20 YEARS OF **HEALTH SYSTEM REFORMS IN EUROPE:** WHAT'S NEW?

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Summary: Reforming health systems is crucial to keeping them fit for purpose and able to meet the needs of the populations they serve. While reforms 20 years ago were focused mostly on improving efficiency, in many countries they are now concentrated on improving quality, strengthening primary care services and promoting integrated care. Several examples are used to illustrate the shift in focus, including in the areas of payment mechanisms, primary care and hospitals. Looking forward, European countries still have the same goals i.e. to ensure the sustainability, efficiency and quality of their health systems. But they face rising challenges, which include overcoming system fragmentation, addressing multimorbidity and effectively using an ever-growing supply of data.

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How has the focus of health system reform changed?

For the last 20 years, the European Observatory on Health Systems and Policies has been providing evidence to support national and international policy making processes by monitoring and analysing health systems across Europe. Several tools have been used for this purpose, including the Health in Transition (HiT) series, analytical studies and policy briefs and, more recently, the Health Systems and Policy Monitor online platform (HSPM)* and the Country Health Profiles (the latter jointly with the OECD).

Owing to the Observatory's varied work across Europe, some observations can be drawn. Overall, there has been a growing recognition of the benefits of adopting a *health system* perspective when tackling reforms. That is, since reforms in one area have implications for other parts of the health system as a whole, policymakers are increasingly aware of the need to formulate plans that go beyond singular policy changes. Furthermore, across Europe there has been a clear shift in the focus of reforms: some changes are in step with national political developments or changing environments (e.g. the financial crisis), while others reflect changing priorities, such as considerations in health care financing or the need to ensure equity

* These resources are freely available from: www.healthobservatory.eu

in tandem with efficiency objectives. This renewed focus on equity can also be linked to international organisations, such as the World Health Organization (WHO), that have long championed the goals of achieving universal health coverage (UHC) and addressing the socio-economic determinants of ill health (**Box 1**; see also the article by Winkelmann et al. in this issue).

Another factor shaping the agenda of health reforms in European Union (EU) countries is the need for Member States to comply with EU legislation. Member States have undertaken reforms in areas such as setting limits on the working hours of doctors and ensuring that the reimbursement of health services are in line with the directive on cross-border care[1] (see also the article by Palm and Wismar, in this issue). In addition, since the onset of the economic crisis some countries, such as Cyprus, Greece, Latvia and Portugal, have pursued quite substantial reforms as part of the conditions specified within Economic Adjustment Programmes tied to financial assistance from international lenders. Such conditions may focus on containing costs and introducing greater efficiencies.[2] In non-EU countries and particularly Former Soviet Union (FSU) countries, transnational actors, including WHO and the World Bank, or bilateral actors such as USAID, play a major role through assisting countries to devise reform plans and by lending or providing aid.

Moving from improving efficiency to tackling new challenges

Broadly speaking, policies in the late 1990s were focused on improving efficiency, often strengthening competition or using market liberalisation as a tool to increase the effective use of resources. Policymakers faced pressures to achieve better control over expenditure and/or greater productivity and efficiency, while still maintaining universal access to care and improving the distribution of services.[3] Changes to payment mechanisms, such as the development of Diagnosis-Related-Group (DRG-) based payment systems, and the increased adoption of Health Technology Assessment to aid decision-making in reimbursement decisions for pharmaceuticals and other technologies were part of these efforts to improve cost-containment and achieve greater value for money.

Since then, the rising burden of chronic illness, and in particular the rapid increase in the number of people with multiple health problems (multimorbidity), along with the ageing of the population have emerged as tangible health system challenges that need attention. In response, there has been a growing acknowledgement of the importance of prevention and health promotion, having a strong primary care system with integrated services, and improving the quality of services.[4] Moreover, rising multimorbidity will necessitate a shift from disease focused health systems to patient-centred health systems, but European countries are generally still at the beginning of this transformation. Being able to monitor health systems' performance so that they meet their stipulated goals and priorities has also emerged as an important objective, although much work still needs to be done in designing feasible and appropriate performance metrics (see the article by Smith et al. in this issue).

Health reform trends over time

In this section we provide a broad description of some health reform trends that illustrate the shift in focus.

Payment mechanisms

Over the past 20 years, almost all countries have reformed (and re-reformed) their payment systems for primary care, specialist ambulatory care, and hospital care. In line with overall trends, the main objective in earlier years was to increase efficiency in service provision. Often existing payment mechanisms (e.g. capitation payments) were combined with other elements (e.g. fee-for-service payments) in order to overcome the negative incentives related to more simple forms of provider payment. These reforms have resulted in different – but increasingly quite similar – forms of blended payments systems across countries. In ambulatory care, most countries in Europe now pay for general practitioner services on the basis of a combination of capitation and fee-for-service. In hospital care, most European countries have refined their payment systems by introducing a variant of DRGs, which is used to determine at least part of the hospital budget. This means that payment depends on the diagnoses of patients treated and on the procedures performed. Nevertheless, global budgets continue to play an important role, for example, as a base payment independent from DRGs or as a limit to the total amount that hospitals can receive on the basis of DRG-based case payments. Furthermore, with the increasing availability of information on quality of care, the focus of payment reform has shifted towards the use of this information in "pay for quality" (P4Q) or "pay for performance" (P4P) initiatives. However, the size of incentives related to quality of care remains limited (e.g. usually 5–15% for primary care, and less than 5% for hospital care).[6] Too often, countries brand their payment scheme P4P, although in fact it is still focused on production and efficiency increases

Box 1: Universal Health Coverage

Achieving *UHC* means that everyone is covered, the type and number of services are appropriate to reflect the population's needs, and people are protected from financial risk through adequate public funding (protecting against high co-payments and other private out-of-pocket spending). Strong political momentum for UHC is endorsed by the 2015 decision of the United Nations General Assembly to adopt health as one of its 17 sustainable development goals (SDGs) and UHC is health target SDG 3.8.[5] In celebrating its 70th anniversary, WHO has spearheaded several initiatives to achieve UHC including "Health for All" and the "UHC 2030 International Health Partnership". The latter is a joint initiative by national governments, international organisations and civil society determined to achieve UHC by 2030.

instead of quality metrics. Furthermore, given the rather inconclusive evidence about the effectiveness of P4Q[7] and continuing debates about the reliability of quality information, it remains to be seen whether the growth of P4Q initiatives will continue.

> rising multimorbidity will necessitate a shift from disease focused to patient-centred health systems

Primary care

While the gatekeeping role of primary care providers is often cited as the main characteristic of a strong primary care system, additional conditions also contribute to the strength of primary care such as the lack of barriers to access, closeness of primary care services to communities, a patient-centred approach, and continuity of care.[8] Over the last decade, the delivery of primary care has moved increasingly from a system of solo gatekeepers to multidisciplinary health centres. There has also been greater emphasis all over Europe on managing chronic care conditions within the primary care setting, For example, multidisciplinary primary care units are the core element of primary care both in Spain and Portugal, providing better integrated primary care for local populations. Recent reforms in Estonia are aiming to achieve this as well.

Primary care also has a substantial role in managing chronic conditions. In fact, a higher use of health services and related costs due to the increase in multimorbidity are among the key concerns currently faced by policymakers in Europe.[4] Most of these health care systems have been designed to 'treat' acute episodes, rather than 'manage' chronic conditions. They are, therefore, not efficiently organised to respond to the changing needs and preferences of users, in particular, those with multiple chronic conditions. In response, countries have been looking at ways to strengthen the coordination between primary care, secondary care and other-level services for the chronically ill. Among several country examples that include Germany and the United Kingdom, we can add Denmark, which in recent years has launched a national strategy on chronic disease management and developed a generic model for chronic disease management programmes together with the regions and municipalities.

Hospitals

Historically, hospital care has been at the very centre of health service delivery. However hospitals have been faced with many challenges which have changed enormously in recent decades. The factors involved are extremely complex and interlinked but broadly include changes in technology (diagnostics and treatments), changes in patients (who are older, frailer and often more socially isolated), changes in staffing (a move towards specialists and multidisciplinary teams), and changes in the models of care (involving networks and integrated pathways).[9] Furthermore, hospitals continue to have a concentration of medical and diagnostic expertise, while at the same time striving to provide integrated care for chronic patients, involving transfer to care in the community and the home as well as managing patient expectations. These profound sets of changes have led to many reforms.

Over the past 20 years, hospital reforms in many European countries have focused on reducing the overall number of hospital beds and concentrating highly specialised care. Furthermore, the emergence of patient safety on the policy agenda, which overlaps to some extent with the concept of quality of care, reflects the need for hospitals to put in place appropriate procedures and new organisational structures. The move in hospital funding towards DRG-based payment systems incentivises hospitals to increase efficiency with the consequence of reducing length of stay. The latter presupposes that patients have somewhere safe and supportive to go to, which requires continuity with other parts of the health and care system.

Long-term care

Over the last 20 years, countries have increasingly developed the public provision of long-term care (LTC) (due to the ageing population, co-morbidities among older people, and the need to provide assistance with daily activities), although the pace of changes has been largely determined by budget constraints. There is a high level of heterogeneity across Europe in the size, organisation and financing of such services, with countries placing different emphasis on the resources dedicated to providing institutional care in nursing homes, formal care within the home and community settings, or providing cash benefits to eligible recipients to purchase the care that they need. An example of a country with a very comprehensive LTC system is the Netherlands, but concerns about its sustainability led to recent reforms which have sought to control spending by keeping people in their homes longer and giving municipalities a stronger role in the coordination of non-residential care. One thing that has not drastically changed over this period is the strong reliance on informal care by family members and other carers, who continue to provide the bulk of care for older people.[10]

Quality of care

Most health reforms in Europe over the last two decades have claimed to aim at improving the quality of care, but they have often been vague about what that actually means. There is an emerging consensus that quality of care is the degree to which health services for individuals and populations are effective, safe, and people-centred.[11] Efforts to improve quality of care around the turn of the century were still mostly focused on assuring the quality of health system inputs or structures, e.g. by defining standards for buildings, professional training, continuous education and technologies. Since then, efforts have shifted to improving health care processes and outcomes and this remnains an open agenda given the difficulty in measuring

Box 2: Strategies for reform: Kyrgyzstan and the Republic of Moldova

The Moldovan National Health Policy (2007–2021) provides a systemic approach to improving the health of the population and outlines the overall priorities for the health system. The importance of cross-party support for health strategies came to the fore during extended periods of political uncertainly in the country such as from April 2009 to March 2012 when political stalemate meant there was no functioning government. This shared political support meant that necessary reforms could still progress.

The first Kyrgyz health programme (*Manas,* 1996–2006) laid the foundations for the rebuilding of the health system following independence from the USSR and extreme economic hardship. The achievements of the first strategy in laying the foundations for a sustainable and equitable health system were consolidated in the second programme (*Manas Taalimi,* 2006–2010). Notably, these plans have had the support of the medical community as well as politicians and donors.

Along with broad stakeholder support, both strategies took a longer-term perspective – beyond a single political cycle – acknowledging that bold reforms to the way health services are financed, organised and provided take time to implement. Both strategies also emphasise how implementation should be monitored and evaluated to ensure they deliver on agreed priorities.

Sources: [12] [13]

health outcomes and of attributing change to a particular intervention or provider. In addition, countries have been increasingly interested in collecting patient-reported experience measures (PREMs) as well as patient reported outcome measures (PROMs), as a means to improve health system quality. Nevertheless, as a result of the increasing availability of information– due to the expansion of information and communication technology (ICT) in health systems and health care organisations– there is a continuously growing potential for using this information in order to measure and improve health care processes and outcomes.

What does it take to successfully reform a health system?

There are several factors that can facilitate or limit the successful reform of a health system which can be captured under two main categories: capacity constraints and political will.

Capacity constraints: As mentioned above, sometimes the spur for health system reform has been some form of external economic shock and policies seek to contain health care spending. However, insufficient resources can limit a system's capacity to reform in times of fiscal constraint. Firstly, lacking policy and managerial capacity to effectively run a reform will blunt implementation efforts. This factor is often overlooked but any reform initiatives should start with an assessment of available policy capacity. Secondly, successful reforms also need to use existing capacity efficiently and if necessary to build capacity in the health system, particularly in the health workforce. If health services need to be provided in a different way, then health workers need the necessary training to implement the required changes. Similarly, health financing reforms are underpinned by capacity building in health care management at the provider level. The successful introduction of active purchasing mechanisms, for example, also relies on good data, so it is necessary to strengthen IT capacity in parallel.

Political will, vision and leadership: The importance of a clear vision and political will to strengthen the health system should not be underestimated.[14] A 'roadmap' with cross-party support and buy-in from a wide range of stakeholders (including health workers) can be a powerful tool for ensuring that deep, systemic reform stays on track (**see Box 2**). Without such consensus, there is a risk that a cycle develops with each new government reforming the health system by unpicking the work of those previously in power along ideological lines. Such a treadmill of reform, where changes are announced but with insufficient consensus, can impede successful implementation. Concrete plans for reforms can be hindered by a lack of stakeholder commitment, un-coordinated actions and/or badly designed incentives. Thus, strong leadership and operational planning are needed to keep reforms on track. Subsequently, evaluation of reforms is crucial to building a knowledge base and maintaining support.[15] Evaluations also allow policymakers to learn from reforms that did not work well or had unintended consequences and to address shortcomings with remedial action.

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Where might reforms be going next?

The emerging patterns of health system reforms point to common challenges facing policymakers across Europe, as well as common difficulties in the implementation of reforms. Looking forward, these challenges include ensuring the sustainability, efficiency and quality of their health systems.

The trends suggest that there will be a continued focus on reforms that aim to guide patients more fluidly through the health system, including enabling primary care systems to manage patients with long term chronic conditions and to better co-ordinate or integrate health services for everyone. This implies that countries need to shift their health systems away from a disease-focused provision of health care

to a patient-centered approach that looks at the patient's (multiple) needs and his or her environment (ie. taking a holistic view) and away from fragmented delivery in several subsystems with separate funding sources (e.g. social care, acute care). Although it is early days, many countries are piloting and exploring population-based integrated care programmes which have the potential to combine the benefits of a patient-centred approach with payment reform, and by doing so, facilitate better cooperation and integration. An ever-growing ambition is to harness the potential of information systems and patient data as enablers of this patient-centred vision and to facilitate the sharing of decision-making between patients, caregivers and doctors. Coupled with more emphasis on prevention and addressing the social-economic determinants of health, policies and new technologies will also aim to identify and target potential health problems further upstream by fostering healthier populations to begin with.

Such developments would reinforce other health system strengthening initiatives that bolster sustainability, such as creating a health workforce that is resilient to future challenges and investing strategically to provide access to health services that are proven, safe and cost-effective. Reforms are also likely to look to innovation to potentially maximise gains and capitalise on experiences elsewhere. This could involve examples of leap-frogging [16] over inferior or less efficient technologies or adopting more innovative delivery structures to accelerate improvements in disease management or health outcomes.

All of this is in keeping with the enduring challenges that have underpinned health system reform trends over the last few decades: to design and implement changes that the health system can afford while at the same time delivering high quality care to the people who need to use its services.

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Reform directions – changing contexts and enduring challenges

Two seminal studies marked the launch of the Observatory in 1998. They basically laid out the groundwork for developing a systematic approach to describing and assessing the development and reform of health systems in Europe.

Both publications – ***European health care reform. Analysis of current strategies*** (1997) and ***Critical challenges for health care reform in Europe*** (1998) were the result of the preparatory work for the 1996 WHO Conference in European Health Care Reforms, held in Ljubljana and helped to shape the recommendations made in the Ljubljana Charter, which was approved by the Member States.

We asked one of the editors and co-founders of the Observatory, **Richard Saltman, Professor of Health Policy and Management at the Rollins School of Public Health, Emory University, USA**, whether the context of health system reforms has fundamentally changed over these last twenty years and if the challenges described back then have been met.

Professor Saltman: *Well, from a clinical perspective, many practical dimensions of day-to-day medical care have indeed changed as the international standard of clinical care has evolved, although the rate and degree of change varies across systems. Patient-wise, there has been substantial improvement in patient choice across tax-funded health systems, and, equally as important, a strong shift across Europe in favour of patient control over their clinical care.*

There have been efforts to strengthen primary care, for example in Denmark (extra payment to manage certain chronic elderly patients) and in Sweden (shifting 50% of primary care physicians and visits to a private sector GP model). In Central Europe and Former Soviet Republics primary care has established deeper, mostly private sector, roots. Managing chronically ill elderly has become a central focus, along with finding better ways to collaborate with social sector actors.

Clearly, IT has altered patient pathways for some chronic conditions, although it can sometimes also become a barrier to effective primary care as GPs spend visit time reporting on the keyboard rather than examining the patient. While there has been considerable clinical innovation, there remains much to do, particularly in tax-funded health systems. The rapid developments in genome-based personal medicine will test existing European health systems going forward.

Structurally, a substantial number of country health systems have undergone major organisational reforms, re-arranging formal reporting, managerial and governance relationships. Governance has been both decentralised to institutional level (various types of self-governing hospitals) while centralised more in national political bodies (e.g. Norway, Denmark, Ireland, Netherlands, Germany, also Czech) especially for financing issues. Management has become stronger at hospital level, supported by IT and, at the executive level, often by boards of trustees.

On the financial level, securing sufficient funding still remains the biggest challenge, especially in tax-funded health systems. Since the economic recovery in Europe following the financial crisis has been weak for nearly a decade, even with recent improvement, a next recession may be difficult for nearly all publicly financed health systems.

Lastly, politically, and perhaps underscoring many of these other points, the policy tension between public and private never goes away in European health policy.