Ray Moynihan, Kerstin Blum,
Reinhard Busse, Sophia Schlette (eds.)

Health Policy Developments 12

- Value for Money
- Funding and Governance
- Access and Equity

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Focus on Value for Money, Funding and
Governance, Access and Equity

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Preface

Dear readers,

Well into its sixth year of existence, the International Network Health Policy & Reform is alive and thriving. With no signs of age or wearing out, we continue to develop ourselves further and venture for new partnerships and cooperations.

New author Ray Moynihan

For this most recent issue number 12 of our biannual series *Health Policy Developments*, we—the long-time editors—take great pride in introducing our new author, *Ray Moynihan*, from Byron Bay, New South Wales, Australia. Though thousands of miles apart, we discovered that we are following the same key themes of health policy, particularly around issues such as access, affordability, and equity, as well as determinants of health and governance issues. Following Ray's suggestion, we also produced a companion video and a short promo film to disseminate the book's key messages the virtual way (watch at www.hpm.org in the download section).

New partner in Spain

We are equally delighted to announce our new partner institute and liaison person from Spain, *Joan Gené Badia*. Based at the University of Barcelona, Joan is an experienced expert on primary care advancements and international developments. With him on board we are somewhat shifting focus from a health economics perspective, so well presented by our former partners from Universidad Pompeu Fabra, to a health services research focus, so active a community these days in Spain.

What should we spend the money on …

So what is number 12 all about? Departing from the primary care and care coordination focus of the previous volume, this current issue focuses more on economic aspects. Quite interestingly, we see this as a re-emerging pattern across the 20 countries that

we observe. While care coordination remains high on the agenda everywhere, countries again turn to funding and efficiency questions. In chapter 1, we examine how health systems are trying to maximize *value for money*, going beyond traditional avenues. In the United Kingdom, for instance, the National Institute for Health and Clinical Excellence no longer just assesses drugs and procedures but now asks how well public health interventions work—and which ones offer value for money.

... and who should pay for what?

However, preceding the value question there is a much simpler question: Where does the money come from in the first place? As rising cost is one of the most consistent pressures on health systems everywhere, cost containment has long been one of the more salient themes in health policy discussions. Chapter 2 therefore looks at debates around *who should pay for what?* How much of total expenditure on health care should originate from general taxation, (social) health insurance, or out-of-pocket? And what should be the share of voluntary or private health insurance? Even in Canada, where this has long been a taboo, some see growing privatization as a way of reducing the costs to the public purse. France, on the other hand, has decided to increase taxes for private health insurers to help fund rising national health expenditure.

Governance in Bismarckian systems

With blurring roles between the private and public sphere and more and more cross-system learnings between classic Bismarckian and Beveridge type healthcare systems taking place, the former continue to suffer from their somewhat inbuilt paradox: Bismarckian systems, while tightly controlled by the state, are based on privately owned and operated funds. The paradox remains, as we will see in chapter 3 on *governance*. For example, in Switzerland, the unresolved question is whether the introduction of more competition will result in a reduction in solidarity if the sick ultimately have to pay a lot more for their premiums than the healthy. And in France, the debate turns the other way: Will decentralized control of purchasing hospital care result in more privatization in provision?

Responding to patients' needs

In Asia, nations as diverse as Japan, South Korea and Singapore are *responding to the needs* of aging populations and the ethical challenges of demographic change. As will be illustrated in chapter 4, a common theme is enabling people to die with dignity

at home or in hospice care, rather than in big hospitals. Countries need to balance how much care is being provided in institutions and how much at home, or in intermediary settings. At the same time, countries have to be cautious: If structures in patients' living environments are not well prepared, sending people home to die might be a simple way to get rid of costly and needy patients (also see our video on www.hpm.org in the download section).

Organizing healthcare services

Last but not least, questions of how to ensure access and equity, and how to guarantee patient safety and quality of care, and how to organize healthcare services do remain high on the policy implementation agenda in the countries we observe. We present the latest measures addressing these questions in chapters 5, 6 and 7.

Reporting period spring to autumn 2008

The sources of information for this book were the expert reports of the International Network for Health Policy & Reform and other materials cited at the end of each chapters. The current volume presents the results of the twelfth half-yearly survey which covers the period from May 2008 to September 2008. From the 82 reports received, we have selected 33 for inclusion in this report.

Our thanks go to all experts from the partner institutions and their external co-authors: Ain Ain Aaviksoo, Gerard Anderson, Toni Ashton, Chantal Cases, Elena Conis, Fiona Cram, Luca Crivelli, Asher Elhayany, Patricia Fernandez-Vandellos, Gisselle Gallego, Joan Gené Badia, Peter P. Groenewegen, Revital Gross, Maria M. Hofmarcher, Jessica Holzer, Soonman Kwon, Margaret MacAdam, Stephanie MacKenzie, Jan Mainz, Ryozo Matsuda, Lim Meng Kin, Julien Mousques, Michel Naidich, Adam Oliver, Zeynep Or, Gerli Paat, Hannele Palosuo Tanaz Petigara, Rade Pribakovic Brinovec, Marita Sihto, Taro Tomizuka, Lauri Vuorenkoski.

We hope you enjoy the read and as always look forward to receiving your feedback and suggestions.

Kerstin Blum, Reinhard Busse, Sophia Schlette

Value for money?

Are we getting value for money in health care? As perplexing as it is important, this monster of a question casts its shadow over almost every debate in health policy, whether we have the temerity to ask it or not. But perhaps an even more frightening question is its lesser-known cousin: How do we know that we are getting value for money in health care? In this opening chapter we look at how some health systems are facing up to these questions and in some cases starting to look for answers.

Leading the way down under

One of the first countries to build this question of cost-effectiveness into the very infrastructure of its healthcare system was Australia. Following changes to the national laws in the early 1990s, all new prescription medicines would be assessed for their benefits, harms and "cost-effectiveness" before they were added to the national list of subsidized drugs, the Pharmaceutical Benefits Scheme (Harris 2008; see also *Health Policy Developments 5*, p. 71). The approach involves independent committees of experts—notably the Pharmaceutical Benefits Advisory Committee—assessing at what price (if any) a new drug might offer value for money, and making a recommendation to the federal health minister to add the drug to the schedule of the Pharmaceutical Benefits Scheme. Initially unhappy with many aspects of the new approach, the pharmaceutical industry has slowly accepted the reality of this method. Moreover, in recent years improvements in transparency have meant that extracts from the cost-effectiveness deliberations are routinely made public.

Calls for value assessments

Now, 15 years later, the importance of analyzing whether a new pill, procedure, or process is cost-effective is widely acknowledged everywhere—at least in theory. In a report on technology assessment and value for money, published by the World Health

Organization on behalf of the European Observatory on Health Systems in 2008, authors wrote that "products that provide the most value for investment must be identified and supported" (Sorenson et al. 2008). The report also recommended more attention giving to transparency in decision-making, and broadening the focus of analysis from technology and treatment to preventive strategies.

Public health: a good punch for the pound?

In the United Kingdom, policy makers have for some time been asking whether new clinical interventions give value for money, but now as we will read in this chapter, there is a fascinating push to examine whether public health strategies are also giving a good bang for the buck—or better: punch for the pound. For almost a decade, the influential National Institute for Health and Clinical Excellence (NICE) in the United Kingdom has been analyzing the cost-effectiveness of clinical interventions—largely but not exclusively looking at pharmaceuticals (see *Health Policy Developments 2*, p. 54). Following criticism that NICE was focused too heavily on clinical interventions, in 2005 its remit was broadened to start examining the effectiveness and cost-effectiveness of public health approaches like programs to increase physical activity in the workplace. Given the large numbers of stakeholders, including non-health players, involved in public health strategies, new systems have been created to analyze whether public health strategies are offering value for money (see report on the United Kingdom, p. 16). The new approach is raising intriguing questions about whether new methods of cost-effectiveness analysis will be needed to assess whether public health strategies offer value for money.

Are personal financial incentives worthwhile?

One such public health strategy in the United Kingdom may well be analyzed to see if it offers value for money: It is the new plan to offer direct personal financial incentives to people to change their behavior in order to prevent illness and improve health (see report on the United Kingdom, p. 20). Proposals at various stages of planning or piloting include incentives for people to exercise more; incentives for pregnant mothers to seek healthy eating advice; and incentives for adherence to certain anti-psychotic medications. The emerging debate around these plans is raising more questions about whether governments should use taxation to pay people to do things many consider they

ought to be doing anyway, and whether such payments will perversely reduce healthy activities already being performed voluntarily.

How about a disincentive?: binge drinking tax

In Australia a different sort of incentive is being introduced: a financial disincentive to drinking alcohol, in the form of a massive increase in taxation on sweet "alcopops" favored by many young people (see report on Australia, p. 23). In early 2008, the then relatively new federal government announced a 70 percent increase in the tax on "ready-to-drink" products, which combine alcohol and non-alcoholic beverages such as soft drinks or milk. The tax increase is part of a new national strategy on binge drinking, and the hopes are that the expected increase in tax revenue will be re-invested into prevention activities. Elements within the spirits and hotels industry are opposed to the plan, and concerns have been raised that the move will not reduce binge drinking because alcopops may be simply be replaced by other drinks. Experience from Germany, which increased taxes for alcopops by around € 1 per bottle as far back as 2004, shows that such replacement partly happens to a small degree. Alcopop consumption declined sharply and certain producers even completely withdrew their products from the market.

Paying physicians for performance

While these examples from Australia and the U.K. show how financial incentives are used to try and influence behavioral patterns in the population, two reports from Estonia and the United States describe current efforts to pay incentives for physicians to improve performance. While both schemes unsurprisingly have had strong support from health professionals, after preliminary evaluations questions remain as to whether such incentives are the best way to spend health resources.

P4P—"success" without much proof

The Estonian Health Insurance Fund is offering family physicians financial incentives to improve the way they prevent disease and monitor chronic illness in their patients, as well as lift their general competence (see report on Estonia, p. 26, and earlier reports on P4P in *Health Policy Developments 6, 9,* and *10*). From the beginning the reform was supported by family physicians, as it was designed in part to enhance the credibility and income of this sector of health professionals. An analysis of data from the Estonian Health Insurance Fund suggests the participation by doctors in the scheme has greatly increased, and more than half

have received bonus payments. However, despite no published data on effects on health outcomes, and no formal published cost-effectiveness evaluation at this time, it appears the scheme is considered a success by the implementing organization, raising the possibility it will be expanded to hospitals. Similarly, financial incentive schemes for physicians in the United States are regarded as popular, despite there being little evidence of positive impact on health outcomes (Petigara 2008). And in the United Kingdom, where doctors are offered similar incentives, serious questions are being raised by some commentators about the value of this approach to trying to improve the quality of care (Heath et al. 2007).

How to assess and control high cost biologics

It's obviously very hard to work out whether we will get value for money from paying people to exercise more, or paying incentives to doctors to perform better. But perhaps more and more pressing is the question of whether we are getting value for money from the resources being invested in expensive new drugs, investments which characterize large and in some cases growing proportions of total health expenditures. So in the United States, for example, will the nation be getting the best use of the roughly one billion dollars a week that it will soon spend on "biologics"? (See report on the United States, p. 29.) Different from conventionally synthesized pharmaceuticals, biologics can cost anywhere from $10,000, to $200,000 per treatment regime, and there are a number of strategies being tested to try and reduce the cost. Given that biologics are part of a different paradigm of therapies, there is now a lively debate about how they should be evaluated and regulated. And the fact that many physicians have actually been making significant profits from dispensing these new therapies raises other questions about the extent to which prescribing behavior—and national expenditure on this class of treatments—is being driven by genuine patient need or naked professional self-interest.

The fearful D-word

The already mentioned recent report on technology assessment calls specifically for post-marketing re-evaluation of new products, to confirm both clinical effectiveness and cost-effectiveness, particularly in the case of novel therapies that have been fast-tracked to market in the first place (Sorenson et al. 2008). Furthermore, the report raises the fearful D-word, arguing that

much more attention should be paid to disinvestment, to remove ineffective or obsolete practices in order to make way for investment in newer approaches. However, making decisions about which old drugs or procedures to abandon because they are no longer cost-effective would require even more than the considerable skill and courage required to assess new ones for their value for money.

Sources and further reading:

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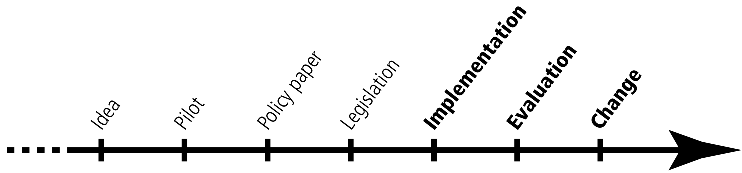
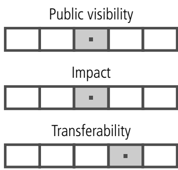
United Kingdom: Value for money from public health care





While it is generally agreed that in principle public health care can have a big impact on the health of a population, there are questions about whether particular public health strategies may have little or no impact. Against this backdrop of uncertainty, the National Institute for Health and Clinical Excellence (NICE) has recently started to assess public health strategies for both effectiveness and value for money (see *Health Policy Developments 7/8*, p. 54). The task is a daunting one, and new committees and methods of assessments have been created, involving multiple stakeholders inside and outside the health arena. The ultimate aim is to improve the effectiveness and cost-effectiveness of public health interventions and programs.

Embracing public health care, too

The decision to move in this direction was motivated by criticism from individuals and groups—including public health specialists—that NICE was too narrowly focused on assessing clinical interventions. Responding to this criticism, in 2005, NICE broadened its remit, and it has started to assess whether public health strategies offer value for money. These strategies are divided into public health interventions and the more broad and complex public health programs. New processes of evaluation are being designed for both types of strategy. The plan is to produce evidence-based "guidances" which are to be re-evaluated every three years or sooner if important evidence comes to light.

Evaluating public health interventions ...

Public health interventions are clearly defined local actions that aim to reduce the chance of occurrence of particular illnesses, or which promote a healthier lifestyle. Examples include providing needle exchange schemes for drug addicts and encouraging breast feeding in new mothers. NICE has formed a committee—the Public Health Interventions Advisory Committee—to consider and interpret the effectiveness and cost-effectiveness evidence of those public health interventions that are selected for

assessment. This new committee has a multidisciplinary membership of 26 healthcare professionals, practitioners, technical experts, and representatives from the general public and community groups. It ultimately produces recommendations on whether an intervention represents good value for money and hence whether it ought to be provided in the National Health Service. It also identifies gaps in the evidence base and makes recommendations for research. The guidance is published on the NICE website, and the process from initial consideration to publication of the guidance is meant to take 12 months.

… and public health programs

Public health programs are broader in scope and are defined as multi-agency packages of policies and services. For these, assessment can be a highly complex and difficult process, because many sectors of public service are potentially involved (education, environment, etc.) that do not see an improvement in health outcomes as their primary concern. Examples of public health programs include services to help support physical activity targets—ranging from traffic calming measures to fun runs—and smoking cessation advice from doctors, pharmacies, local authorities and employers. As for interventions, NICE has formed a new multidisciplinary group—which varies its membership depending on the program under consideration—to develop guidance based on its consideration of the effectiveness and cost-effectiveness of public health programs. This Program Development Group comprises up to 16 members, including professionals, community members and technical experts, and takes 18 months to develop its guidance on any particular program.

Recommendations for different audiences and settings

The public health strategies to be assessed can include anything from interventions targeting individuals to programs targeting the broader social determinants of health. The recommendations can thus affect a whole range of health determining factors, from traditional health promotion activities around individual behavior to environmental and structural determinants of health. This means that in practice the recommendations can target many different levels within the society, including the individual, the family, the community, and the organization—such as employers.

Clearly these new processes of assessing value for money in public health care, and making recommendations targeting such

Many stakeholders and much consultation

a wide range of players, are demanding new levels of stakeholder engagement—in line with broader trends to engage more stakeholders—in the health technology assessment processes (Sorenson et al. 2008). According to NICE, stakeholders in public health are an extraordinarily wide array of players, including the national public; community and care organizations; health professionals and interested researchers; providers, purchasers, local government and the voluntary sector; and various departments including health, home office and education. The new plan allows for stakeholders to comment on the scope of proposed guidances, the review of the evidence about effectiveness and cost-effectiveness, and the draft recommendations before final recommendations are made.

New methods of cost-effectiveness analysis?

The method currently used for analyzing the cost-effectiveness of clinical interventions involves the standard Quality-Adjusted Life Year, or QALY method. While this is currently the dominant form of analysis, it is possible that it could change over time because the methods for assessing public health strategies are under review. Several factors make this assessment more complex than assessing clinical procedures and interventions, not least because public health approaches impact on and are impacted by many areas within the public and private sector—beyond the reach of the traditional health service. A recent article highlighted the challenges of this new kind of assessment and called for a reduction in the "disconnect" between health economists and public health practitioners (Neumann et al. 2008). There is even discussion about whether "health" and "maximization of health" are appropriate outcomes for public health policies. And with non-health players now involved, other questions are arising about just how much jurisdiction health agencies like NICE will have anyway.

Toothless tiger? The challenge of implementation

An extensive global survey of organizations involved in the bridge between research and action found that implementation was often the poor cousin in the translation of research into recommendations and action on the ground (Moynihan et al. 2008). Even the best evidence-based guidance that has been informed by systematic reviews, commented on by stakeholders and produced transparently can come to nothing if its recommendations are not implemented. This of course is the motivation for the global