Reading list

International health care comparisons

January 2014

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- holds a database of over 100,000 bibliographic records, catalogued using an authoritative thesaurus of over 11,000 indexing terms
- contributes health policy and management content to NHS Evidence
  Go to: http://www.evidence.nhs.uk/

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- photocopies of journal articles (for a small fee).
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Contact details

Information Centre
The King's Fund
11-13 Cavendish Square
LONDON
W1G 0AN

Tel: 020 7307 2568
Email: library@kingsfund.org.uk
Twitter: https://twitter.com/kingsfund_lib
Website: http://www.kingsfund.org.uk/library

BOOKS / REPORTS

Thomson, Sarah, et al., Editors
The Commonwealth Fund
International profiles of health care systems, 2013 : Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the United States.
New York : The Commonwealth Fund, 2013 *Web publication*
This publication presents overviews of the health care systems of Australia, Canada, Denmark, England, France, Germany, Japan, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States. Each overview covers health insurance, public and private financing, health system organization and governance, health care quality and coordination, disparities, efficiency and integration, use of information technology and evidence-based practice, cost containment, and recent reforms and innovations. In addition, summary tables provide data on a number of key health system characteristics and performance indicators, including overall health care spending, hospital spending and utilization, health care access, patient safety, care coordination, chronic care management, disease prevention, capacity for quality improvement, and public views.
http://www.commonwealthfund.org/~/media/files/publications/fund-report/2013/nov/1717_thomson_intl_profiles_hlt_care_sys_2013_v2.pdf

Squires, David
The Commonwealth Fund
Multinational comparisons of health systems data, 2013.
New York : Commonwealth Fund, 2013 *Web publication*
This chartbook uses data collected by the Organization for Economic Cooperation and Development to compare health care systems and performance on a range of topics, including spending, hospitals, physicians, pharmaceuticals, prevention, mortality, and quality of care. It presents data across several industrialized countries: Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.
http://www.commonwealthfund.org/~/media/Files/Publications/In%20the%20Literature/2013/Nov/PDF_OECD_multinational_comparisons_hlt_sys_data_2013.pdf

ISBN: 9780335247264
Papanicolas, Irene and Smith, Peter C., Editors
European Observatory on Health Systems and Policies
Health system performance comparison : an agenda for policy, information and research.
Maidenhead : Open University Press, 2013 *HIBd (Pap)*

Smith, Peter C. and Papanicolas, Irene
European Observatory on Health Systems and Policies
Health system performance comparison : an agenda for policy, information and research.
Policy summary ; 4
Copenhagen : WHO ROE, 2012 *Web publication*
International health system performance comparisons have the potential to provide a rich source of evidence as well as policy influence. Country comparisons that are not conducted with properly validated measures and unbiased policy interpretations may prompt adverse policy impacts and so caution is required in the selection of indicators, the methodologies used, and the interpretations made.
http://www.euro.who.int/__data/assets/pdf_file/0010/162568/e96456.pdf

ISBN: 9789198068726
Björnberg, Arne
Health Consumer Powerhouse
Euro health consumer index 2013.
Brussels : Health Consumer Powerhouse, 2013 *Web publication*
The Euro Health Consumer Index (EHCI) 2013 is the seventh study made on European healthcare systems. The Index takes a consumer and patient perspective. EHCI, like the 16 other Health Consumer Powerhouse Indexes, offers reality checks for policy makers, empowerment to patients and consumers and an opportunity for stakeholders to highlight weak and strong aspects of healthcare.
http://www.healthpowerhouse.com/files/ehci-2013/ehci-2013-report.pdf
Associated documentation:
http://healthpowerhouse.com/index.php?option=com_content&view=article&id=364:euro-health-consumer-index-2013&catid=36:euro-health-consumer-index&Itemid=55

NHS Confederation
Tough times, tough choices : how does the NHS financial situation compare?
Factsheet ; (March 2013)
London : NHS Confederation, 2013 *Web publication*
The NHS faces an unprecedented financial dilemma: the supply of funding is struggling to match the growing rate of demand for healthcare. This factsheet looks at how NHS expenditure compares with other health systems abroad and examines how other countries are adapting to the financial constraints placed upon their health systems.
http://www.nhsconfed.org/Publications/Documents/Tough-times-financial-compare.pdf

Smith, Judith, et al.
Nuffield Trust and The King's Fund
Securing the future of general practice : new models of primary care.
Research report ; July 2013.
London : Nuffield Trust, 2013 *Web publication*
This report from the Nuffield Trust and The King's Fund examines the new GP organisations forming to allow care provision at greater scale. To inform the challenges facing primary care, the former Midlands and East Strategic Health Authority - now NHS England (Midlands and East) - commissioned the Nuffield Trust and The King's Fund to undertake a review of UK and international models of primary care, focusing on those that could increase capacity and help primary care meet the pressures it faces.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/130718_securing_the_future_of_general_practice_full_report_0.pdf
Associated documentation:
http://www.nuffieldtrust.org.uk/publications/securing-future-general-practice

ISBN: 9789264200715
Organisation for Economic Co-operation and Development
Health at a glance : Europe 2013.
Paris : OECD, 2013 *Web publication*
This seventh edition of Health at a Glance provides the latest comparable data on different aspects of the performance of health systems in OECD countries. It provides evidence of large variations across countries in the costs, activities and results of health systems. Key indicators provide information on health status, the determinants of health, health care activities and health expenditure and financing in OECD countries.
http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf
Associated documentation:
http://www.oecd.org/els/health-systems/health-at-a-glance.htm

ISBN: 9789264179066
Siciliani, Luigi, et al., Editors
Organisation for Economic Co-operation and Development
Waiting time policies in the health sector : what works?
OECD Health Policy Studies.
[Paris] : OECD, 2013 *HOHG (Sic)*

Royal College of Nursing
Moving care to the community : an international perspective.
Policy briefing 12/13 ; (May 2013).
London : RCN, 2013 *Web publication*
This report sets out the current policies and initiatives in Canada, Australia, Norway, Sweden and Denmark to move care closer to home. It also outlines the impact of these reforms on the nursing workforce, and offers recommendations for key stakeholders in the UK.
http://www.rcn.org.uk/__data/assets/pdf_file/0006/523068/12.13_Moving_care_to_the_community_an_international_perspective.pdf

ISBN: 9789289000307
Marmot, Michael, Chair
World Health Organization. Regional Office for Europe and UCL Institute of Health Equity
Review of social determinants and the health divide in the WHO European Region : final report.
Copenhagen : WHO ROE, 2013 *Web publication*
This review of inequities in health across the 53 Member States of the Region was commissioned to support the development of the new European policy framework for health and well-being, Health 2020. The report builds on the global evidence and recommends policies to reduce health inequities and the health divide across all countries, including those with low incomes.
http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/the-evidence/review-of-social-determinants-and-the-health-divide-in-the-who-european-region.-final-report
Executive summary:
http://www.euro.who.int/__data/assets/pdf_file/0007/215197/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-executive-summary-Eng.pdf
Associated documentation:
http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/the-evidence

World Health Organization
World health statistics 2013.
Geneva : W.H.O., 2013 *Web publication*
World Health Statistics 2013 contains WHO's annual compilation of health-related data for its 194 Member States, and includes a summary of the progress made towards achieving the health-related Millennium Development Goals (MDGs) and associated targets. This year, it also includes highlight summaries on the topics of reducing the gaps between the world's most-advantaged and least-advantaged countries, and on current trends in official development assistance (ODA) for health.
http://apps.who.int/iris/bitstream/10665/81965/1/9789241564588_eng.pdf
Alternative format http://www.who.int/gho/publications/world_health_statistics/2013/en/index.html
Earlier reports http://www.who.int/gho/publications/world_health_statistics/en/index.html

ISBN: 9780335247516
Mackenbach, Johan P. And McKee, Martin, Editors
World Health Organization. Regional Office for Europe
Successes and failures of health policy in Europe : four decades of divergent trends and converging challenges.
European Observatory on health systems and policies series
Maidenhead : Open University Press, 2013 *HI (Mac)*

Accenture
Connected health : the drive to integrated healthcare delivery.
London : Accenture, 2012 *Web publication*
This report documents the findings of a year-long international study of connected health, entailing interviews of health leaders, surveys of physicians and case studies across eight countries: Australia, Canada, England, France, Germany, Singapore, Spain and the United States.
Free registration required to access this document:
http://nstore.accenture.com/acn_com/PDF/Accenture-Connected-Health-Global-Report-Final-Web.pdf

ISBN: 9781846194368
Brimblecombe, Neil and Nolan, Peter, editors
Mental health services in Europe : provision and practice.
London : Radcliffe, 2012 *IJHd (Bri)*
This book examines and critiques the state of specialist mental health services in ten EU countries, focusing on existing services, their development, the care provided, factors preventing better service delivery and suggestions for improvement.

Squires, David A.
The Commonwealth Fund
Explaining high health care spending in the United States : an international comparison of supply, utilization, prices, and quality.
Issues in international health policy ; (May 2012)
New York : The Commonwealth Fund, 2012 *Web publication*
This analysis uses data from the Organization for Economic Cooperation and Development and other sources to compare health care spending, supply, utilization, prices, and quality in 13 industrialized countries: Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. The U.S. spends far more on health care than any other country. However this high spending cannot be attributed to higher income, an older population, or greater supply or utilization of hospitals and doctors. Instead, the findings suggest the higher spending is more likely due to higher prices and perhaps more readily accessible technology and greater obesity. Health care quality in the U.S. varies and is not notably superior to the far less expensive systems in the other study countries. Of the countries studied, Japan has the lowest health spending, which it achieves primarily through aggressive price regulation.
http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf

DEMOS
Ageing across Europe.
Cardiff : WRVS, 2012 *Web publication*
Many European countries, including the UK, are now facing the dual challenge of responding to the demographic changes brought by population ageing, while also implementing tough austerity measures following the 2008 financial and economic crisis. With increasing pressure on public budgets, this is an important moment to consider what it is that makes a country a good place to grow old, and where possible to learn lessons from our European neighbours on the policies and services that are most effective in giving older people a good quality of life. This new evidence will contribute to a national debate in the UK about our aspirations for our older citizens and how we might best achieve them in an increasingly challenging fiscal environment.
http://www.wrvs.org.uk/Uploads/Documents/Reports%20and%20Reviews/ageing_across_europe_may24_2012.pdf

Economist Intelligence Unit
Preventive care and healthy ageing : a global perspective.
London : Economist Intelligence Unit, 2012 *Web publication*
This report investigates the challenges and pressures that an ageing population puts on healthcare systems and economies worldwide, and how eight countries - Brazil, China, India, Japan, Russia, South Africa, the UK and the US - are promoting preventive care and healthy ageing.
http://digitalresearch.eiu.com/healthyageing/content/files/download/report/EIU_Pfizer_WEB_r1.pdf
Associated documentation: http://digitalresearch.eiu.com/healthyageing/

European Commission
Patient involvement : aggregate report.
[Brussels] : European Commission, 2012 *Web publication*
This research explores views on patient involvement in healthcare across fifteen European member states. Interviews were carried out with five healthcare practitioners and ten patients in each country. Practitioners and patients were asked their overall opinion of national healthcare, who they perceived to be responsible for healthcare, feeling on patient trust and control, their understanding of the concept of patient involvement, perceived benefits and risks of patient involvement and perceived barriers and improvements.
http://ec.europa.eu/health/healthcare/docs/eurobaro_patient_involvement_2012_en.pdf

European Federation of Nurses Associations
Caring in crisis : the impact of the financial crisis on nurses and nursing : a comparative overview of 34 European countries.
[Brussels] : EFN, 2012 *Web publication*
This country-by-country report looks at the impact of the economic crisis on nurses and nursing in Europe. It illustrates the current and future challenges facing the nursing profession, and offers a view of the specific dynamics in each country, as well as a tool to take action and tackle these challenges.
http://www.fons.org/resources/documents/News/EFN-Report-on-the-Impact-of-the-Financial-Crisis-on-Nurses-and-Nursing-2012.pdf

ISBN: 9789289000031
Jakubowski, Elke and Saltman, Richard B., Editors
European Observatory on Health Systems and Policies
The changing national role in health system governance : a case-based study of 11 European countries and Australia.
Observatory Studies Series ; 29
Copenhagen : WHO ROE, 2012 *Web publication*
This study of twelve countries provides an overview of recent changes in national governments' role in the governance of health systems, focusing on efforts to reconfigure responsibilities for health policy, regulation and management; the resultant policy priorities; and the initial impact. The shift in responsibilities shows little uniform direction: a number of countries have centralized certain areas of decision-making or regulation but decentralized others. The study reviews common trends, based on the country cases, and assesses potential future developments.
http://www.euro.who.int/__data/assets/pdf_file/0006/187206/e96845.pdf

Mladovsky, Philipa, et al.
European Observatory on Health Systems and Policies, et al.
Health policy responses to the financial crisis in Europe.
Policy summary ; 5
Denmark : WHO ROE, 2012 *Web publication*
Results of a survey of health policy responses to the financial crisis in the European Region reveal that a mix of policy tools is being used to cut public expenditure on health in many countries. The analysis suggests some of these policies, such as integration of primary and secondary care and reduction of pharmaceutical prices, are more likely to increase efficiency than others such as increasing user charges. In many countries, a missed opportunity has been enhancing value through policies to improve public health.
http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf

ISBN: 9789279235429
Ilves, Toomas Hendrik Chair
European Union. eHealth Task Force
Redesigning health in Europe for 2020.
Luxembourg : Publications Office of the European Union, 2012 *Web publication*
This report outlines the Task Force's conclusions regarding the key issues faced by a fundamental re-organisation of healthcare to make use of already existing information technologies. These solutions are often not medical at all, but rather deal with how in the future we will need to treat data, privacy, research as well as the physician/patient relationship.
http://ec.europa.eu/information_society/activities/health/docs/policy/taskforce/redesigning_health-eu-for2020-ehtf-report2012.pdf
Associated documentation:
http://ec.europa.eu/information_society/activities/health/policy/ehtask_force/index_en.htm

Global Health Policy Forum
Global Health Policy Summit 2012 : report of the inaugural meeting 1 August 2012, London.
Global Health Policy Summit
[London] : Global Health Policy Forum, 2012 *Web publication*
On 1 August 2012 the Global Health Policy Summit was launched at the Guildhall in London. The Summit is a partnership between the Institute of Global Health Innovation, Imperial College London, Qatar Foundation and corporate supporters. It brought together over 500 ministers, policymakers, thinkers, business and health leaders from over 40 countries to discuss the innovation needed to meet the health challenges of the future. This report summarises the key themes that emerged from the Summit, outlines the plans for the future and provides a synopsis of the discussions on 1 August 2012.
https://workspace.imperial.ac.uk/global-health-innovation/Public/GHPS_2012_Summit_Report.pdf
Associated documentation
http://www3.imperial.ac.uk/global-health-innovation/globalhealthpolicysummit/thesummit/summitreports

Hope, Phil, et al.
Global Health Policy Forum
Creating sustainable health and care systems in ageing societies : report of the Ageing Societies Working Group 2012.
Global Health Policy Summit
[London] : Global Health Policy Forum, 2012 *Web publication*
An ageing revolution is taking place across the world. Increased longevity is a cause for celebration, but it also raises a challenge for health systems. High- and middle-income countries are at a crossroads now – they can reform their health and care systems to be sustainable for an ageing society, or they can prepare to face age-based rationing or heavily increased expenditure. Low-income countries are approaching that crossroads, and should take the opportunity of making changes now in order to create health systems that are sustainable for the future. It's a huge challenge for all countries, but innovations exist that show how it is possible to deliver better care in a sustainable way. This report develops an Ageing and Health Sustainability Framework of key actions and innovations that will help countries assess and enhance the robustness of their health systems. Over the next twelve months, we want to work with a number of countries to refine this work into an Ageing and Health Sustainability Index, and create benchmarks for countries to gauge the sustainability of their health and care systems and to target innovations where they will make the most difference.
https://workspace.imperial.ac.uk/global-health-innovation/Public/GHPS_Ageing_Societies_Report.pdf

Oldham, John, et al.
Global Health Policy Forum
Primary care : the central function and main focus : report of the Primary Care Working Group 2012.
Global Health Policy Summit
[London] : Global Health Policy Forum, 2012 *Web publication*
Primary care is a highly effective means of healthcare delivery in terms of cost and quality, but its potential is rarely realized. The drivers of health care demand in all countries are principally people with multiple chronic diseases. Current, largely hospital-based, models of meeting that demand are unsustainable. Primary care offers an alternative, but the seven challenges that must be addressed for primary care to realise its potential are: 1. Poor patient access and perception; 2. Insufficient Co-ordination and Integration; 3. Low professional prestige and workforce availability; 4. Lack of infrastructure investment; 5. Misaligned incentives; 6. Under-utilisation of information and technology; and 7. Variable quality standards and regulation. Existing innovations provide some of the answers to meeting these challenges and are cited in a range of examples, including Family Health Programme in Brazil, Medicall in Mexico and Southcentral Foundation in Alaska Governments can use these international lessons and mandate, fund or support changes to improve primary care. This paper considers three aspects in particular: action on incentives, information and technology, and quality standards/regulation. These are the areas that governments across the world can most consistently influence.
https://workspace.imperial.ac.uk/global-health-innovation/Public/GHPS_Primary_Care_Report.pdf
Associated documentation:
http://www3.imperial.ac.uk/global-health-innovation/globalhealthpolicysummit/thesummit/summitreports

Banks, James and Smith, James P.
The Institute for the Study of Labor (IZA)
International comparisons in health economics : evidence from aging studies.
IZA Discussion Paper ; 6297 (January 2012)
Bonn : IZA, 2012 *Web publication*
We provide an overview of the growing literature that uses micro-level data from multiple countries to investigate health outcomes, and their link to socioeconomic factors, at older ages. Since the data are at a comparatively young stage, much of the analysis is at an early stage and limited to a handful of countries, with analysis for the U.S. and England being the most common. What is immediately apparent as we get better measures is that health differences between countries amongst those at older ages are real and large. Countries are ranked differently according to whether one considers life-expectancy, prevalence or incidence of one condition or another. And the magnitude of international disparities may vary according to whether measures utilize doctor diagnosed conditions or biomarker-based indicators of disease and poor health. But one key finding emerges – the U.S. ranks poorly on all indicators with the exception of self-reported subjective health status.
http://ftp.iza.org/dp6297.pdf

ISBN: 9781780320595
Mooney, Gavin
The health of nations : towards a new political economy.
London : Zed Books, 2012 *HOHC (Moo)*
The Health of Nations analyses how power is exercised both in health-care systems and in society more generally. In doing so, it reveals how too many vested interests hinder efficient and equitable policies to promote healthy populations, while too little is done to address the social determinants of health.

ISBN: 9781905030538
Rumbold, Benedict, et al.
Nuffield Trust
Rationing health care : is it time to set out more clearly what is funded by the NHS?
Research report ; February 2012
London : Nuffield Trust, 2012 *Web publication*
This report examines both the feasibility, and the advantages and disadvantages, of setting out explicitly the care patients are entitled to, in the form of a nationally specified NHS 'benefits package'. It draws on the experience of countries that have sought to explicitly define the health care benefits that their publicly-funded health systems will pay for. It outlines the current system in which decisions for determining which treatments are funded by the NHS are arrived at implicitly and makes several recommendations for how the system could be improved.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/rationing_health_care_240212_0.pdf

ISBN: 9781905030507
Hurst, Jeremy and Williams, Sally
Nuffield Trust
Can NHS hospitals do more with less?
Research report ; January 2012
London : Nuffield Trust, 2012 *Web publication*
The NHS needs to make unprecedented efficiency savings of £20 billion over the next four years (four per cent per year) to bridge the gap between a virtual freeze in real-terms funding, and rising demand. Its chances of doing this will depend to a significant extent on hospitals improving productivity and efficiency, since hospitals account for the bulk of health spending and have seen a fall in their quality-adjusted productivity in recent years. This report seeks to understand the factors that determine efficiency within hospitals and how hospital trusts can best make cost savings by improving efficiency, based on UK and international experience.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/can-nhs-hospitals-do-more-with-less_full-report-120112.pdf

Nolte, Ellen
RAND Europe
Evaluating disease management programmes : learning from diverse approaches across Europe.
Project REsource
Cambridge : RAND Europe, 2012 *Web publication*
The DISMEVAL consortium examined approaches to chronic disease management and its evaluation in 13 countries across Europe. The project identified and validated evaluation methods that can be used in situations where randomisation is not possible.
http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9687.pdf

ISBN: 9781905730667
Cawston, Thomas, et al.
Reform
Healthy competition.
London : Reform, 2012 *Web publication*
This report presents ten case studies of successful health reform. Each case study shows how a radical change in the delivery of healthcare can result in improved quality and productivity. The case studies show that successful health reform leads to: reduced costs through integration and competition; reduced costs through standardisation of clinical practice; greater patient safety through service reconfiguration; and greater patient safety through better data.
http://www.reform.co.uk/resources/0000/0364/Healthy_competition.pdf

Royal College of Nursing
Mandatory nurse staffing levels.
Policy briefing ; 03/12 (March 2012)
London : RCN, 2012 *Web publication*
At the Royal College of Nursing Congress 2011, RCN members voted overwhelmingly in favour of legally enforceable staffing levels to safeguard patient care. This briefing paper provides background to the RCN position, with an overview of the evidence around nurse staffing levels and experiences of other countries who have introduced mandatory nurse-to-patient ratios.
http://www.rcn.org.uk/__data/assets/pdf_file/0009/439578/03.12_Mandatory_nurse_staffing_levels_v2_FINAL.pdf

ISBN: 9789814313971
Armstrong, Elizabeth G., et al.
The health care dilemma :a comparison of health care systems in three European countries and the US.
New Jersey ;London : World Scientific, 2011 *HIB (Arm)*

Willcox, Sharon, et al.
The Commonwealth Fund
Strengthening primary care : recent reforms and achievements in Australia, England, and the Netherlands.
Issues in international health policy ; 27 (November 2011)
New York : The Commonwealth Fund, 2011 *Web publication*
This briefing provides a summary of a study which examined quality improvement strategies in countries which have gone through recent health care reforms.
http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Nov/1564_Willcox_strengthening_primary_care_Aus_Engl_Neth_intl_brief.pdf

Squires, David A.
The Commonwealth Fund
The U.S. health system in perspective : a comparison of twelve industrialized nations.
Issues in International Health Policy ; July 2011
New York : Commonwealth Fund, 2011 *Web publication*
The Organization for Economic Cooperation and Development (OECD) tracks and reports on more than 1,200 health system measures across 34 industrialized countries. This analysis concentrated on 2010 OECD health data for Australia, Canada, Denmark, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. Health care spending in the U.S. towers over the other countries. The U.S. has fewer hospital beds and physicians, and sees fewer hospital and physician visits, than in most other countries. Prescription drug utilization, prices, and spending all appear to be highest in the U.S., as does the supply, utilization, and price of diagnostic imaging. U.S. performance on a limited set of quality measures is variable, ranking highly on five-year cancer survival, middling on in-hospital case-specific mortality, and poorly on hospital admissions for chronic conditions and amputations due to diabetes. Findings suggest opportunities for cross-national learning to improve health system performance.
http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Jul/1532_Squires_US_hlt_sys_comparison_12_nations_intl_brief_v2.pdf
Associated documentation:
http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2011/Jul/US-Health-System-in-Perspective.aspx?omnicid=20

Deloitte
2011 survey of health care consumers global report : key findings, strategic implications.
London : Deloitte, 2011 *Web publication*
This annual survey assesses health care consumers behaviours, attitudes and unmet needs in order to quantify year-to-year changes. It found that consumers remain largely confused about their health care system; grade their system as underperforming relative to what they know of other systems; and believe spending is wasteful in their country's health system.
http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_2011ConsumerSurveyGlobal_062111.pdf

ISBN: 9789289002479
Wismar, Matthias, et al., editors
European Observatory on Health Systems and Policies
Health professional mobility and health systems : evidence from 17 European countries.
Observatory Studies Series ; 23
Copenhagen : World Health Organization, 2011 *Web publication*
Conducted within the framework of the European Commission's Health PROMeTHEUS project, the research posed a set of questions of key interest to policy-makers: what are the scale and characteristics of health professional mobility in the EU?; what have been the effects of EU enlargement?; what are the motivations of the mobile workforce?; what are the resulting impacts on health system performance?; what is the policy relevance of those impacts?; and what are the policy options to address health professional mobility issues? This publication presents research on the gaps in knowledge about the numbers, trends, impacts and policy responses to this dynamic situation, in particular in Austria, Belgium, Estonia, Finland, France, Germany, Hungary, Italy, Lithuania, Poland, Romania, Serbia, Slovakia, Slovenia, Spain, Turkey and the United Kingdom.
http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf

ISBN: 978928902547
Saltman, Richard B., et al., editors
The European Observatory on Health Systems and Policies
Governing public hospitals : reform strategies and the movement towards institutional autonomy.
Observatory studies series ; 25
Copenhagen : World Health Organization, 2011 *HOAd (Eur)*
This study focuses on hospital-level decision-making and draws together both theoretical and practical evidence. It includes an in-depth assessment of eight different country models of semi-autonomy, in the Czech Republic, England, Estonia, Israel, the Netherlands, Norway, Portugal and Spain.
http://www.euro.who.int/__data/assets/pdf_file/0017/154160/e95981.pdf

Baltagi, Badi H., et al.
The Institute for the Study of Labor (IZA)
Medical technology and the production of health care.
IZA Discussion Paper ; 5545 (March 2011)
Bonn : IZA, 2011 *Web publication*
This paper investigates the factors that determine differences across OECD countries in health outcomes, using data on life expectancy at age 65, over the period 1960 to 2007.
http://ftp.iza.org/dp5545.pdf

Pritchard, Colin and Wallace, Mark S.
Journal of the Royal Society of Medicine
Comparing the USA, UK and 17 Western countries' efficiency and effectiveness in reducing mortality.
JRSM Short Reports ; Volume 2, Number 7 (July 2011)
London : Royal Society of Medicine Press, 2011 *Web publication*
In cost-effective terms, i.e. economic input versus clinical output, the USA healthcare system was one of the least cost-effective in reducing mortality rates whereas the UK was one of the most cost-effective over the period 1979– 2005.
http://shortreports.rsmjournals.com/content/2/7/60.full.pdf+html

ISBN: 9789264122307
Organisation for Economic Co-operation and Development
Health reform : meeting the challenge of ageing and multiple morbidities.
Paris : OECD, 2011 *HIB (Org)*
When the OECD was founded in 1961, health systems were gearing themselves up to deliver acute care interventions. Sick people were to be cured in hospitals, then sent on their way again. Medical training was focused on hospitals; innovation was to develop new interventions; payment systems were centred around single episodes of care. Health systems have delivered big improvements in health since then, but they can be slow to adapt to new challenges. In particular, these days, the overwhelming burden of disease is chronic, for which 'cure' is out of our reach. Health policies have changed to some extent in response, though perhaps not enough. But the challenge of the future is that the typical recipient of health care will be aged and will have multiple morbidities. This book examines how payment systems, innovation policies and human resource policies need to be modernised so that OECD health systems will continue to generate improved health outcomes in the future at a sustainable cost.
http://www.oecd.org/dataoecd/51/36/49151107.pdf

Vincent, Charles Editor
1000 Lives Plus
Is healthcare getting safer?
Improving Healthcare White Paper Series ; 5
Cardiff : 1000 Lives Plus, 2011 *Web publication*
This paper is based on a seminar by Professor Charles Vincent from Imperial College, presented in Cardiff in June 2011. He considers what has been the result of over a decade of national and international work to improve safety in healthcare.
http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Is%20healthcare%20getting%20safer.pdf

JOURNAL ARTICLES

Mou, Haizhen
The political economy of the public-private mix in heath expenditure : an empirical review of thirteen OECD countries.
Health Policy 2013; 113 (3): 270-283 (December 2013)
This study investigates the factors that may have influenced the public-private mix of health expenditure in 13 OECD countries from 1981 to 2007. The degree to which health services are socialized is regarded as the product of a trade-off between the desire to redistribute income through the fiscal system and the losses some citizens will incur when the public health care system expands. The estimation results show that, greater income inequality and population aging are associated with a smaller share of public health expenditure in total health expenditure. The more ideologically left-leaning the electorate is, the larger the share of public health expenditure. Private health insurance tends to erode the political support for the public health care systems in countries with private duplicate health insurance, but not in countries with private primary health insurance. The findings suggest that the role of private sources of funding for health care is likely to grow in developed countries. The expansion of public coverage to include pharmaceuticals and long-term care in some countries may (theoretically) encounter less opposition if the current insurance holders have no duplicate coverage, if the voters as a whole share more left-leaning political ideology, and if low-income voters are more politically mobilized. [Abstract]

Kringos, Dianne

The strength of primary care in Europe : an international comparative study.

British Journal of General Practice 2013; 63 (616): 582-583 (November 2013)

The strength of primary care systems, based on dimensions of structure and service delivery, varies among European countries. There is an urgent need to address problems of investment, workforce and patient access to services in some countries. [Introduction]

McKee, Martin and Mackenback, Johan

How well are European countries performing in advancing public health?

Eurohealth 2013; 19 (3): 7-10

Governments make choices on what priority to place on promoting health and how to achieve it. We have developed a composite measure of how successful they have been in ten areas of health policy and identified factors that can explain success or failure. We document large differences in how governments respond to the same evidence and find that, although there are many nationally specific factors, overall those countries where the population has moved furthest from the struggle to survive and is able to articulate a vision of where it is going have been most successful, although success is reduced in ethnically divided societies that are less willing to invest in public goods. [Summary]

http://www.euro.who.int/__data/assets/pdf_file/0006/216843/Eurohealth_v19-n3.pdf

Karanikolos, Marina

Financial crisis, austerity, and health in Europe.

Lancet 2013; 381 (9874): 1323-1331 (13 April 2013)

The financial crisis in Europe has posed major threats and opportunities to health. We trace the origins of the economic crisis in Europe and the responses of governments, examine the effect on health systems, and review the effects of previous economic downturns on health to predict the likely consequences for the present. We then compare our predictions with available evidence for the effects of the crisis on health. Whereas immediate rises in suicides and falls in road traffic deaths were anticipated, other consequences, such as HIV outbreaks, were not, and are better understood as products of state retrenchment. Greece, Spain, and Portugal adopted strict fiscal austerity; their economies continue to recede and strain on their health-care systems is growing. Suicides and outbreaks of infectious diseases are becoming more common in these countries, and budget cuts have restricted access to health care. By contrast, Iceland rejected austerity through a popular vote, and the financial crisis seems to have had few or no discernible effects on health. Although there are many potentially confounding differences between countries, our analysis suggests that, although recessions pose risks to health, the interaction of fiscal austerity with economic shocks and weak social protection is what ultimately seems to escalate health and social crises in Europe. Policy decisions about how to respond to economic crises have pronounced and unintended effects on public health, yet public health voices have remained largely silent during the economic crisis. [Abstract]

Mackenbach, Johan, et al.

Health policy in Europe : factors critical for success.

BMJ 2013; 346 (7901): 16-19 (30 March 2013)

Large health gains could be made if all countries in Europe adopted the health policies of the best performing country. Johan P Mackenbach, Marina Karanikolos, and Martin McKee examine the differences between countries and the reasons behind them. [Introduction]

Wolfe, Ingrid, et al.

Health services for children in western Europe.

Lancet 2013; 381 (9873): 1221-1234 (6 April 2013)

Western European health systems are not keeping pace with changes in child health needs. Non-communicable diseases are increasingly common causes of childhood illness and death. Countries are responding to changing needs by adapting child health services in different ways and useful insights can be gained through comparison, especially because some have better outcomes, or have made more progress, than others. Although overall child health has improved throughout Europe, wide inequities remain. Health services and social and cultural determinants contribute to differences in health outcomes. Improvement of child health and reduction of suffering are achievable goals. Development of systems more responsive to evolving child health needs is likely to necessitate reconfiguring of health services as part of a whole-systems approach to improvement of health. Chronic care services and first-contact care systems are important aspects. The Swedish and Dutch experiences of development of integrated systems emphasise the importance of supportive policies backed by adequate funding. France, the UK, Italy, and Germany offer further insights into chronic care services in different health systems. First-contact care models and the outcomes they deliver are highly variable. Comparisons between systems are challenging. Important issues emerging include the organisation of first-contact models, professional training, arrangements for provision of out-of-hours services, and task-sharing between doctors and nurses. Flexible first-contact models in which child health professionals work closely together could offer a way to balance the need to provide expertise with ready access. Strategies to improve child health and health services in Europe necessitate a whole-systems approach in three interdependent systems' practice (chronic care models, first-contact care, competency standards for child health professionals), plans (child health indicator sets, reliable systems for capture and analysis of data, scale-up of child health research, anticipation of future child health needs), and policy (translation of high-level goals into actionable policies, open and transparent accountability structures, political commitment to delivery of improvements in child health and equity throughout Europe). [Introduction]

Mackenbach, Johan, et al.

The unequal health of Europeans : successes and failures of policies.

Lancet 2013; 381 (9872): 1125-1134 (30 March 2013)

Europe, with its 53 countries and divided history, is a remarkable but inadequately exploited natural laboratory for studies of the effects of health policy. In this paper, the first in a series about health in Europe, we review developments in population health in Europe, with a focus on trends in mortality, and draw attention to the main successes and failures of health policy in the past four decades. In western Europe, life expectancy has improved almost continuously, but progress has been erratic in eastern Europe, and, as a result, disparities in male life expectancy between the two areas are greater now than they were four decades ago. The falls in mortality noted in western Europe are associated with many different causes of death and show the combined effects of economic growth, improved health care, and successful health policies (eg, tobacco control, road traffic safety). Less favourable mortality trends in eastern Europe show economic and health-care problems and a failure to implement effective health policies. The political history of Europe has left deep divisions in the health of the population. Important health challenges remain in both western and eastern Europe and signify unresolved issues in health policy (eg, alcohol, food) and rising health inequalities within countries. [Summary]

Appleby, John

Rises in healthcare spending : where will it end?

BMJ 2012; 345 (7882): 18-19 (10 November 2012)

John Appleby examines why countries spend more and more of their wealth on healthcare and assesses the long term affordability. [Introduction]

Klein, Rodolf

Comparing the United States and United Kingdom : contrasts and correspondences.

Health Economics, Policy and Law 2012; 7 (4): 385-391 (October 2012)

The conventionally antithetical stereotypes of the United Kingdom and United States health care systems needs to be modified in the case of the elderly. Relative to the rest of the population, the over-65s in the United States are more satisfied with their medical care than their UK counterparts. There is also much common ground: shared worries about the quality of elderly care and similar attitudes towards assisted death. Comparison is further complicated by within country variations: comparative studies should take account of the fact that even seemingly polar models may have pools of similarity. [Abstract]

Blumenthal, David and Dixon, Jennifer

Health-care reforms in the USA and England : areas for useful learning.

Lancet 2012; 380 (9850): 1352-1357 (13 October 2012)

Two landmark and controversial bills reforming health care in the USA and England were recently passed. Despite the different history and context to health care in both countries, there is much room for mutual learning. This paper identifies three areas relating to financing, organisation, and information technology. For example, new payment mechanisms to encourage higher quality and efficiency are being developed and tested, particularly bundled payments, pay for performance, and value-based purchasing. In the USA, new national bodies to scrutinise payments in health care and to test promising new interventions to improve quality and efficiency will have lessons for the NHS. The faster adoption of electronic health records and their use in England to assess quality is a useful lesson for the USA. The new accountable care organisations and clinical commissioning groups have much to learn from each other as they develop. [Summary]

Ettelt, Stefanie, et al.

Policy learning from abroad : why it is more difficult than it seems.

Policy and Politics 2012; 40 (4): 491-504 (October 2012)

This article explores the process of policy learning from abroad from a knowledge utilisation perspective, using examples of health policy making in the Department of Health in England. It argues that information about policy abroad is often heterogeneous and difficult to obtain systematically and therefore does not fit easily with notions of evidence-based policy making. While some officials interviewed for this study did regard policy examples from other countries as a substitute for evidence, especially in areas in which research evidence was insufficient, others appeared to be less confident about its validity and generalisability. Department of Health officials reported a great variability in strategies to obtain such information, with processes often constrained by pressures on time and resources. They were also highly selective in exploring policy examples from abroad, with most respondents stating that they were largely interested in generating ideas to address domestic policy problems, often relating to details of policy. The iterative process of using this information thus raises questions about the extent to which looking abroad contributed to genuine policy learning. [Abstract]

Nolte, Ellen and McKee, C. Martin

In amenable mortality - deaths avoidable through health care - progress in the US lags that of three European countries.

Health Affairs 2012; 31 (9): 2114-2122 (September 2012)

We examined trends and patterns of amenable mortality—deaths that should not occur in the presence of timely and effective health care—in the United States compared to those in France, Germany, and the United Kingdom between 1999 and 2007. Americans under age sixty-five during this period had elevated rates of amenable mortality compared to their peers in Europe. For Americans over age sixty-five, declines in amenable mortality slowed relative to their peers in Europe. Overall, amenable mortality rates among men from 1999 to 2007 fell by only 18.5 percent in the United States compared to 36.9 percent in the United Kingdom. Among women, the rates fell by 17.5 percent and 31.9 percent, respectively. Although US men and women had the lowest mortality from treatable cancers among the four countries, deaths from circulatory conditions—chiefly cerebrovascular disease and hypertension—were the main reason amenable death rates remained relatively high in the United States. These findings strengthen the case for reforms that will enable all Americans to receive timely and effective health care. [Abstract]

Savedoff, William D., et al.

Political and economic aspects of the transition to universal health coverage.

Lancet 2012; 380: (9845): 924-932 (8 September 2012)

Countries have reached universal health coverage by different paths and with varying health systems. Nonetheless, the trajectory toward universal health coverage regularly has three common features. The first is a political process driven by a variety of social forces to create public programmes or regulations that expand access to care, improve equity, and pool financial risks. The second is a growth in incomes and a concomitant rise in health spending, which buys more health services for more people. The third is an increase in the share of health spending that is pooled rather than paid out-of-pocket by households. This pooled share is sometimes mobilised as taxes and channelled through governments that provide or subsidise care—in other cases it is mobilised in the form of contributions to mandatory insurance schemes. The predominance of pooled spending is a necessary condition (but not sufficient) for achieving universal health coverage. This paper describes common patterns in countries that have successfully provided universal access to health care and considers how economic growth, demographics, technology, politics, and health spending have intersected to bring about this major development in public health. [Abstract]

Hsiou, Tiffany and Pylypchuk, Yuriy

Comparing and decomposing differences in preventive and hospital care : USA versus Taiwan.

Health Economics 2012; 21 (7): 778-795 (July 2012)

As the USA expands health insurance coverage, comparing utilization of healthcare services with countries like Taiwan that already have universal coverage can highlight problematic areas of each system. The universal coverage plan of Taiwan is the newest among developed countries, and it is known for readily providing access to care at low costs. However, Taiwan experiences problems on the supply side, such as inadequate compensation for providers, especially in the area of preventive care. We compare the use of preventive, hospital, and emergency care between the USA and Taiwan. The rate of preventive care use is much higher in the USA than in Taiwan, whereas the use of hospital and emergency care is about the same. Results of our decomposition analysis suggest that higher levels of education and income, along with inferior health status in the USA, are significant factors, each explaining between seven per cent and 15 per cent of the gap in preventive care use. Our analysis suggests that, in addition to universal coverage, proper remuneration schemes, education levels, and cultural attitudes towards health care are important factors that influence the use of preventive care. [Abstract]

Reynolds, Lucy, et al.

Ditching the single-payer system in the National Health Service : how the English Department of Health is learning the wrong lessons from the United States.

International Journal of Health Services 2012; 42 (3): 539-547

Reforms to the British National Health Service introduce major changes to how health care will be delivered. The core elements include the creation of new purchaser organizations, Clinical Commissioning Groups, which unlike their predecessors will be able to recruit and reject general practices and their patients without geographical restriction. The Clinical Commissioning Groups are to transition from statutory bodies to freestanding organizations, with most of their functions privatized and an increasingly privatized system of provision, In this paper, we explore the likely consequences of these proposals, drawing in particular on the experience of managed care organizations in the United States, whose approach has influenced the English proposals extensively. We argue that the wrong lessons are being learned and the English reforms are likely to fundamentally undermine the principles on which the British National Health Service was founded. [Abstract]

Wendt, Claus, et al.

Confidence in receiving medical care when seriously ill : a seven-country comparison of the impact of cost barriers.

Health Expectations 2012; 15 (2): 212-224 (June 2012)

OBJECTIVE: This paper examines how negative experiences with the health-care system create a lack of confidence in receiving medical care in seven countries: Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. METHODS: The empirical analysis is based on data from the Commonwealth Fund International Health Policy Survey 2007, with nationally representative samples of adults aged 18 and over. For the analysis of the experience of cost barriers and confidence in receiving medical care, we conducted pairwise comparisons of group percentages as well as country-wise multivariate logistic regression models. RESULTS: Individuals who have experienced cost barriers show a significantly lower level of confidence in receiving safe and quality medical care than those who have not. This effect is most pronounced in the United States, where people who have foregone necessary treatment because of costs are four times as likely to lack confidence as individuals without the experience of cost barriers (adjusted odds ratio 4.00). In New Zealand, Germany, and Canada, individuals with the experience of cost barriers are twice as likely to report low confidence compared with those without this experience (adjusted odds ratios of 1.95, 2.19 and 2.24, respectively). In the Netherlands and UK, cost barriers are only a marginal phenomenon. CONCLUSIONS: The fact that the experience of financial barriers considerably lowers confidence indicates that financial incentives, such as private co-payments, have a negative effect on overall public support and therefore on the legitimacy of health-care systems. [Abstract]

Tenbensel, Tim, et al.

Comparing health policy agendas across eleven high income countries : islands of difference in a sea of similarity.

Health Policy 2012; 106 (1): 29-36 (June 2012)

Does the way in which health systems are financed influence whether health policymakers are more or less interested in accessible and equitable health services? Are social democratic governments more interested in primary health care reform than conservative governments? Have particular domains of health policy really become more important over the past decade across a range of countries? In this exploratory article, we investigate the similarities and differences in patterns of attention in health policy in eleven high income countries using data from the Health Policy Monitor database from 2003 to 2010. Our study suggests significant 'islands of difference' in an overall 'sea of similarity' between the health policy agendas of the selected countries. The key findings are: (i) that improving population health outcomes is more likely to be on the agenda under tax-based systems and when centre-left parties are dominant in government; (ii) health systems funded through social insurance are more preoccupied with efficiency and cost-containment than tax-funded systems; (iii) the political complexion of governments is not a major factor shaping health policy agendas; and (iv) since 2003 there has been an increasing interest in initiatives that address public health concerns, access and equity, and population health outcomes. [Abstract]

Smith, Peter C., et al.

Leadership and governance in seven developed health systems.

Health Policy 2012; 106 (1): 37-49 (June 2012)

This paper explores leadership and governance arrangements in seven developed health systems: Australia, England, Germany, the Netherlands, Norway, Sweden and Switzerland. It presents a cybernetic model of leadership and governance comprising three fundamental functions: priority setting, performance monitoring and accountability arrangements. The paper uses a structured survey to examine critically current arrangements in the seven countries. Approaches to leadership and governance vary substantially, and have to date been developed piecemeal and somewhat arbitrarily. Although there seems to be reasonable consensus on broad goals of the health system there is variation in approaches to setting priorities. Cost-effectiveness analysis is in widespread use as a basis for operational priority setting, but rarely plays a central role. Performance monitoring may be the domain where there is most convergence of thinking, although countries are at different stages of development. The third domain of accountability is where the greatest variation occurs, and where there is greatest uncertainty about the optimal approach. We conclude that a judicious mix of accountability mechanisms is likely to be appropriate in most settings, including market mechanisms, electoral processes, direct financial incentives, and professional oversight and control. The mechanisms should be aligned with the priority setting and monitoring processes. [Abstract]

Wranik, Dominika

Healthcare policy tools as determinants of health-system efficiency : evidence from the OECD.

Health Economics, Policy and Law 2012; 7 (2): 197-226 (April 2012)

This paper assesses which policy-relevant characteristics of a healthcare system contribute to health-system efficiency. Health-system efficiency is measured using the stochastic frontier approach. Characteristics of the health system are included as determinants of efficiency. Data from 21 OECD countries from 1970 to 2008 are analysed. Results indicate that broader health-system structures, such as Beveridgian or Bismarckian financing arrangements or gatekeeping, are not significant determinants of efficiency. Significant contributors to efficiency are policy instruments that directly target patient behaviours, such as insurance coverage and cost sharing, and those that directly target physician behaviours, such as physician payment methods. From the perspective of the policymaker, changes in cost-sharing arrangements or physician remuneration are politically easier to implement than changes to the foundational financing structure of the system. [Abstract]

Slomski, Anita

US can draw insight from other nations' experiences with evidence-based medicine.

JAMA 2012; 307 (15): 1567-1569 (18 April 2012)

The pathways taken by various nations in applying findings of comparative effectiveness research vary a great deal. Some countries evaluate a broad swath of clinical services, while others focus primarily on pharmaceutical agents. [Introduction]

Ingleby, David, et al.

How the NHS measures up to other health systems.

BMJ 2012; 344 (7846): 25-27 (3 March 2012)

The government's plans for reorganising the English National Health Service have sparked heated discussions about the performance of the UK health system in comparison with that of other countries. Politicians favouring reform have emphasised real and perceived shortcomings of the NHS, while opponents have lauded its successes. Objective data have been sadly lacking in much of this debate. Arbitrary examples of good or bad performance from the UK and various other countries have been thrown back and forth, often using totally incommensurable data. Two new publications from the Commonwealth Fund, a New York based health policy institute, shed some much needed light on these questions. We analyse the data and discuss the strengths and weaknesses of the NHS in the light of current proposals for reform. [Abstract]

Fahy, Nick

Who is shaping the future of European health systems?

BMJ 2012; 344 (7849): 44-45 (24 March 2012)

The bailout deals for Ireland, Portugal, and Greece include startlingly detailed changes for their national health systems. Nick Fahy asks whether the tighter European rules proposed to save the euro will mean the EU steering national health systems across all of Europe? [Introduction]

Maynard, Alan

The powers and pitfalls of payment for performance.

Health Economics 2012; 21 (1): 3-12 (January 2012)

Throughout the world, healthcare policy makers confront common problems: expenditure inflation, inefficiency and inequity in access to care. The development of health economics during the last 20 years has produced a consensus (outside the USA) about the merits of 'single-payer' systems and the need to evaluate the cost-effectiveness of competing medical technologies. These are necessary but not sufficient conditions for expenditure control and efficient rationing (Williams, 1972; Reinhardt, 1982; Hsiao, 2011; Maynard, 1997; Culyer and Rawlins, 2004). Recent reforms have had a modest effect on the efficiency of resource allocation in health care. Exacerbated by the global economic downturn, the desire for more radical improvements in efficiency has led to increased interest amongst policy makers in a vigorous payment-for-performance (P4P) culture based principally on the belief that financial incentives are efficient ways of mitigating variations in clinical practice and ensuring the delivery of conservative, cost-effective interventions. The failure of public and private healthcare markets to deliver patient care efficiently, equitably and within budgets has a long history. This is reviewed in the next section and followed by a discussion of case studies of P4P, primarily in the context of healthcare provision. A selective use of this literature is used to draw out a list of central research questions to be addressed by the rapidly evolving P4P initiatives. [Abstract]

Propper, Carol

Competition, incentives and the English NHS.

Health Economics 2012; 21 (1) 33-40 (January 2012)

This paper considers what evidence there is internationally and from the United Kingdom that introducing competition between hospitals has improved outcomes. It also looks at what evidence is available regarding the effectiveness of moving treatment out of hospitals into community settings and into high volume centres for more severe cases. In both areas the author concludes that evidence is limited. [KJ]

Dixon, Anna and Poteliakhoff, Emmi

Back to the future : ten years of European health reforms.

Health Economics, Policy and Law 2012; 7 (1): 1-10 (January 2012)

The challenges facing European health systems have changed little over 30 years but the responses to them have. Policy ideas that emerged in some countries spread to others; however, the way policies were implemented and the impact they have had has been shaped by specific national contexts. Comparative policy analysis has evolved in response to this, moving away from simple classifications of health systems and crude rankings to studies that try and understand more deeply what works, where and why. For policymakers interested in how other countries have dealt with common challenges, it is important that they avoid the naïve transplantation of policy solutions but understand the need to translate policies to fit the institutional context of a particular country. Policies that cross borders will necessarily be shaped by the social and political institutions of a country. These dimensions should not be ignored in comparative research. The next decade will require health systems to deliver improved care for people with complex needs while at the same time delivering greater value. Policymakers will benefit from looking backwards as well as to their neighbours in order to develop appropriate policy solutions. [Abstract]

Sorenson, Corinna and Chalkidou, Kalipso

Reflections on the evolution of health technology assessment in Europe.

Health Economics, Policy and Law 2012; 7 (1): 25-45 (January 2012)

Health technology assessment (HTA) has assumed an increasing role in health systems in recent years, with many countries establishing agencies or programmes to evaluate health technology and other interventions to inform policy decisions and clinical practice. This paper reflects upon its development and evolution in Europe over the last decade, with a focus on England, France, Germany and Sweden. In particular, we explore how HTA has evolved over time as well as its impact on policy and practice. While countries share many of the same objectives, there are differences in the way HTA agencies and programmes are organised, operate, and influence decision making. Despite these differences, all systems are faced with opportunities and challenges related to stakeholder involvement and acceptance, the suitability and transparency of assessment requirements and methods, balancing evidence and values in decision making, and demonstrating impact. [Abstract]

Vrangbaek, Karsten, et al.

Choice policies in Northern European health systems.

Health Economics, Policy and Law 2012; 7 (1): 47-71 (January 2012)

This paper compares the introduction of policies to promote or strengthen patient choice in four Northern European countries - Denmark, England, the Netherlands and Sweden. The paper examines whether there has been convergence in choice policies across Northern Europe. Following Christopher Pollitt's suggestion, the paper distinguishes between rhetorical (discursive) convergence, decision (design) convergence and implementation (operational) convergence (Pollitt, 2002). This leads to the following research question for the article: Is the introduction of policies to strengthen choice in the four countries characterised by discursive, decision and operational convergence? The paper concludes that there seems to be convergence among these four countries in the overall policy rhetoric about the objectives associated with patient choice, embracing both concepts of empowerment (the intrinsic value) and market competition (the instrumental value). It appears that the institutional context and policy concerns such as waiting times have been important in affecting the timing of the introduction of choice policies and implementation, but less so in the design of choice policies. An analysis of the impact of choice policies is beyond the scope of this paper, but it is concluded that further research should investigate how the institutional context and timing of implementation affect differences in how the choice policy works out in practice. [Abstract]

O'Reilly, Jacqueline, et al.

Paying for hospital care : the experience with implementing activity-based funding in five European countries.

Health Economics, Policy and Law 2012; 7 (1): 73-107 (January 2012)

Following the US experience, activity-based funding has become the most common mechanism for reimbursing hospitals in Europe. Focusing on five European countries (England, Finland, France, Germany and Ireland), this paper reviews the motivation for introducing activity-based funding, together with the empirical evidence available to assess the impact of implementation. Despite differences in the prevailing approaches to reimbursement, the five countries shared several common objectives, albeit with different emphasis, in moving to activity-based funding during the 1990s and 2000s. These include increasing efficiency, improving quality of care and enhancing transparency. There is substantial cross-country variation in how activity-based funding has been implemented and developed. In Finland and Ireland, for instance, activity-based funding is principally used to determine hospital budgets, whereas the models adopted in the other three countries are more similar to the US approach. Assessing the impact of activity-based funding is complicated by a shortage of rigorous empirical evaluations. What evidence is currently available, though, suggests that the introduction of activity-based funding has been associated with an increase in activity, a decline in length of stay and or a reduction in the rate of growth in hospital expenditure in most of the countries under consideration. [Abstract]

Helderman, Jan-Kees, et al.

The rise of regulatory state in health care : a comparative analysis of the Netherlands, England and Italy.

Health Economics, Policy and Law 2012; 7 (1): 103-124 (January 2012)

In a relatively short time, regulation has become a significant and distinct feature of how modern states wish to govern and steer their economy and society. Whereas the former 'dirigiste' state used to be closely related to public ownership (e.g. hospitals), planning (volume and capacity planning) and centralised administration (e.g. fixed prices and budgets), the new regulatory state relies mainly on the instrument of regulation to achieve its objectives. In this paper, we wish to relate the rise of the 'regulatory state' to the path-dependent trajectories and institutional legacies of discrete European health-care systems. For this purpose, we compared the Dutch corporatist social health insurance system, the strongly centralised National Health Service (NHS) of England and federal regionalised NHS system of Italy. Comparing these three different health-care systems suggests that it is indeed possible to identify a general trend towards the rise of the regulatory state in health care in the last two decades. However, although the three countries examined in this paper face similar problems of multilevel governance of networks of third-party payers and providers, each system also gives rise to its own distinct regulatory challenges. [Abstract]

Nolte, Ellen, et al.

Overcoming fragmentation in health care : chronic care in Austria, Germany and the Netherlands.

Health Economics, Policy and Law 2012; 7 (1): 125-146 (January 2012)

The growing recognition of care fragmentation is causing many countries to explore new approaches to healthcare delivery that can bridge the boundaries between professions, providers and institutions and so better support the rising number of people with chronic health problems. This paper examines the role of the regulatory, funding and organisational context for the development and implementation of approaches to chronic care, using examples from Austria, Germany and the Netherlands. We find that the three countries have implemented a range of policies and approaches to achieve better coordination within and across the primary and secondary care interface and so better meet the needs of patients with chronic conditions. This has involved changes to the regulatory framework to support more coordinated approaches to care (Austria, Germany), coupled with financial incentives (Austria, Germany) or changes in payment systems (the Netherlands). What is common to the three countries is the comparative 'novelty' of policies and approaches aimed at fostering coordinated care; however, the evidence of their impact remains unclear. [Abstract]

Schoen, Cathy

New 2011 survey of patients with complex care needs in eleven countries finds that care is often poorly coordinated.

Health Affairs 2011; 30 (12): 2437-4448 (December 2011)

Around the world, adults with serious illnesses or chronic conditions account for a disproportionate share of national health care spending. We surveyed patients with complex care needs in eleven countries (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States) and found that in all of them, care is often poorly coordinated. However, adults seen at primary practices with attributes of a patient-centered medical home--where clinicians are accessible, know patients' medical history, and help coordinate care--gave higher ratings to the care they received and were less likely to experience coordination gaps or report medical errors. Throughout the survey, patients in Switzerland and the United Kingdom reported significantly more positive experiences than did patients in the other countries surveyed. Reported improvements in the United Kingdom tracked with recent reforms there in health care delivery. Patients in the United States reported difficulty paying medical bills and forgoing care because of costs. Our study indicates a need for improvement in all countries through redesigning primary care, developing care teams accountable across sites of care, and managing transitions and medications well. The United States in particular has opportunities to learn from diverse payment innovations and care redesign efforts under way in the other study countries. [Abstract]

http://www.commonwealthfund.org/~/media/Files/Publications/In%20the%20Literature/2011/Nov/IHP%20Survey/1563_Schoen_2011_survey_patients_complex_care_needs_HA_112011_ITL_v3.pdf

Damiani, Gianfranco, et al.

Patterns of long term care in 29 European countries : evidence from an exploratory study.

BMC Health Services Research 2011; 11 (316): (18 November 2011)

BACKGROUND: The challenges posed by the rapidly ageing population, and the increased preponderance of disabled people in this group, coupled with the rising level of public expenditure required to service the complex organization of long term care (LTC) delivery are causing increased pressure on LTC systems in Europe. A pan-European survey was carried out to evaluate whether patterns of LTC can be identified across Europe and what are the trends of the countries along them. METHODS: An ecological study was conducted on the 27 EU Member States plus Norway and Iceland, referring to the period 2003-2007. Several variables related to organizational features, elderly needs and expenditure were drawn from OECD Health Data and the Eurostat Statistics database and combined using Multiple Factor Analysis (MFA). RESULTS: Two global Principal Components were taken into consideration given that their expressed total variance was greater than 60 per cent. They were interpreted according to the higher (more than 0.5) positive or negative correlation coefficients between them and the original variables; thus patterns of LTC were identified. High alignment between old age related expenditure and elderly needs characterizes Nordic and Western European countries, the former also having a higher level of formal care than the latter. Mediterranean as well as Central and South Eastern European countries show lower alignment between old age related expenditure and elderly needs, coupled with a level of provision of formal care that is around or slightly above the average European level. In the dynamic comparison, linear, stable or unclear trends were shown for the studied countries. CONCLUSIONS: The analysis carried out is an explorative and descriptive study, which is an attempt to reveal patterns and trends of LTC in Europe, allowing comparisons between countries. It also stimulates further researches with lower aggregated data useful to gain meaningful policy-making evidence. [Abstract]

http://www.biomedcentral.com/1472-6963/11/316

Calciolari, Stefano and Ilinca, Stefania

Comparing (and learning from) integrated care initiatives : an analytical framework.

Journal of Integrated Care 2011; 19 (6): 4-13

PURPOSE: Care integration has been the hallmark of most proposed solutions to current and prospective challenges of health systems. However, it is an imprecise umbrella term encompassing heterogeneous models and little substantive knowledge exists on the basic mechanisms leading to positive outcomes. This study aims to address this gap by identifying the environmental conditions and the configurations of factors associated with service delivery success in integrated care initiatives. DESIGN/METHODOLOGY/APPROACH: On the basis of an extensive literature review, an analytical framework aimed at structuring and interpreting the relations between contextual, cultural and organizational factors and the outcomes of integrated care initiatives is proposed. The framework is applied to four successful cases of care integration in the USA, Canada, Italy and Switzerland. FINDINGS: The results suggest that positive outcomes mainly depend on the correct matching of macro-level factors with a balanced mix of operating means at the micro-level, rather than on the intense focus on any one element of the framework. RESEARCH LIMITATIONS/IMPLICATION: The analysis infers, from a small-purposive sample, that successful initiatives are a matter of appropriate configuration of contextual, organizational and technical factors. Generalizability of results would benefit from additional international cases and using the framework on decentralized health systems. ORIGINALITY/VALUE: This framework can guide future research efforts in the field as it is adaptable and relatively easy to operationalize. It can also be a useful tool for practitioners and policy-makers, to bring structure and reduce the complexity of efforts aimed to design, evaluate and improve integrated care initiatives. [Abstract]

Boeckxstaens, Pauline

Primary care and care for older persons : position paper of the European Forum for Primary Care.

Quality in Primary Care 2011 19 (6): 369-389

This article explores how to address the needs of the growing number of older patients in primary care practice. Primary care is not a fixed organisational structure but a combination of functional characteristics which has developed variably in European countries with differing responses to the emerging needs of older persons. Multimorbidity, frailty, disability and dependence play out differently in older persons; a key challenge for primary care is to provide a response that is adapted to the needs of individuals - as they see them and not as the professional defines them. Indeed, growing experience shows how to involve older persons in taking decisions. Contrary to popular opinion, older persons often rate their quality of life as high. Indeed, comprehensive primary care offers health promotion and prevention: also older people may benefit from measures that support their health and independence and some case descriptions show this potential. Although most people prefer to be in their own environment (home, community) during the last stage of life, providing end-of-life care in the community is a challenge for primary care because it requires continuity and coordination with specialist care. Successful models of care however do exist. Delivering seamless integrated care to older persons is a central theme in primary care. Rather than disease management, in primary care, case management is the preferred approach. Proactive geriatric assessment of individual medical, functional and social needs, including loneliness and isolation, has been shown to be useful and its place in primary care is the subject of further research. Clinical practice guidelines for multimorbidity are badly needed. Non-adherence to medication, linked to multiple and uncoordinated prescriptions, is a widespread and costly problem. Successful approaches in primary care are being developed, including the use of electronic patient files. With the general practitioner (GP) as the central care provider, primary care is increasingly teamwork, and the role of nurses and other (new) professions in primary care is developing constantly. The composition and coordination of teams are two components of one of the major complexities to address: how to provide individualised care with standardisation at organisation the level. (Lack of) Coordination with specialist care remains a widespread problem and needs attention from policy makers and practitioners alike. Alignment with home care and social services remains a challenge in all countries, not least because of the different funding arrangements between the services. Further priorities for research and development are summarised. [Abstract]

Appleby, John

The King's Fund

Which is the best health system in the world?

BMJ 2011; 343 (7826): 722-723 (8 October 2011)

It may be nice to find your country at the top of healthcare rankings, but the relevance to policymakers is strictly limited, explains John Appleby. [Introduction]

Salway, Sarah M., et al.

Contributions and challenges of cross-national comparative research in migration, ethnicity and health : insights from a preliminary study of maternal health in Germany, Canada and the UK.

BMC Public Health 2011; 11 (514): (29 June 2011)

BACKGROUND: Public health researchers are increasingly encouraged to establish international collaborations and to undertake cross-national comparative studies. To-date relatively few such studies have addressed migration, ethnicity and health, but their number is growing. While it is clear that divergent approaches to such comparative research are emerging, public health researchers have not so far given considered attention to the opportunities and challenges presented by such work. This paper contributes to this debate by drawing on the experience of a recent study focused on maternal health in Canada, Germany and the UK. [Abstract]

http://www.biomedcentral.com/content/pdf/1471-2458-11-514.pdf

Ovretveit, John

Widespread focused improvement : lessons from international health for spreading specific improvements to health services in high-income countries

International Journal for Quality in Health Care 2011; 23 (3): 239-246 (June 2011)

Patients and citizens want more and better healthcare, and want to pay less for it. One way rapidly to respond to these demands is to spread proven or promising improvements in treatments or service delivery models. However, there is little research from high-income countries about effective ways to spread these improvements. In international health there is more experience and knowledge of scale-up, more variety in research approaches used to study the subject, and fewer resources and infrastructure for scaling-up improvements across a nation. This paper draws on reviews of research and experience in international health to contribute to conceptual and empirical knowledge as well as to practical strategies. It describes and illustrates three approaches: hierarchical control, participatory adaptation and facilitated evolution. It presents lessons from international health which could be of use to those studying, choosing, planning and progressing strategies to increase the uptake of proven or promising interventions to health services in high-income countries. [Abstract]

Marmor, Theodore R., et al.

Part VI: critical comparisons.

Journal of Health Politics, Policy and Law 2011; 36 (3): 565-576 (June 2011)

Through cross-national comparisons, the essays in this section illuminate the key elements of the U.S. approach to health care. When European nations have passed major health care reforms, the leaders of those countries have presented a strong moral argument for reform. Theodore R. Marmor finds that element missing in the U.S. case and ponders its implications. Carolyn Hughes Tuohy provides a comparative framework for understanding different approaches to reform and to understand better the U.S. choice to pursue what she calls a mosaic approach. Finally, as a European observer of U.S. reform and a longtime health policy expert, Kieke G. H. Okma reflects on how Europeans view the U.S. approach to reform. [Abstract]

Meijer, Erik, et al.

Internationally comparable health indices.

Health Economics 2011; 20 (5): 600-619 (May 2011)

One of the most intractable problems in international health research is the lack of comparability of health measures across countries or cultures. We develop a cross-country measurement model for health, in which functional limitations, self-reports of health, and a physical measure are interrelated to construct health indices. To establish comparability across countries, we define the measurement scales by the physical measure while other parameters vary by country to reflect cultural and linguistic differences in response patterns. We find significant cross-country variation in response styles of health reports along with variability in genuine health that is related to differences in national income. Our health indices achieve satisfactory reliability of about 80 per cent and their gradients by age, income, and wealth for the most part show the expected patterns. Moreover, the health indices correlate much more strongly with income and net worth than self-reported health measures. [Abstract]

Antunes, Vanessa and Moreira, J. Paulo

Approaches to developing integrated care in Europe : a systematic literature review.

Journal of Management and Marketing in Healthcare 2011; 4 (2): 129-135 (May 2011)

PURPOSE: Many European countries have been undertaking measures to promote integration of health and social care. The purpose of this study is to identify different approaches to integrated care and retrieve a number of experiences and approaches of working in some European countries. METHODS: A systematic review of the integrated care literature was conducted in a 3-month period. The Pubmed, Embase, and BioMed Central databases were searched for articles from 2002 through 2008. The articles were selected according to inclusion and exclusion criteria. A standard form was used for data extraction. FINDINGS: A total of 24 studies that conformed to the criteria were found. The analysed articles describe integrated care in 16 European countries: UK, Germany, Finland, Sweden, Austria, Spain, Netherlands, Ireland, Portugal, Denmark, France, Greece, Italy, Norway, Poland, and Switzerland. The studies' setting was primary care, social care, home care, or a combination of these. In majority of the studies similar challenges to health care systems were identified: advances in health care, ageing population, multi-system nature of chronic diseases, hospital-based care system, insufficient provision of community care services, lack of cooperation among health and social care providers, fragmentation of the health and social care systems, and rurality. These challenges are seen as a stimulus to the integration of care. The articles also mentioned some integration strategies that were categorized according to: changes in organizational structure, workforce reconfiguring, and changes in the financing system. Integrated care definitions were also derived from the articles, and from the verbatim text when possible. Definitions were grouped according to their sectorial focus: community-based care, combined health and social care, combined acute and primary care, the providers, and in a more comprehensive approach the whole health system. CONCLUSION: Despite integrated care being implemented in some European countries since the beginning of the millennium, it is a relatively new concept in health management discourse. There is room for more studies on the need for integrated care and the effectiveness of the implemented strategies. Despite integration models having a similar background there is no European consensus about the definition of integrated care. The data collected are useful for debate on the topic within the international health management and marketing community. [Abstract]

Schreyögg, Jonas, et al.

Costs and quality of hospitals in different health care systems : a multi-level approach with propensity score matching.

Health Economics 2011 20 (1): 85-100 (January 2011)

Cross-country comparisons of costs and quality between hospitals are often made at the macro level. The goal of this study was to explore methods to compare micro-level data from hospitals in different health care systems. To do so, we developed a multi-level framework in combination with a propensity score matching technique using similarly structured data for patients receiving treatment for acute myocardial infarction in German and U.S. Veterans Health Administration hospitals. Our case study shows important differences in results between multi-level regressions based on matched and unmatched samples. We conclude that propensity score matching techniques are an appropriate way to deal with the usual baseline imbalances across the samples from different countries. Multi-level models are recommendable to consider the clustered structure of the data when patient-level data from different hospitals and health care systems are compared. The results provide an important justification for exploring new ways in performing health system comparisons. [Summary]

WEB RESOURCES

Commonwealth Fund - International Health Policy Center
http://www.commonwealthfund.org/Topics/International-Health-Policy.aspx

EUROPA : European Commission : public health
http://ec.europa.eu/health/index_en.htm

European Centre for Social Welfare Policy and Research
http://www.euro.centre.org/

European Health Management Association
http://www.ehma.org/

European Observatory on Health Systems
- including full text access to the Health Systems in Transition country Profiles and *Eurohealth* journal
http://www.euro.who.int/observatory

Health care - Employment, Social Affairs and Inclusion
European Commission
http://ec.europa.eu/social/main.jsp?catId=754&langId=en

Health spending map of the world
The Guardian
http://www.guardian.co.uk/news/datablog/interactive/2012/jun/30/health-spending-map-world

Health Systems and Policy Monitor
European Observatory on Health Systems and Policies
http://www.hspm.org

International Healthcare Comparisons
Rand Europe
http://www.international-comparisons.org.uk/

Learning from other health systems - The King's Fund
http://www.kingsfund.org.uk/projects/learning-other-health-systems

World Health Organization
http://www.who.int
- including access to the WHO library database at http://www.who.int/library/