complexity to the policy debate, as each sub-market has its own dynamics and specific set of factors that impact on demand and supply. In addition, information on available positions and on working conditions is highly accessible and social media allow working experiences to be shared with the click of a mouse. This makes 'managing' the image of an employer or of a sector increasingly important and demanding.

To recruit qualified personnel will be a permanent challenge in the expected 'war for talent' contest, in which health care providers will compete for a scarce resource in an international, but uneven playing field. As a consequence, health care employers must review their approach to the labour market, from reactive (e.g. recruiting only when a position becomes available) to proactive (e.g. looking for potential good recruits on a continuing basis), and from demand-based to supply-oriented tactics, with greater attention given to the personal and professional expectations of potential recruits. This requires a holistic approach to the labour market, in which the employer is no longer in a dominant position, but rather a temporary partner who offers working conditions that can help realise personal ambitions such as prosperity, personal development and work-life balance. Although primary working conditions, such as a good compensation package, will remain important in the future, secondary working conditions such as continuous professional development, flexibility, a good company image and a pleasant living environment are becoming at least as important.

The shift in recruitment practices also makes traditional recruitment methods obsolete. Posting advertisements in print or online (the 'post and pray' strategy) will become a last resort measure when methods such as an attractive website, social media, open applications, database searches, campus recruitment, internship or referral programmes fail. Modern recruiters will understand the various labour markets, detect where the opportunities lie and will be able to take advantage of them. They will also be aware of future developments and problems an organisation will be faced with, and be able to assess their possible impact on the health workforce.

If recruiting will be a challenge, retention will be as challenging, if not more. Here we refer to retaining well-performing professionals who may be tempted to look for greener pastures. This type of turnover is costly in many ways. For example, investments in integrating outgoing personnel are lost; there are costs associated with replacement; and when the person leaving is highly specialised some services may be disrupted. It is in the interest of employers, and service users, to avoid the loss of qualified and well-performing personnel because they are not satisfied with their working conditions, and yet, currently little attention is given to staff retention.[7] It is as if employers have taken for granted that to be a doctor, nurse or any other health professional is intrinsically rewarding and that there is no need to pay special attention to factors such as work-life balance, professional recognition or the expectation of continuing professional growth.

> employers need to review their approach to the labour market

Employers and managers will increasingly be expected to create and maintain good working environments, through developing an organisational culture and climate that builds trust, respects professional autonomy, supports multi-professional work, promotes mutual respect and recognition among different health professions, while encouraging and rewarding individual talent. This is

certainly a challenging agenda, but if it is not at the core of recruitment and retention strategies, keeping a stable and motivated workforce in the health sector will remain a permanent struggle.

The need for greater collaboration and health management capacity

Addressing health workforce shortages and imbalances are challenges that need to be urgently addressed at both an organisational and higher policy level. The *Joint Action on European Health Workforce Planning and Forecasting* provides a platform for different countries and stakeholder groups to come together and collaborate on effective forecasting and policy planning mechanisms. This article has put considerable focus on organisational challenges, specifically at the levels of recruitment and retention of health professionals. Meeting these challenges in practice will require (human resource) managers with a new remit, in particular to scan new trends on the job market and changing demands from health workers, and to develop strategies to build and maintain a stable workforce to ensure the quality and continuity of services.

To be able to do so, managers and their organisations will need the support of a policy environment which is better adapted to the dynamics of the health labour market. This includes policies that encourage the adaptation of education programmes[8] supported by adequate financial investments so that new competencies can be acquired and renewed throughout professionals' careers; that allow for more flexibility in the distribution of tasks among the different categories of professionals to ensure that teamwork produces the expected effectiveness and efficiency gains; that create incentive systems that are compatible with the expectations of the new generations of health professionals and with the needs of services, such as better geographical accessibility;[9] and to build managerial capacity to help better utilise and develop an increasingly 'scarce resource'.

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New HiT for Canada

By: Gregory P. Marchildon

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In Canada there has been a major reinvestment in publicly funded health care since the cuts of the early to mid-1990s. The last two decades have produced a dense network of intergovernmental agencies, and while collaboration has succeeded in some areas (e.g. ensuring universal accessibility to hospital and physician services), it has been less effective in other areas (e.g. more effective use of IT). The Canadian government has focused on improving the timeliness, quality and safety of health care, and this has resulted in more doctors and nurses, as well as an increase in the proportion of both, relative to the general population. In addition, governments have invested heavily in capital infrastructure including medical equipment, and recently, there have been improvements in quality outcomes as well as reductions in waiting times, although primary care performance remains weak in Canada.

PAY-FOR-PERFORMANCE IN THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA: BETWEEN A GOOD TITLE AND A BAD REFORM

By: Vladimir Lazarevik and Blasko Kasapinov

Summary: The government of the former Yugoslav Republic of Macedonia has introduced pay-for-performance for all specialist doctors in all public hospitals. The system is based on mandatory reporting of each intervention a doctor performs; it measures an individual doctor's workload, and not the performance of clinical teams. There are no performance measures such as quality, teamwork, complexity of the interventions, nor does it include any hospital outcome measures. Implementation of this reform created enormous frustrations and distress among the majority of physicians who went on a 42-day general strike. The implications of this system as currently implemented may lead towards greater numbers of doctors moving to private hospitals or going to work abroad.

Keywords: *Pay For Performance, FYR Macedonia, Hospital Doctors, Policy Implementation*

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Introduction

On 1 July 2012, the Ministry of Health of the former Yugoslav Republic of Macedonia (FYR Macedonia) introduced a new pay-for-performance (P4P) system in all public hospitals.[1] The impetus for this reform had been gaining momentum over the past ten years in health policy-making circles.[2] Policy-makers expected that this approach would increase quality of care, improve efficiency and reduce costs. However, the initial enthusiasm and success in the implementation of variations of P4P projects[3] is still under challenge since there is no clear and replicated evidence of the success of these reforms.[4] Existing evidence suggests that there is no straightforward model of successful P4P projects.[5] Namely, there are growing concerns among policy-makers as to whether this approach will improve value for health.[6] Three months after its implementation the reform had created enormous frustration and distress among the majority of doctors, leading them to carry out a general strike that lasted 42-days. This was the first general strike of doctors over policy reform since the country gained independence in 1991.

History of doctors' payments in FYR Macedonia

Historically, all doctors in FYR Macedonia have been paid a salary. The first reforms in doctors' payments were introduced in 2007 with completion of the privatisation of primary health care providers. All primary health care doctors (including those in general practice, family medicine, gynaecology and paediatrics at the primary health care level) are now paid by a capitation formula. This formula is based on the per capita monthly income of each citizen enrolled on the doctors' lists. Other doctors who remained employed in public health facilities, such as hospitals, institutes and health centres, continued to receive fixed salaries.

> "the P4P system is unfair

Calculations of doctors' salaries are defined in a collective agreement, signed between the Ministry of Health and the Doctors' Union. Variations in salaries depend on professional profile, complexity of tasks, work experience, overtime, night shifts, on-call shifts, work on public holidays and general working conditions.[7] This payment system did not have any financial incentives to encourage a greater volume of work to be completed, nor to encourage delivered services to be more efficient and of a better quality.

Pay-for-performance for doctors

In order to change the status quo with regard to hospital doctors' salaries and with the aim of providing incentives to improve the quality and efficiency of health care services, the government decided to introduce new financial incentives through a policy on P4P implemented in all public hospitals as of 1 July 2012. The P4P in FYR Macedonia is based on mandatory reporting of each intervention/procedure that individual physicians perform. A special web-based application was developed and each doctor has online login information to register the interventions that he or she performs. Data are analysed at provider level and are also available for comparison at the Ministry of Health. The model measures individual physicians' workload as reported by the doctors themselves. It does not measure the performance of clinical teams, departments or hospitals.

The existing P4P model does not contain any evaluation system, nor does it include quality measures at the present stage of development. In financial terms, it considers the 100% full time equivalent salary of individual physicians as a starting point. Monthly variations in salaries of +/–20% per physician are allowed. A doctor's performance is compared within their own department, and not against the other doctors working at similar public providers. If one hospital/department has on average 50 interventions/procedures per month, while another provider has on average ten interventions/procedures per month, the model may generate lower salaries for doctors working in the provider delivering more services. The difference is explained by the fact that doctors working in smaller institutions on average treat more patients than those working in larger hospitals. Therefore, in order to achieve better performance the latter need to deliver more services. In essence, the model measures an individual doctor's workload as the quantity of interventions delivered over one month. It does not integrate other performance measures such as quality, teamwork, complexity of intervention, nor does it include any hospital outcome measures.

Table 1: Doctors' responses to four main questions related to P4P

Question	Yes	No
1. P4P: Is it fair and justly reflects your work?	4.8% (N=15)	95.2% (N=295)
2. Does it reflect positively on teamwork?	11.7% (N=36)	88.3% (N=274)
3. Does it increase unnecessary diagnostic procedures?	70.0% (N=217)	28.1% (N=87)
4. Will it be positive for the doctor/patient relationship?	8.0% (N=18)	61.0% (N=189)

Notes: N = Number of responses; For Q3, there were six non responses. For Q4, there were two non responses and 101 neutral responses.

E-mail survey

In total, 1863 specialist physicians including psychiatrists employed in all public hospitals are included in the P4P reform. In order to assess these doctors' attitudes towards the proposed P4P, we conducted a rapid email survey focused on four main issues – fairness, team work, relationship with patients and the delivery of services. We contacted 500 doctors participating in P4P by e-mail and had responses from 310 (62%).

Attitudes towards P4P

The overwhelming majority of the surveyed doctors, 95.2% (N=295), expressed concerns that the P4P system as implemented is unfair and does not give justice to the work performed by doctors (**see Table 1**). Only 4.8% of all surveyed doctors expressed positive attitudes towards the question of fairness. Responses to the question on teamwork were similar. The great majority, 88.3%, when asked *"How does P4P reflect on teamwork in your department?"* chose the negative option and 70% of surveyed doctors stated that the scheme encourages the use of unnecessary diagnostic procedures. Finally, 61% of respondents felt that the system may have a negative impact on the doctor/patient relationship.

These responses were supported by additional written comments to each question. In total, over 900 individual comments and justifications of responses were collected. All comments were integrated and carefully screened to determine the magnitude of the different concerns that were raised. Table 2 presents the most common comments received.

Discussion

The attempt to implement P4P among specialist doctors employed in public hospitals in FYR Macedonia appears to be a dialogue among the deaf. The government continues to claim that the

Table 2: Content analysis: main groups of doctors' problems and key statements

1. Why the P4P project is not fair? (250 comments)
a. "There is no quality measure, it only measures quantity of workload."
b. "There are no methodologies or standards to evaluate my work."
c. "There is no weight on the specific procedures we perform."
d. "One doctor can have 50 successful cataract operations, while another has 60 unsuccessful procedures; the one who is unsuccessful will take 20% of my salary."
e. "The evaluation of doctors' work is subjective."
f. "It considers patients as numbers, not as individuals."
g. "I receive points due to success in producing numbers, but in fact I am an unsuccessful doctor."
2. How it adversely impacts on teamwork? (181 comments)
a. "It created an atmosphere of competition between colleagues. We are all focused on numbers and not on the quality of work."
b. "We take patients from each other."
c. "It creates conflict, jealousy and clashes between colleagues."
d. "It goes against teamwork. It stimulates an individual approach, one doctor: one patient."
e. "No one talks to anyone."
3. Does it encourage unnecessary procedures? (153 comments)
a. "We schedule patients for examinations more frequently; we examine even those who do not have real medical needs."
b. "We refer patients for unnecessary diagnostic procedures to increase our workload and gain points."
c. "We hospitalise those patients who should not be hospitalised."
d. "More check-ups for more points."
e. "We are all trying to show more work."
f. "We register fictitious check-ups and interventions to earn more points."
g. "Caesarean section, instead of normal delivery."
How does it impact on the doctor/patient relationship?
a. "Less time to devote to patients."
b. "The patients are numbers."
c. "We are nervous, and this is transferred to patients."

policy is designed to introduce competition between doctors, improve efficiency and to stimulate better performance. On the other hand, 95% of the physicians surveyed stated that they felt that the policy as it stands is unfair, destroying clinical teamwork and creating perverse incentives to provide more services to patients.

We have come up with four key points that may have serious policy implications. Firstly, the vast majority of surveyed doctors perceived the P4P project to be unfair and not acceptable. This was confirmed in two separate surveys.[1] Secondly, the P4P system puts in jeopardy clinical teamwork that is essential for the normal functioning of hospitals.[8] Doctors have provided a number of written comments and examples that strongly back this up. Thirdly, findings suggest that the project gives perverse incentives to doctors to increase the number of unnecessary procedures to influence individual performance.[9] Again, this was explicitly stated and repeated by many doctors in their written comments. And fourthly, the overall effect of the reform may negatively affect the doctor/patient relationship.

The findings of our survey pose many questions to policy-makers that have remain unanswered. For example, what may be the consequence of a reform that is strongly refuted by the great majority of doctors? How can successful implementation of this reform be expected when it creates personal conflicts among those who are about to implement it? What are the costs to the health care system of unnecessary procedures for patients? How many physicians will leave public hospitals and how will this affect health care delivery in the country? It is not easy to provide quick answers to any of these questions and it will take time and resources to quantify the impacts of this reform. However, we can speculate on possible policy implications if this reform remains unchanged.

> does not integrate other performance measures

Policy implications

The main goal of any modern health care system is integration in the delivery of health care services. The implemented model of P4P moves in the opposite direction to this principle. Instead of leading to integration and collaboration among doctors, it leads towards disintegration and the creation of personal conflicts. This may have far reaching negative consequences for patients. Careful planning, design and implementation of reforms are crucial steps in each policy-making cycle. Moreover, engaging with all actors and understanding the reward system are essential prerequisites if a policy-maker wishes to have desirable outcomes.[10] Unfortunately, the P4P experience in FYR Macedonia provides an example of serious weaknesses in each part of the policy-making cycle. The most serious negative policy implication of this reform is that it may compel doctors to move to private hospitals or to look for employment opportunities abroad. In February 2012, a survey conducted among doctors employed in public hospitals suggested that 45% had considered changing their

workplace, while 57% of them would like to move abroad.[11] If this happens it would put the country in serious jeopardy and at risk of losing an important component of its skilled and trained health workforce.

> “leads towards disintegration and the creation of personal conflicts

Final remarks

The findings of our email survey are in line with doctors' general attitudes toward this reform. After a 42 day strike doctors resumed their work despite no agreement with the Ministry of Health on modifying the P4P system. The implications for both future government policies and the delivery of health care services remain unclear. One thing that is clear is that this reform has deepened doctors' frustrations and increased their job dissatisfaction. On the surface, it looks like the government has just adopted a good title for a bad reform. Let's hope that this example will prevent other policymakers from making similar mistakes.

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BALANCING REGULATION AND FREE MARKETS: THE BULGARIAN PHARMACEUTICAL SECTOR

By: Maria Rohova, Antoniya Dimova, Emanuela Mutafova, Elka Atanasova, Stefka Koeva and Ewout van Ginneken

Summary: The restructuring of the pharmaceutical sector has been a pivotal part of the reform of the Bulgarian health system since 1990. Today, Bulgaria has one of the highest shares of pharmaceutical spending as a proportion of total health costs in Europe. This article discusses reforms in the pharmaceutical market as well as in pricing and reimbursement. Although important progress was made in establishing this framework and in access to pharmaceuticals, important challenges remain with regard to containing cost and ensuring access. These include effective price regulation; development of health technology assessment capacity; monitoring overuse of medication; and finding the right balance between government intervention and free market regulation.

Keywords: *Pharmaceutical Legislation, Governance, Market, Pricing, Reimbursement, Bulgaria*

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Introduction

The Bulgarian health care system has experienced a long and difficult transition in the last 20 years. An important part of these reforms was the restructuring of the pharmaceutical sector, which started in the mid-1990s, and subsequently, containing the cost of pharmaceutical spending in both the public and private sector. Their importance is obvious. Bulgaria has one of the highest shares of pharmaceutical spending as a proportion of total health costs in Europe. This is a common struggle especially among some lower income European Union (EU) countries due to high relative price levels. Spending on pharmaceuticals and medical goods was 36.9% of total health expenditure in 2009, compared to 11.5% in Denmark, 13.5% in the Netherlands, 21.7% in France, 21.8% in Germany, 37% in Slovakia and 37.7% in Hungary.[1] Effective regulation could free up scarce public funds to invest in other parts of the public system, which is important in times of austerity. But it could also alleviate the very high out-of-pocket pharmaceutical spending. This article provides a brief overview of the key legislative changes and policy measures that have occurred in the sector and then examines their effectiveness so far. Some future challenges and policy recommendations are then discussed.

Health system background

Until the 1990s, the Bulgarian health care system was highly centralised with a state monopoly on the ownership of health care establishments and other organisations in the health sector. Following the model of the Soviet Union formed after World War II, the system in Bulgaria was based on the principles of socialist health care and characterised by central planning, universal access, inefficiency, hospital overcapacity and poor quality health care. A state monopoly was introduced from 1948 to 1950 and private hospitals and pharmacies were nationalised during this period. The building of a state-owned pharmaceutical distribution network started in 1955 and in 1973 the physicians' and pharmacists' cooperatives as well as private medical practice were banned.[2]

Reforming the pharmaceutical market

In the early 1990s, the production and distribution of pharmaceuticals in Bulgaria were under the monopoly of the State Pharmaceutical Company. In 1995, the *Law on Medicinal Products and Pharmacies in Human Medicine* was introduced and passed by Parliament. It privatised the overall system of drug supply, although some restrictions apply to the supply of certain types of costly medications for certain diseases. The functions of the state agencies were regulatory and supervisory. Pharmacies and pharmacists were among the first health care facilities and health professionals that were privatised or allowed to operate their own private business. Among the most debated issues, even after passing the law, were the provisions that only pharmacists with a Master's degree had the right to open a pharmacy and the prohibition of pharmaceutical chains. In the following years the law was changed several times. Ultimately, the requirements distinguished ownership from management of pharmacies. A pharmacist with a Master's degree can manage only one pharmacy irrespective of its ownership. In practice this has led to the establishment of pharmacy chains.

In 2007, the law was completely revised and renamed as the *Law on Medicinal Products in Human Medicine*. It regulates the manufacturing, import, wholesale and retail of drugs in order to comply with EU regulations. Completely new articles concern the import of medicinal products, registered in EU Member States, parallel trade of pharmaceuticals, as well as the new engagements of Bulgarian institutions in connection with free trade in the EU area. The law also regulates the governance of the pharmaceutical sector, a Positive Drug List* (PDL) and pharmaceutical prices.

> "the cost of pharmaceuticals borne by the MoH grew by 69% from 2008 to 2010

Since 2007, the *Law on Medicinal Products in Human Medicine* has been amended several times. The last changes took place in 2011 and involved the PDL and price regulation. The pharmaceutical market is regulated by the Ministry of Health's (MoH) Commission on Prices and Reimbursement of Medicinal Products and the Bulgarian Drug Agency (BDA). This commission regulates the prices of prescription medicines. The BDA assesses and supervises the quality, safety and efficiency of medical products.

Hospitals and other health care establishments providing inpatient services can operate pharmacies but only for their own supply. According to the BDA register, there are approximately 4,140 pharmacies in Bulgaria, including pharmacies in health care establishments.[3] Their number has been rising in recent years but seems to have levelled off due to the fact that each licensed pharmacist may manage only one pharmacy. A natural person or legal entity may own up to four pharmacies.

Retail sale of prescription-only pharmaceuticals is allowed only in pharmacies. The law explicitly forbids the sale of prescription-only pharmaceuticals in other outlets, as well as on the Internet. Nevertheless, the law allows some exceptions for remote areas without a pharmacy. In this case physicians or dentists may also sell medications but only with the permission of the MoH. Over-the-counter (OTC) pharmaceuticals for personal use are available both at pharmacies and at drugstores, the latter of which cannot sell prescription drugs. There are more than 4,100 pharmacies and 900 drugstores in Bulgaria, registered by the BDA and by the Regional Health Inspectorates – the regional divisions of the MoH respectively.[4]

According to the *Law on Medicinal Products in Human Medicine,* wholesale activities can be carried out by natural persons or legal entities holding a permit issued by a regulatory authority of any EU Member State. If the warehouses are located in Bulgaria, a wholesale authorisation from the BDA is needed. The authorised wholesalers may also import registered medicinal products. Approximately 190 wholesalers are currently licensed by the BDA, some of them with divisions in several cities.[5]

Pharmaceutical manufacturers and importers are entitled to distribute their products based on the manufacturing or import license. They can participate directly in procurement tenders organised by the MoH, the National Health Insurance Fund (NHIF) or hospitals. Public health care establishments are supplied by wholesalers, manufacturers or importers and purchasing is regulated through the *Public Acquisition Act*. Commercial relations between wholesalers and retailers are not regulated except with regard to the wholesaler mark-up, which is specified in an ordinance of the MoH.

* The Positive Drug List determines which pharmaceuticals are covered by social health insurance through the budget of the National Health Insurance Fund and which are covered by the Ministry of Health through the state budget.

Reforming pricing and reimbursement

Several specialised commissions inform the Minister of Health. The Commission on Medicinal Products Prices sets price limits for prescription medicines and registers the maximum retail selling prices of OTC medicinal products. The Commission on the Positive Drug List makes decisions for inclusion, changes or exclusion of medicinal products from the PDL. In 2011, in the search for efficiency, the latter two commissions were merged into the Commission on Prices and Reimbursement of Medicinal Products. The decisions of the latter can be appealed at the Transparency Commission.

Social health insurance partially or fully covers insured persons' access to medicinal products. Until 2010, people with oncological and rare diseases, irrespective of their insurance status, received pharmaceuticals paid for by the state. In 2010, the MoH shifted payments for medicines for oncological diseases to the NHIF. As a result, prices of some pharmaceuticals have increased several times. This is due to the pricing mechanism. While the MoH purchases pharmaceuticals after tender, the NHIF purchases medicines included in the PDL at prices defined in the list.

The Commission on Prices and Reimbursement of Medicinal Products compiles the PDL determining which pharmaceuticals are covered by social health insurance and through the state budget. The PDL is organised in pharmacological groups with relevant international non-proprietary names and includes the defined daily dose (DDD), the reference value for the DDD and the reference price. Pharmaceuticals included in the list are selected on the basis of several criteria such as efficacy, therapeutic effectiveness, and safety, as well as on the basis of pharmacoeconomic analysis.

The Commission on Prices and Reimbursement of Medicinal Products approves the prices of medicinal products included in the PDL and determines the maximum prices of prescription-only pharmaceuticals. The ex-factory price of a given product in the PDL is calculated based on a system of international price comparisons with eight key EU Member States – Romania, France, Estonia, Greece, Slovakia, Lithuania, Portugal and Spain and if this information is not available, then Belgium, the Czech Republic, Poland, Latvia and Hungary are considered as well. The lowest price in any one of these countries is set as the Bulgarian ex-factory price. Despite the international price comparisons and regulated pharmaceutical prices, the cost of pharmaceuticals borne by the MoH grew by 69% from 2008 to 2010, in contrast to the relatively stable expenditures made by the NHIF. The positive fact is that since 2003, the market share of generics has exceeded that of branded drugs. However, at the same time, the prices of generic drugs have been rising, while the prices of patented products have remained relatively stable.[6]

Reference prices are generally used to determine reimbursement levels. The MoH determines the mark-up of wholesalers and pharmacies depending on the manufacturer (or importer) ex-factory price per package. For OTC pharmaceuticals, the Commission only registers maximum retail prices, suggested by the producer or importer. Reimbursement levels of pharmaceuticals covered by social health insurance are determined according to the NHIF budget for the respective year (capped for outpatient drugs) and are specified in the Reimbursement List. In recent years, expenditures for pharmaceuticals represented approximately 20% of the NHIF's payments. Reimbursement may be also provided under voluntary (private) health insurance coverage.

Problems remain

The Bulgarian pharmaceutical market has been growing since 1999 despite the economic crisis and extensive regulation. In 2009, the value of the total pharmaceutical market reached approximately €801 million, an increase of 27% compared to 2004. Hospital consumption represented 18.4% of the total market, while private purchases accounted for 63.4%; and the remaining 18.2% were ambulatory care pharmaceuticals reimbursed by the NHIF and the MoH. In 2009, OTC pharmaceuticals represented 16.6% of the total market.[7] Retail medicine consumption in Bulgaria was €65 per capita in 2008, while total consumption (including hospital sales) amounted to €80 per capita and was among the lowest in the EU.[8] However, an important share of this is borne out-of-pocket and incomes are low compared to other European countries. In recent years, two main trends can be observed: 1) large pharmacy chains are gradually replacing independent entrepreneurs; and 2) the manufacturer-wholesaler-pharmacy value chain is consolidating, particularly through vertical integration.[8]

> "procurement of pharmaceuticals is insufficiently transparent

Furthermore, the prices of pharmaceuticals in Bulgaria remain high in comparison with other EU Member States. According to a national representative survey, high prices have made certain pharmaceuticals unaffordable for a large proportion of citizens: 23.2% declared that they lacked the financial means to purchase prescribed medications, while 56.0% could not always afford all prescribed drugs necessary for their treatment.[9] Moreover, co-payments for pharmaceuticals, covered partially by social health insurance, are also comparably high.

Another important problem in the pharmaceutical sector in Bulgaria is that the selection and procurement of pharmaceuticals is insufficiently transparent and too vulnerable to conflicts of interest. A study by the United States Agency for International Development (USAID) in 2005 also found evidence of attempts by some international and local drug producers to exert influence at almost every level of the system.[10] Signs of corruption have appeared frequently in recent years and attest to ineffective

oversight in the selection process of the drugs listed in the PDL and very limited public input.

Conclusion

Pharmaceuticals are an important high-value input for health systems. The pharmaceutical sector has a crucial role and impact for achieving the general objectives of the health system in terms of accessibility, affordability, cost-effectiveness and efficiency. Although important steps have been made, challenges remain.

Pharmacies are irregularly distributed across the country. While in the big cities their number exceeds needs, the number of pharmacies in small cities and villages is insufficient and in some locations are absent. There is no solid evidence on whether legislation has increased the number of pharmacies, yet there are several factors that have influenced their distribution: there are no limitations on the number of pharmacies per population (as in Romania, for example); the regime of pharmacy registrations is quite liberal so the leading factor in pharmacy openings is economic interest; and there are no financial incentives to open pharmacies in small villages. As a result, severe competition in the big cities coupled with the economic crisis has led to the closure of smaller pharmacies. In some small villages, people have no access to pharmaceutical care.

There is no regular and systematic research on the rational use of medicines; however, there is anecdotal evidence of serious problems with medicines reimbursed by the NHIF. Some of these medicines are more expensive than patients would pay for them on the free market. In addition, there has been debate that some of the reimbursed medicines are not the most efficient; however, scientific evidence to back this claim is lacking.

Future challenges in the Bulgarian pharmaceutical sector include effective price regulation; development of systems for research and pharmacoeconomic analysis, as well as technical assessment; the provision of costly medications by the MoH and NHIF; and stricter control over medication use. Finding the right balance between government intervention and free market regulation of pharmaceutical supply is particularly important for the effective functioning of the sector and for the health system's future ability to contain cost and ensure access to quality medicines.

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NEW PUBLICATIONS

Home care across Europe. Current structure and future challenges

Edited by: N Genet, W Boerma, M Kroneman, A Hutchinson and R B Saltman

Copenhagen: World Health Organization 2012 (acting as the host organisation for, and secretariat of, the European Observatory on Health Systems and Policies). Observatory Studies Series No. 27, 2012.

Number of pages: xiii + 145 pages

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Available online at: http://www.euro.who.int/__data/assets/pdf_file/0008/181799/e96757.pdf

For every person over the age of 65 in today's European Union, there are four people of working age but, by 2050, there will only be two. Demand for long-term care, of which home care forms a significant part, will inevitably increase in the decades to come. Despite the importance of the issue, however, up-to-date and comparative information on home care in Europe is lacking. This book attempts to fill some of that gap by examining current European policy on home care services and strategies.

Home care across Europe probes a wide range of topics including the links between social services and health-care systems, the prevailing funding mechanisms, how service providers are paid, the impact of governmental regulation, and the complex roles played by informal caregivers. The text will help frame the coming debate about how best to serve older citizens as European populations age.

Policy-makers, academics and those responsible for service delivery will find comparable information on many aspects of the organisation, financing and provision of home care across Europe. Formal structures are addressed as well as the reality of home care, including system failures and unmet needs.

Contents:
Preface; List of tables, figures and boxes; List of abbreviations; Chapter 1 Introduction and background; Chapter 2 The policy perspective; Chapter 3 Clients in focus; Chapter 4 Management of the care process; Chapter 5 Conclusions and the way forward; Appendix I Terminology; Appendix II Case narratives (vignettes).

Building European reference networks in health care. Exploring concepts and national practices in the European Union

Edited by: W Palm, I A Glinos, B Rechel, P Garel, R Busse and J Figueras

Copenhagen: World Health Organization 2013 (acting as the host organisation for, and secretariat of, the European Observatory on Health Systems and Policies). Observatory Studies Series No. 28, 2013.

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Under the European Directive on the application of patients' rights in cross-border health care, the development of European reference networks was promoted as one of the prime areas for cross-border cooperation among Member States. These networks are meant to improve access to and provision of high-quality specialised health care to those patients who need it, and to act as focal points for medical training and research, information dissemination and evaluation, especially for rare diseases.

This book examines the ways in which reference networks have developed in European countries, for what kind of medical conditions or interventions, the motivations behind their establishment, the regulatory and administrative processes involved, and the financial arrangements needed. The study outlines the key policy implications and challenges, and will assist policy-makers, health professionals, administrators and others involved in implementing the Directive.

Contents:
Foreword; Acknowledgements; List of tables and boxes; List of abbreviations; Introduction and objectives; Mapping national practices and experiences – Baltic States, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Malta, the Netherlands, Norway, Poland, Romania, Slovenia, Spain, Sweden, United Kingdom (England); Discussion and preliminary conclusions ; References; Annex I Some examples of (European) reference networks; Annex II Overview table.

NEWS

International

Dublin: Health Ministers discuss impact of economic crisis on EU health systems

On 5 March the Irish Minister for Health, James Reilly, concluded a meeting of EU Health Ministers as part of Ireland's Presidency of the Council of the European Union. The Minister and his European counterparts dealt with a range of important health issues. In particular, they discussed the impact of the economic crisis on health systems across the EU, as well as childhood obesity, progress to achieving a smoke-free environment and helping children with complex developmental needs.

There was broad support among ministers to address the challenge of childhood obesity, which is a major public health issue across the EU and requires multi-sectoral action. The Minister was particularly pleased that the Commission responded positively to the Presidency's call for an Action Plan on Childhood Obesity. This work will be taken forward by the EU High Level Group on Nutrition and Physical Activity. It will contribute to the broader Europe 2020 Strategy through enhancing productivity and economic growth and reducing the burden of chronic diseases on EU health care systems. The Minister stated that the "initiative reflects the importance that my colleagues and I attach to the issue of childhood obesity which has short-term and long-term implications at both an individual and a broader socio-economic level".

Minister Reilly said that across the EU, the impact of the economic crisis was being felt in the health sector. "In Ireland, we are seeking to reduce the cost of services, not the services themselves, through a range of measures that encompass structural reform as well as efficiency measures". During the lunchtime discussion, ministers shared experiences in order to learn from colleagues how expenditure can be reduced and more efficient services provided in a way that minimises the effects on quality".

The Minister continued: "my colleagues expressed their deep concerns about the negative effects of the economic challenges on health. We are all engaged in similar efforts in order to continue to meet growing demand for health care with limited resources. Time and again, evidence-based policy making and evidence-based care and treatment were cited as the best way to enhance outcomes for patients". Minister Reilly suggested this topic should be kept on the agenda for future meetings of Health Ministers and of the Senior Level Working Party.

At the meeting, ministers also discussed progress on achieving a smoke-free environment, with the Minister stating that "more work remains, at national and EU level, in order to address this issue and promote smoke-free environments. Smoking is optional – breathing is not". The Commission also presented a progress report on the implementation of the Council Recommendations on Patient Safety, including health care associated infections. Considerable progress had been achieved but much work remained to be done and ministers discussed priority action areas across all health policies. Ministers also shared examples of best practice and other information in relation to services for children with complex developmental needs, in particular, autism.

More information on the informal meeting of ministers of health at: http://eu2013.ie/events/event-items/informalmeetingofministersforhealth-20130304/

Tobacco in the EU: Exposure to second hand smoke still too high

Exposure to second hand tobacco smoke is a wide-spread source of mortality, morbidity and disability in the EU. According to conservative estimates, more than 70,000 adults in the EU died due to exposure to tobacco smoke in 2002, many of them non-smokers or employees exposed to second hand smoking at their workplaces. A new report from the European Commission suggests that protection from second hand smoke has improved considerably in the EU. 28% of Europeans were exposed to second hand smoke in bars in 2012, down from 46% in 2009. Belgium, Spain and Poland are examples of countries where the adoption of comprehensive legislation led to very significant drops in exposure rates within a short period of time.

The report draws on self-reporting by the 27 Member States, following the 2009 Council Recommendation on Smoke-free Environments (2009/C 296/02), which called upon governments to adopt and implement laws no later than November 2012 to fully protect their citizens from exposure to tobacco smoke in enclosed public places, workplaces and public transport. The report dispels concerns about smoking bans impacting negatively on the revenues of bars and restaurants, by showing that their economic impact has been limited, neutral and even positive over time. All Member States report that they have adopted measures to protect citizens against exposure to tobacco smoke. About half of the Member States have adopted or strengthened their smoke-free legislation since 2009. Many also started earlier.

However, the report also illustrates that some Member States are lagging behind, in terms of comprehensive laws protecting public health, and enforcement. Enforcement seems to be a problem in some Member States. Complex legislation (i.e. legislation with exemptions) is found to be particularly difficult to enforce.

For more information on the implementation of smoke-free legislation in the EU see: http://ec.europa.eu/health/tobacco/smoke-free_environments/index_en.htm

Common rules on medical prescriptions when travelling to another EU country

The current diversity of prescriptions across the EU can make it difficult to have them properly recognised in another EU country. While the number of cross-border prescriptions is low at around 2.3 million per year, or between 0.02% and 0.04% of all EU prescriptions, for specific groups of patients, improving the recognition of cross-border prescriptions could make an important difference. For example, for patients with chronic diseases wishing to travel to another country, for patients living in border regions or smaller Member States for whom filling out a cross-border prescription is a necessity, and for patients

with a rare disease, where the best expertise can be found across a border.

In December 2012, therefore, the European Commission adopted pan-EU rules on a minimum list of elements to be included in a medical prescription taken by a patient travelling from one EU country to another. The provisions are to be put into national law by the Member States by 25 October 2013. Coordination of medical prescriptions for both pharmaceuticals and medical devices will improve the authentication of cross-border prescriptions and translate into an estimated extra 200,000 prescriptions every year.

The new rules take the form of an Implementing Directive. They introduce a common set of descriptive elements to help identify prescribers, patients and prescribed products. They do not, however, deal with the appearance, format or language of the prescription. Nor do they preclude further elements, in line with local practices, being added by prescribers. These common elements are limited to cross-border prescriptions requested by the patient, not prescriptions used within a country (unless a Member State so chooses). National contact points, established under the Cross-border Health Care Directive will inform patients on the right to travel with a cross-border prescription when visiting another Member State, as well as the minimum list of elements that it should contain.

More information on cross-border health care, including prescriptions at: http://ec.europa.eu/health/cross_border_care/policy/index_en.htm

New WHO report reveals unequal improvements in health in Europe and calls for measurement of wellbeing as a marker of progress

While the overall level of health across the World Health Organization (WHO) European Region has clearly improved, European health statistics show inequalities persist within and between countries, according to the European health report 2012. Life expectancy has increased by five years since 1980 to reach 76 years in 2010. This has mainly resulted from decreases in certain causes of death and efforts to address risk factors and socio-economic conditions.

People over 65 years of age are projected to comprise more than 25% of the total population in the Region by 2050. Nevertheless, major inequalities in life expectancy are found between men and women, countries and population groups. For example, life expectancy for women reached an average of 80 years in 2010, while that for men was 72.5 years. Lifestyle and occupational differences largely explain this gap. Mortality rates are highest in the eastern part of Region and lowest in western countries. Non-communicable diseases account for the largest proportion of deaths: some 80%. Diseases of the circulatory system, including ischaemic heart disease and stroke, account for nearly 50% of all deaths, followed by cancer, which is responsible for 20% of deaths.

Communicable diseases remain a concern, particularly tuberculosis (TB), AIDS and sexually transmitted diseases. AIDS incidence is though decreasing, while deaths from TB in the Region fell by 30% between 1990 and 2010. The leading health risk factors today include tobacco and harmful alcohol use, with alcohol accounting for an estimated 6.5% of all deaths in the Region, while 27% of the population aged over 15 are smokers.

Focus on wellbeing

The report also has a focus on wellbeing. For the first time in over 60 years, WHO Europe aims to provide clarity in defining well-being, outline ways to measure it and develop a regional target and indicators on it by the end of 2013. The report stresses that wellbeing and health are interactive and multi-dimensional concepts, with some common determinants, such as the health system. Ensuring a good life is not the domain of any one sector or service, but a multi-dimensional concept with multiple determinants. It requires an approach involving the whole of government and of society.

WHO Europe has also developed a roadmap to devise a new approach to measuring wellbeing that includes a collaborative agenda to collect, analyse and make use of health data Region-wide, along with a research agenda that improves the use of information to support policy-making to improve health and wellbeing.

More information at: http://www.euro.who.int/en/what-we-do/data-and-evidence/european-health-report-2012

Country news

England: Mid Staffordshire NHS Foundation Trust inquiry report published

On 17 March 2009, the Healthcare Commission, the then independent health regulator, published a damning report into the failings of emergency care provided by the Mid Staffordshire NHS Foundation Trust. Subsequently two independent inquiries led by a judge Robert Francis were undertaken.

The first, which reported in 2010, focused on failings at the hospital trust. It found that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care. For many patients the most basic elements of care were neglected. Calls for help to use the bathroom were ignored and patients were left lying in soiled sheeting and sitting on commodes for hours, often feeling ashamed and afraid. Patients were left unwashed, at times for up to a month. Food and drinks were left out of the reach of patients and many were forced to rely on family members for help with feeding. Staff failed to make basic observations and pain relief was provided late or in some cases not at all. Patients were too often discharged before it was appropriate, only to have to be re-admitted shortly afterwards. The standards of hygiene were at times awful, with families forced to remove used bandages and dressings from public areas and clean toilets themselves for fear of catching infections.

The report found that a chronic shortage of staff, particularly nursing staff, was largely responsible for the substandard care. Problems at the Trust were exacerbated at the end of 2006/07 when it was required to make a £10 million saving. The Board's focus on financial savings was a factor leading it to reconfigure its wards in an essentially experimental and untested scheme, whilst continuing to ignore the

concerns of staff. Staff who spoke out felt ignored and there was strong evidence that many were deterred from doing so through fear and bullying.

The second inquiry commissioned in 2010 by the then Health Minister Andrew Lansley focused on broader issues. In particular it was asked to examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at the Trust. It examined why problems at the Trust were not identified sooner and was to make recommendations on lessons for the future operation of the NHS.

Published on 6 February 2013, the results of the second inquiry included 290 recommendations. Speaking at the launch of the report Robert Francis said that five essential things needed to change to improve the NHS. Firstly there should be a "structure of clearly understood fundamental standards" where "non-compliance cannot be tolerated" while "any organisation unable consistently to comply should be prevented from continuing".

There should also be "openness, transparency and candour throughout the system". This should help hospital employees concerned about patient care speak out and also provide better information to patients and their families when things go wrong. Judge Francis also called for better training for nurses and care assistants to deliver "compassionate care". The judge also raised concerns over the quality of leadership in the NHS and recommended both more accountability for NHS leaders and the need for a "NHS leadership staff college".

He also called for "patients, the public, employers, commissioners and regulators [to have] access to accurate, comparable and timely information", in order to benchmark and rank trusts to see if standards were improving or falling.

Responding to the Inquiry's findings, Prime Minister David Cameron said that "what happened at the Mid-Staffordshire NHS Foundation Trust between 2005 and 2009 was not just wrong, it was truly dreadful. Hundreds of people suffered from the most appalling neglect and mistreatment". He said that the government would respond in detail to all of the recommendations but highlighted three core areas – patient care, accountability and defeating complacency – on which immediate progress could be made. He said that "we will create a single failure regime where the suspension of the Board can be triggered by failures in care, as well as failures in finance". He also announced that a new 'friends and family' test – where patients and staff are asked whether they would recommend the service to a loved one – will be introduced into every hospital in England from April 2013. He hoped that this would also be extended to primary care surgeries, district nursing and community hospitals. The results would be published and Trust "Boards held to account for their response". He noted that "nurses should be hired and promoted on the basis of having compassion as a vocation not just academic qualifications" and called for "pay to be linked to quality of care rather than just time served at the hospital" questions about the role of regulatory bodies have to be answered, given that no-one had been dismissed from the medical register despite the failings at the Trust. The government will also "look very closely at the recommendation to transfer the right to conduct criminal prosecutions away from the Health and Safety Executive to the Care Quality Commission" – a body that has a better understanding of the NHS. To address the culture of complacency the Prime Minister also announced the establishment of a Chief Inspector of Hospitals to take personal responsibility for assess whether a hospital is clean, safe and caring.

The findings of the Inquiry are available at:
http://www.midstaffspublicinquiry.com/report

The Prime Ministers response is available at:
http://tinyurl.com/bfnvtff

Spain: Catalan Minister of Health warns health system on verge of financial collapse

In the Catalonian Autonomous Community in Spain debts to pharmacies and the health sector now over amount to more than €900 million. Catalan Minister of Health, Boi Ruiz, has warned that the Catalan health system has crossed a red line and is on the verge of a "financial collapse". The minister made his comments given the need for budget cuts to meet the new target deficit limit of 0.7% of GDP. The Advisory Council for Economic Recovery *(Consejo Asesor para la Reactivación Económica)* is now pressing for the introduction of new revenue streams into the health and social care system from co-payments.

Meantime, 3,100 owners of pharmacies in Cataluña voted on 12 March to take further protest actions against the failure of the regional government to pay what is due to them, with the risk of pharmacy lockouts making access to medicines more difficult. They are demanding interest on the €303 million they are collectively owed. In the last two years they have had to wait 120 days for payment, 85 days more than in their agreement with the Department of Health.

Fourteen pharmacies have closed in the last seven months, while the four pharmaceutical professional associations have indicated that another 267 pharmacies are in severe financial distress, with almost half of these in Barcelona.

More information in Spanish at:
http://tinyurl.com/cty9ndg

Greece 'facing medicine shortage'

On 28 February the *Guardian* newspaper reported that social insurance funds and hospitals in Greece owe pharmaceutical companies about €1.9bn. It has uncovered concerns about shortage of some medicines, with pharmaceuticals being exported to wholesalers in other countries, given that prices are 20% lower than elsewhere in Europe. The National Organisation for Medicines (NOM) stated that companies are ceasing some supplies for this reason. NOM has introduced export bans for nearly 60 medicines to reduce opportunities for parallel trade.

The full article is available at:
http://tinyurl.com/bdgn8yj

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OBSERVATORY **VENICE** SUMMER SCHOOL 2013

Time for Change: Innovative Ways of Improving Population Health

21–27 July 2013,
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This year's theme

Background: European countries increasingly recognise the importance of population health interventions in national health policy. Too often though, population health runs along traditional lines, drawing on established knowledge and training but overlooking key developments and issues such as new contextual challenges; improvements in measurement of health needs, risks, health outcomes and performance; new evidence on the effectiveness and cost-effectiveness of fiscal, regulatory and behavioural interventions on health determinants; technological advances in human genomics and biomarkers; information systems and social communication; as well as innovations in organisation and skill mix.

Objectives

The Summer School will build on participants' own knowledge and expertise in population health and marshal the latest evidence on new developments to:

- Provide a state of the art account of innovative strategies to improve population health;
- Assess the implications of improved measurement (of burden of disease, determinants of health; health outcomes and well-being) for both old and new challenges;
- Interpret what innovative interventions mean for improving population health; and
- Draw practical policy and implementation lessons to deliver better population health interventions.

Approach

The **six day course** combines a core of formal teaching with a participative approach that includes participant presentations, round tables, panel discussions and group work. It mobilises the latest evidence; a multidisciplinary team of experts; and the insights of key international organisations including WHO, the European Commission and professional organisations, such as EUPHA, ASPHER and EPHA.

Modules

The course is organised around three modules. **Module 1** looks at what is the problem? Understanding the new challenges to population health. **Module 2** addresses what can we do? The evidence on innovations to improve population health. **Module 3** looks at how do we make it happen? Governing and implementing population health. Participants' experiences and practice will be central and they will share their perspectives, work in groups and develop a case study that cuts across themes. They will also be able to engage in political dialogue with senior policy makers and representatives of professional bodies.

Accreditation

The Summer School is accredited by the **European Accreditation Council for Continuing Medical Education** and counts towards ongoing professional development in all EU Member States.

Applicants/participants

The Summer School is primarily aimed at senior to mid-level policy-makers although some more junior professionals will be included. All participants should be working in a decision-making or advisory institution that focuses on policy and management at a regional, national or European level. The cost is €1,950 and covers all accommodation and meals, the course, teaching materials, transfers to and from the airport and the social programme. Potential participants are asked to apply by **7 June 2013**. Early applications are encouraged.

For more information and updates:
www.observatorysummerschool.org