The Irish Health System in an International Context

Improving Performance - A framework for decision making

Dublin, 12th October 2016

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European Observatory on Health Systems and Policies
a partnership hosted by WHO

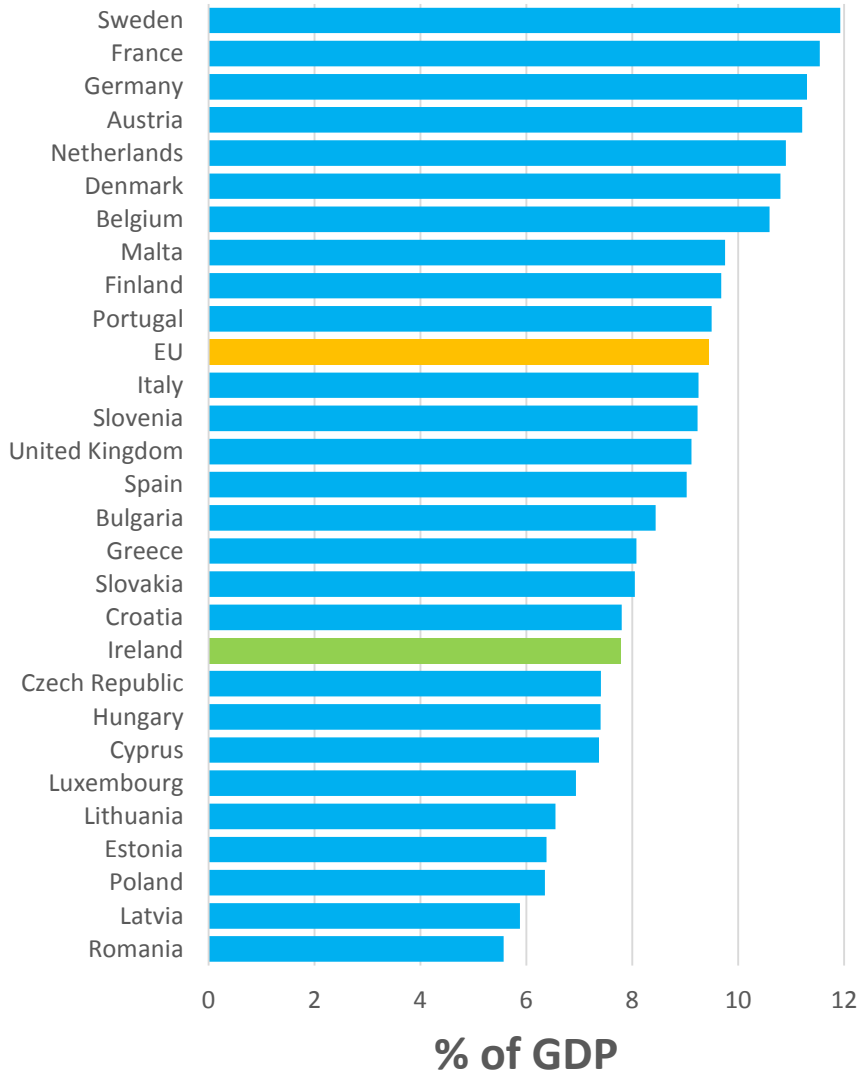
Responding to the crisis…
A growing body of evidence

www.healthobservatory.eu

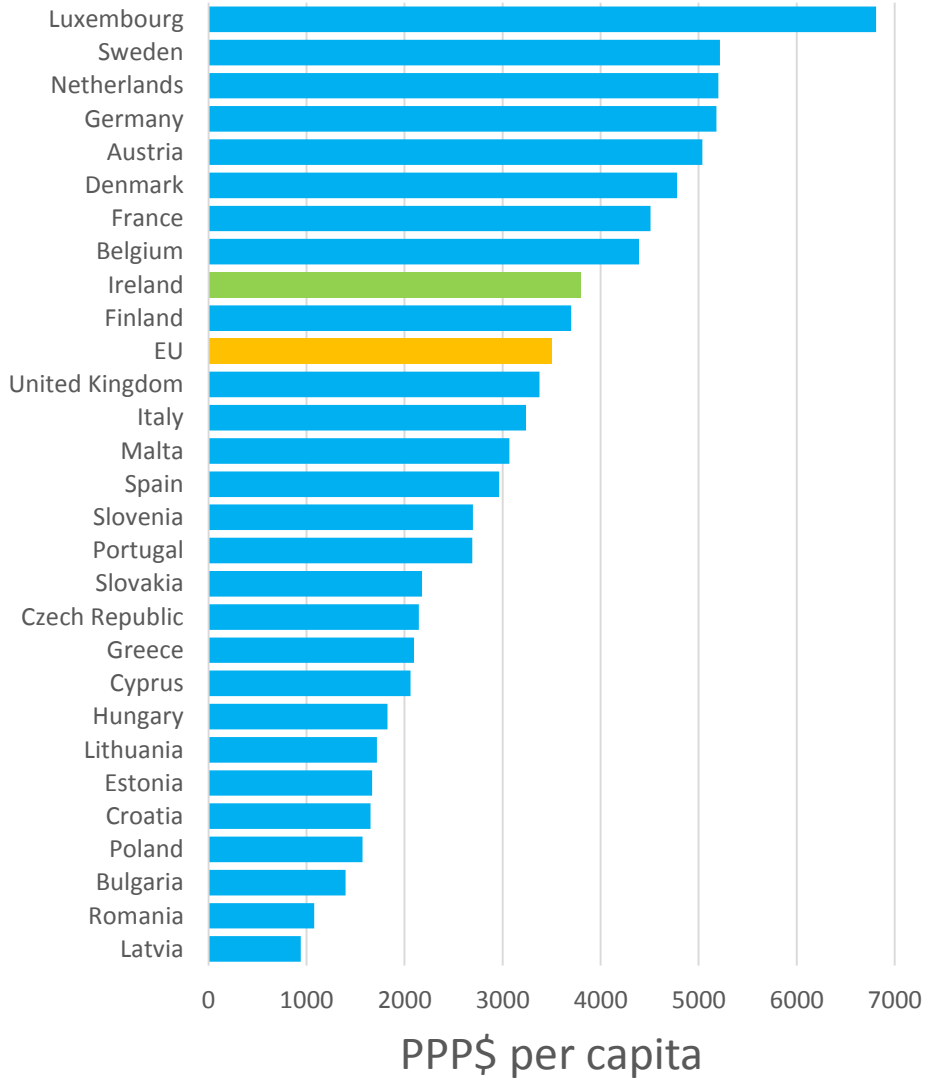
Do we get value for money?

Expenditure vs Health Outcomes

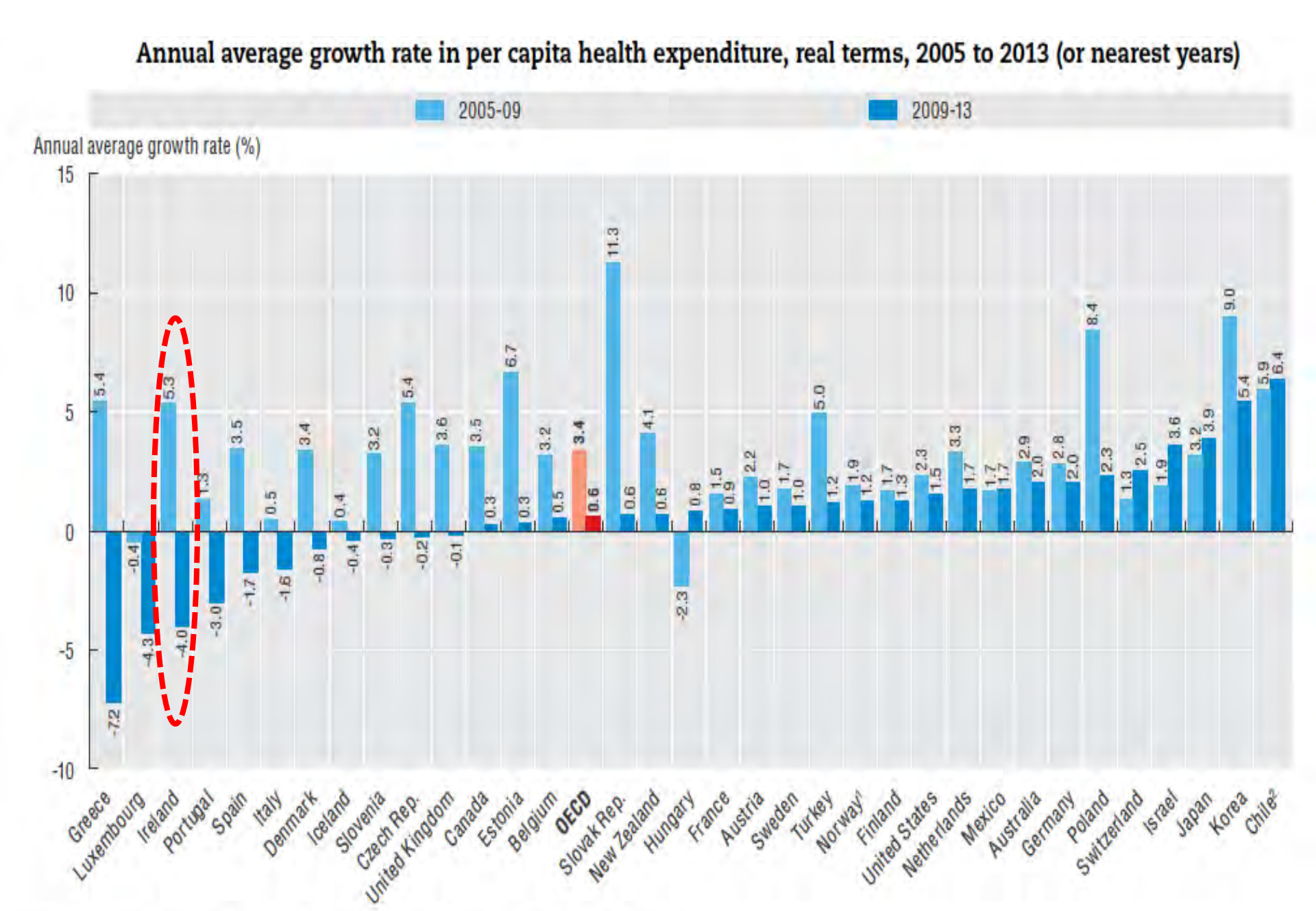
Total health expenditure as % of GDP, WHO estimates, 2014



Total health expenditure, PPP$ per capita, WHO estimates, 2014



Source: WHO Health for all database, 2016

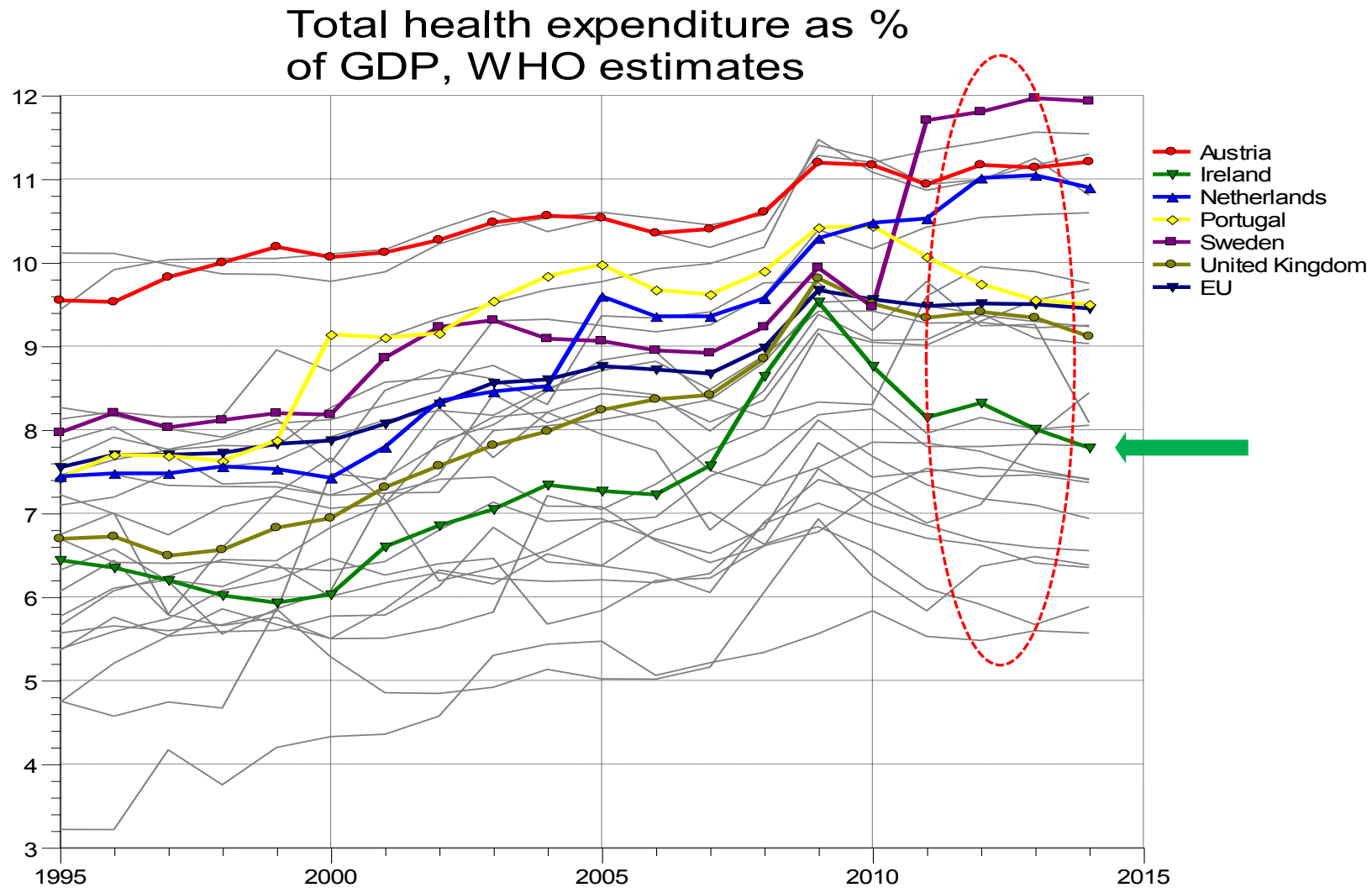


1. Mainland Norway GDP price index used as deflator. 2. CPI used as deflator

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en

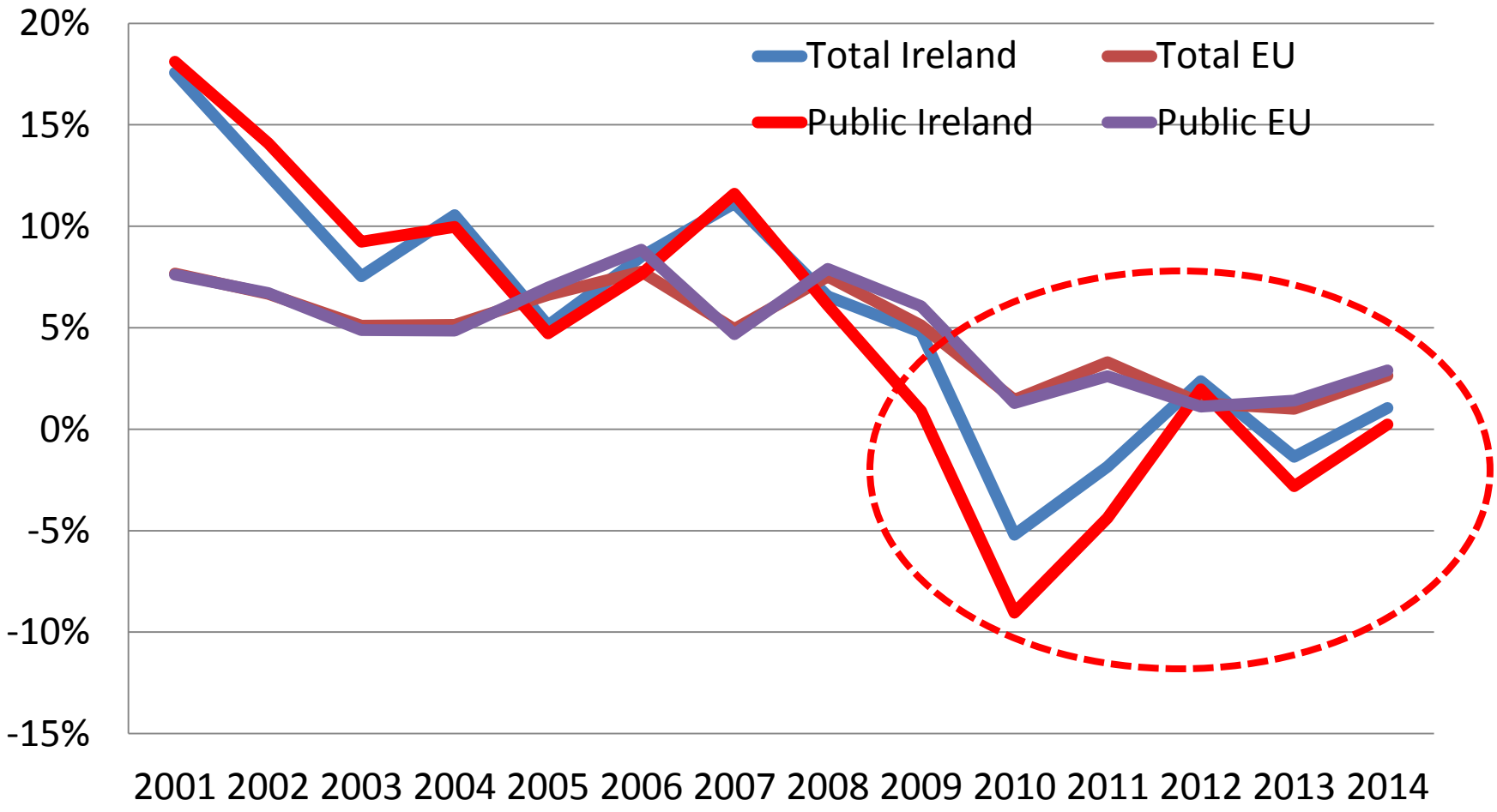
Source: OECD, Health at a glance 2014, G Lafortune

An ever increasing curve ..?

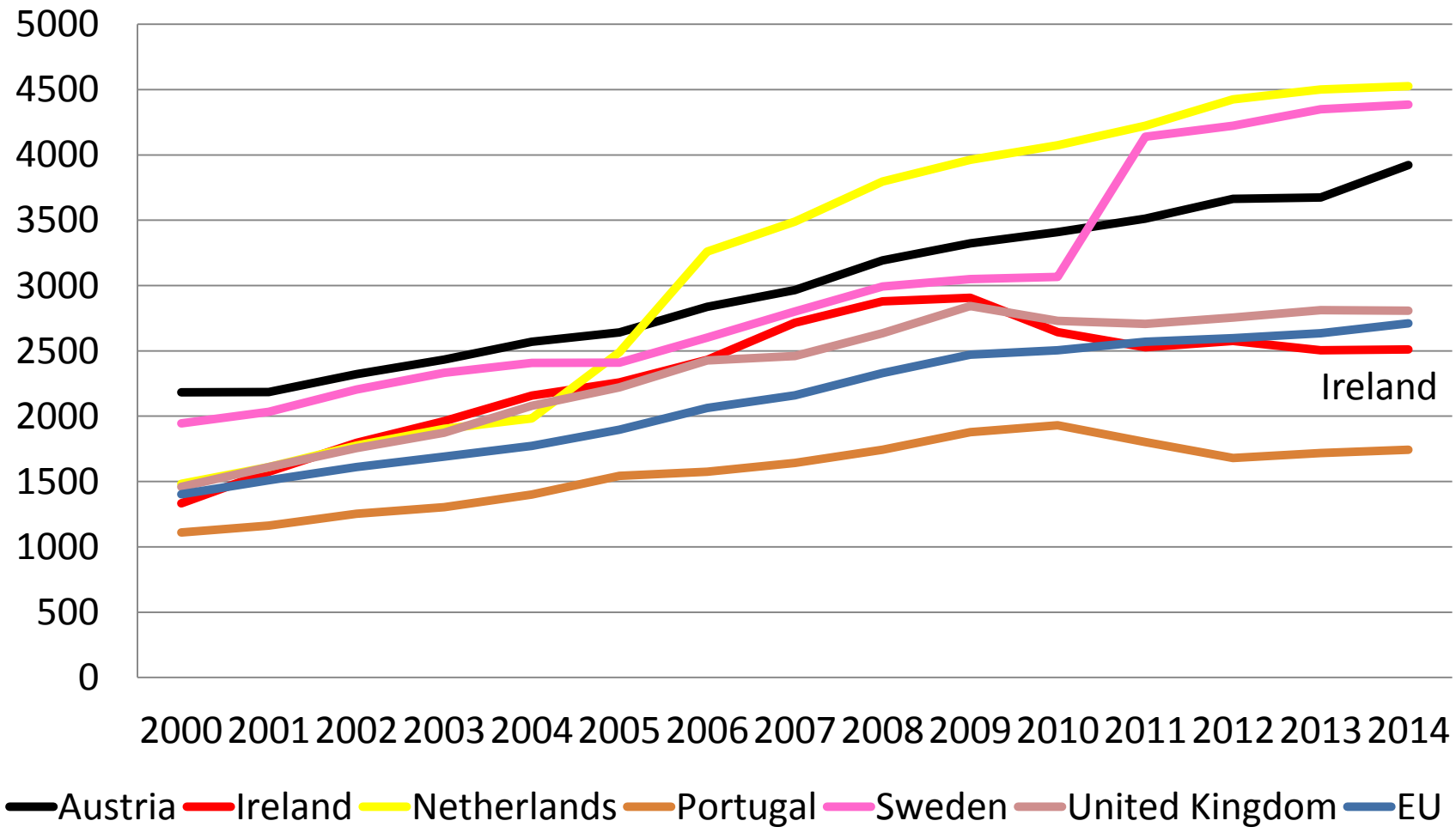


Source: WHO Health for all database, 2016

Health expenditure (PPP$ per capita) growth, 2001-2014

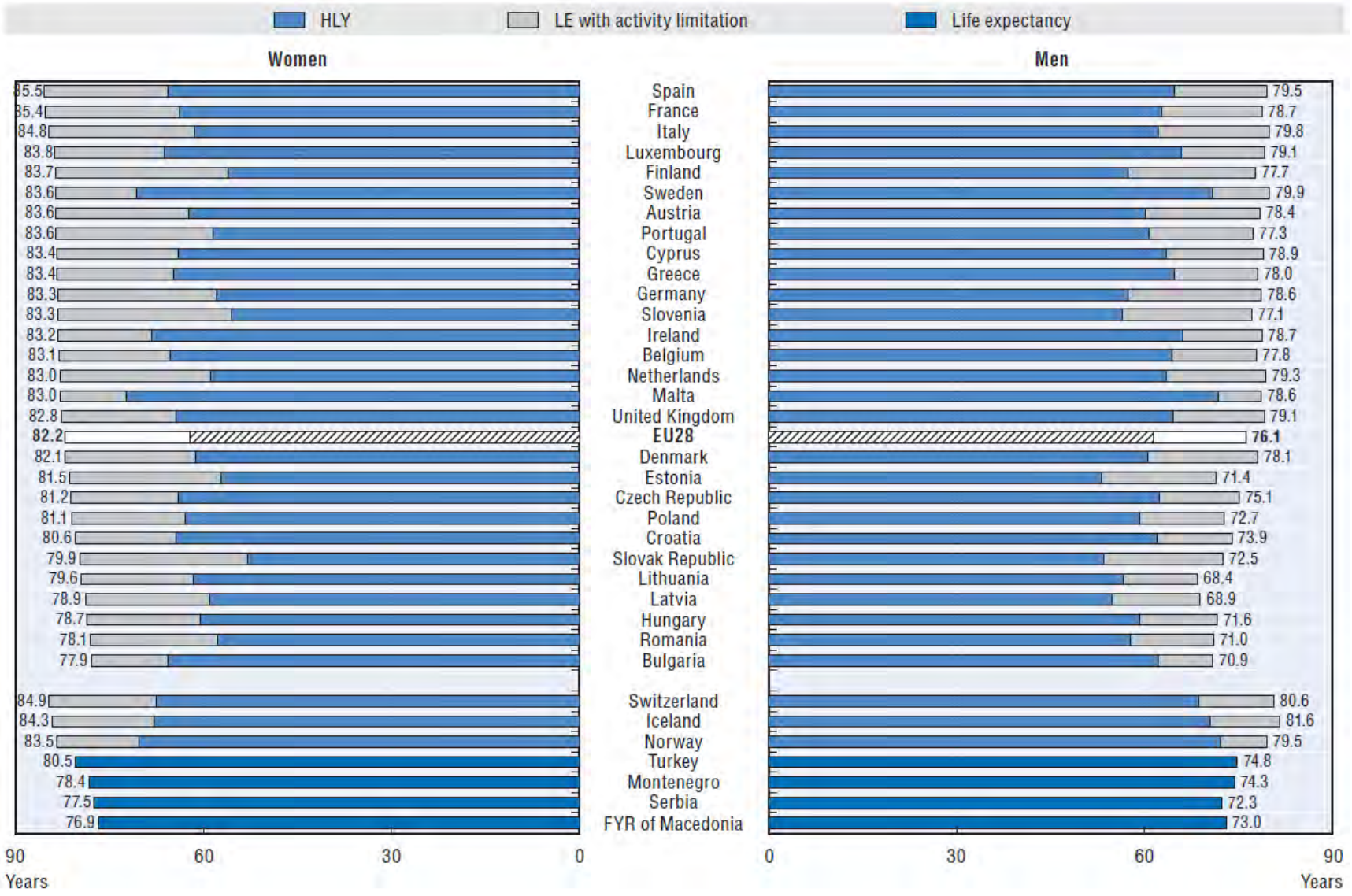


Source: WHO Health for all database, 2016


Public expenditure on health, PPP$ per capita, WHO estimates
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014
Ireland
Austria
Ireland
Netherlands
Portugal
Sweden
United Kingdom
EU

Women live six years longer than men on average across EU countries, but the gender gap is one year only for healthy life years

2012 (or nearest year)



Source: ***Eurostat Statistics Database***

Source: OECD, Health at a glance 2014, G Lafortune

How does Ireland compare?

Source: OECD Health at Glance, 2014

	Ireland				OECD average		Rank among OECD countries*
	2012		2000		2012	2000	
Health status							
Life expectancy at birth (years)	81.0		76.6		80.2	77.1	16 out of 34
Life expectancy at birth, men (years)	78.7		74.0		77.5	74.0	15 out of 34
Life expectancy at birth, women (years)	83.2		79.2		82.8	80.2	20 out of 34
Life expectancy at 65, men (years)	18.0		14.6		17.7	15.6	18 out of 34
Life expectancy at 65, women (years)	21.1		18.0		20.9	19.1	17 out of 34
Mortality from cardiovascular diseases (age-standardised rates per 100 000 pop.)	272.0	(2010)	475.2		296.4	428.5	15 out of 34
Mortality from cancer (age-standardised rates per 100 000 pop.)	227.3	(2010)	269.4		213.1	242.5	10 out of 34
Risk factors to health (behavioural)							
Tobacco consumption among adults (% daily smokers)	29.0	(2007)	33.0	(1998)	20.7	26.0	3 out of 34
Alcohol consumption among adults (liters per capita)	11.6		14.2		9.0	9.5	4 out of 34
Obesity rates among adults, self-reported (%)	15.0	(2007)	11.0	(1998)	15.4	11.9	17 out of 29
Obesity rates among adults, measured (%)	23.0	(2007)	..		22.7	18.7	9 out of 16
Health expenditure							
Health expenditure as a % GDP	8.9		6.2		9.3	7.7	23 out of 34
Health expenditure per capita (US$ PPP)	3890		1787		3484	1888	14 out of 34
Pharmaceutical expenditure per capita (US$ PPP)	666		248		498	300	6 out of 33
Pharmaceutical expenditure (% health expenditure)	17.8		15.1		15.9	17.9	12 out of 33
Public expenditure on health (% health expenditure)	67.6		74.1		72.3	71.4	25 out of 34
Out-of-pocket payments for health care (% health expenditure)	16.9		15.7		19.0	20.5	18 out of 34
Health care resources							
Number of doctors (per 1000 population)	2.7		..		3.2	2.7	24 out of 34
Number of nurses (per 1000 population)	12.6		12.3	(2004)	8.8	7.5	5 out of 34
Hospital beds (per 1000 population)	2.8		..		4.8	5.6	27 out of 34

* Note: Countries are ranked in descending order of values.

Top third performers
Middle third performers
Bottom third performers

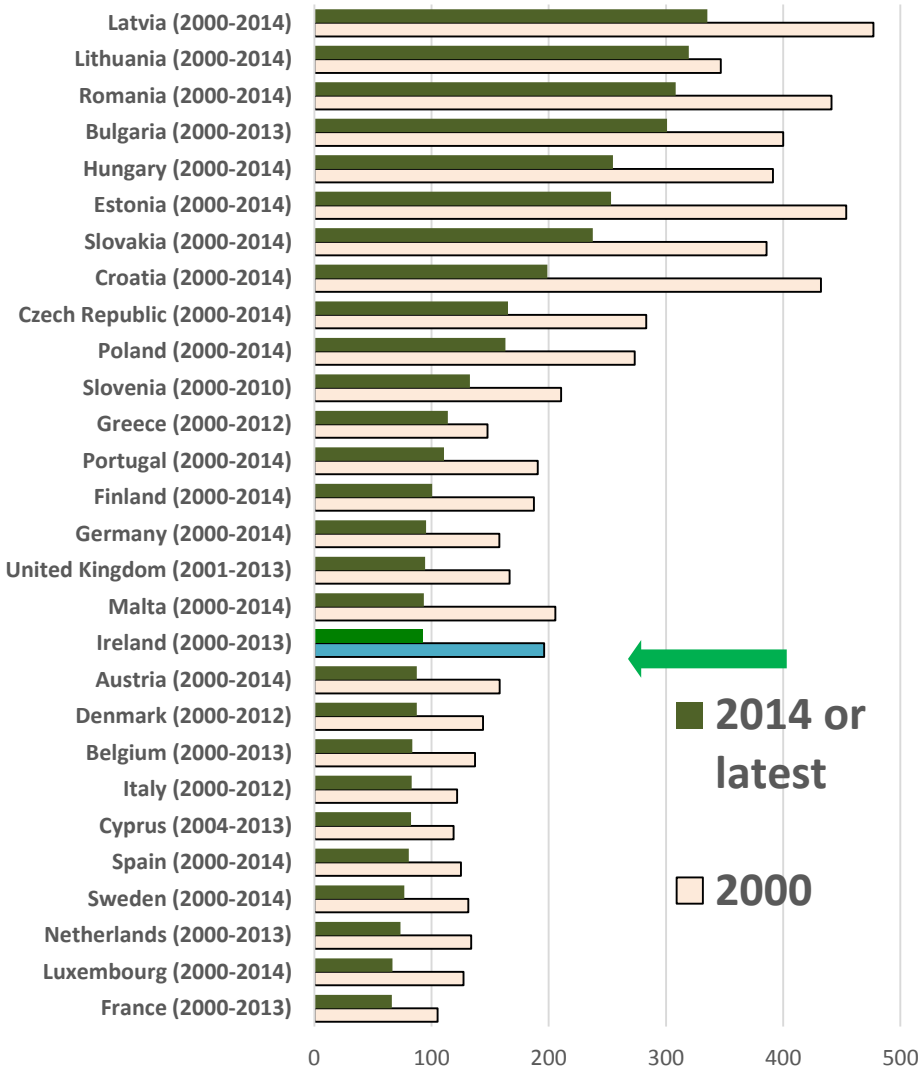
Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. For the mortality indicator, the top performers are countries with the lowest rates.

Indicator	Life expectancy at birth - Men	Life expectancy at birth - Women	Life expectancy at 65 - Men*	Life expectancy at 65 - Women*	Mortality from cardiovascular diseases**
Australia	8	7	3	7	7
Austria	18	13	16	13	26
Belgium	22	19	23	14	15
Canada	13	17	10	10	5
Chile	27	27	27	28	16
Czech Rep.	28	28	29	30	31
Denmark	21	25	25	26	10
Estonia	32	26	31	27	32
Finland	23	8	20	9	24
France	15	3	2	2	2
Germany	18	19	16	22	25
Greece	17	9	13	11	27
Hungary	33	33	34	34	33
Iceland	2	16	10	20	23
Ireland	15	23	19	24	21
Israel	3	11	3	17	3
Italy	3	4	8	4	17
Japan	5	1	6	1	1
Korea	20	5	20	5	4
Luxembourg	9	11	6	8	12
Mexico	34	34	28	32	22
Netherlands	11	19	16	20	8
New Zealand	11	19	8	17	18
Norway	9	13	15	14	11
Poland	30	29	30	28	30
Portugal	24	9	23	11	14
Slovak Rep.	31	31	33	31	34
Slovenia	25	17	26	14	26
Spain	5	2	3	3	6
Sweden	5	13	10	17	19
Switzerland	1	6	1	5	13
Turkey	29	32	32	33	29
United Kingdom	14	24	14	23	9
United States	26	29	22	25	20

* Life expectancy at 65 is not presented in chapter 3 on health status, but rather in chapter 11 on ageing and long-term care.

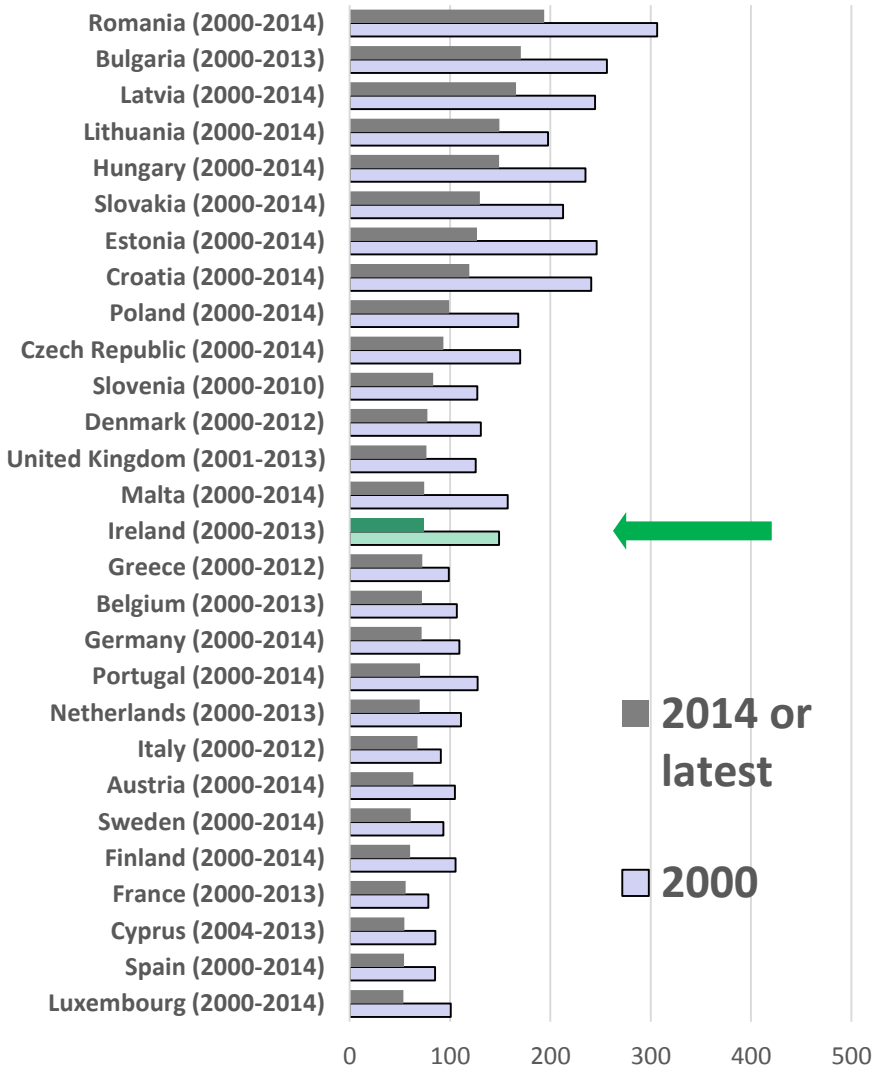
Source: OECD, Health at a glance 2014, G Lafortune

Amenable mortality in the EU28, males



Age-standardised rate per 100,000

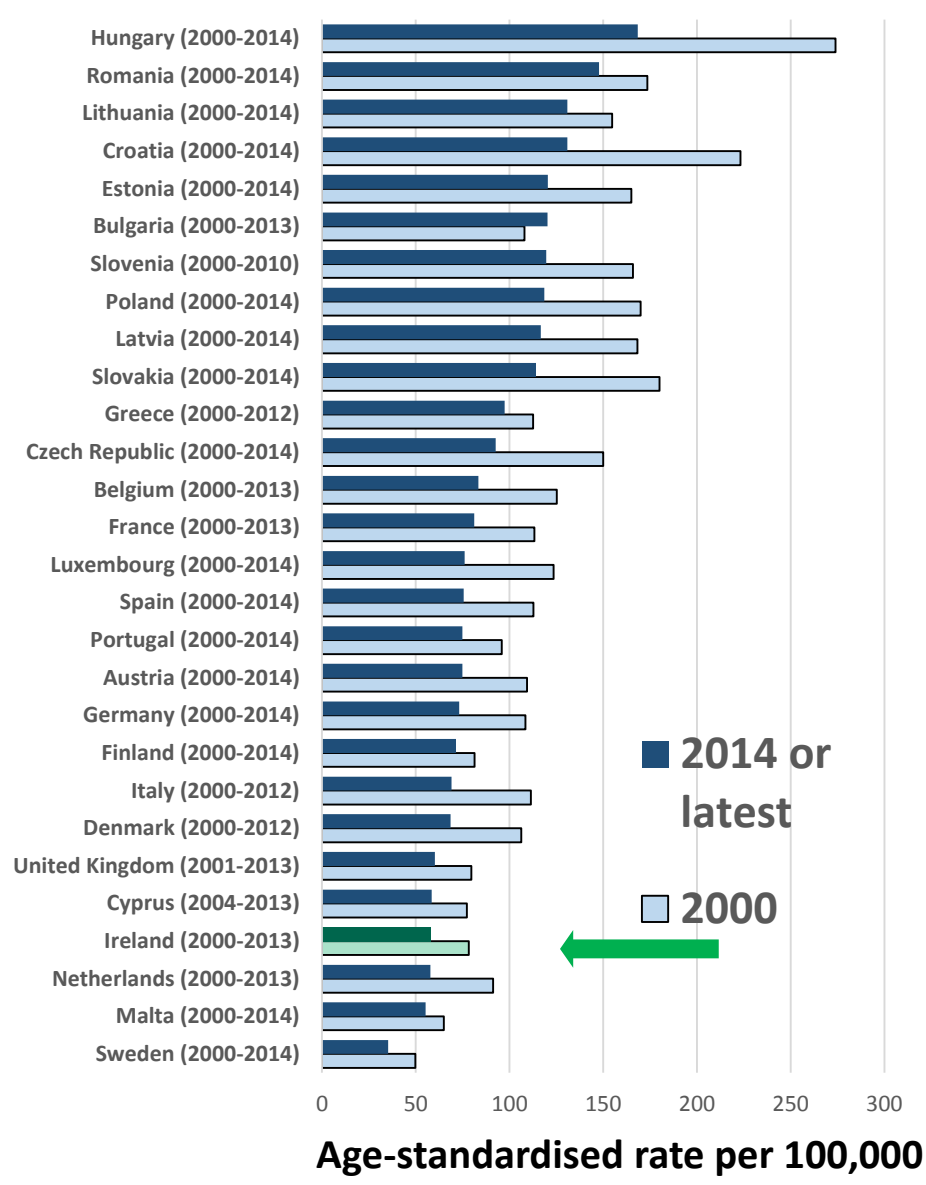
Amenable mortality in the EU28, females



Age-standardised rate per 100,000

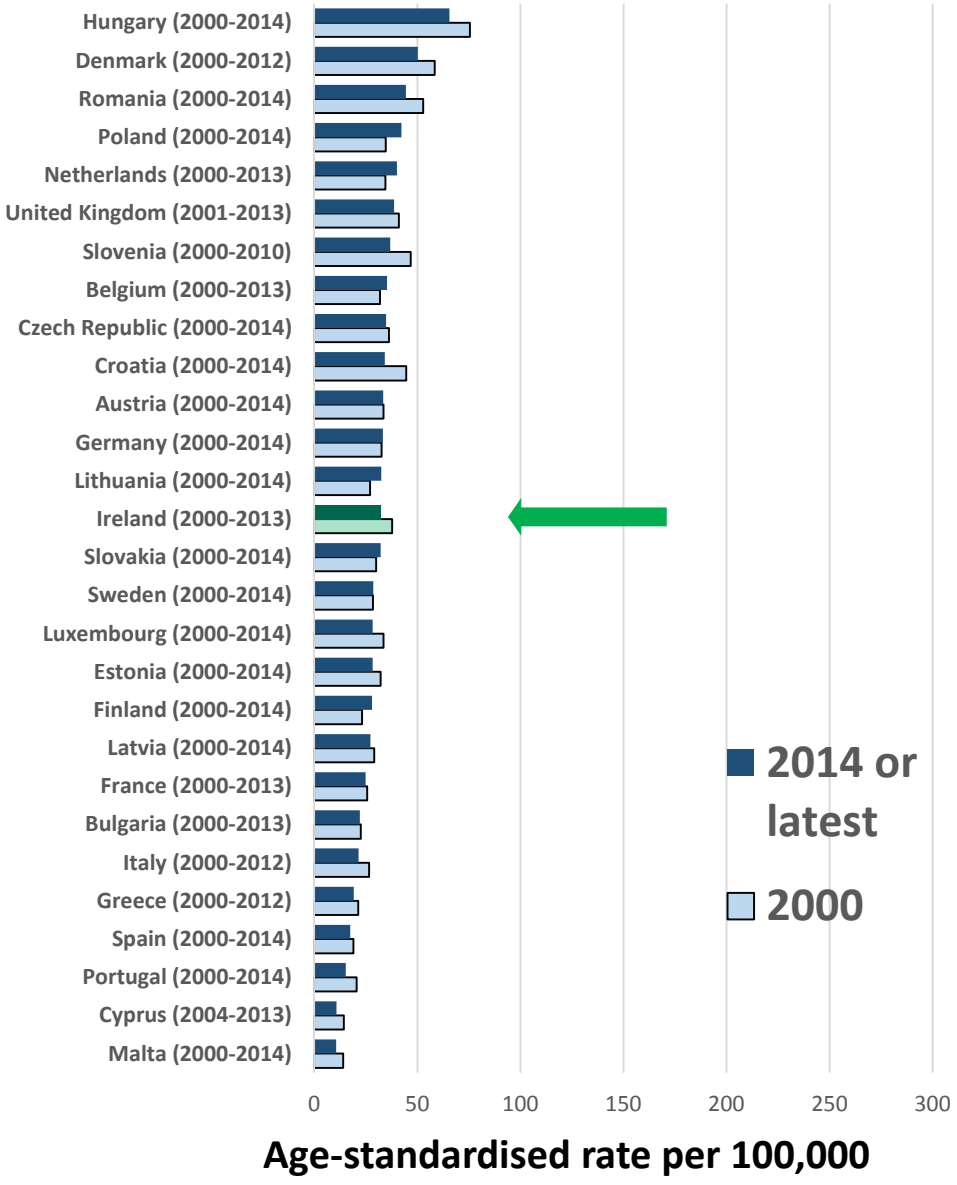
Source: WHO mortality database, 2015

Preventable mortality in the EU28, males (deaths from lung cancer, liver cirrhosis and traffic accidents)



Age-standardised rate per 100,000

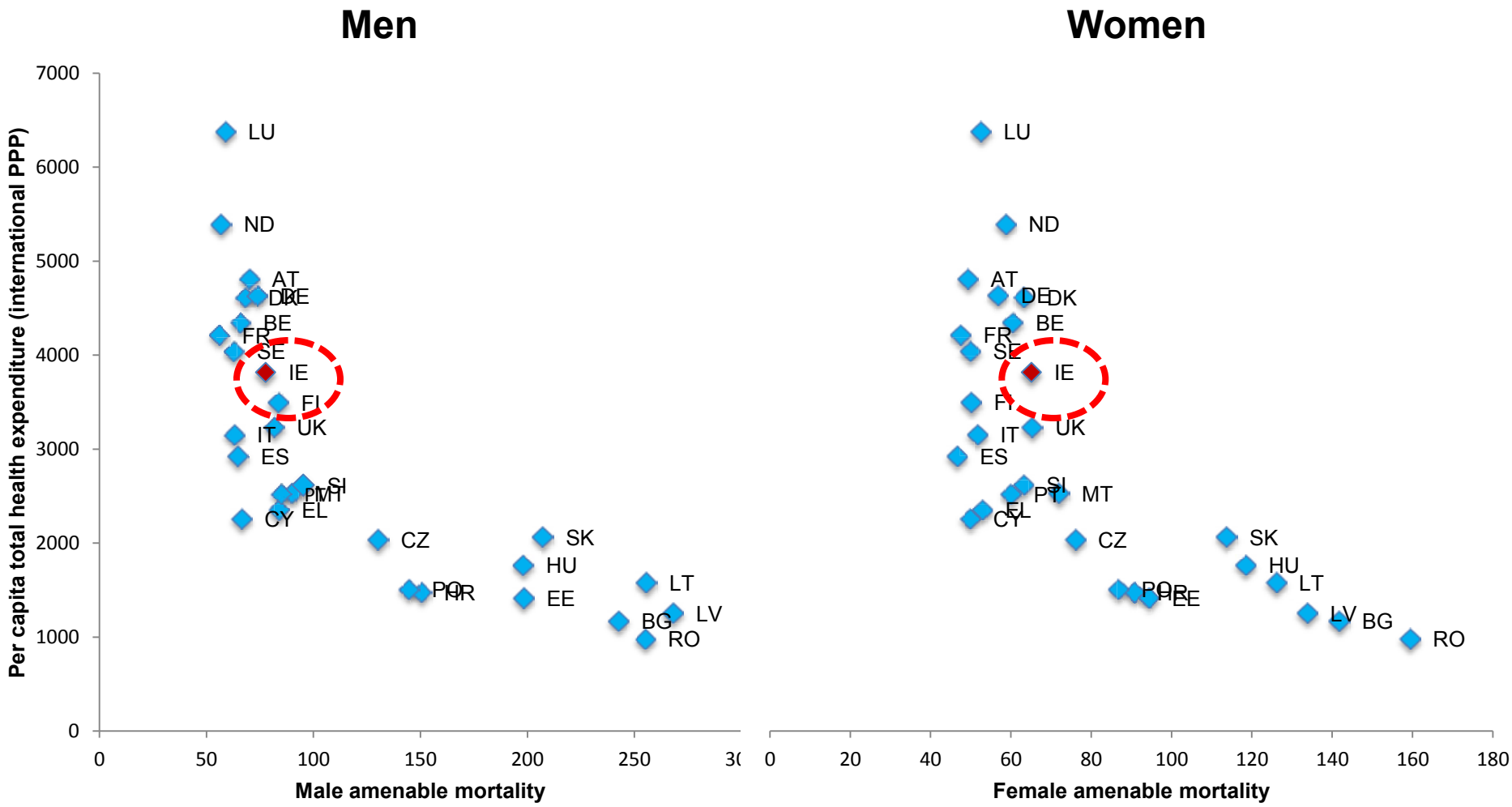
Preventable mortality in the EU28, females (deaths from lung cancer, liver cirrhosis and traffic accidents)



Age-standardised rate per 100,000

Source: WHO mortality database, 2015

*Countries vary in **value for money***
***Amenable mortality** vs expenditure*



Source: WHO HFA and WHO Mortality database, 2016

Options - Outline

1. Reform the statutory funding system?
2. Raise extra statutory revenues?
3. Ration coverage: Shifting to private expenditure?
4. Improve performance: Squeeze efficiency?
   - Expanding practice guidelines & protocols
   - Stepping up innovation: ICT / E Health
   - Linking provider payment to performance
   - Improve pharmaceutical / technology policies
   - Enhancing Integrated Care
   - Skill Mix Optimisation
   - Strengthening Primary Care
   - Improving Public Health

Options - Outline

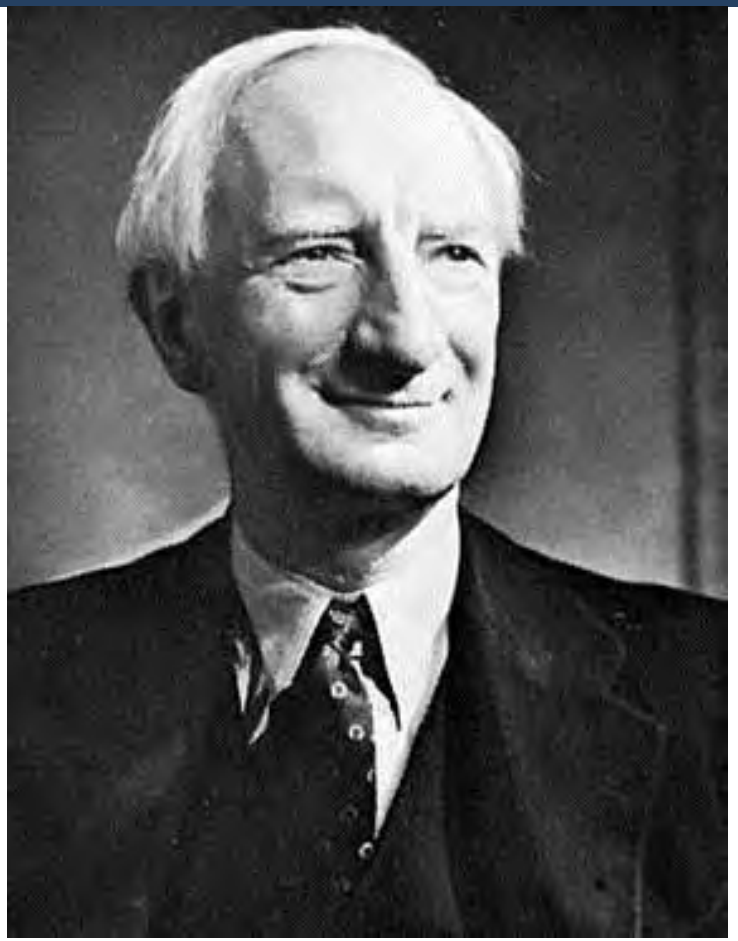
1. Reform the statutory funding system?
2. Raise extra statutory revenues?
3. Ration coverage: Shifting to private expenditure?
4. Improve performance: Squeeze efficiency?
5. Act on health determinants: Health in All Policies?
6. Focus on implementation

1. Reform the statutory funding system

The founding funding fathers of European health systems

Otto von Bismarck

1815-1898



William Henry Beveridge

1879-1963

Bismarck or Beveridge?

- It’s just a label, a way (source) of funding!
- Most systems funded by a mix of taxation and social health insurance
- Virtually no differences terms of purchasing, payment and organization of health services
- Ultimately UHC / financial protection is key
- Assessing them against revenue raising principles

Bismarck or Beveridge?

- Revenue raising objectives
  - Adequate levels of statutory resources
  - Stability and predictability in revenues
  - Fairness in the funding of health services
  - Efficiency and transparency
  - Impact on labour market and competitiveness
  - Earmarking for health

Bismarck or Beveridge?
'Bisridge' or 'Bevermarck'?

"It doesn't matter whether the cat is black or white. As long as it catches mice!"

Deng Xiao Ping

2. Raise extra statutory revenues?

2. Raise extra statutory revenues?

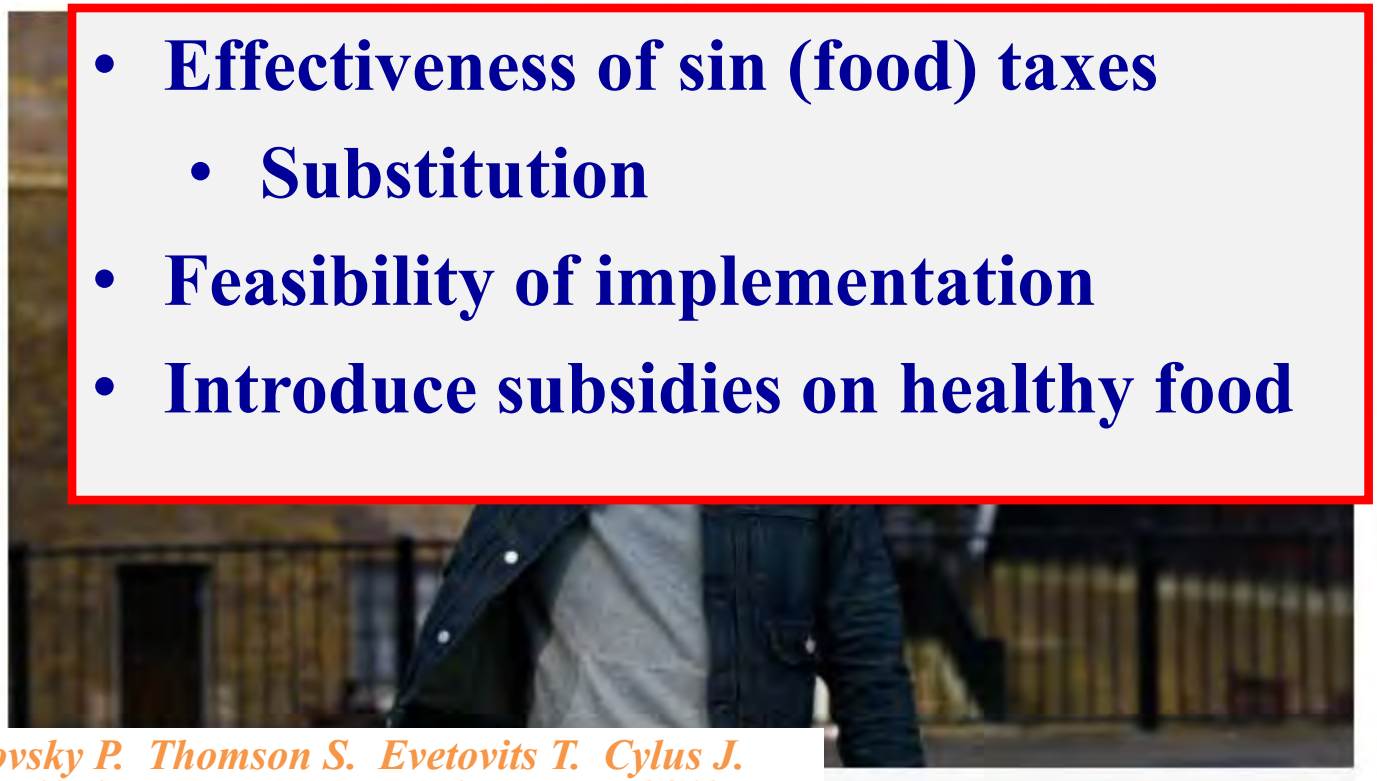
SIN TAXES??

- Rev
- Inc

Sugar s to sue government

Previous challenges have been successful in Finland and Denmark

- **Effectiveness of sin (food) taxes**
  - **Substitution**
- **Feasibility of implementation**
- **Introduce subsidies on healthy food**



Mladovsky P. Thomson S. Evetovits T. Cylus J. Karanikolos M. McKee M. Figueras J. 2012

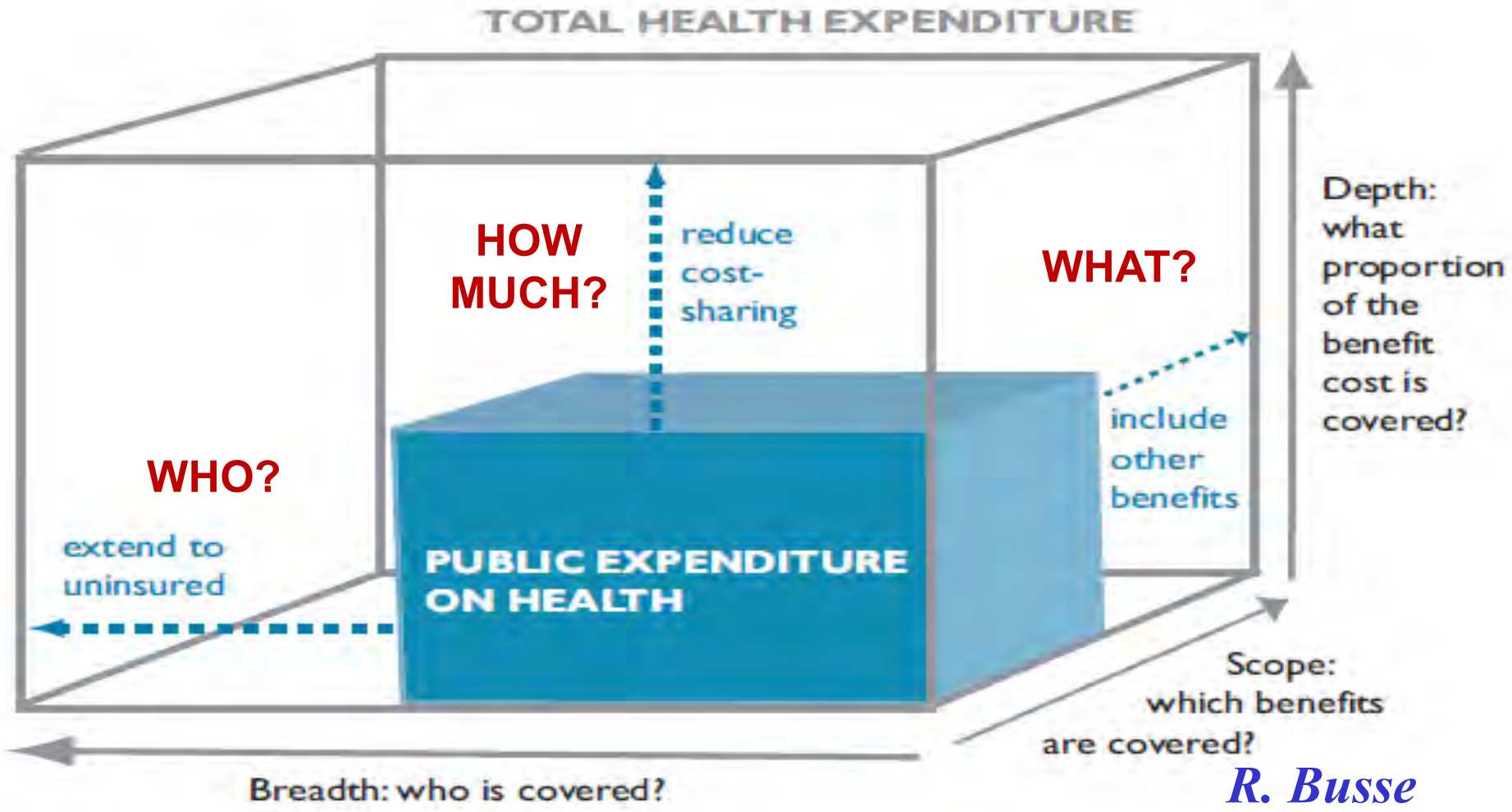
Jamie Oliver celebrates the introduction of a levy on sugary drinks

3. Ration Coverage

Shifting to private expenditure?

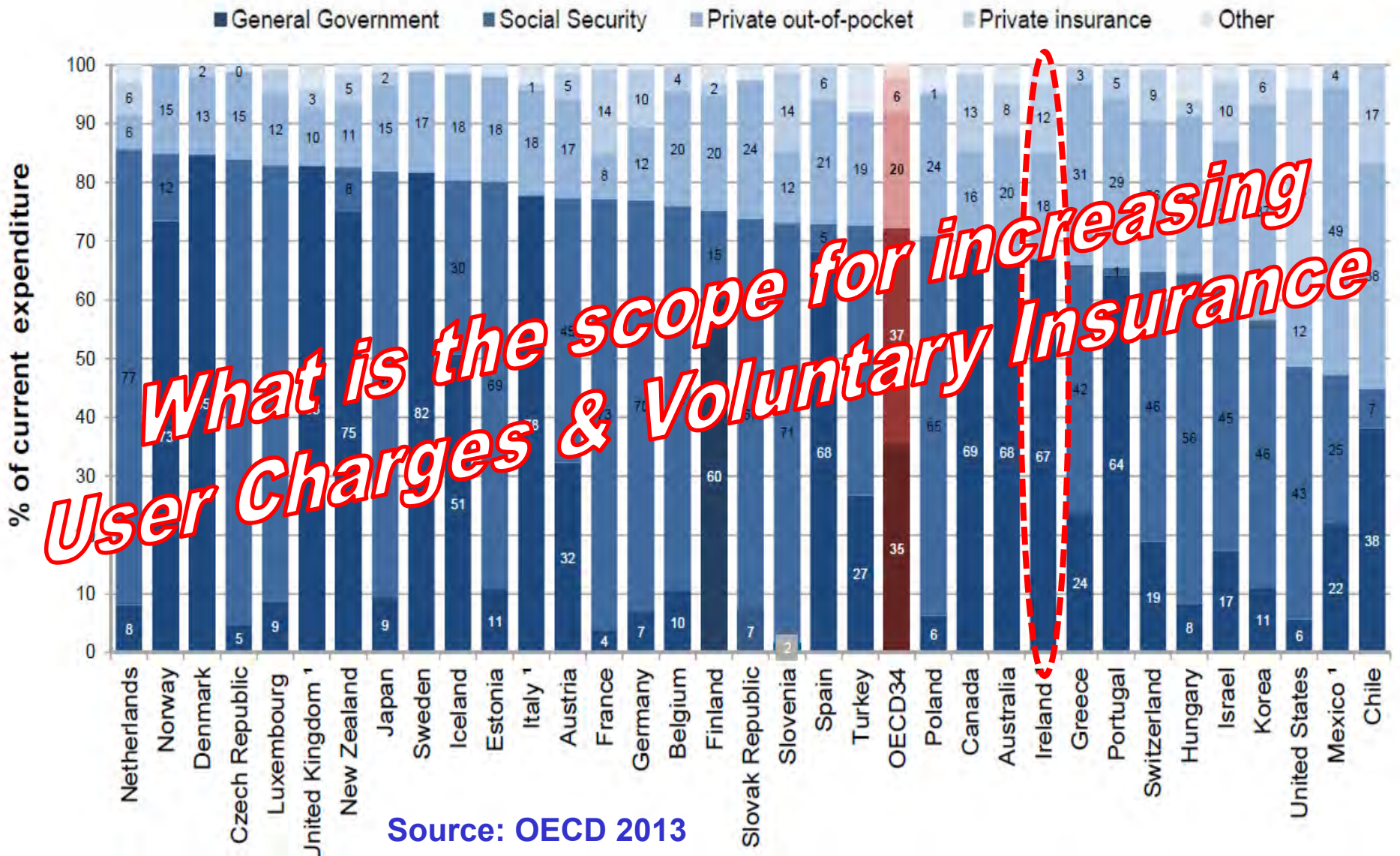
3. Ration coverage
Shifting to private expenditure?

Coverage Dimensions



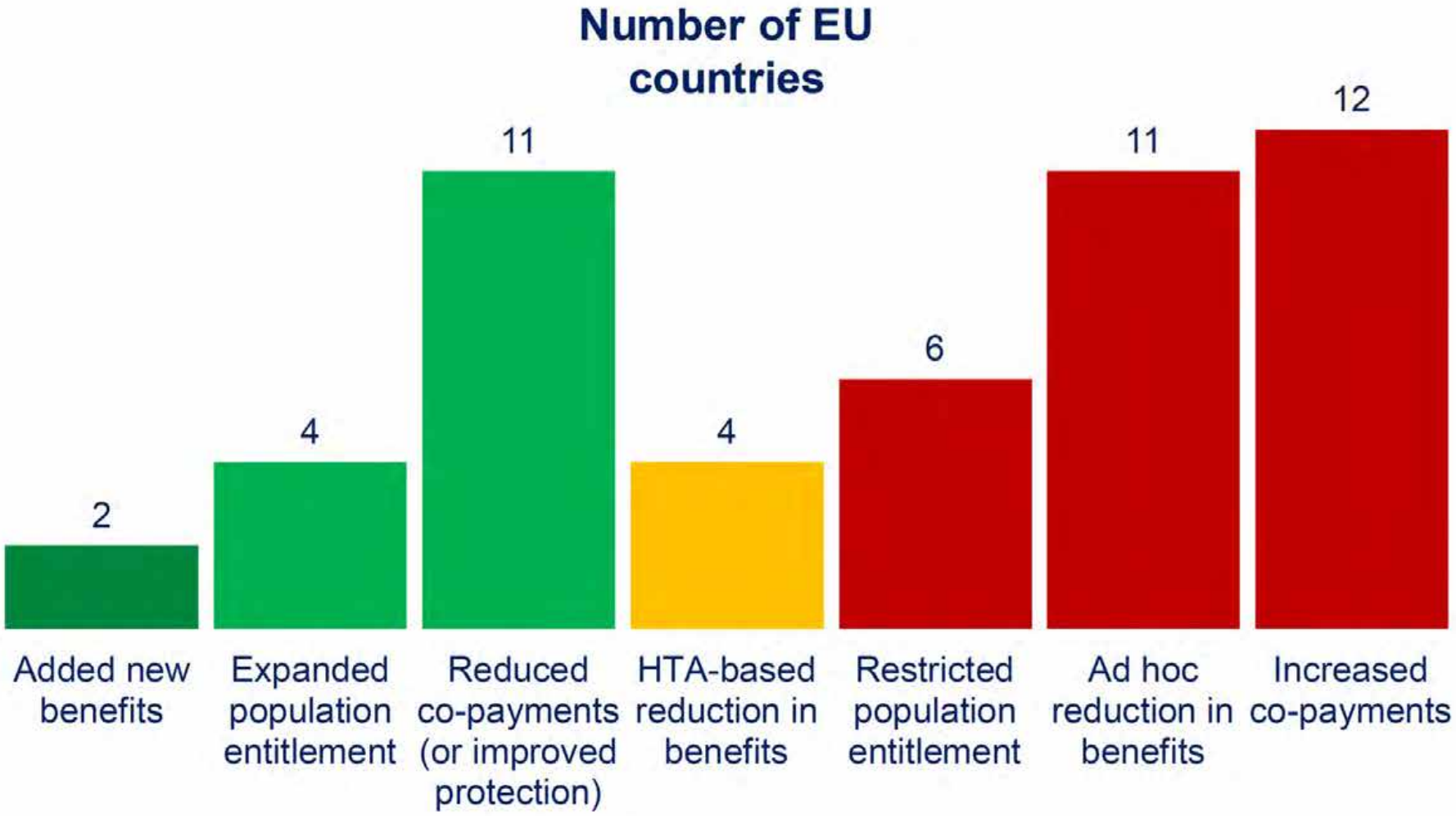
R. Busse

3. Ration coverage
Shifting to private expenditure?



Source: OECD 2013

3. Ration (or expand) coverage? Response to the Financial Crisis



Thomson S et al 2015

Rationing population coverage (breadth)?

- Universal coverage maintained in most
- Limited changes in some
  - Cyprus further postponement of universal coverage
  - Czech republic excluded some foreigners
  - Hungary increased checks on entitlements
  - Spain excluded migrants from statutory coverage

Mladowsky, P, et al. 2012 Thomson S et al 2014

Rationing benefits coverage (scope)?

- Implicit rationing

  e.g. increase in waiting times in many countries
- Limited explicit rationing
  - E.g. Czech Republic, Hungary Ireland, Netherlands & Portugal.
  - Negative lists e.g. pharmaceuticals list in Spain
- HTA: Significant potential for cost effectiveness

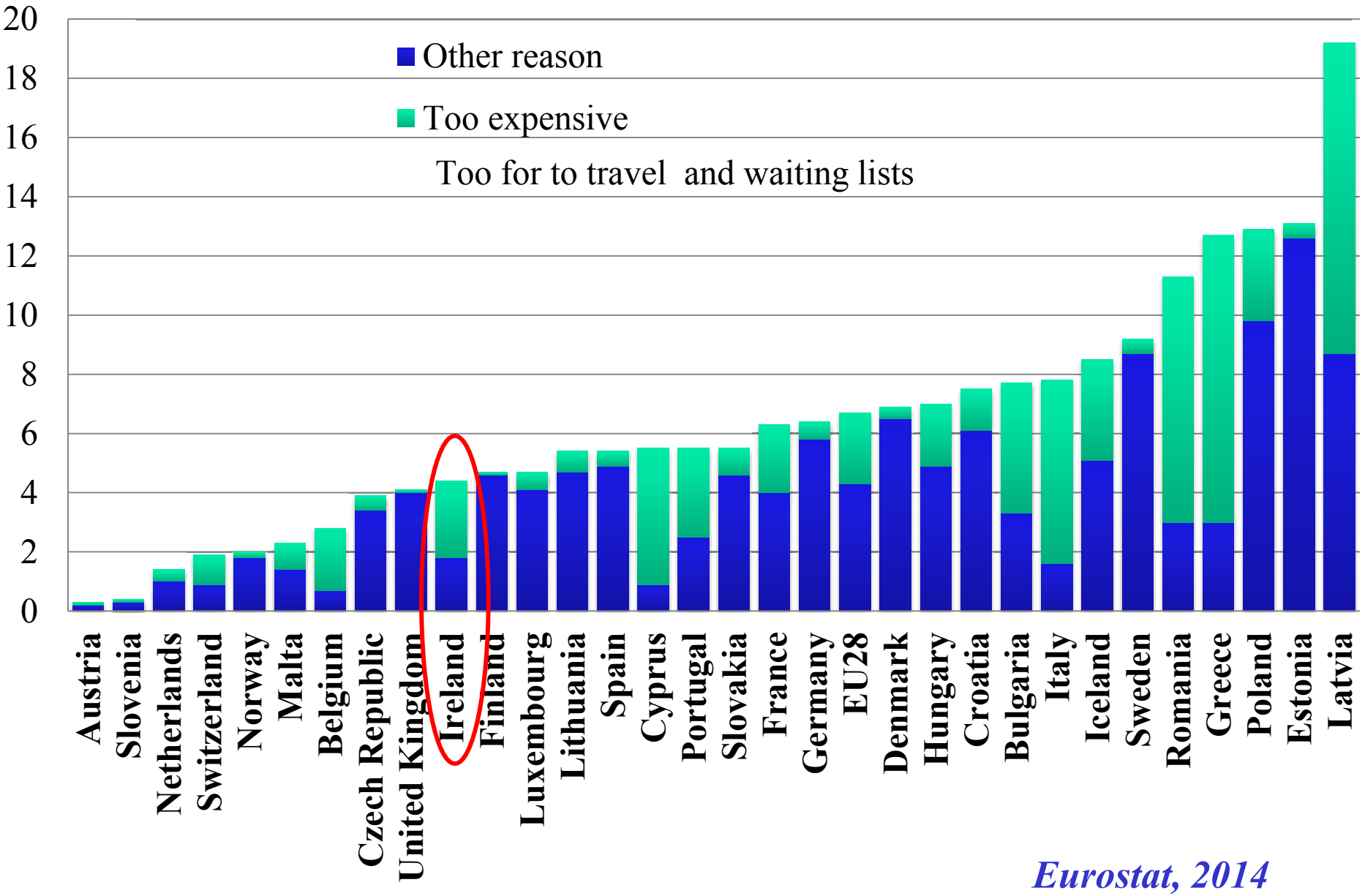
Mladowsky, P, et al. 2012 Thomson S et al 2015

Increasing user charges (depth)?

- Increasing user charges in 13 countries
- New charges for some health services
  e.g. Estonia, France, Ireland, Italy, Latvia, Netherlands, Portugal and Romania, Slovenia
- Increase in level of existing user charges
  e.g. Czech republic, Denmark, Finland, France, Greece, Ireland and Portugal
- Services affected
  - Pharmaceuticals (8 countries)
  - Hospital sector (5 countreies)
  - Ambulatory sector (3 countries
  - Emergency departments (2 countries)

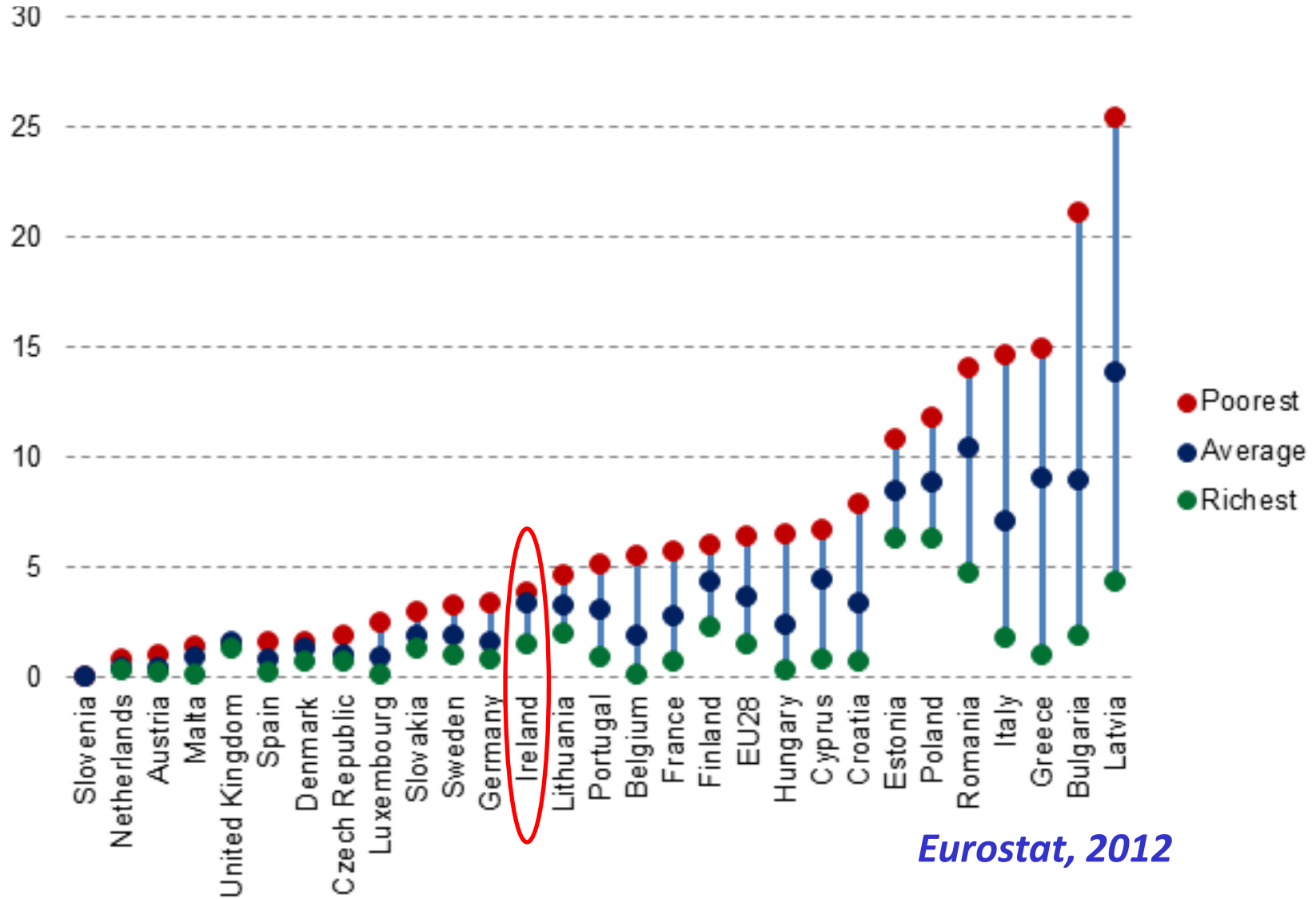
But some countries have decreased user charges to ensure access of vulnerable populations

Unmet needs for medical care % of population (too expensive or too far to travel or waiting list), 2014



Eurostat, 2014

Unmet need *of medical examination for financial or other reasons by income groups EU-SILC 2012*



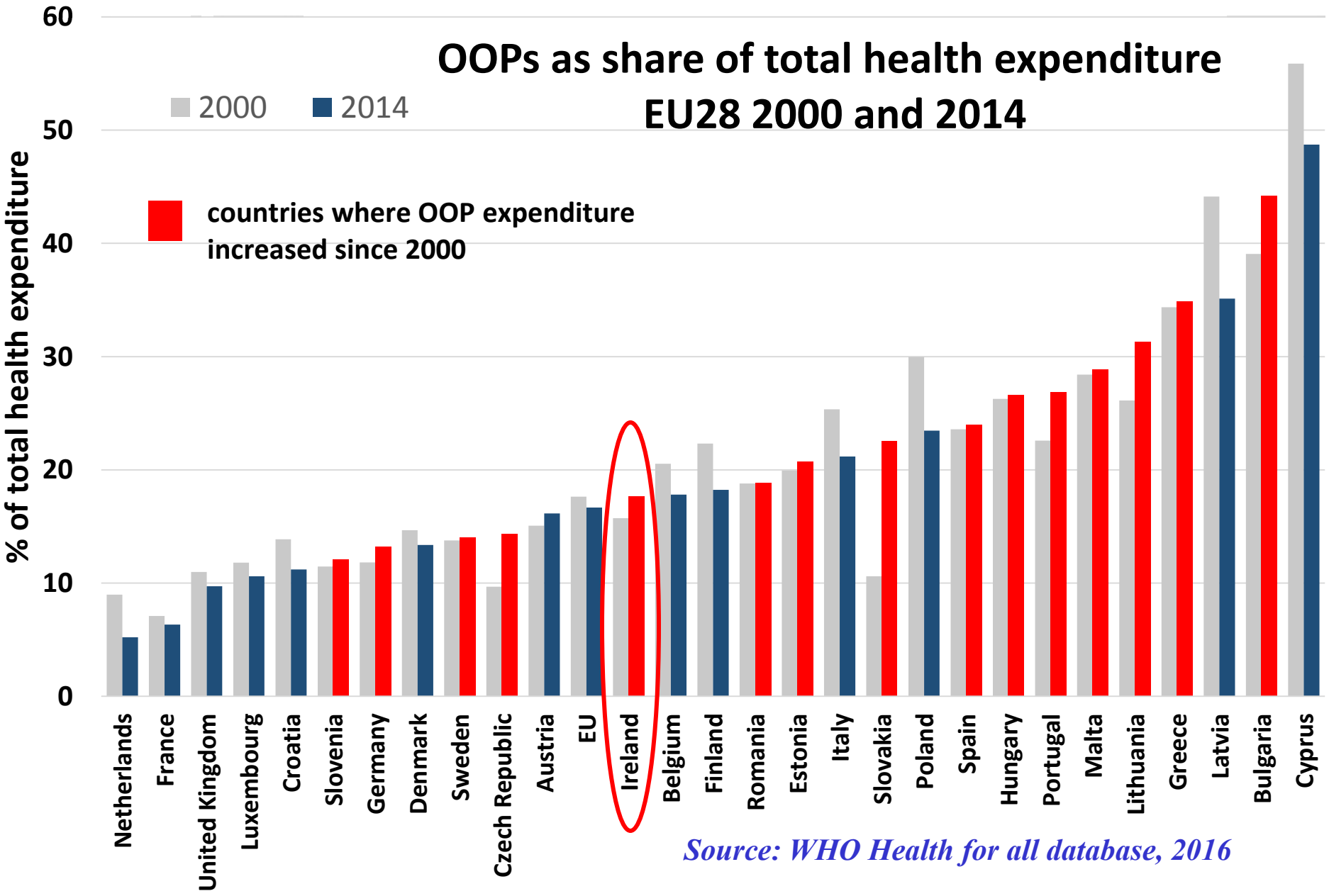
Eurostat, 2012

Efficiency arguments for user charges

- Contain costs
- Reduce ‘unnecessary’ use
- Raise revenue (user pays principle)
- Direct people to more cost-effective use

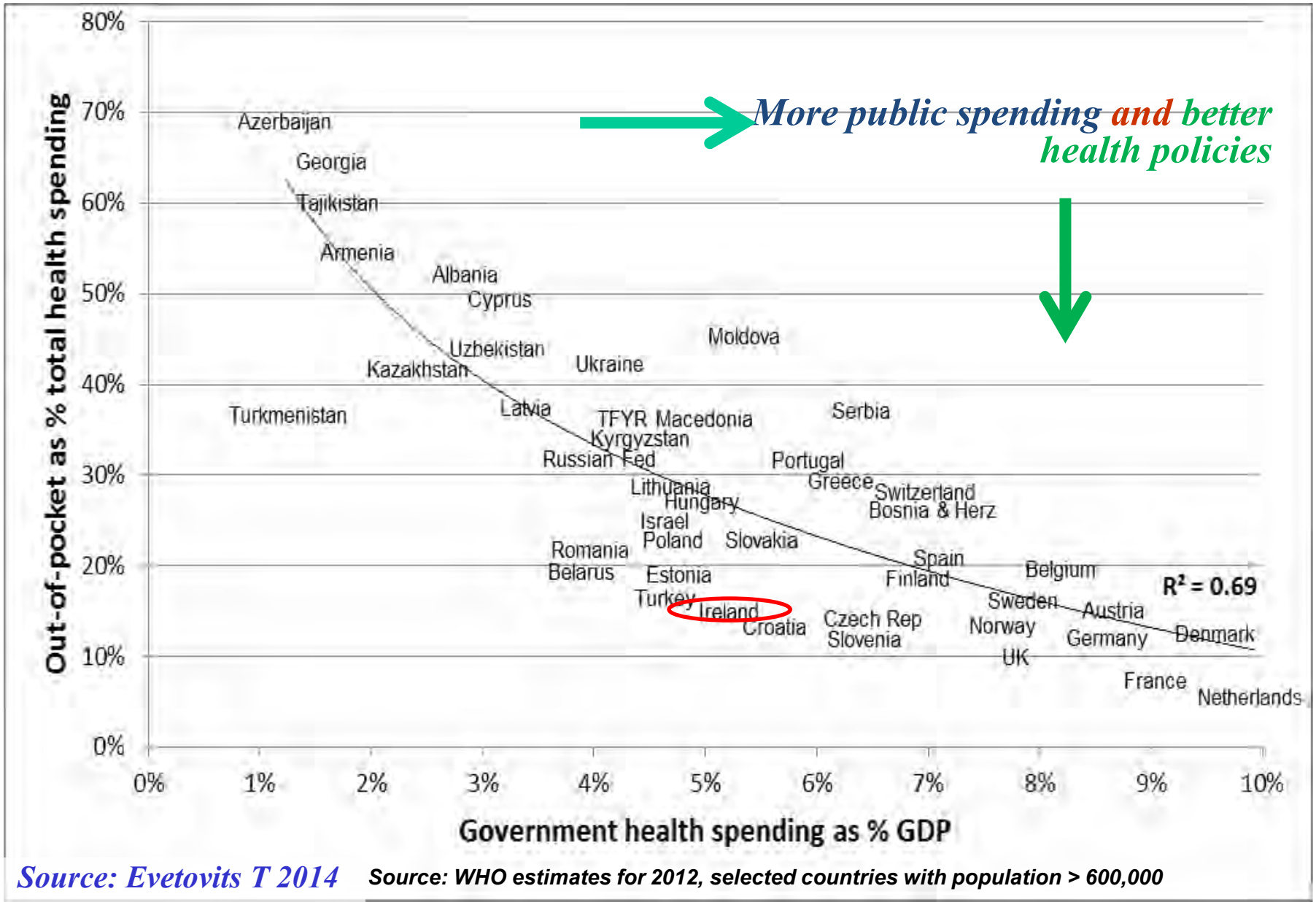
- User charges may enhance efficiency
  - If no negative effect on health AND
  - No increased use of other health resources

Out-of-pocket as % of total health spending



Source: WHO Health for all database, 2016

More public spending means lower burden on patients.

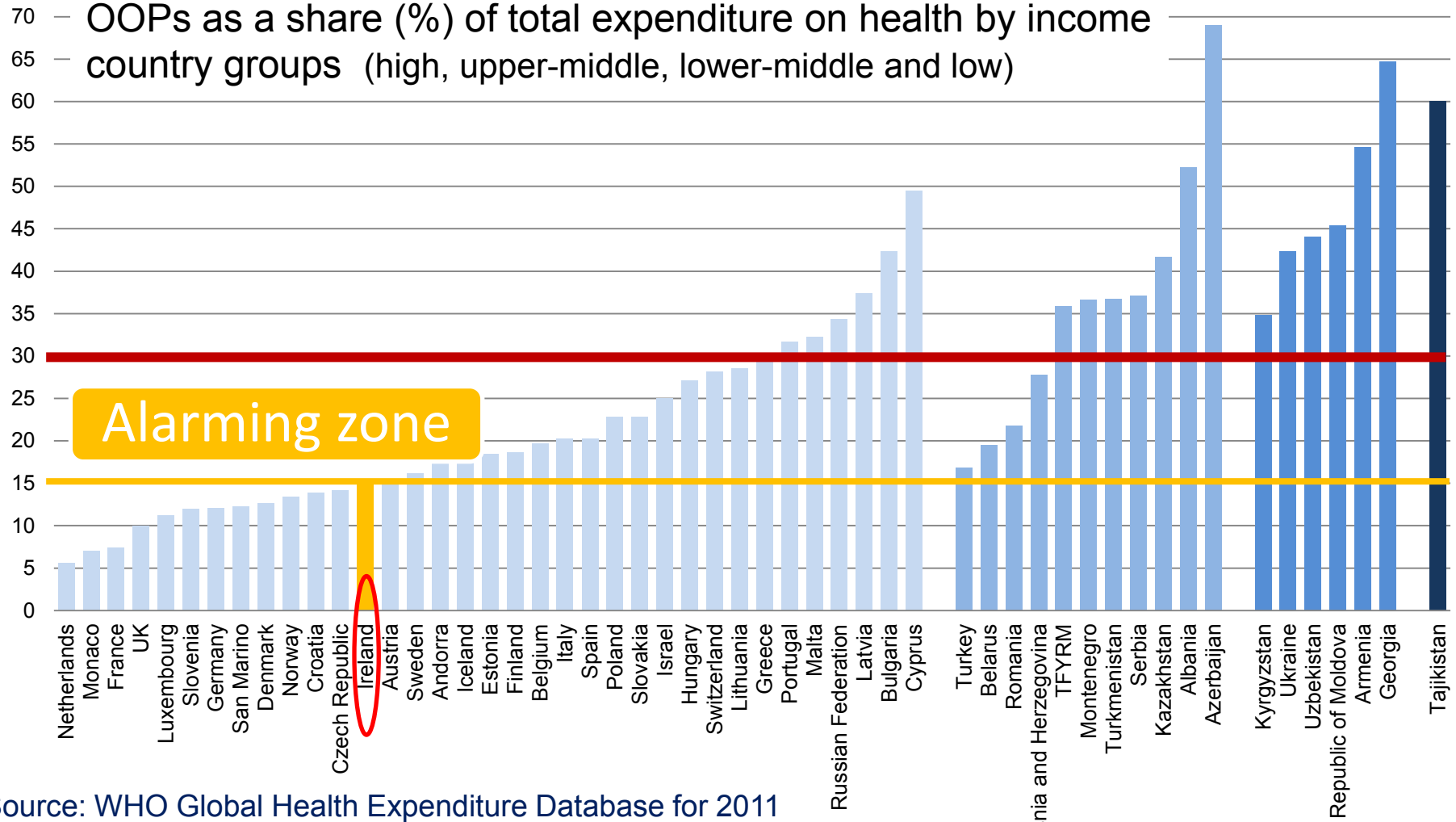


Source: Evetovits T 2014

Source: WHO estimates for 2012, selected countries with population > 600,000

Financial protection is borderline

Out-of-pocket payments (OOPs) is 15%



Source: WHO Global Health Expenditure Database for 2011

Note: Data for Netherlands underestimates the true level of OOPs

Source: Evetovits T 2014

User charges impact on health & costs

- Reduce both appropriate & inappropriate care
  - *Blunt tool of limited selective effect*
- Disproportionate effect on poor & ill
  - *10 % population account 70% expenditure*
- Increased in unwanted (***more expensive***) effects
- No evidence of long term cost control
  - Squeezed balloon effect
  - User charges little impact on prices, intensity, technology, excess capacity

User charges: the right policy tool?

- May undermine efficiency
  - *Not selective / substitution effects / inequities*
- Ensure careful design:
  - Clarity about goals
  - Monitor impact on access
  - Protect poor & chronic conditions (exemptions, caps)
  - Consider transaction costs
- If so limited impact on cost containment
- To secure efficiency focus on supply & purchasing

User charge caps

	Primary care annual cap	OP prescription annual cap	Inpatient annual cap (daily charge)
AT	€10 (poor free)	2%	28 days (10%)
BE	€450-1,800 depending on income		
CH	€580		
DE	2% (1% for chronically ill)		
DK	FREE	€480 (chronic only)	FREE
FI	€630 (minors free)	x	7 days (minors only) (€32)
FR	x (chronic free, minors free primary care)		31 days (€18 + 20%)
IE	**x (poor free)**	**€120-€1,440 (chronic free, low for poor)**	**€750 (poor free) (€75)**
NL	FREE	€220	
NO	€250		
SE	€105	€205	x (€10)
UK	FREE	€130	FREE

Source: Thomson and Reed (2012)

What role for VHI?

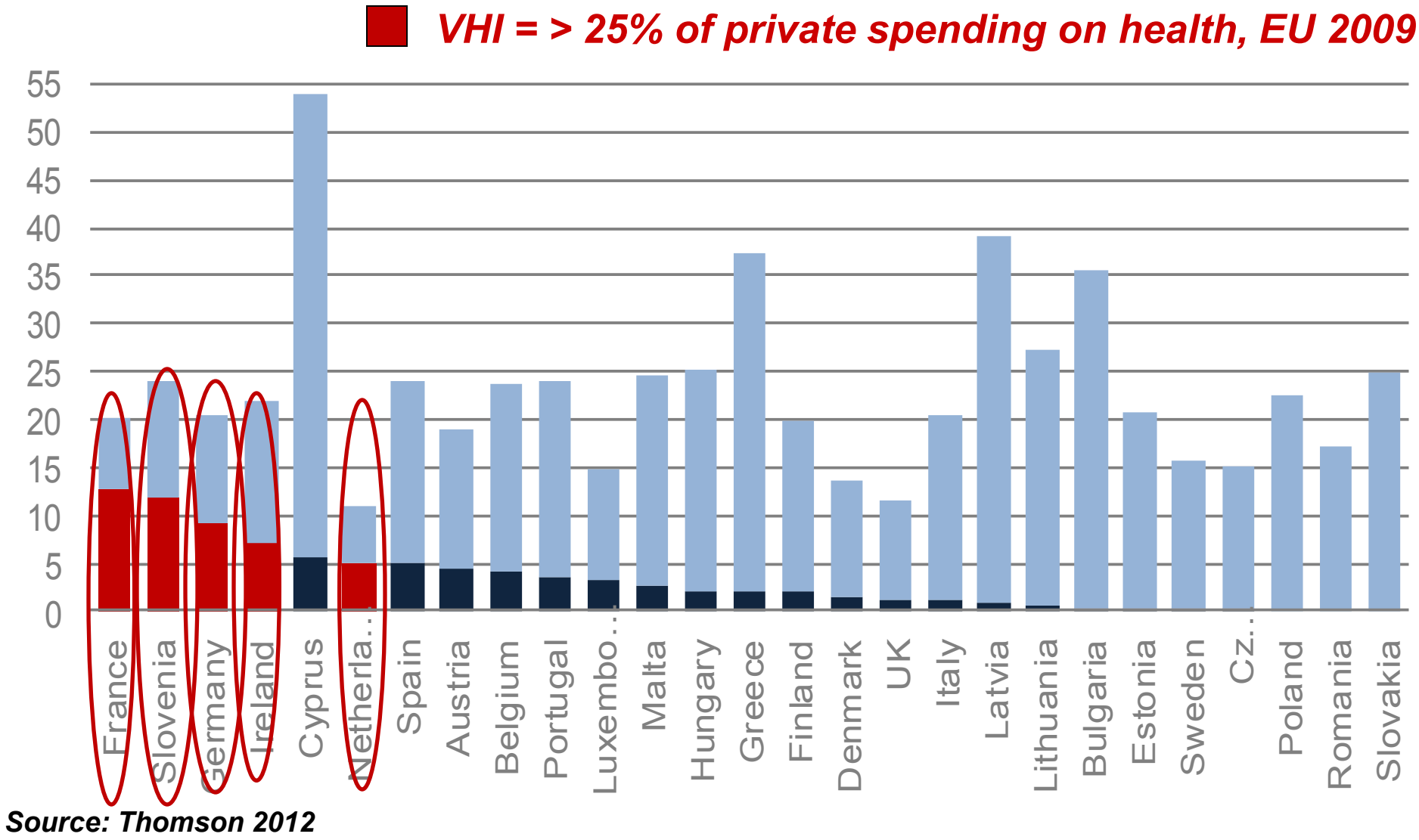
Market driver	VHI role	VHI covers	Examples
population coverage	**substitutive**	**groups excluded or opting out**	Germany, Neths pre-2006
service coverage	**complementary (services)**	**excluded services**	Netherlands
cost coverage	**complementary (user charges)**	**statutory user charges**	France, Slovenia
consumer satisfaction	**supplementary**	**faster access & consumer choice**	Ireland, UK, Poland

European Observatory on Health Systems and Policies

Increasing Voluntary Health Insurance? The right policy tool?

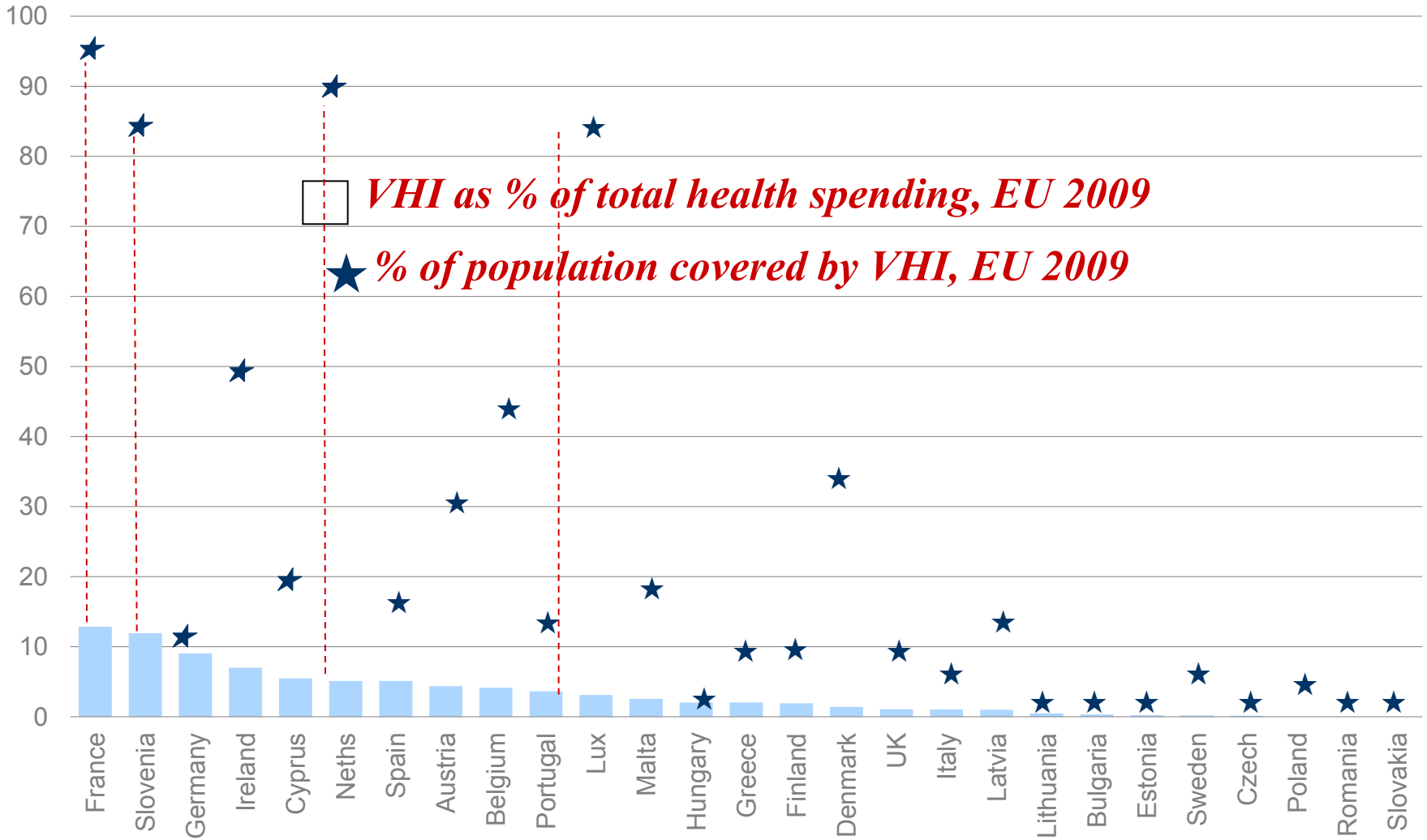
- Contain costs?
- Relieve fiscal pressure on public budgets?
- Address health coverage gaps?
  - Population (breadth)
  - Services / benefits (scope)
  - Costs (depth)
- Will those who need have access to it?
- Does it undermine value in public spending health?
- Strengthen health systems performance?

VHI does not do well in filling gaps in coverage



Source: Thomson 2012

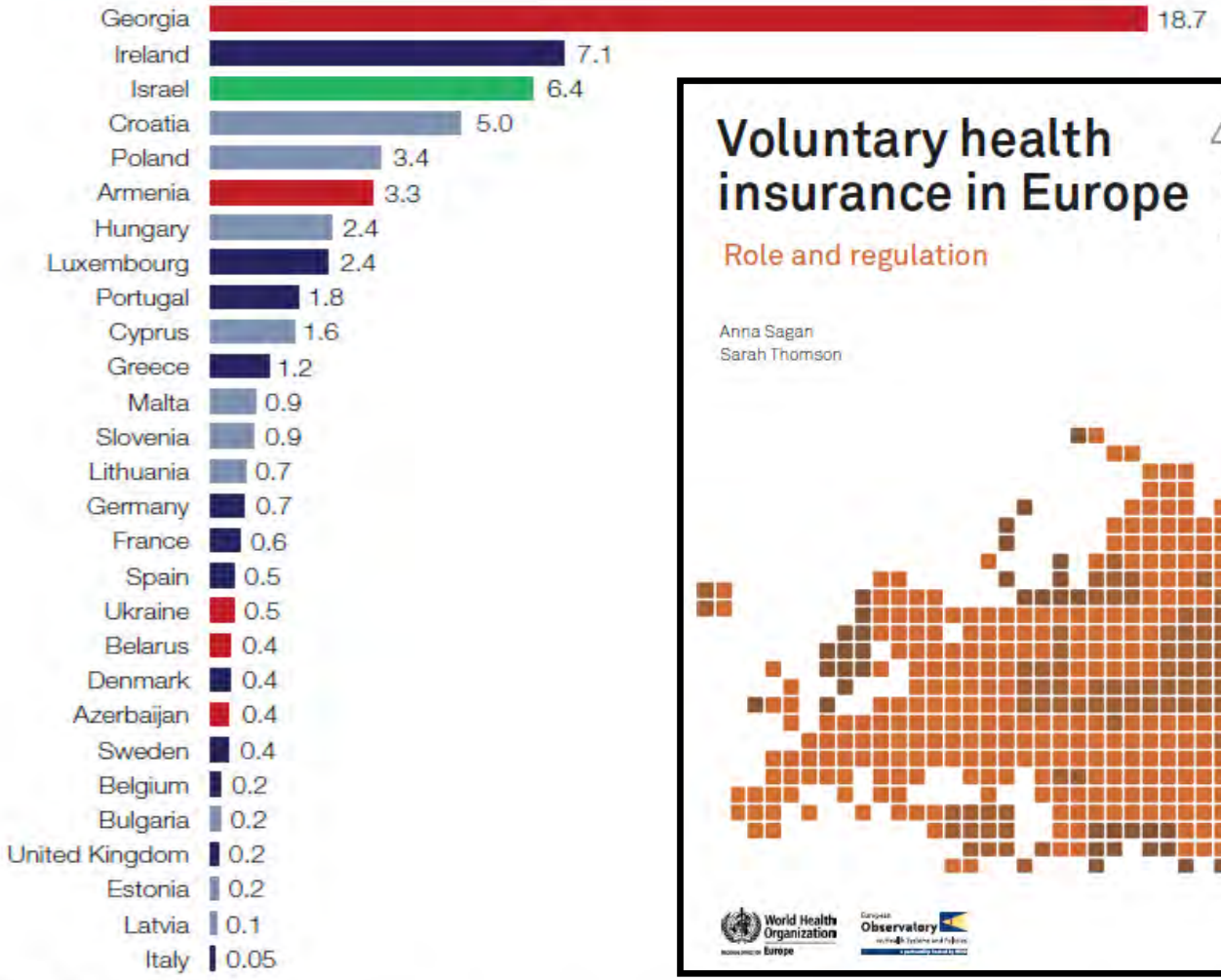
Large variation in market size: spending & coverage



Source: Thomson 2012

Source: Thomson 2012 forthcoming

Figure 2.2 *Countries in which VHI's share of total spending on health grew between 2000 and 2014 (% point change)*



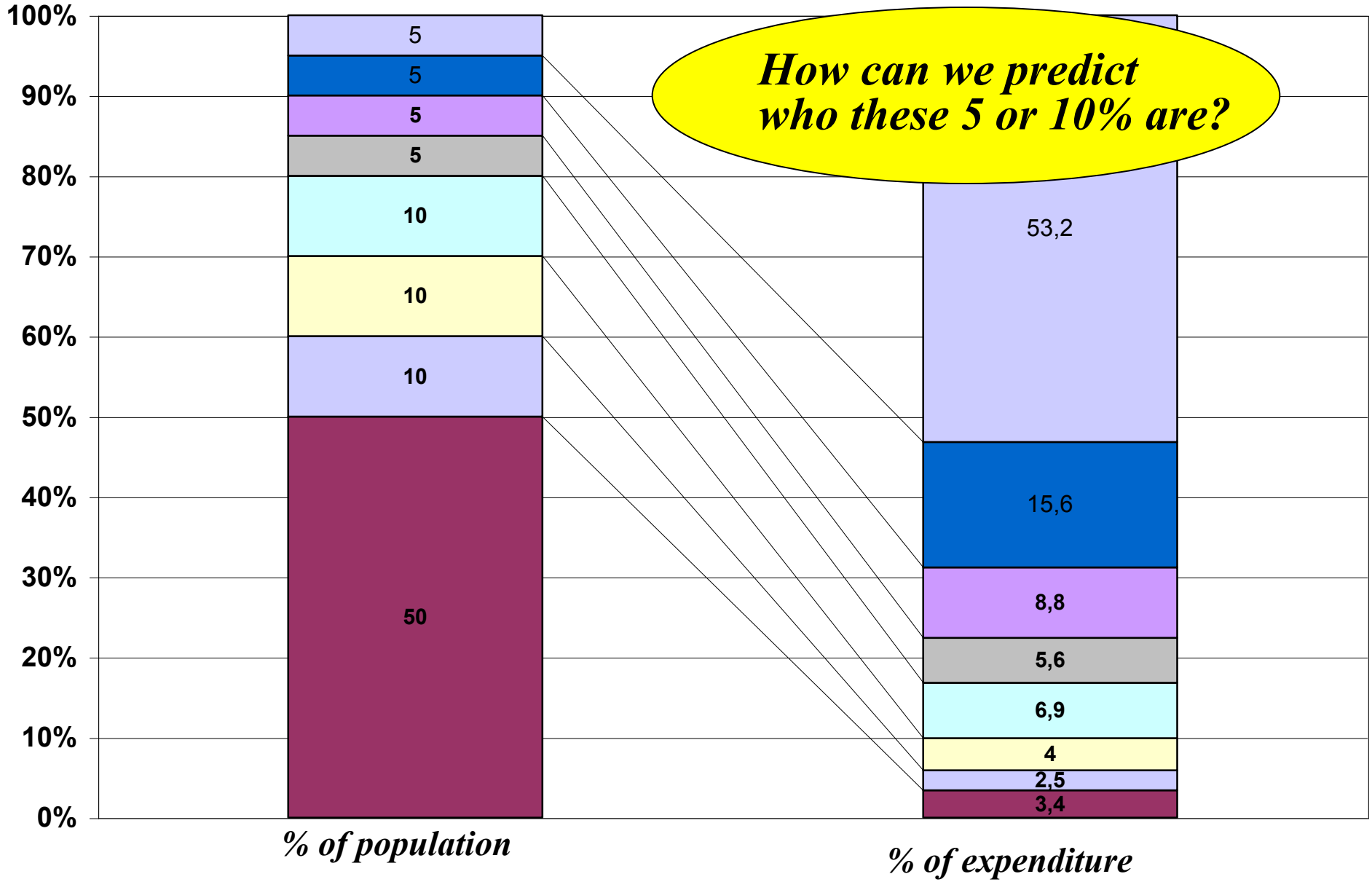
Source: WHO (2016).

Notes: Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of total spending on health in Hungary is overestimated (see Szigeti, Lindeisz & Gaál, 2016). See Appendix B for information on data availability and assumptions made.

Issues with VHI

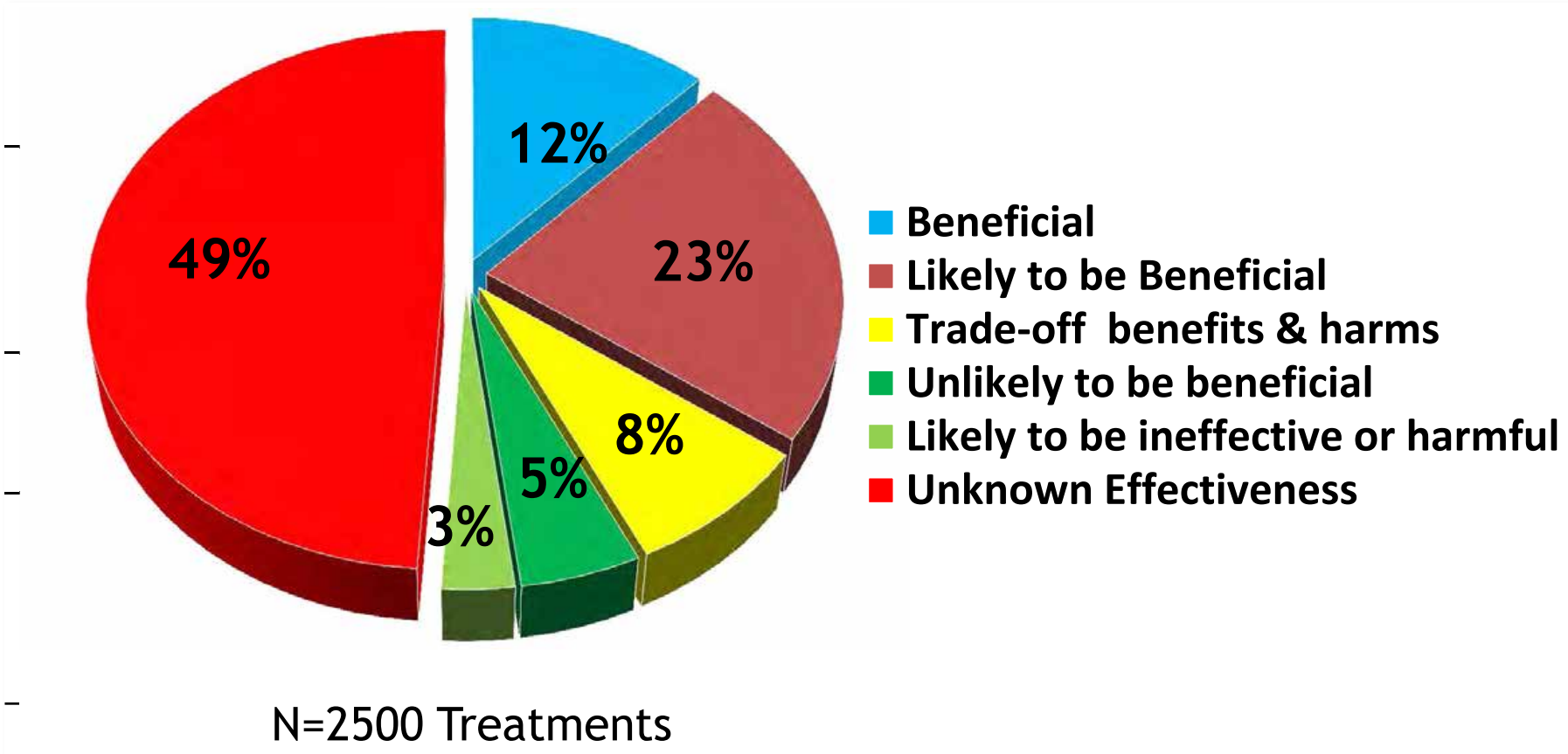
- May exacerbate fiscal pressures (substitutive)
- ***Careful & strong policy design***
- ***Clarity of policy goals***
- ***Large contextual differences***
  - ***How VHI interacts with health system***
- ***Regulatory capacity & oversight***
- No market will develop (complementary / excluded)

The well-known 20/80 distribution – actually the 5/50 or 10/70 problem



3. Rationing or Value Based Coverage?

Clinical Effectiveness



N=2500 Treatments

Clinical Evidence, BMJ 2009

3. Ensure Value Based Coverage

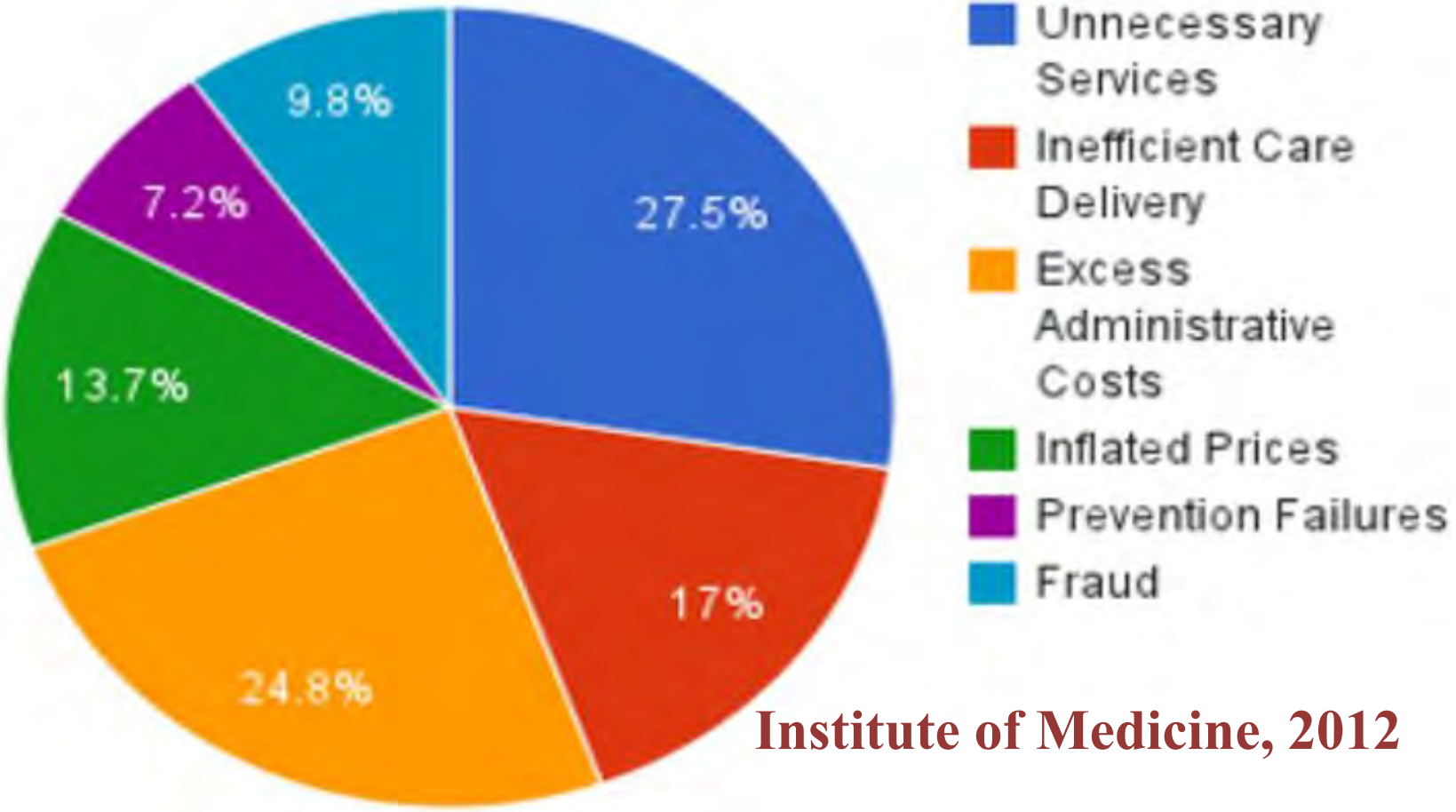
- **Health Technology Assessment** (e.g.)
  - **NICE** *UK,* **HAS** *FR*, **SBU** *SE*, **KCE** *BE*, **IQWiG** *DE*
  - Network of regional HTA agencies *ES*
  - ***EUNetHTA*** (European Network of HTA)
- **Priority Setting / Benefit Packages**
- **Stepping up negative lists (goods & services)**
- **Value Based User Charges (?)**

4. Improve Performance?

4. Improve Performance (Efficiency)

Sustainability (savings) ≠ efficiency

How the US Health System wastes $750 billion a year



Institute of Medicine, 2012

4. Improve performance

- **Expanding practice guidelines & protocols**
- **Stepping up innovation: ICT / E Health**
  - Electronic Health Records (e.g.)*: DK,SE,NL,UK,AT,...*
- **Linking provider payment to performance**
  - Case mix payment (e.g.): *AT, BG,CZ,HU,LT,…*
  - Procurement drugs & devices (e.g.): *BG,CZ, EL, SK,UK*
  - Value based pricing (e.g.)**:** *DE, ES, FR, IT,…*

Mladowsky, P, et al 2012 Thomson S 2015

4. Improve performance

- Improve pharmaceutical / technology policies

  Most EU27 strengthened policies to reduce the prices of medical goods or improve the rational use of drugs
  - Austria, Belgium, Czech Republic, France, Estonia, Greece, Ireland, Hungary, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Slovakia, Slovenia and Spain
- Wide variety of measures
  - generic substitution
  - Improve quality of prescribing
  - claw-back mechanisms
  - negotiations on prices

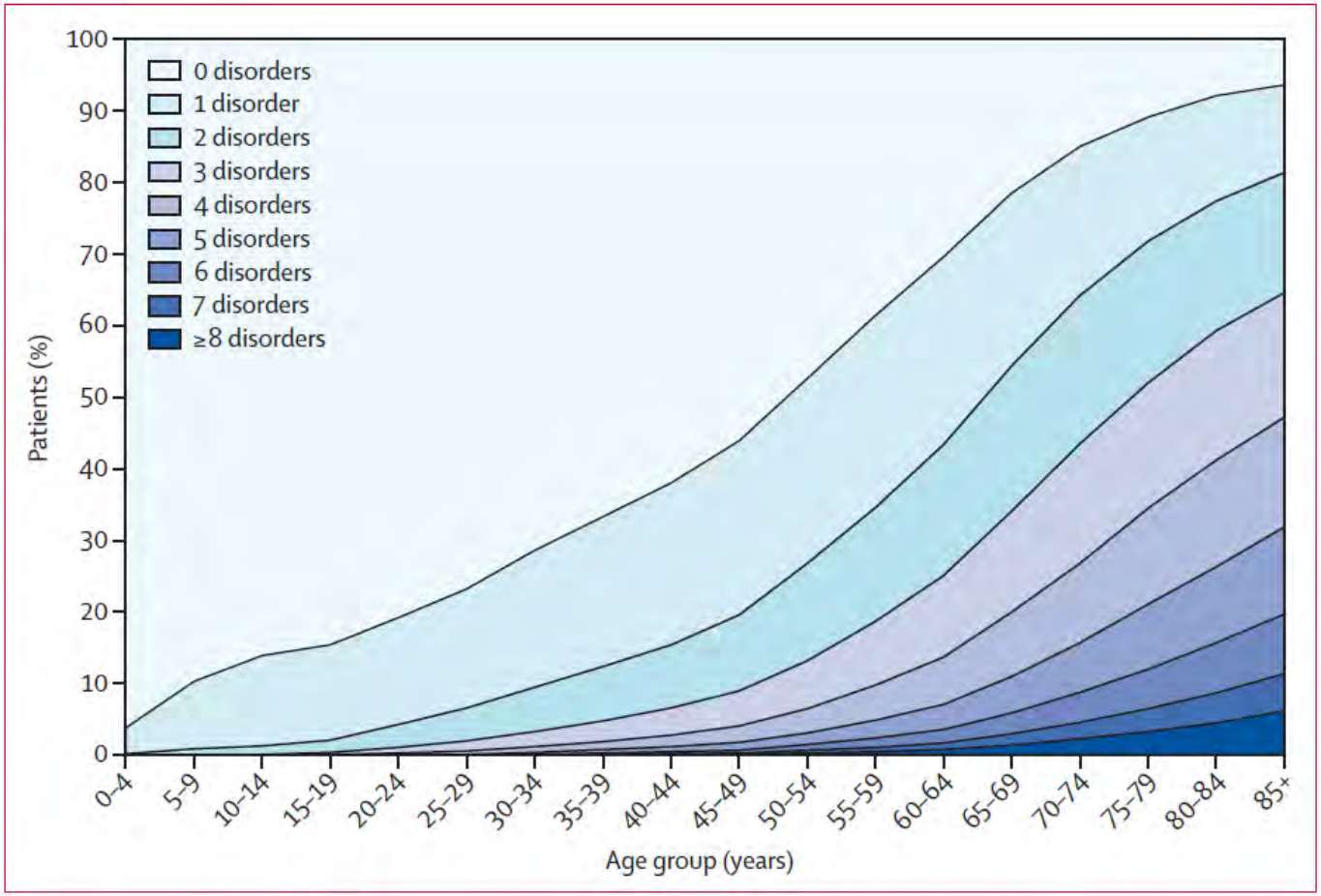
Mladowsky, P, et al 2012 Thomson S 2015

4. Improve performance

- **Enhancing Integrated Care**
  - Disease Management Programmes
    E.g. *AT, DE, DK, FR, HU, IT, NL*
  - Paying for integrated care (e.g.)
    Bundled Payments *NL,* ***QOF*** *UK,* ***CAPI*** *FR,* ***Personal Health Budgets*** *NL, UK,* ***'Gesundes Kinzigtal'*** *DE*
- **Rationalising hospital / specialist services**
  - Closures, mergers, restructuring & centralization
    E.g. *BG,CY,CZ,DK,EL,HU,IT,LT,LV,PT,SK,SI,ES*
  - European Centres of Reference

Mladowsky, P, et al 2012 Thomson S 2015

Multimorbidity is most common among older people (Scottish data)



Source: Barnett et al. (2012)

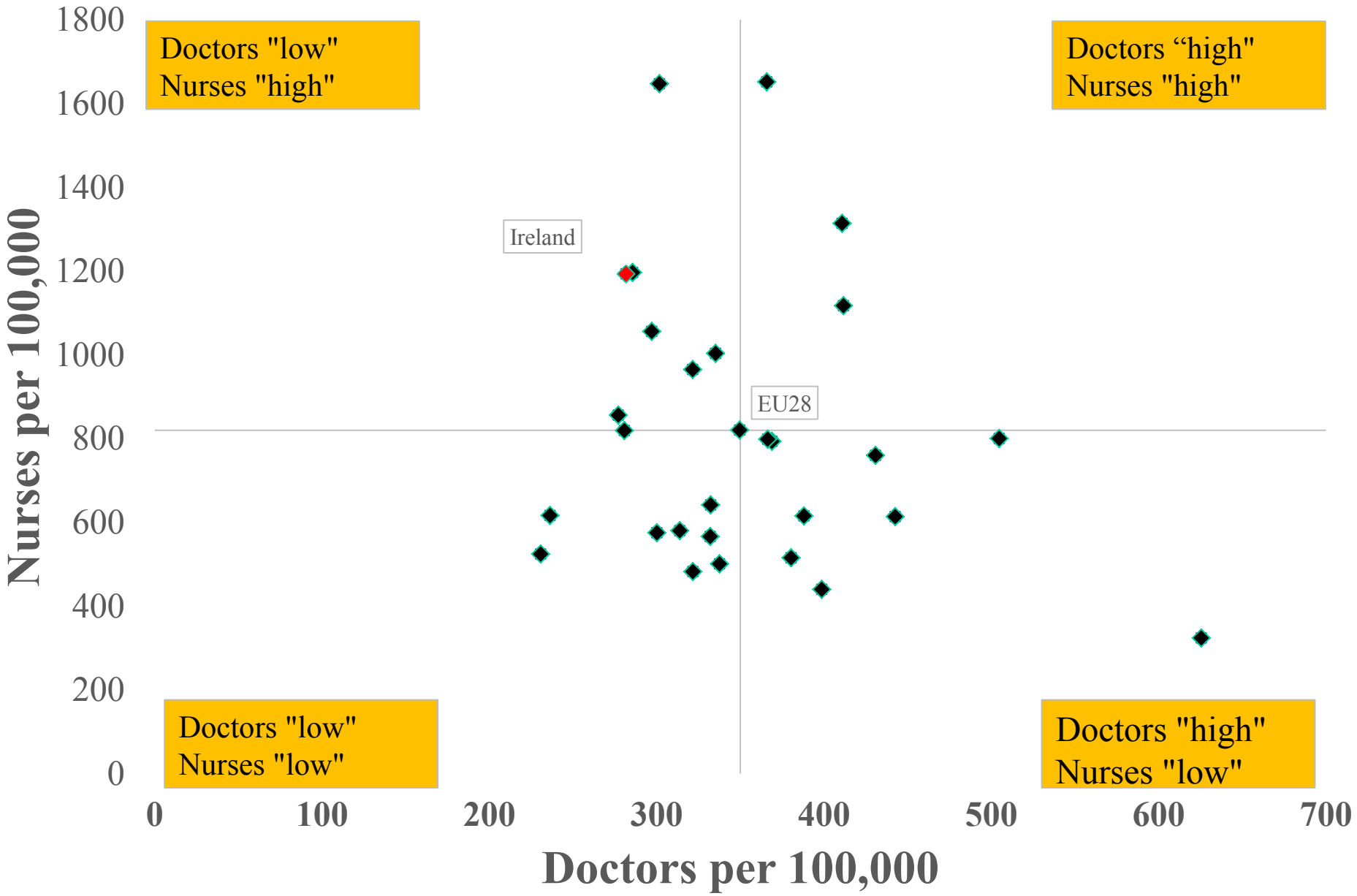
4. Improve performance

- **Skill Mix Optimisation**
  - Advance Practice Nurses (e.g.) *ES, FI, UK,*
- **Strengthening Primary Care**
  - Key in crisis response (e.g.) *EE,ES,EL,HU,LT,LV,PT,SI*
- **Improving Public Health**
  - Introducing health promotion policies
    E.g. *BE, CR, EL, HU, LT, MT, UK*
  - Introducing or increasing sin taxes
    E.g. *BG, CR, CY, DK, EE, FR, HU, PT, SI, ES*

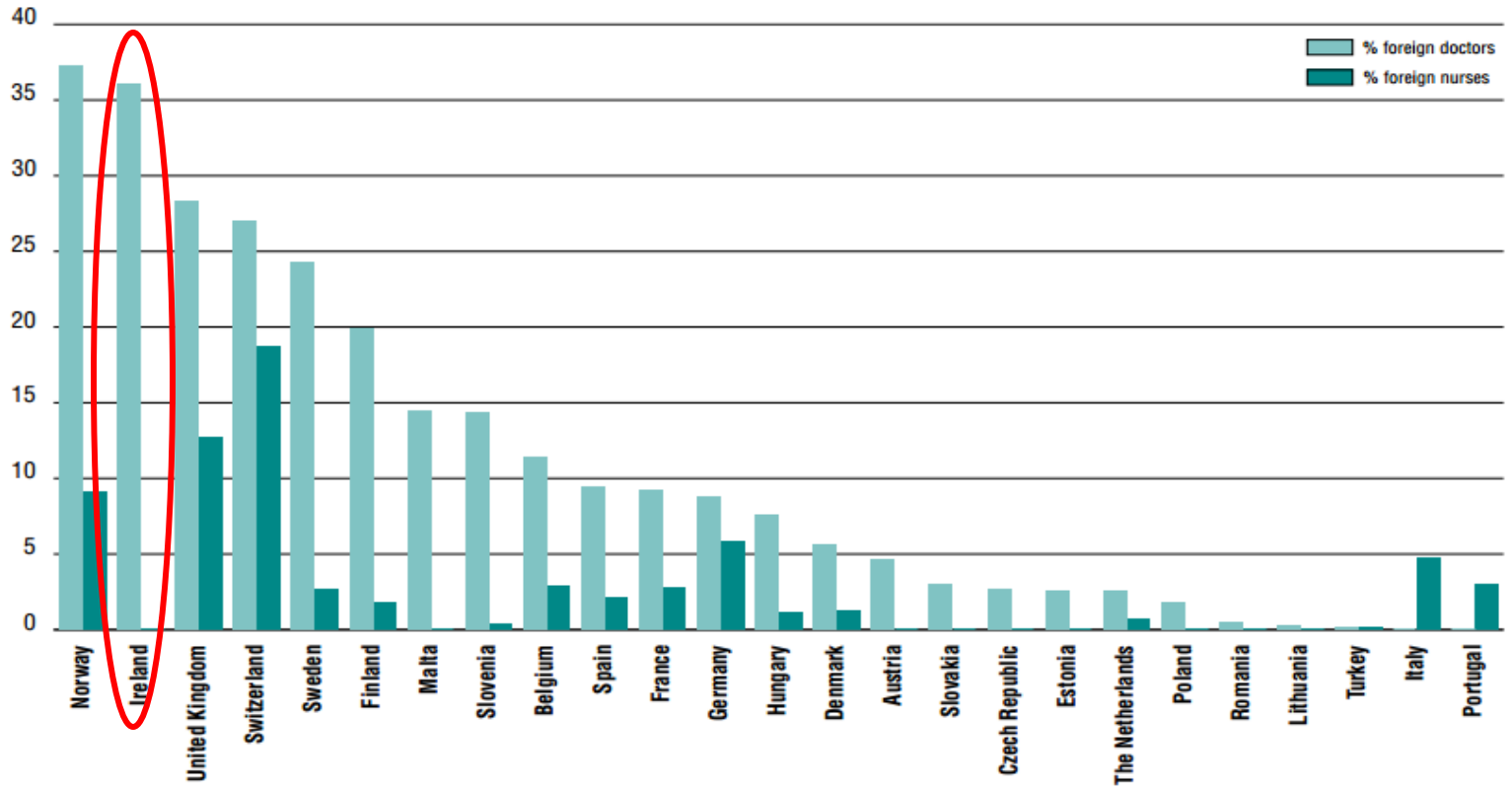
Skill Mix optimization

Doctors and nurses density, 2014 or latest

Source: Eurostat, WHO Health for all database

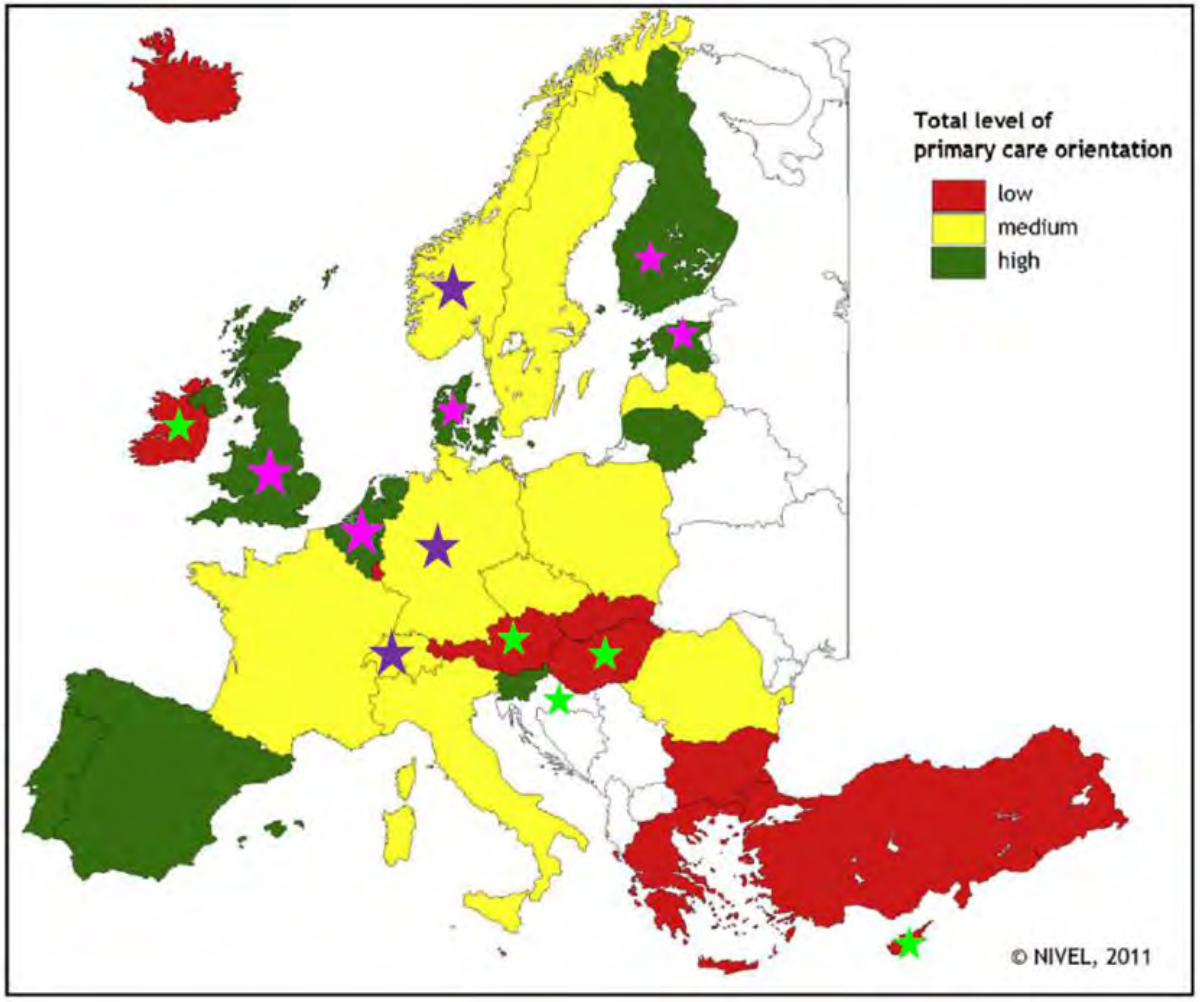


Reliance on foreign doctors and nurses in selected European countries, 2014 or latest year available



Source: Glinos et al, 2015

Variation in primary care strength accross Europe



Source: Kringos et al 2013

EXHIBIT 1

Strength Of Key Primary Care Aspects In Thirty-One European Countries, 2009–10

Country	Structure	Accessibility	Continuity	Coordination	Comprehensiveness
Austria	2.22	2.27	2.19	1.38	2.33
Belgium	2.21	2.13	2.38	1.70	2.53
Bulgaria	2.14	2.15	2.33	1.44	2.54
Cyprus	1.91	2.11	2.32	1.49	2.19
Czech Rep.	2.14	2.35	2.41	1.64	2.33
Denmark	2.38	2.46	2.43	1.96	2.40
Estonia	2.29	2.21	2.42	1.71	2.41
Finland	2.31	2.20	2.32	1.74	2.51
France	2.16	2.06	2.33	1.63	2.47
Germany	2.20	2.25	2.38	1.38	2.34
Greece	2.10	2.08	2.25	1.96	2.17
Hungary	2.08	2.34	2.33	1.46	2.29
Iceland	1.77	2.28	2.40	1.60	2.42
Ireland	2.20	1.96	2.38	1.57	2.36
Italy	2.33	2.27	2.31	1.73	2.13
Latvia	2.14	2.15	2.38	1.65	2.41
Lithuania	2.27	2.29	2.30	1.98	2.56
Luxembourg	1.90	2.03	2.31	1.63	2.42
Malta	2.12	2.17	2.17	1.82	2.38
Netherlands	2.50	2.38	2.26	2.20	2.32
Norway	2.27	2.25	2.36	1.56	2.55
Poland	2.12	2.35	2.33	1.92	2.29
Portugal	2.41	2.34	2.35	1.62	2.47
Romania	2.31	2.26	2.33	1.55	2.20
Slovak Rep.	2.02	2.27	2.39	1.39	1.98
Slovenia	2.36	2.47	2.30	1.84	2.32
Spain	2.43	2.44	2.43	1.84	2.51
Sweden	2.23	2.17	2.25	2.32	2.49
Switzerland	2.04	2.17	2.37	1.63	2.42
Turkey	2.27	2.05	2.15	1.61	2.36
UK	2.52	2.40	2.37	1.88	2.52

SOURCE Kringos DS. The strength of primary care in Europe (Note 9 in text). **NOTE** Scores range from 1 (weak primary care) to 3 (strong primary care).

Strength of countries' primary care

(Source: Kringos et al, 2013)

Country	The structure of primary care			The service-delivery process of primary care				Overall primary care system strength
	Primary care governance	Economic conditions of primary care	Primary care workforce development	Access to primary care	Continuity of primary care	Coordination of primary care	Comprehensiveness of primary care	
Austria	Medium	Medium	Weak	Medium	Weak	Weak	Weak	Weak
Belgium	Medium	Strong	Medium	Weak	Strong	Medium	Strong	Strong
Bulgaria	Medium	Weak	Weak	Weak	Medium	Weak	Strong	Weak
Cyprus	Weak	Weak	Weak	Weak	Medium	Weak	Weak	Weak
Czech Republic	Medium	Weak	Weak	Strong	Strong	Medium	Weak	Medium
Denmark	Strong	Medium	Strong	Strong	Strong	Strong	Medium	Strong
Estonia	Strong	Weak	Medium	Medium	Strong	Medium	Medium	Strong
Finland	Medium	Strong	Strong	Medium	Medium	Medium	Strong	Strong
France	Medium	Medium	Medium	Weak	Medium	Medium	Strong	Medium
Germany	Medium	Strong	Medium	Medium	Strong	Weak	Medium	Medium
Greece	Medium	Weak	Weak	Weak	Weak	Strong	Weak	Weak
Hungary	Weak	Medium	Medium	Strong	Medium	Weak	Weak	Weak
Iceland	Weak	Weak	Weak	Medium	Strong	Weak	Medium	Weak
Ireland	Weak	Weak	Strong	Weak	Strong	Weak	Medium	Weak
Italy	Strong	Strong	Medium	Medium	Weak	Medium	Weak	Medium
Latvia	Medium	Medium	Weak	Weak	Strong	Medium	Medium	Medium
Lithuania	Strong	Medium	Medium	Strong	Weak	Strong	Strong	Strong
Luxembourg	Weak	Weak	Weak	Weak	Weak	Medium	Medium	Weak
Malta	Weak	Weak	Strong	Weak	Weak	Strong	Medium	Weak
Netherlands	Strong	Strong	Strong	Strong	Weak	Strong	Medium	Strong
Norway	Strong	Weak	Medium	Medium	Medium	Weak	Strong	Medium
Poland	Weak	Weak	Weak	Strong	Medium	Strong	Weak	Medium
Portugal	Strong	Medium	Strong	Strong	Medium	Medium	Strong	Strong
Romania	Strong	Strong	Medium	Medium	Medium	Weak	Weak	Medium
Slovak Rep.	Weak	Medium	Weak	Medium	Strong	Weak	Weak	Weak
Slovenia	Strong	Strong	Strong	Strong	Weak	Strong	Weak	Strong
Spain	Strong	Strong	Strong	Strong	Strong	Strong	Strong	Strong
Sweden	Medium	Medium	Medium	Medium	Weak	Strong	Strong	Medium
Switzerland	Weak	Medium	Strong	Weak	Medium	Medium	Medium	Medium
Turkey	Medium	Medium	Medium	Weak	Weak	Weak	Medium	Weak
UK	Strong	Strong	Strong	Strong	Medium	Strong	Strong	Strong

Making the case for PHC-based health services delivery

ACCESS

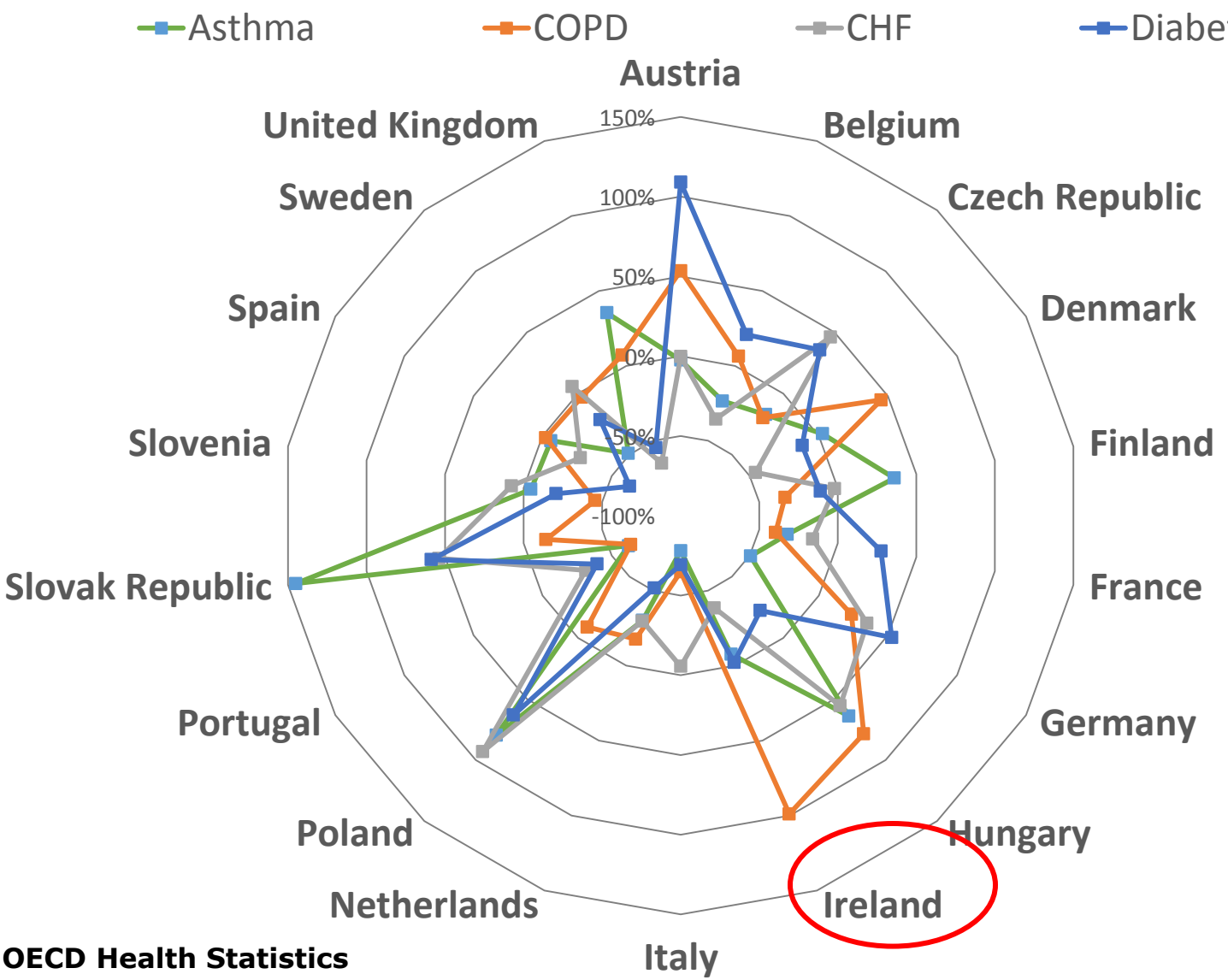
Total access to primary care score by country
(scale 1 (low) – 3 (high))

INTEGRATION

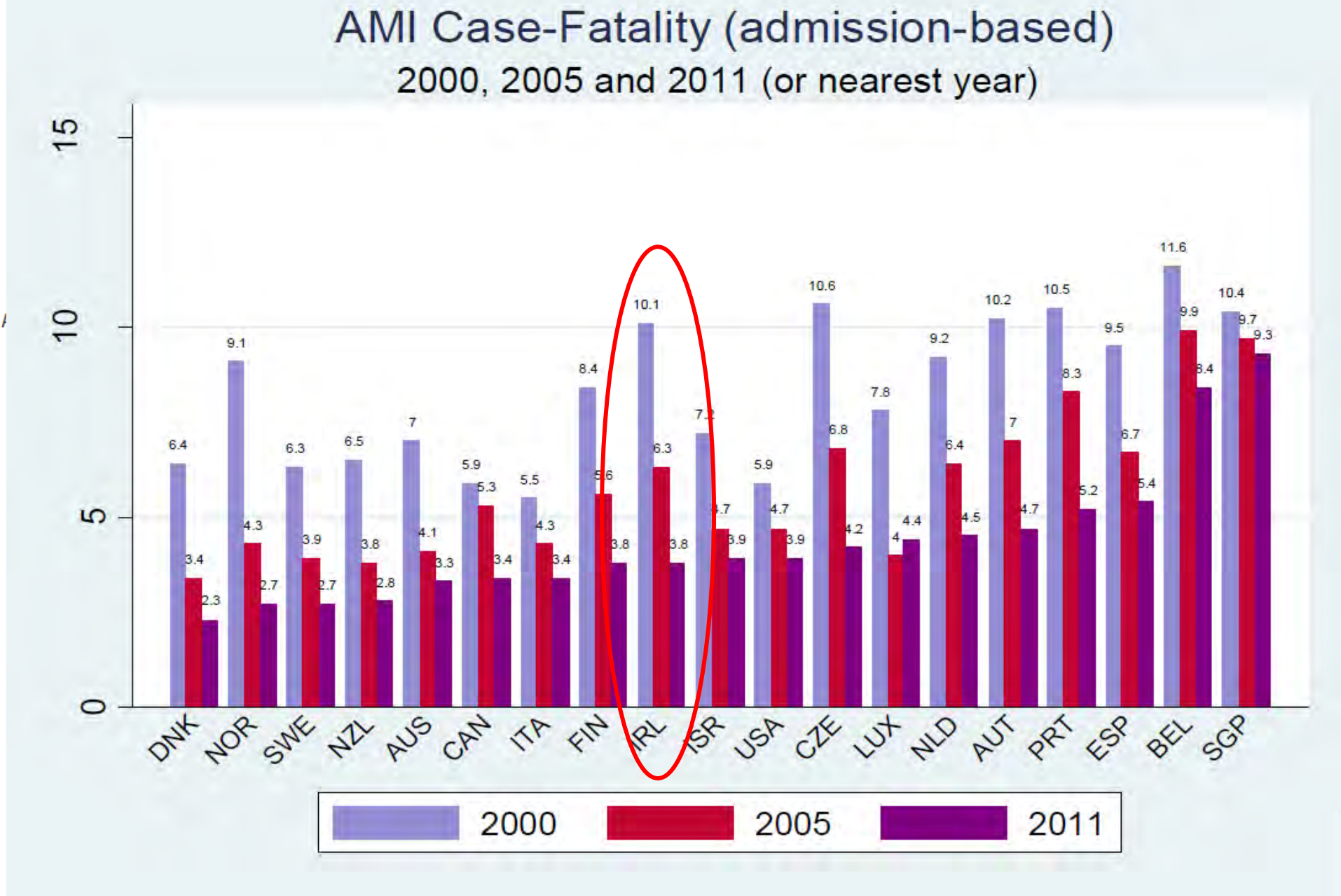
Total coordination of primary care by country
(scale 1 (low) – 3 (high))

Source: http://www.euro.who.int/__data/assets/pdf_file/0018/271170/BuildingPrimaryCareChangingEurope.pdf

Avoidable admission rates, % difference from average selected OECD countries, 2013 or latest



Source: OECD Health Statistics



Source: ***Health at a Glance: Europe 2014*****, OECD**

Acute care quality: admission based

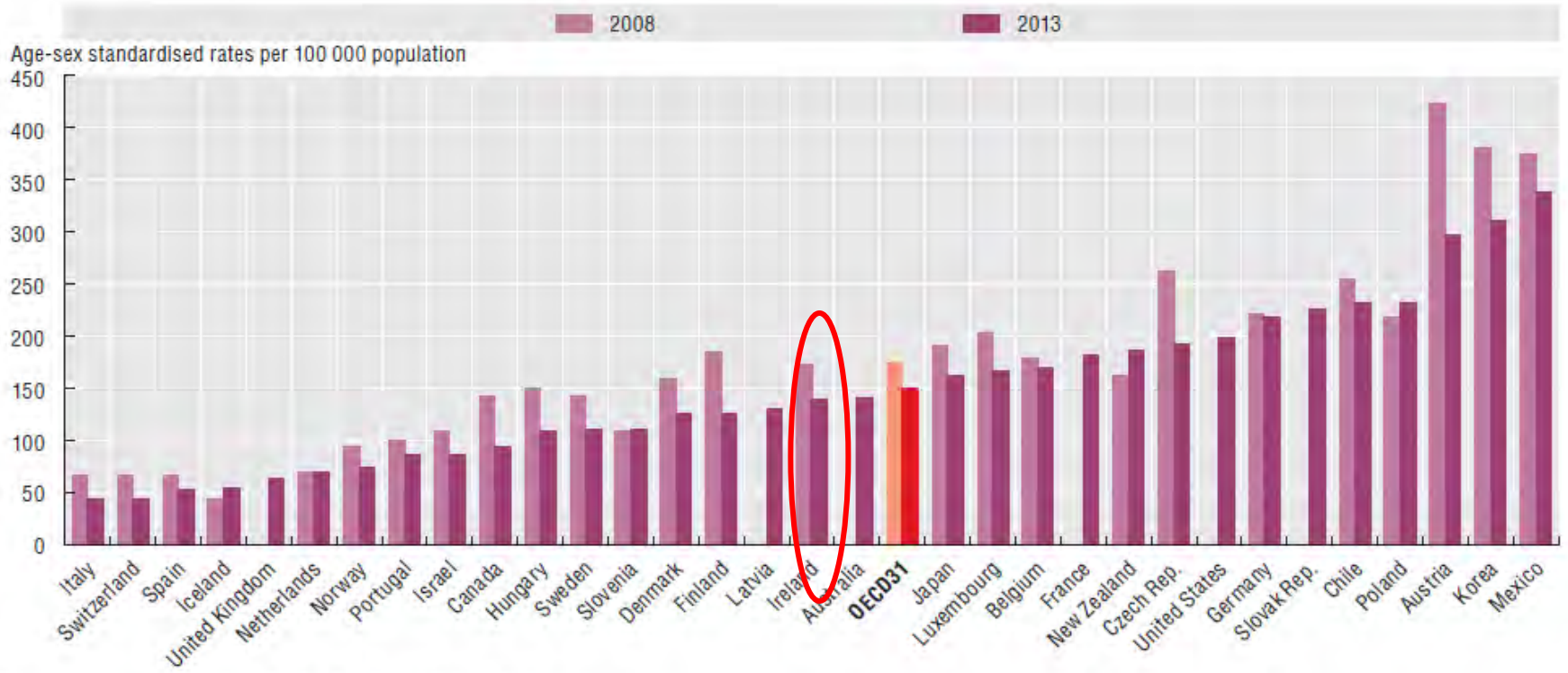
	AMI		Ischemic stroke		Haemorrhagic stroke	
	Case-fatality rate %	Annual % change	Case-fatality rate %	Annual % change	Case-fatality rate %	Annual % change
Admission-based						
Australia	4.8	-6.9	10	-1.6	22.2	-1.5
Austria	7.7	-6.7	6	-3.6	14.4	-2.9
Belgium	7.6	-6.5	9.2	-1.4	30.5	-0.6
Canada	5.7	-5.3	9.7	-3.1	22.2	-3.1
France	6.2	-4.7	8.5	-4.3	24	-1.2
Germany	8.9	-3.6	6.7	-4.4	17.5	-3.7
Iceland	5.7	-4.3	7.4	6.7	16.7	-10.4
Ireland	6.8	-7.4	9.9	-3.4	26.2	-1.2
Italy	5.8	-4.4	6.5	-2.4	19.9	-0.5
Japan	12.2	-1.8	3	-1.1	11.8	0.9
Mexico	27.2	1.5	19.6	1.3	29.7	-1.6
Portugal	8.4	-5.5	10.5	-2.5	23.8	-0.6
Singapore	12.5	-1.5	7.6	-0.4	22	-1.5
Slovak Republic	7.6	-10.4	11	-4.8	28	-4.5
Switzerland	5.9	-6.3	7	-3.2	16.5	-3.8
Turkey	10.7		11.8		32	
United States	5.5	-4.4	4.3	-2.1	22.3	-2.2

Best third | Middle third | Worst third

Source: ***Health at a Glance: Europe 2014*****, OECD**

…with proven success in areas such as diabetes management

Diabetes hospital admission in adults, 2008 and 2013 (or nearest years)

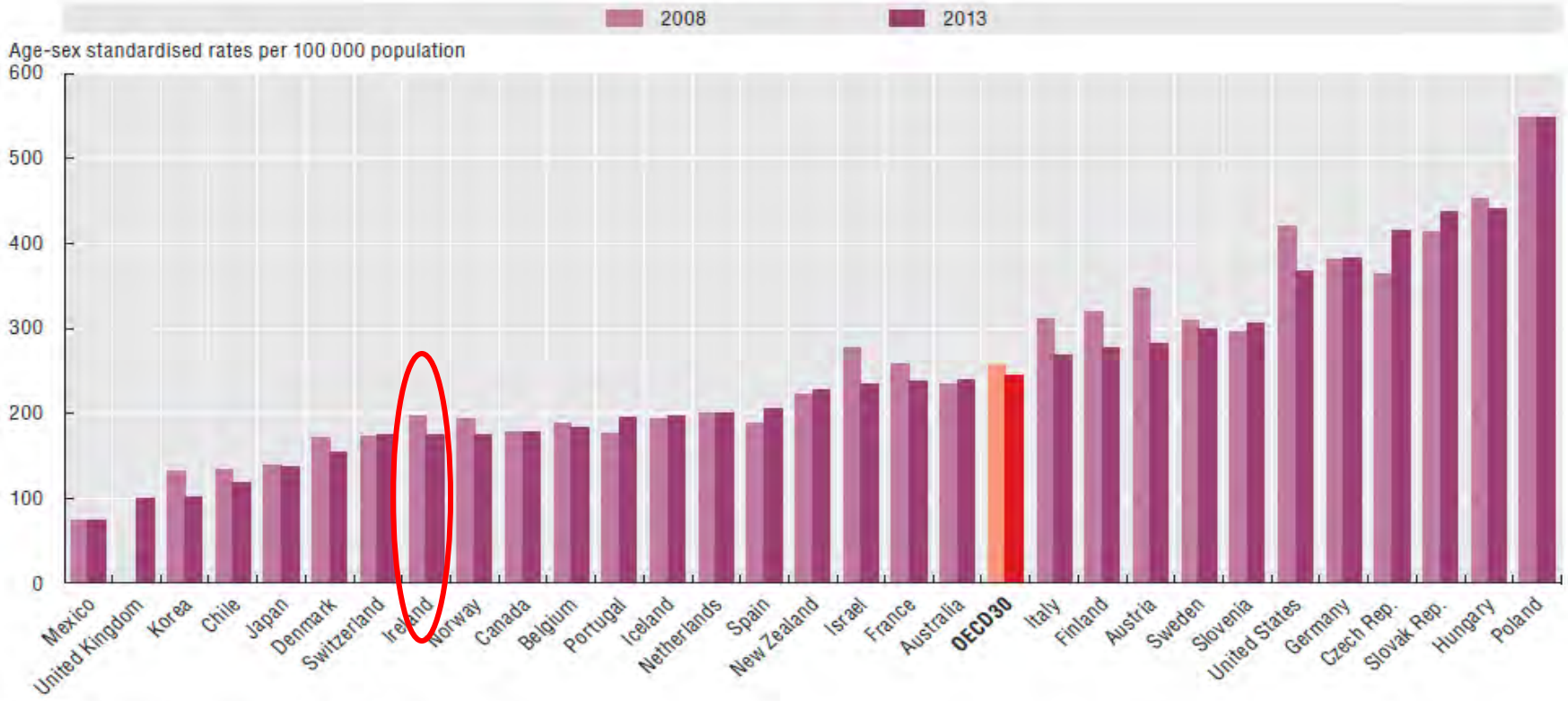


Note: Three-year average for Iceland and Luxembourg.
Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933281111

Opportunities to strengthen health services delivery performance…

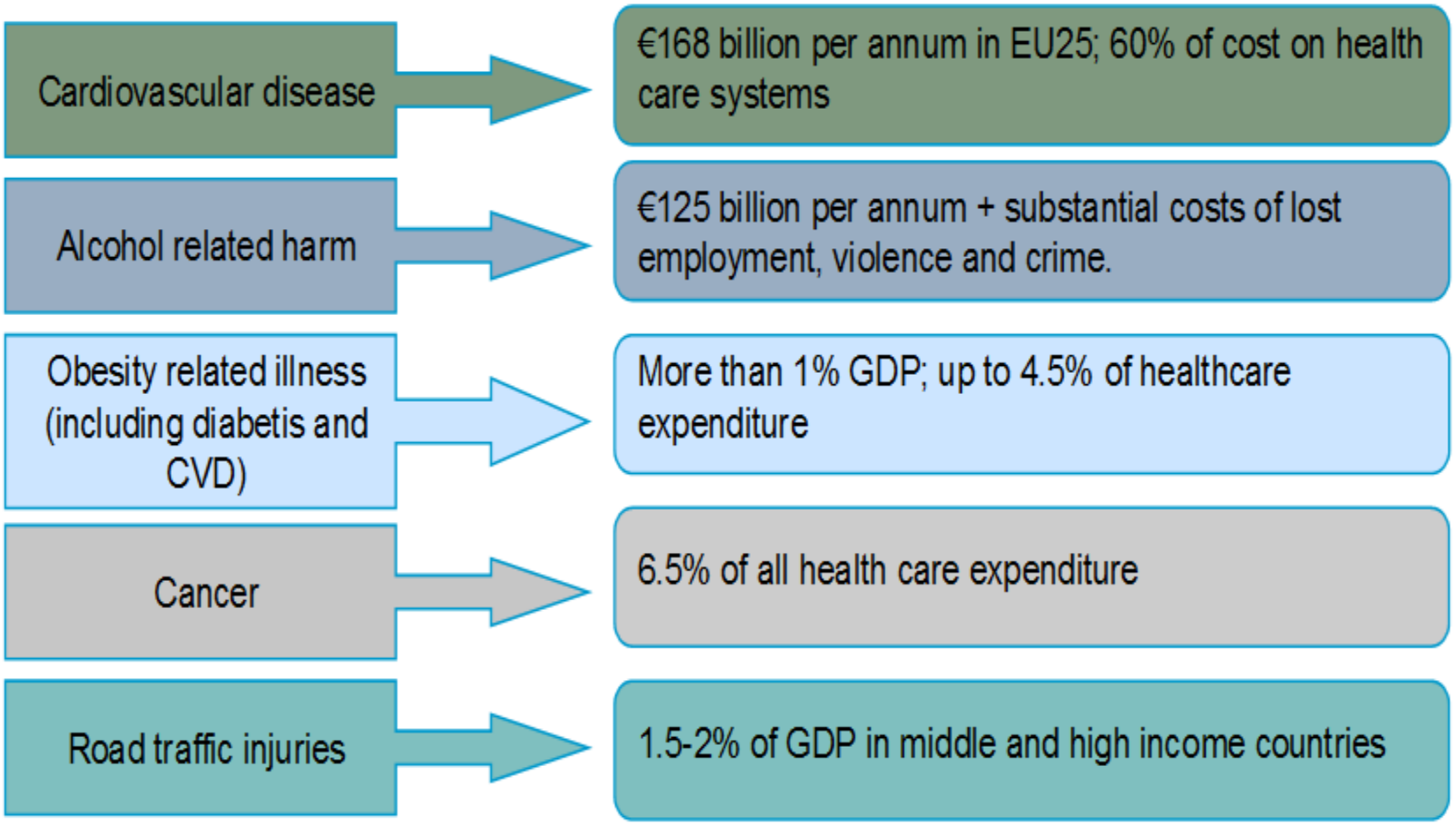
Congestive heart failure hospital admission in adults, 2008 and 2013 (or nearest years)



Note: Three-year average for Iceland.
Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933281105

5. Acting on Determinants?



Sources: Leal (2006), Sassi (2010), Stark (2006)

Figure 10: DALYs attributable to leading risk factors, both sexes, all ages, EU and EFTA, 2010

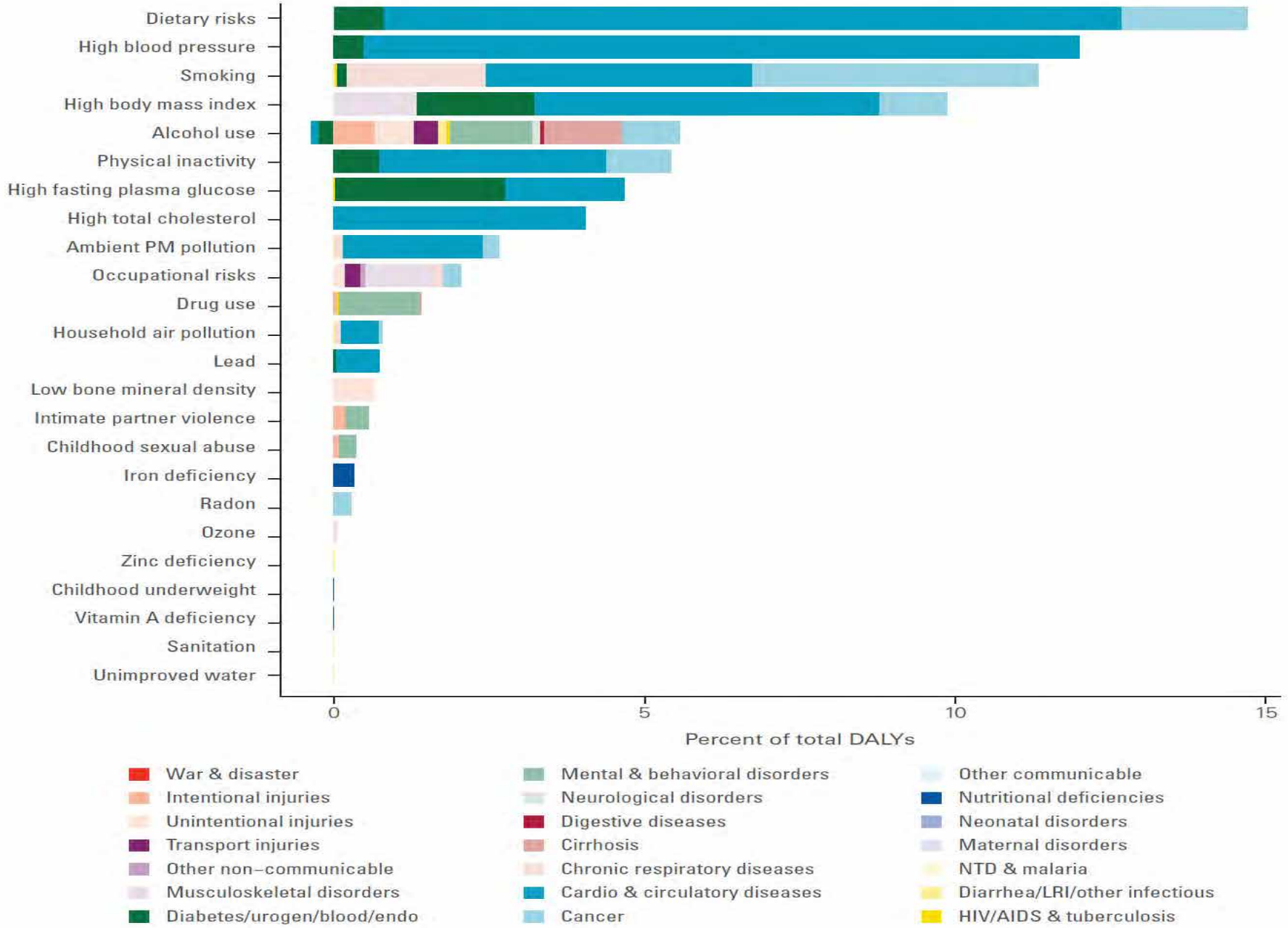
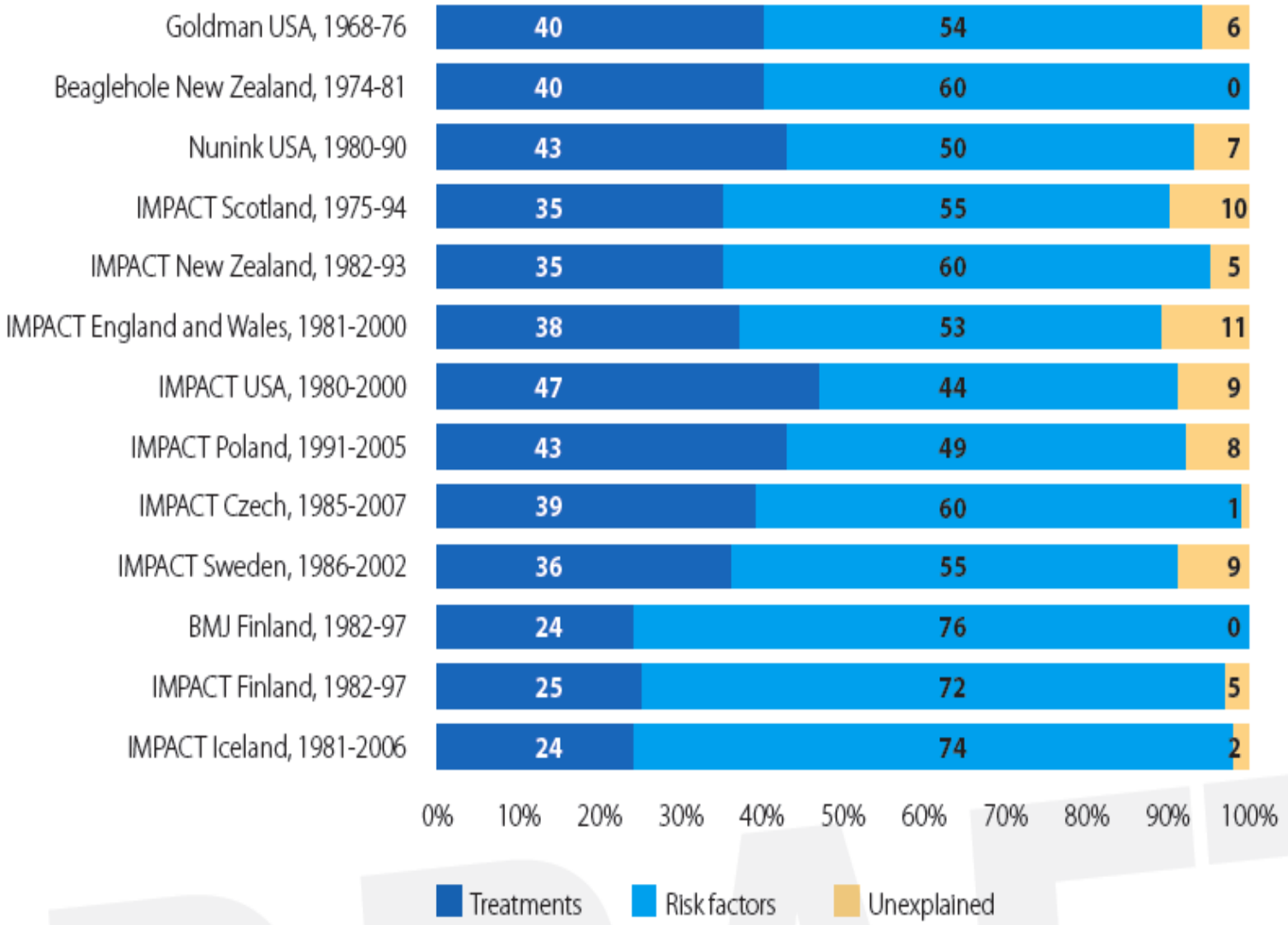
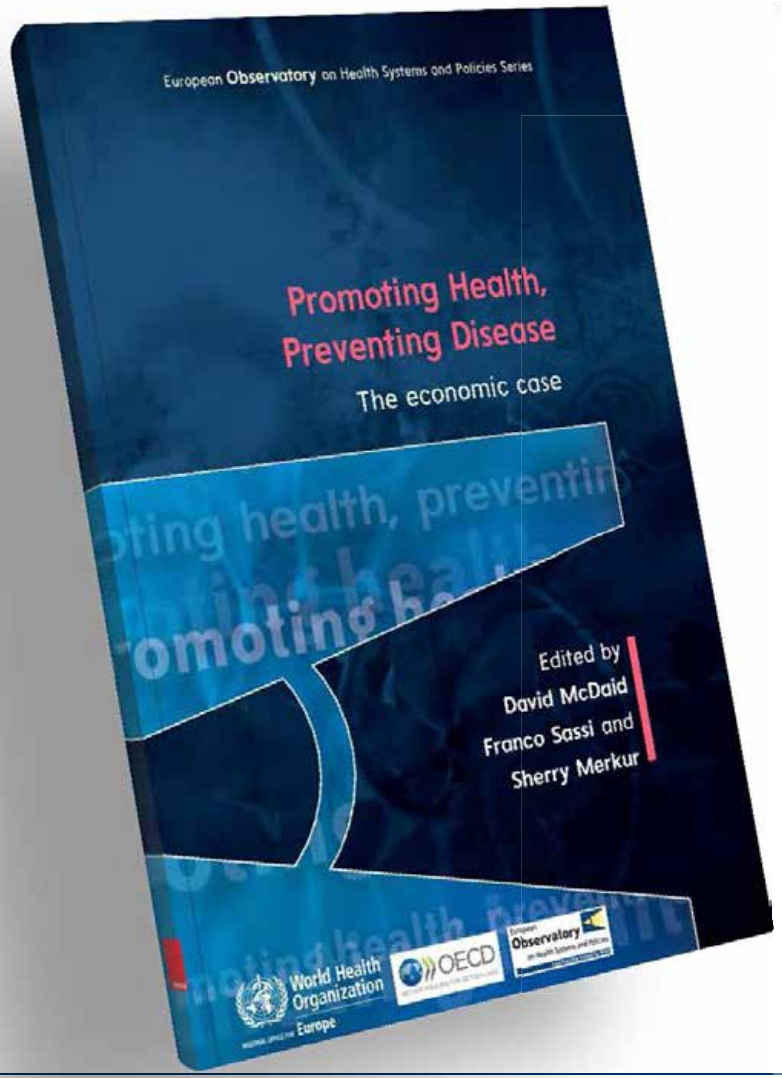


Fig. 2. Contribution of treatment and risk factor reduction to the decline in global coronary heart disease mortality



Source: Ford et al. *(11).*

Prevention: Making the Economic Case
The Evidence….



- **Raising cigarette prices to the EU average $5.50: save 00000's lives; 100,000 in Russia alone**
- **Children advertising: 10,000 years in good health / year in W Europe**
- **Regulation of salt content in food: 44,000 life years in England alone**
- **Road traffic accidents: 3% GDP, strategies generate cost savings**
- **Health Inequalities in EU25: 1.4 GDP , 20% HC costs, 15% SS costs**

Economics of Prevention

Table 3.3 Dominant (cost-saving) preventive interventions for non-communicable disease, ACE–Prevention

Topic area	Intervention	Lifetime health impact*	Annual intervention cost*	Strength of evidence
Alcohol	Volumetric tax	++	+	Likely
	Tax increase 30%	+++	+	Likely
	Advertising bans	+	+	Limited
	Raise minimum legal drinking age to 21	+	+	Limited
Tobacco	Tax increase 30% (with or without indexation)	+++	+	Likely
Physical activity	Pedometers	++	++	Sufficient
	Mass media	++	++	Inconclusive
Nutrition	Community fruit and vegetable intake promotion	+	++	May be effective
	Voluntary salt limits	+	+	Likely
	Mandatory salt limits	+++	+	Likely
Body mass	10% tax on unhealthy food	+++	+	May be effective
Blood pressure and cholesterol	Community heart health program	++	+	May be effective
	Polypill $200 for >5% CVD risk	+++	+++	Likely
Osteoporosis	Screen women aged 70+ and alendronate	++	++	Sufficient
Hepatitis B	Vaccine and immunoglobulin to infants born to carrier or high-risk mothers	+	+	Sufficient
	High-risk infant vaccination	+	+	Sufficient
	Selective vaccination of infants with mothers from highly endemic countries	+	+	Sufficient
Kidney disease	Proteinuria screen and ACE inhibitors for diabetics	++	+	Sufficient
Mental disorders	Problem-solving post-suicide attempt	+	+	Sufficient
	Treatment for individuals at ultra-high risk for psychosis	+	+	Likely
Oral health	Fluoridation drinking water, non-remote	+	+	Limited

ACE, angiotensin-converting enzyme; CVD, cardiovascular disease

Very Cost Effective Interventions – Vos et al 2010

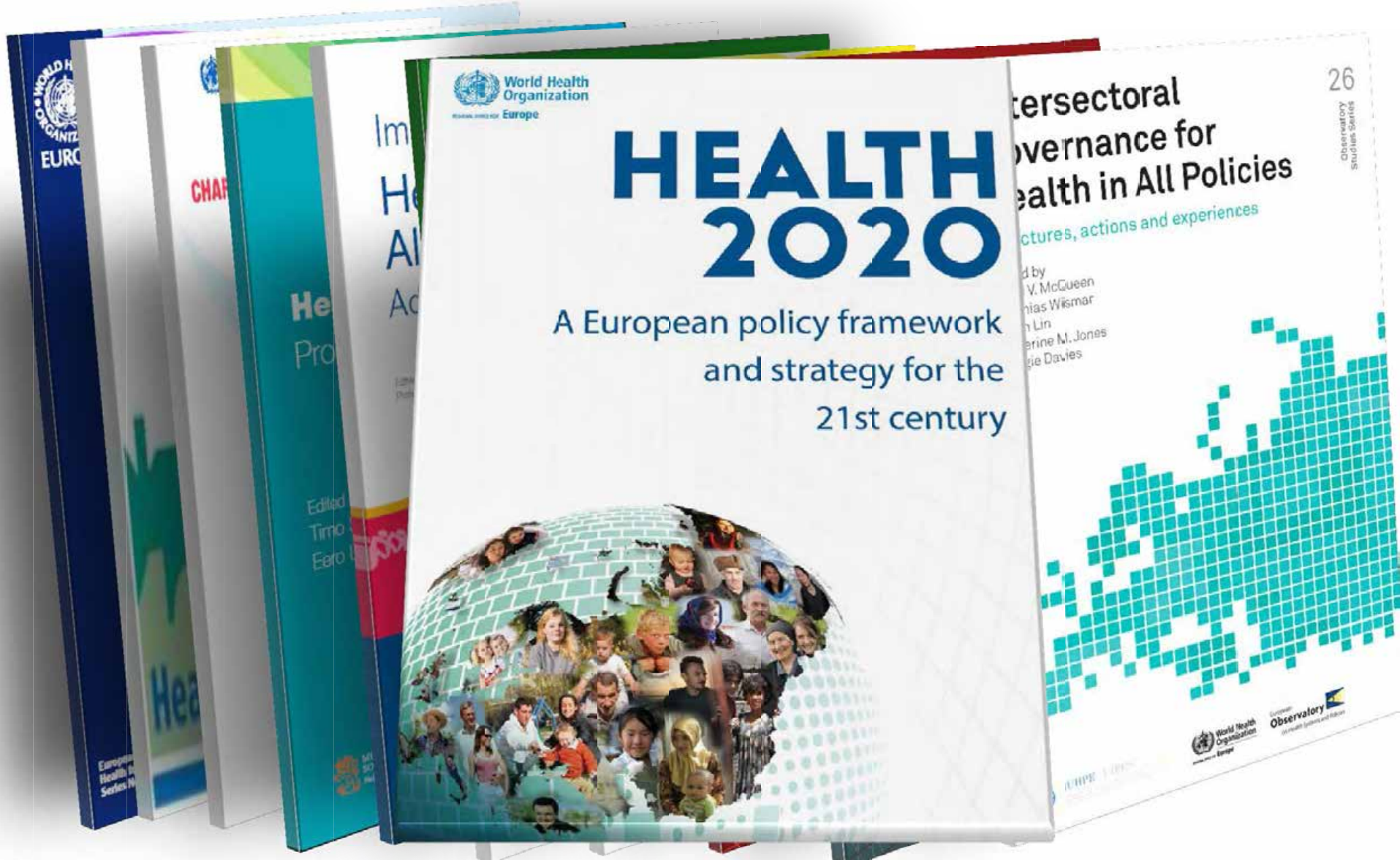
Table 3.4 Very cost-effective preventive interventions ($0–10,000 per DALY) for non-communicable disease, ACE–Prevention

Topic area	Intervention	Lifetime health impact*	Annual intervention cost*	Strength of evidence
Alcohol	Brief alcohol intervention GP with or without telemarketing and support	+	+	Sufficient
	Licensing controls	+	+	Likely
Tobacco	Cessation aid: varenicline	++	+++	Sufficient
	Cessation aid: bupropion	++	+++	Sufficient
	Cessation aid: nicotine replacement therapy	++	++	Sufficient
Physical activity	GP Green Prescription	+	+++	Limited
	Internet intervention	+	++	Sufficient
Nutrition	Information mail-out, multiple re-tailored to promote fruit and vegetable intake	+	+	Limited
Body mass	Gastric banding for severe obesity	+++	+++	Sufficient
Blood pressure and cholesterol	Low-dose diuretics >5% CVD risk	+++	+++	Sufficient
	Polypill $200 to ages 55+	+++	+++	Likely
	CCBs >10% CVD risk	++	++	Sufficient
	ACE inhibitors >15% CVD risk	++	++	Sufficient
Mental disorders drugs/suicide	Screen and bibliotherapy to prevent adult depression	+	++	Likely
	Screen and psychologist to prevent childhood/adolescent depression	+	++	Sufficient
	Screen and bibliotherapy to prevent childhood/adolescent depression	+	+	Limited
	Responsible media reporting for the reduction of suicide	+	+	Likely
	Parenting intervention for the prevention of childhood anxiety disorders	+	+	Sufficient
Other	Universal infant hepatitis B vaccination	+	++	Sufficient

ACE, angiotensin-converting enzyme; CCB, calcium channel blocker; CVD, cardiovascular disease

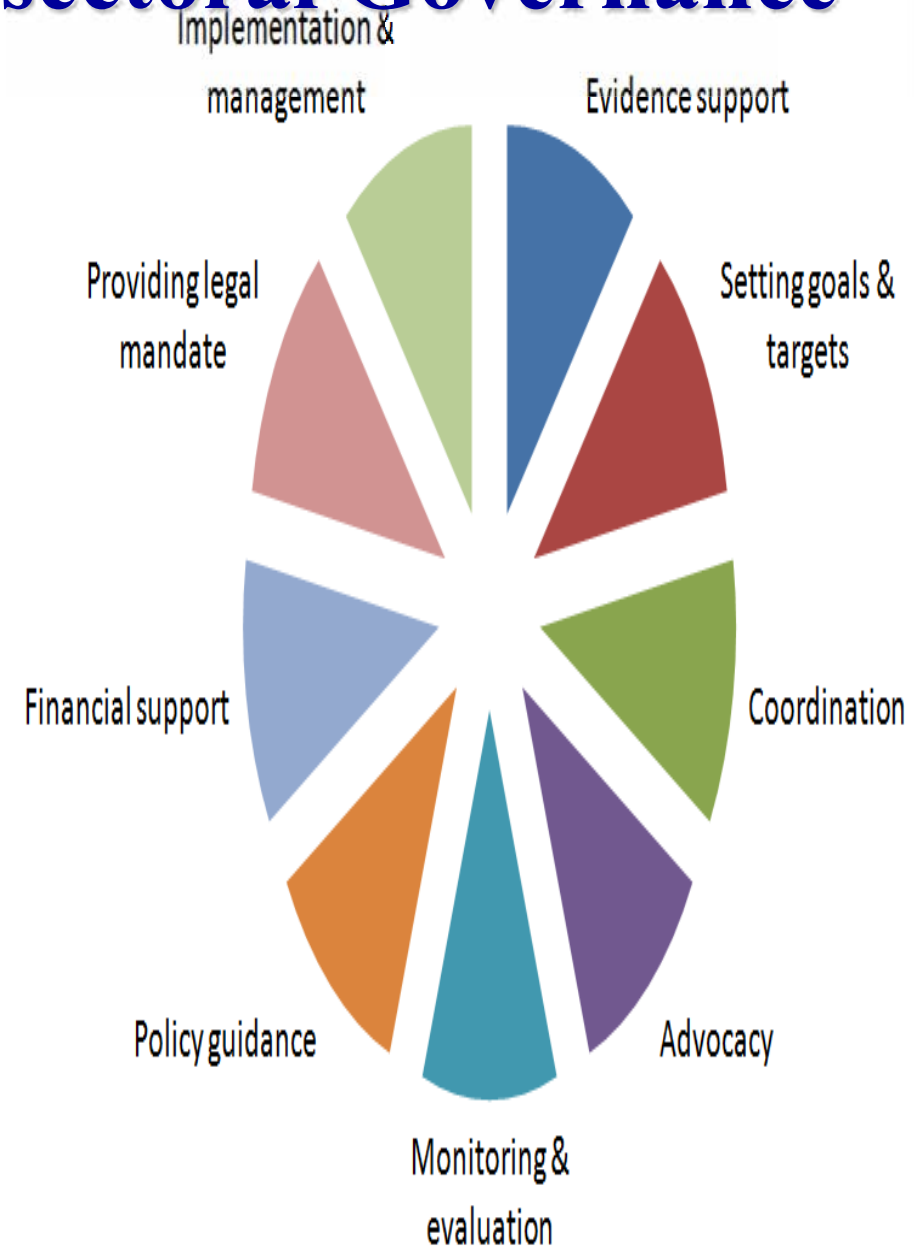
* See Section 2.5 for an explanation of table symbols and colour-coding.

Convergence towards Health in All Policies



Strengthening Intersectoral Governance

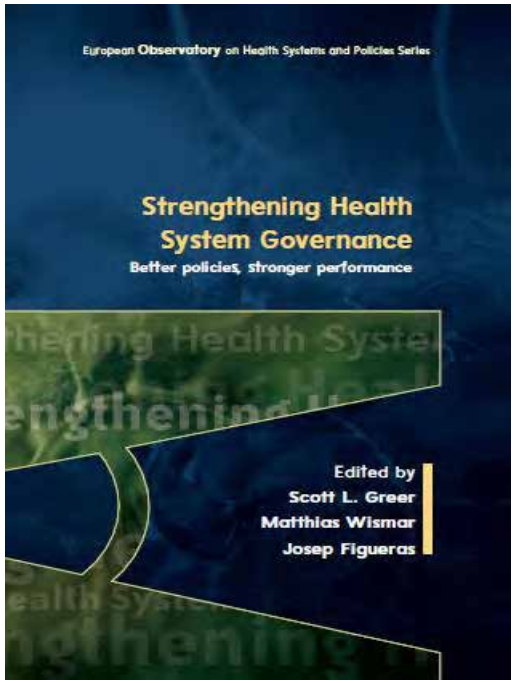
Government	*Cabinet Committees and Secretariats*
Parliament	*Parliamentary Committees*
Civil service	*Interdepartmental Committees & Units* *Mega-ministries / Mergers*
Funding arrangements	*Joint Budgeting* *Delegated Financing*
Engagement beyond government	*Public* *Stakeholder* *Industry*



6. Focus on Implementation

Good Governance

- Transparency
  - Makes decisions & their grounds clear
- Participation
  - Affected parties engaged in decision making
- Accountability
  - Clear reporting to principals with sanctions
- Integrity
  - Weberian virtues: clear jobs, hiring, tenure etc.
- Policy capacity
  - Skills for policy analysis at center




Integrated Care
HTA Benefit Packages
Skill Mix
Innovation ICT
Clinical Guidelines
Public Health
Payment for Performance
Strengthen Good Governance
•Technical & political capacity to implement
•Information /Transparency
•Knowelege brokering
•Participation
Based on Repullo JR, Bengoa R
European Observatory on Health Systems and Policies

6. Strengthen (Good) Governance Central in times of reforms

- **Policy capacity, vision and leadership**
- **Transparency (performance measurement)**
  - Provider (e.g. hospitals) benchmarking
- **Participation of and Communication with**
  - Health Professionals e.g. to identify & address waste
  - Consumers e.g. to increase acceptability of reform

6. Focus on implementation

- Design in light of path dependency and context
- Alignment of reforms / incentives
- Process and pace of implementation
  - Complexity
  - Uncertainty & Piloting
- Technical Capacity
- IT & skills required

6. Focus on implementation

- Reform flexibility
  - adaptability to local circumstances
  - Bottom up reform
- Framework legislation
- Focus (often limited) organizational and political resources to priority areas in light of
  - evidence,
  - political consensus and
  - probability of quick success ‘low hanging fruit’.
- Communication to population and key stakeholders is key

www.healthobservatory.eu