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## **The impact of the economic crisis on health care systems**

by Charalampos Economou,

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**T**he current global economic crisis has given rise to concerns about its implications for health care sector and the ability of the health systems to provide adequate and qualitative services to the citizens. Experiences from the past are indicative of the impact that deep economic recessions have on health services. More specifically, four recessions of the twentieth century and their effects on health have been studied: the interwar Great Depression, the recession of the late 1970s and 1980s, the collapse of the former European socialist countries in early 1990s and the East Asian financial crisis in the second half of the 1990s (Levy and Sidel 2009, Stuckler et al. 2009).

The first of these recessions, the Great Depression, caused serious public health problems in the USA. Public health policies failed to address the impact of unemployment on child and maternal health during the 1930s. The welfare provision aimed at pregnant and nursing mothers was not effectively counteracting the adverse consequences of the economic depression, illustrated by the rise in maternal mortality (Webster 1985). Furthermore, curtailment of health budgets, reduction in health personnel, and limiting of projects, such as preventive campaigns against diphtheria, typhoid fever, etc. were reported (Dublin 1932, Editorial of American Journal of Public Health and the Nation's Health 1934).

The recession of the late 1970s and 1980s had serious consequences for the Third World countries. The Structural Adjustment Programs (SAP) implemented by the heavily borrowing countries under the auspices of the IMF and the WB, had negative effects on health sector. Cuts in public expenditure, and the emphasis on cost recovery, made public health services inaccessible to the most vulnerable social groups, especially in rural areas. The problem was further aggravated by the increased dependence of adjusting countries' health sectors on external support (Alubo 1990, Asthana 1994, Stewart 1989, Woodward 1992, Logie and Woodroffe 1993).

In early 1990s, during their transition from a command-and-control system to a free-market capital economy, many of the ex-socialist countries of the Central and Eastern Europe adopted a process of rapid economic reforms, known as "shock therapy" (Murrell 1993). The consequence of this strategy was the deterioration of health services and health conditions reflected in increasing mortality and morbidity (Field 1995). The Semashko type of national health system inherited at the beginning of the 1990s begun to change towards a Bismarckian social insurance model. The exaggerated emphasis placed on the efficient management of resources and expansion of financing sources, downgraded the important problem of equity in access and improvement of health status to a second priority. The transition to a social insurance system raised questions at a moment when the basic prerequisites, such as a strong economy with a high rate of employment and a sufficiently high wage level to allow for insurance contributions, did not exist. The introduction of market elements and the expansion of the role played by private payments, whether in the form of private insurance or in the form of additional insurance, deductibles, co-payments or direct payments, negated the criterion of equity (Figueras et al., eds 2004).

The last case study for exploring the impact of economic crisis on health sector is the East Asian crisis which occurred in 1997. At the time, some countries of Latin America, including Argentina and Mexico, were also plagued by fiscal deficits. Evidence from Indonesia (Hotchkiss and Jacobalis

1999, Simms and Rowson 2003, Waters et al. 2003) shows that between 1997 and 1999 there was a 20% reduction in per person spending and a 25% cut in government health spending. The devaluation of rupiah reduced even more real public health expenditure and household purchasing power. Between 1996 and 1997 there was a 25% fall in real spending on drugs that happened in parallel with price increases of about 170%, resulting from rupiah's devaluation. The use of health care services by children from poor backgrounds dropped by about 17% compared with 8% in children from wealthier settings. Immunization coverage was declined almost 25% between 1995 and 1999. Rates of use of services by low-income households fell between 26% and 47%. From 1997 to 1998, outpatient contact rates declined by 25.4% for public health facilities and 9% for private facilities. In this context, the negative effects of the economic crisis on household purchasing power and government revenues undermined the viability of the government's attempt to introduce managed care health reform. Similar trends in relation to cuts in health expenditures and lower utilization of health services were also observed in Korea (Yang et al. 2001).

In Latin America, the experience of Argentina highlights that the 2001 economic crisis exacerbated the problems of the health system. Provincial inequities in terms of health status, access to services and financing widened, and the health system became more fragmented and inefficient. Health insurance coverage decreased sharply and access to services was restricted, especially for the poorest, who suffered a decrease in health insurance coverage three times greater than that of the non-poor. The crisis also threatened the effectiveness of priority public health programs and services, and worsened the economic and financial situation of many insurers and service providers, thus increasing the debt prevailing in the health sector. In addition, total health expenditure per capita, decreased from US\$669 in 1997 to US\$242 in 2002 (Cavagnero and Bilger 2010, World Bank 2003). In Mexico, the 1995-6 crisis reduced income and resources for goods that improve or maintain health, such as out-of-pocket medical spending or nutrition. It also reduced public sector funds for health services, which affected groups dependent on those services. As a result, mortality rate increased by 5-6 percent among the population aged 60 and over, and by 7 percent among children aged 0-4, compared to the expected based on pre-crisis trends (Cutler et al. 2002).

The impact that the recent economic crisis of OECD countries has on health systems is well summarized in a report published by the WHO in 2009. In countries that have required emergency assistance from the International Monetary Fund, the spending restrictions imposed during loan repayment, negative GDP growth, substantial increases in unemployment and decreasing revenues impact on household income, government spending and the capacity of other actors in the private and voluntary sector to contribute to the health effort, despite the fact that all this is happening at a time of greater health need. Due to the drop in household income, patients turn from the private to the public sector, and as governments feel the financial need to cut back and public sector services are underfunded, quality of care deteriorates and access to services is restricted. Reductions in total expenditure have an impact on the composition of health spending, resulting in savings in salaries, infrastructure and equipment. In less developed countries, diminishing resources are accompanied by currency devaluations which increase costs in local currencies of all imported health expenditures including medicines and biomedical technology. In addition, in these countries, official development assistance from individual donors has fallen massively.

The above evidences indicate the negative effects of economic crisis on health care sector. This is especially true for countries where the crisis took the form of a fiscal and debt crisis. The fact that the development model of countries such as Greece is characterized by slow progress, weak

industrial base, the long existence of agricultural structures and institutional backwardness, make them vulnerable to international fluctuations and turmoil, especially in relation to the monetary exchange rate and fiscal sector, i.e. the sector which had financed their growth and where the signs of the international crisis were evident. In the context of the EU, the solution chosen to the problem is internal devaluation and cuts in social expenditure and more specifically cuts in pensions and health care (Sakellaropoulos 2012).

Nonetheless, it can be argued that under certain circumstances, economic shocks is possible to create windows of opportunity for significant policy change, by disrupting the self-referentiality of the health care system. Health system-specific deficits do not suffice in explaining health reforms. The paradigm of Greece and the health sector reform initiatives undertaken after the Memorandum show that the role of economic shocks is crucial in promoting changes, in the case that political actors, decision makers and stakeholders appear to disagree fundamentally over the values and the directions of health reforms and “party thinking” blocks the implementation of changes (Economou 2012). Yet, this is the one side of the coin. The other side concerns the question about the direction of the changes and their impact on the effective and efficient functioning of the health system, as well as on the equitable access to quality services. From this point of view, it can be argued that most of the reform measures adopted in the Greek health care sector are in the right direction. They put emphasis on the efficient functioning of the health system, and they try to remedy the shortcomings of public primary health care services, to rationalize hospital funding and professionalize its management, and to better control pharmaceutical expenditures. However, there are many other measures aiming at the privatization of selected public services and the increase or the introduction of new user charges and as a consequence they raise serious questions about the accessibility of health services, especially for low income citizens (Economou 2012). In addition, the fact that the government called for cuts in health services budgets while at the same time an increase in utilization of public health services is observed, puts the low income households and the vulnerable groups at risk (Kentikelenis and Papanicolas 2012).

The present volume reflects on the health care reforms introduced in European countries in the era of economic crisis. More specifically, Mourão et al., analyze the Portuguese health policies and health system, in the context of the present economic, financial and social crisis. Based on the speeches of policy-makers and experts about the processes of governance and contingency measures, they consider the criteria of efficiency and effectiveness. Verspohl examines the issue of the privatization of health services and the consequences of the introduction of market instruments in health systems. Her paper studies the power of ideas within the framework of structural reform pressure and institutional path-dependency in two countries representing the two ideal types: the Netherlands for Social Health Insurance and Sweden for the National Health Service. Geitona presents an overview of the rewarding innovation pharmaceutical regulatory systems in Greece, focusing on recent major pharmaceutical reforms. Liaropoulos et al., discuss the proposal for the reform of Greek Hospital Sector, also known as “hospital mergers”. They propose a new pattern of organizing hospitals in groups based on the reform of emergency care and the management of five main chronic diseases, namely AMI, Stroke, Cancer, Diabetes Mellitus and COPD. Minogiannis, in his paper argues for the necessity of a new managerial approach to be implemented in Greek public hospitals, which would sufficiently answer to the main four problematic conundrum of today: the perverse unaccountability of medical subjectivity, the obsolete management model, the lack of human resources management tools and the unhealthy financing of hospitals.



## Bibliographical references

- Alubo O., (1990), "Debt crisis, health and health services in Africa", *Social Science & Medicine* 31, 6: 639-648.
- Asthana S., (1994), "Economic crisis, adjustment and the impact on health", in: Phillips D. and Verhasselt Y., (eds), *Health and development*, p.p. 50-64, London: Routledge.
- Cavagnero E., Bilger M., (2010), "Equity during an economic crisis: financing the Argentine health system", *Journal of Health Economics* 29: 479-488.
- Cutler D., Knaul F., Lozano R., Mendez O., Zurita B., (2002), "Financial crisis, health outcomes and ageing: Mexico in the 1980s and 1990s", *Journal of Public Economics* 84: 279-303.
- Dublin L., (1932), "The Depression and public health", *American Journal of Public Health and the Nation's Health* 22: 395-396.
- Economou Ch., (2012), "The performance of the Greek healthcare system and the Economic Adjustment Programme: 'Economic crisis' versus 'system-specific deficits' driven reform", *Social Theory* 2 (in print).
- Editorial of American Journal of Public Health and the Nation's Health, (1934), "The Depression and public health expenditures", *American Journal of Public Health and the Nation's Health* 24: 755-756.
- Field M., (1995), "The health crisis in the former Soviet Union: A report from the 'post-war' zone" *Social Science & Medicine* 41, 11: 1469-1478.
- Figueras J., McKee M., Cain J., Lesos S., (eds), (2004), *Health systems in transition: learning from experience*. Copenhagen: European Observatory on Health Systems and Policy, WHO EURO.
- Hotchkiss D., Jacobalis S., (1999), "Indonesian health care and the economic crisis: is managed care the needed reform?", *Health Policy* 46: 195-216.
- Kentikelenis A., Papanicolas I., (2012), "Economic crisis, austerity and the Greek public health care", *European Journal of Public Health* 22(1): 4-5.
- Levy B., Sidel V., (2009), "The economic crisis and public health", *Social Medicine* 4, 2: 82-87.
- Logie D., Woodroffe J., (1993), "Structural adjustment: the wrong prescription for Africa?", *BMJ* 307: 41-44.
- Murrell P., (1993), "What is shock therapy? What did it do to Poland and Russia?", *Post-Soviet Affairs* 9, 2: 111-140.
- Sakellaropoulos Th., (2012), "Debt crisis and the welfare state in Greece", Global Express, February 12, International Sociological Association, (<http://www.isa-sociology.org/global-dialogue/2012/03/debt-crisis-and-the-welfare-state-in-greece/>).
- Simms Ch., Rowson M., (2003), "Reassessment of health effects of the Indonesian economic crisis: donors versus the data", *The Lancet* 361: 1382-1385.
- Stewart F., (1989), "Recession, structural adjustment and infant health: the need for a human face", *Transactions of the Royal Society of Tropical Medicine and Hygiene* 83: 30-31.

- Stuckler D., Basu S., Suhrcke M., McKee M., (2009), "The health implications of financial crisis: A review of the evidence", *Ulster Medical Journal* 78, 3: 142-145.
- Waters H., Saadah F., Pradhan M., (2003), "The impact of the 1997-98 East Asian economic crisis on health and health care in Indonesia", *Health Policy and Planning* 18, 2: 172-181.
- Webster Ch., (1985), "Health, welfare and unemployment during Depression", *Past and Present* 109: 204-230.
- WHO, (2009), *The financial crisis and global health*. Report of a high-level consultation, Geneva.
- Woodward D., (1992), *Debt, adjustment and poverty in developing countries*. Volume 2. *The impact of debt and adjustment at the household level in developing countries*. New York: St. Martin's Press.
- World Bank, (2003), *Argentina. The health sector in Argentina. Current situation and options for improvement*. Human Development Department Argentina, Chile, Paraguay, and Uruguay Country Management Unit, Latin America and the Caribbean Region. Washington D.C.: The World Bank.
- Yang B.-M., Prescott N., Eun-Young B., (2001), "The impact of economic crisis on health-care consumption in Korea", *Health Policy and Planning* 16, 4: 372-385.



# Health governance in a context of crisis - the perspective of efficiency and effectiveness in the Portuguese health system

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## Η διακυβέρνηση της υγείας στο πλαίσιο της κρίσης - η προοπτική της αποδοτικότητας και της αποτελεσματικότητας στο Πορτογαλικό σύστημα υγείας

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### ABSTRACT

The financial and economic crisis from 2008 has a great impact in welfare states, notably in one of their fundamental pillars – health. In Portugal, the total spending on health reached 10.1% of GDP in 2008 and will increase in view of the current panorama. The objective of this study is to analyze the health policies and the Portuguese health system, in a context of economic, financial and social crisis, in the light of the speeches of policy-makers and experts about the processes of governance and contingency measures, considering dimensions of analysis efficiency and effectiveness. In the dimension of effectiveness, measures have been pointed out for protecting the most vulnerable, for the empowerment of citizens, for reduction of inequalities and for the protection and promotion of health. Finally, in the dimension of efficiency, there are important measures to cut off expenditure, of mobilization of financial resources, in the rationalization of resources and services and in professional and organizational development. In theoretical domains of risk and uncertainty, we see through the speeches of policy-makers and experts, that these are domains for the exercise of policies on critical governance processes, determined by identified sources of insecurity, processes of public debate and in terms of policy dispute.

**KEY WORDS:** Health system, crisis, governmentalization, risk, effectiveness, efficiency, Portugal

### ΠΕΡΙΛΗΨΗ

Ο στόχος της παρούσας εργασίας είναι να αναλύσει τις πολιτικές για την υγεία και το σύστημα υγείας της Πορτογαλίας, στο πλαίσιο της οικονομικής, χρηματοπιστωτικής και κοινωνικής κρίσης, θέτοντας ως βάση τον λόγο των ίδιων των διαμορφωτών πολιτικής και των εμπειρογνομόνων, σχετικά με τις μεθόδους διακυβέρνησης και τα μέτρα έκτακτης ανάγκης, λαμβάνοντας υπόψη ως διαστάσεις της ανάλυσης την αποδοτικότητα και την αποτελεσματικότητα. Ως προς τη διάσταση της αποτελεσματικότητας, επισημαίνονται μέτρα για την προστασία των πλέον ευάλωτων ομάδων, για την ενδυνάμωση των πολιτών, για τη μείωση των ανισοτήτων και για την προστασία και την προαγωγή της υγείας. Τέλος, στο πλαίσιο της διάστασης της αποδοτικότητας, επισημαίνονται σημαντικά μέτρα για την περικοπή των δαπανών, την κινητοποίηση των οικονομικών πόρων, τον εξορθολογισμό των πόρων και των υπηρεσιών και την επαγγελματική και οργανωτική ανάπτυξη. Αναφορικά με τις έννοιες του κινδύνου και της αβεβαιότητας, διαπιστώνεται, μέσα από τους λόγους των υπευθύνων χάραξης πολιτικής και των εμπειρογνομόνων, ότι αυτοί είναι τομείς που συνδέονται με την άσκηση πολιτικών αναφορικά με κρίσιμες διαδικασίες διακυβέρνησης, που προσδιορίζονται από καθορισμένες πηγές ανασφάλειας, διαδικασίες δημόσιας συζήτησης και σε όρους πολιτικής διαφωνίας.

**ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ:** Σύστημα υγείας, κρίση, διακυβερνητισμός, κίνδυνος, αποτελεσματικότητα, αποδοτικότητα, Πορτογαλία

## 1. Introduction

One of the impacts of the worldwide and national financial and economic crisis that erupted in 2008 is the reduction of the social protection by the welfare state, mediated as a process of risk privatization, namely in one of its basic pillars - Health.

The Portuguese National Health Service (NHS), created in 1979, materializes the right of access to Health, described in the Portuguese Constitution as universal and tending to be free. Since then, Health services have developed bringing benefit for all citizens that access to it, however with some difficulty in corresponding to the critical challenges of its qualification.

The total expense with Health, in Portugal, was 10,1% of the GDP in 2009 and tends to increase with the aging population, increase of chronically ill people and medical technological innovation. In a crisis panorama, it is important to have a strategy of financing and improving administration and coordination of the NHS, developed in the optic of efficiency and effectiveness that assures the welfare of the citizens and in a context of GDP reduction, as in economic recession.

## 2. Economic, financial and social crisis: Impacts in health governance

The world is going through one of the major economic and financial crises since the Great Depression of 1930. The valuable growth of the world annual production decreased from 4%, in 2006-2007 to 1,6% in 2008 and to -2% in 2009 (United Nations, 2011).

Social impacts of the crisis are diverse: (i) reduction of families' purchasing power; (ii) growing unemployment rate with material and psychosocial consequences; (iii) and a limited ability from State to reply by the social protection nets (OPSS, 2011).

Europe, in particular, experiences a great economic contraction with devastating impact in people's lives. Labour flexibility and unemployment are the main consequences. Unemployment rate evolved from 7,1% in 2007, to 9,3% in 2010 (Ebner, 2010; United Nations, 2011). In Portugal, unemployment rate evolved from 8,9% in 2007 to 12,9% in 2011 and to 14,8% (Eurostat, 2012).

*The Global Social Crisis. Report in the Social World Situation* underlines social trends in the European Union in the context of global crisis: (i) social factor with a greater impact will be unemployment ; (ii) slow recovery of the crisis will increase long-term unemployment and cuts in social supports; (iii) cuts resulted from the weakness of social protection structures; (iv) devaluation of the housing sector will lie heavier in the financial affairs; (v) and the wellbeing of families will suffer with a reduction of the purchase power (European Commission, 2010).

With welfare state crisis and the development of different response strategies to this crisis in the main economies of the world, there is a reduction of the social protection supplied by the State, which becomes weak when confronted with the necessities and the normal indicators in the European social model. Reduction in the supply of some services by the welfare state disclosures the dismantling of the public social politics and the growing participation of the enterprise sector and the non-lucrative sector in the social rendering of services raising a functional trend and a strategy of reduction of costs on the part of states.

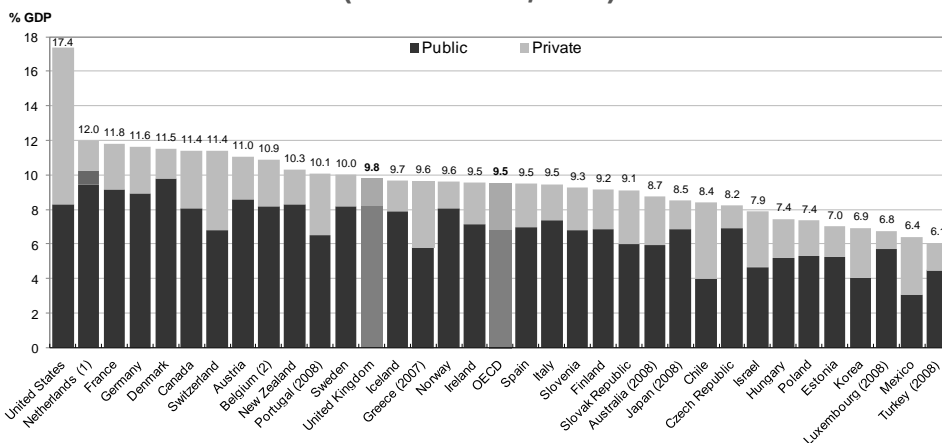
In the conjuncture of social changes caused by the crisis, the global concern with health stands out as one of the main pillars of the welfare system. To assure sustainability and equity, health systems are submitted to revaluation and readjustment to the crisis period.

With demographic aging and life expectancy growth, population health needs increase as well as responsibility of providing efficient health care for all. Reduction of funds to invest in health is an essential question imposing political measures that allow reduction of costs associated to the delivering of health cares without affecting quality.

Portuguese health expenditure rose, in the last decade, compared with the majority of the countries of the OECD, growing from 7,5% of the GDP in 1993 to 9,9% in 2006, (OECD, 2010). However, the pressure of current conjuncture has consequences in public expenses in health that tends to diminish, through cuts in the state budget invested. Public expenditure in Health decreased from 7,1% of the GDP in 2006 to 6,3% in 2009.

The total of Portuguese health expenditure reached 10.1% of the GDP in 2009, in Figure 1 (OECD, 2011), and will tend to increase due to the extension of health care, the growing weight of chronic diseases and technological innovation, along with the rise of average life expectancy and population aging. However, when analysing per capita expenditure, the country spends only EUR 1.700 while the average of the OECD is EUR 2.200 (OECD, 2011).

**Figure 1: Health expenditure as a share of GDP - OECD countries, 2009**  
(source: OECD, 2011)



Since 1979, the Portuguese Health System is composed by the NHS, the voluntary and private health insurances, the health subsystems of health and by private health renders of the non-lucrative sector. The NHS is financed by taxes on incomes and less for the moderating fees in the moment of the health care delivery.

In 2012, payments in the act have raised from EUR 2.15 in a primary care appointment to EUR 5 an increase of 133% from 2007 to 2012, and EUR 9.2 in urgency hospital appointment to EUR 20 as a minimal charge that can go up to EUR 50 including complementary diagnostic methods, an increase of 117% and 443%.

The financing of the Portuguese National Health System, as previously referred, is a combination of public and private resources, as happens in the majority of the countries of the European Union. According to *OECD Health Data 2010* (2010), in 2006, 71.7% of total financing of the health expenditure, came from the State and remaining 28.3% resulted from co-payments and private health insurances, among others. In health sector, public expenditure is the more affected and the private sector has a complementary role.

Deloitte Report (2011) states the main problems in Portuguese health sector as being the financial unsustainability of the system, the lack of strategic planning and the elevated levels of inefficiency. The challenge in a time of crisis is making necessary structural reforms such as: (i) reorganization and regulation of health system regarding elimination of duplications; (ii) reorganization of care delivery in three essential questions: a biggest allocation of financial resources for prevention and primary care, accountability of health institutions managers and revision of their financing model; (iii) a good strategic planning based diagnosis of population health needs.

To answer the challenges and improve the performance of the Portuguese health system, World Health Organization (WHO, 2010) recommends: (i) promotion of health policies leading to healthy life styles, reduction of health inequalities and improvement of citizens health literacy; (ii) increase of the investment in Health, prioritizing primary care, public health and the efficiency of delivered services; (iii) assuring participation of citizens in health policy decisions, that should answer the needs and expectations of population; (iv) clarifying the role of private sector, providing this partner with legal and political framing; (v) a better articulation between public system and subsystems, where these will have a supplementary role; (vi) decentralization in health services delivery; (vii) reduction of economic barriers in the access to health, especially in case of populations with lesser incomes; (viii) develop of human resources strategies to correct the actual shortage in some geographical areas and of some specialists and clarify the role of health professionals and their organizations; (ix) and improvement of health governance quality, promoting investigation on the services and systems of health and evaluation of the impact of technological programs while assuring transparency and responsibility.

In a context of budgetary restriction and austerity as that of the European and national crisis, it becomes necessary to adopt strong measures, in the diverse related areas that contribute for effectiveness and sustenance of the NHS and for more efficient management of the existing resources.

The Memorandum of understanding on specific economic policy conditionality (European Union, 2011) approved by Portuguese government, sets a goal of reduction in health budget of 550ME, through measures of efficiency and effectiveness: (i) Review and increase overall NHS moderating fees; (ii) Cut substantially tax allowances for healthcare and health care subsystems; (iii) Pricing and reimbursement of pharmaceuticals; (iv) Monitoring of prescription; (v) Implement the existing legislation regulating pharmacies; (vi) Centralized purchasing and procurement; (vii) reinforcement of primary care services; (viii) Reduction of EUR 200 million in the operational costs of hospitals in 2012 ; (ix) Finalise the set-up of a system of patient electronic medical records.; (x) Reduce costs for patient transportation by one third.

### 3. Methodological and theoretical options

**T**his study intends to analyse health policies and the Portuguese health system, in a context of economic, financial and social crisis, bearing in mind the speeches of policy-makers and experts about the processes of governance and contingency measures, considering as dimensions of analysis, efficiency and effectiveness.

Assuming a constructivist perspective of risk and governmentalization, it deals with the perspective of agents, which allows discussion of discursive and praxiological dimensions of risk (Marinker, 2006). The central theoretical approach of this study applied to health policies,

makes visible forms of governmentalization in health area, as well as various procedures used in construction of new political agendas.

The work of Foucault is in evidence among studies on the concept of governmentalization. The author defined governmentality through three key elements: (i) combination of institutions, practices and knowledge that exert a certain power on population by security mechanisms and economic policies; (ii) tendency for the prominence of state power; (iii) and governmentalization of administrative state, in combination with the effects of this governmentalization with the interactions of society, State and individuals. (Foucault, 2000). Rose, O'Malley and Valverde (2006), from the perspective of governmentality, refer that the command-control model of power is replaced by a more subtle form involving citizen's empowerment to act and power training and exercise through control technologies of the individuals.

Governmentality emphasizes a multiplicity of power relations and the diversity of their origin and effects. Governmentalization is the practice of governmentality. In health area, techniques of governance have been based on the existence of risks. (O'Malley, 2007). The discourse of key actors in health policies emerges possible ways of governance, being a form of power, according to the theory of governmentality.

The methodology of the study was based on two processes: (i) analysis of documents, official and statistical sources and bibliography searches on topics related with the subject; (ii) and analysis of discourse of involved actors in designing and implementing public health policies.

For empirical support, 20 in-depth interviews were applied between January and October 2011, to privileged actors in health area, chosen through a snowball sample, allowing the saturation of information and collect and analyse political plans and respondents proposals that could be the basis of health governance.

The types of actors interviewed were the following: (i) 6 policy-makers (Ministers, State Secretaries, congressmen and members of political parties, experts in the field of health; (ii) 14 scientific and technical experts (researchers and professors, hospital administrators, doctors, nurses, representatives of professional orders, consultants in the area of health quality).

Analysis of information obtained through interviews was made by analysis content procedure, through four distinct phases (Bardin, 2008), supported by the software MAXQDA: (i) full transcript of interviews; (ii) careful reading of interviews and identification of categories of analysis; (iii) construction of interviews synopses and of analysis of MAXQDA matrix; (iv) descriptive categorical analysis of interviews.

The present study analyses health policies through the discourse of interviewed actors, considering the dimensions of efficiency and effectiveness, in the definition of programs and measures for a better organization and coordination of health services.

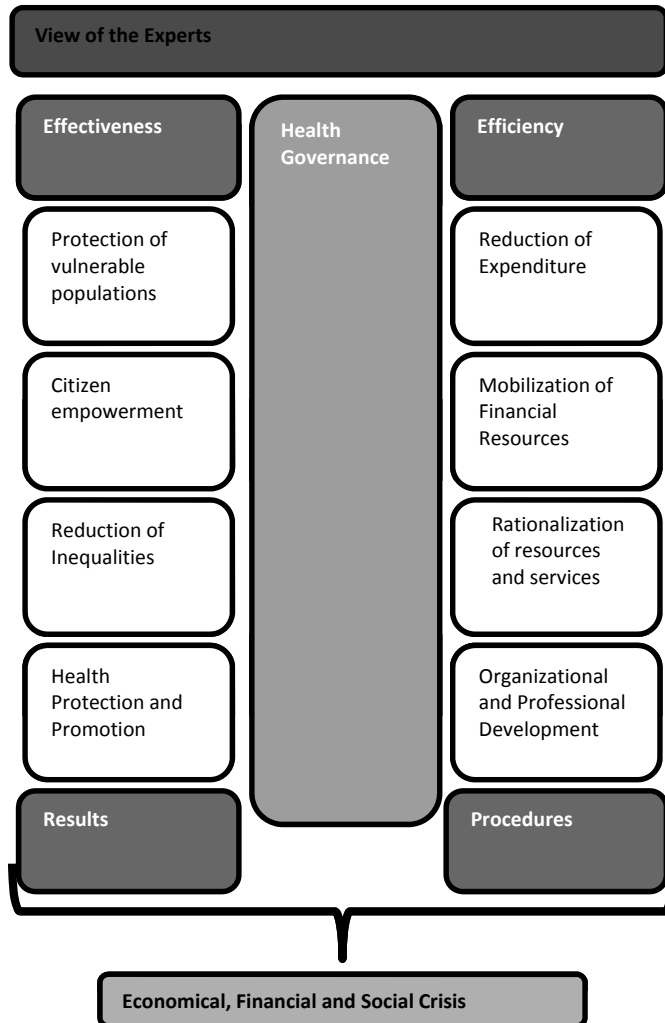
These dimensions are essential for a good evaluation on the performance of organizations and programs. According to Bilhim (2008) measuring effectiveness and efficiency is an obligation created by the need to know if organization is actively seeking to achieve its objectives. Effectiveness can be defined as a normative measure of achievement of organization global results, while efficiency is considered a measure of the means, procedures and methods used which need to be planned and organized for the optimization of available resources.

Since this study is about governance measures implemented in the health system, the use of these dimensions allowed, through the speech of respondents, establishing of decision-making criteria that seal any shortcomings of orientation and system failures and direct investments and actions for the pursuit of the NHS objectives.



Figure 2 presents the analysis model, putting in each dimension the corresponding categories.

**Figure 2: Model analysis based on the criteria of efficiency and effectiveness in health governance**



In the dimension of effectiveness were established the following categories: (i) protection to the most vulnerable (regards access to healthcare, protection and prevention actions and promoting specific health actions); (ii) citizens empowerment (literacy promotion and active participation and informed choice of citizens) (iii) inequality reduction (access and financing of health care); (iv) protection and promotion of health (public health strategies and plans).

Finally, in the dimension of efficiency, the categories were: (i) reduction of expenditure; (ii) mobilization of financial resources (mobilization through taxes, co-payments or supplementary

insurance); (iii) rationalization of resources and services (fighting inefficiency in supply, demand and use of services); and (iv) professional and organizational development (human resources management, professional satisfaction and clinical governance).

## 4. A look of the experts on the national health system: Measures of governance

The analysis of dimensions of effectiveness and efficiency on measures proposed by the interviewees in the quest for good health governance and activation and modification of existing policies induced by risk in the current panorama, allows to evaluate decision-making criteria that point to the control of conditions and desired results, for structuring of the objectives and for deficiencies resolution in health system in this context of crisis, from the perspective of the actors.

In short, starting from readings and analysis of in-depth interviews conducted, answers it were searched to optimize expenses and investments in health and to increase effectiveness of the NHS, in an environment of economic, financial and social crisis, where the sustainability of protective systems, in particular the health system, is a point of weakness of governance in Portugal.

### 4.1 Effectiveness – promotion of equity and universality of health care

As already stated above, in the dimension of effectiveness the following categories were established: (i) protection of the most vulnerable; (ii) reducing inequalities (iii) empowerment of citizens; and (iv) health protection and promotion.

In the category “protecting the most vulnerable”, respondents pointed out a set of measures which enable a better financial protection and facilitate access to general and specific health care.

Choices made in terms of public and private for profit and non-profit funding, can determine the level of degree of health care coverage. Respondents pointed out a moment of medium/long term uncertainty about the nature of needs of the most vulnerable citizens, and therefore better financial management will keep the public funding of access. Guarantee of access to health care for all citizens, no matter their age or socio economic statute, must be a priority in the health system, being this a basic right, that State should assure in a tending to be free system (Int1; Int6; Int8; Int12).

Investment in primary health care and in proximity care is another measure widely defended (Int2, Int3, Int5, Int15 and Int17) that allows a better management and mediation of health process for users. The vision centred in the hospital will have to be substituted by one more centred in primary health care, strengthening the relation of the user with the family health unit and his family doctor, leaving for the hospital more acute cases and preventing the surcharge of services with less urgent cases.

In this sense, interviewees underlined importance of the central role of general practitioners, as privileged informers, on methods of tracing, risk behaviours and healthy life choices. Investment in prevention, promotion and education for health, assumed by several professionals and organizations must be strengthened (Int4, Int.5, Int6, Int7, Int9, Int13).

Non-lucrative sector has an important role in the intervention among populations in bigger risk of exclusion to health access (Int11, Int13, Int16, Int17, Int18, Int19).

Another access related aspect referred by the interviewees is the management of waiting lists for consultations and surgeries. The following measures were suggested for the reduction of

waiting time within the stated periods foreseen in the law: (i) spreading of the Letter of Rights of Access of the NHS users; (ii) publishing of maximum stated periods for consultations and surgeries; (iii) diagnostic, following and evaluation of waiting lists; (iv) redefinition of health professionals role; (v) better planning and management of human and material resources; and (vi) reinforcement of primary cares (Int1, Int3, Int4, Int5, Int8, Int9).

In the category “reduction of inequalities”, the access and financing to health care and information and actions on inequalities in health are discussed. In this scope, beyond some measures analysed in previous dimension, interviewee referred the need of revision of co-payment of medication according with needs of chronically ill, with population incomes and with strategies of national health plan, promoting the equity of access to therapeutic (Int2).

The category “Empowerment of the citizens”, relates to active citizenship, information and literacy in health and to participation of the citizen as subscriber of the health contract, is constant in the answers of the interviewees, given its preponderant role in persecution of health system goals.

As the main subscriber of social contract, citizens emerge in the interviews as a central element in the planning and implementation of health public politics that must have in account the needs and public discussion of health budget. Int20 referred as a diagnostic methodology and information focus groups to listen to all sectors of population about evaluation of health services and proposals for improvements in the sector.

Citizens must be conscious of their rights and duties, of their contributions and expenses in the NHS, moderating the consumption and adapting their expectations to possibilities of the State, for the full exercise of a responsible and informed citizenship. (Int3, Int10, Int12, Int13, Int17, Int18, Int20). The role of citizen in management of health care process must be active, contributing for a culture of commitment, evaluation and accountability. (Int8, Int14, Int15, Int18).

Through interviews analysis, it became clear the relation between information and health literacy and an informed choice in the individual process of health with a bigger conscience of belonging to social contract (Int1, Int2, Int5, Int7, Int9, Int14). Debate on literacy concludes on the need to invest in health education and information and in a platform of information on behaviours and lifestyles and use of communication technologies, promoting an active evolvement of citizens.

In the perspective of “health promotion and protection”, referring to public health, to the management of risks and to the cooperation between the health sector and other sectors, interviewees stated the need to bet in prevention and in tracing of illnesses, as main focus of the questions of public health (Int2, Int7, Int9).

The effective action in identifying territories of bigger fragility and in developing adequate programs to complexity of human being implies a good articulation between municipalities and ministries, such as the Ministry of Health and the Ministry of Solidarity and of Social Affairs, as well as the participation of the civil society associations (Int5, Int11, Int13, Int18, Int19).

## ***4.2 Efficiency - Strategies, procedures and methods for the optimization of the National Health Service***

Concerning the dimension of efficiency, the considered categories are: (i) reduction of public expense; (ii) mobilization of financial resources (iii) rationalization of resources and services; and (iv) organizational and professional development.

The category of “reduction of public expense” relates to a set of actions, pointed by interviewee, aiming control and containment of expenditure growth in health sector, in areas as medication and acquisition of goods and services for Ministry of Health.

The central question of public expense in health is defined as the mechanism of decision on the budget ratio of a certain state to be spent in health. The need to rethink and to promote a public debate on the health budget is then a key point that must consider not only the economic growth but also the welfare of citizens. (Int1, Int8).

The current expense in health is 10.1% of the GDP in 2009. However the Portuguese GDP is relatively low when compared with other countries and this expenditure tends to be effectively less, although occupying a bigger percentage. In this sense, interviewees advised to increase GDP, thus improving the percentage allocated to Health (Int10, Int11).

Aiming the reduction of the expenditure, Int10 defends less fiscal deductions of the health expenditures. Interviewees also remark the reduction of expenditure with medication, privileging the following measures: (i) preference for the generics use (Int2, Int6, Int7, Int9, Int11, Int17 and Int19) and setting of its price in a maximum of 60% of the price of original medication (Int18) (ii) importation of medication with reduced prices (Int5 and Int13) or (iii) centralization of purchases (Int2, Int5, Int6, Int12) and (iv) organization of public contracts for acquisitions (Int3, Int8, Int12, Int17); (v) instauration of guidelines for prescriptions, examinations and procedures (Int3, Int12, Int14, Int17); (vi) electronic prescription followed by the quality control (Int18); and (vii) prescription of medications by amounts and individual doses (Int9, Int17).

The resource to finance the access to quality health services is mobilized through taxes, co-payments and supplemental insurances. The continuity of the investment in health, in crisis times is emphasized by Int7, with the objective of guarantying to the population one of its basic and universal rights. The NHS financing must be assured by governmental budget, where the moderating taxes have only a symbolic role (Int6, Int10). The mobilization through taxes must have in account a bigger social justice as for example raised taxes for the bigger economic and financial groups (Int5, Int8, Int10) and the mobilization through co-payments, pointed by Int10 and Int19 that consider the ADSE reintegration (public subsystem) in the NHS.

Interviewees pointed a need for a better rationalization and efficiency of health resources on supply, demand and use of resources and health services. Strategic orientation for the gradual equilibrium of relative accounts in health, recommended by Int8, that must have in account the elimination of harmful management and frauds, among other topics. In the same view, Int1, 5, 9, 12, 16 and 17 enhance need of a better strategic planning for health and of a rigorous middle and top management that does not compromise the quality and the efficiency of the services.

The offer of consultations, mainly of specialties, will have to be moderate because it increases the unnecessary demand (Int10 and Int11), being preferential the investment in primary care (Int18). Another measure for elimination of inefficiencies and wastefulness is to diminish useless prescription and the duplication of medications and exams (Int1, Int3, Int6, Int8, Int10, Int14, Int16, Int20). With this goal the improvement of information management and the informatization of health processes (Int2, Int3, Int14, Int15) and elaboration of a list of equipment and resources (Int2) allow the prevention of duplicate efforts and resources and a bigger control of supply and demand of services. Finally, evaluation processes and the following of cost practical efficiency for the technologies, politics and of management in the health sector (Int5, Int8).

The last category is "organizational and professional development" that includes the components of development of new instruments of management and clinical and organizational governance.

Effective middle and top governance in the health units is one of the questions more emphasized by interviewees. A governance independent of political interests, articulated with the activities of some organisms, public and private, as well as recruitment according with professional

profiles and skills, and nominations for positions by merit (Int3, Int4, Int6, Int9, Int12, Int20). Another objective is a good monitoring to guarantee the systematic evaluation of contractualization results (Int8), attributing responsibilities to hospital managers and their teams for the results of services they represent (Int14, Int16, Int20).

Management of human resources must have a strategy of optimization of existing resources, solving the scarcity of doctors and nurses in some geographic zones and specialties (Int4, Int7, Int11, Int12, Int15, Int16, Int17). It has also been referred the redefinition of health professional profiles, as for example, attributing more functions to nurses and specialized technicians (Int3, Int5, Int7, Int10 and Int13). Human resources planning imply the regulation of the professional abilities to basic and continued training (Int4, Int5 and Int7).

## 5. Risk and uncertainty in discourses of social actors as space of policies exercise in health

Over the years, Portuguese health system has undergone several reforms to improve and to monitor the needs of the population. Recently, there have been strict measures and expenditure retrenchment policies imposed by budget constraints with the aim of reducing the expense and system inefficiencies.

The impact of the crisis worsens or decreases with ability of governments to deal with and neutralize the effects of crisis. This ability depends on efficiency and strength of macroeconomic policy mechanisms of social protection systems, on legal frameworks and on the structures of governance and political stability (United Nations, 2011) to cope with social implications adjacent to the crisis.

The current and future challenge of Portuguese government is to find a balance between needs of providing quality health care to citizens and the increasing demand for health care, aging population and technological development that financially pressure the Portuguese health system (Paulo, 2010).

Public expenditure on health in Portugal has been increasing, which implies reforms geared towards the better use of resources and effectiveness of the system. This panorama of social risk and health issues emerge as a social arena and a field of study, where different constellations of power, management technologies and theoretical perspectives confronts, representing alternative visions of the world from different subjects and political agents (Sakellarides, 2006). Initially, policies arise from new scientific discoveries, epidemiological and demographic trends, needs, perceptions of risk threats, public dissatisfaction regarding the campaigns of specific interest groups, political parties and media agendas (Marques & Torgal, 2002). For the implementation of policies and measures, there must be a media discussion of the theme, which can occur when more international, national or local level (Marinker, 2006).

In this same theoretical reading, domains of risk and uncertainty become spaces for the exercise of policies determined by the identification of sources of insecurity and consequent areas of human interaction, in particular through the emergence of processes of debate and political contestation in relation to that same identification (Huysmans, 2006).

In the speech of the interviewees, their conceptions of risk and uncertainty are evident in the context of proposals for intervention in the sector, reflected in the objectives and needs of health and their own media, public and political agendas. This framework of crisis is also verified in the

international context of its proposals, which fit in forward-looking measures of other international actors engaged in analysis of health system performance, such as WHO, OECD, United Nations and also in the European Council Implementing Decision, providing policy makers and various social authors a set of recommendations aimed to improve health system performance.

The debate on need for improving effectiveness and efficiency of the healthcare system in Portugal is verified in the speeches of respondents, who suggest new forms of governance in this panorama of crisis and risk and with the goals they intend to achieve in health, through concrete actions that incorporate a tactical and strategic vision and with impact in the short and long term on health sector. Dominant discourse on health expresses the challenges and costs of change, in a risk context in which it arises as a scenario that validates certain governmental practices, namely the reduction of expenditure and the decrease of social protection in health by the State.

## 6. Final considerations

**B**riefly, this study allows to understand how contingencies of crisis situation and the risks that it entails, triggering the need for decisions and attempts to transform the unpredictable consequences of civil decisions into predictable and controllable and lead to the introduction of additional mechanisms of cost containment that have direct implications on the allocation of resources to health sector.

Situation of contingency – crisis - in Portugal enforces actions and decisions aiming a greater effectiveness and efficiency of the NHS that ensures the wellbeing of citizens, without forgetting the need for country's economic growth.

Effectiveness of the system or fulfilment of the goal of universality of access implies the protection of the most vulnerable and the reduction of inequalities in access, in particular through the maintenance of public funding of the NHS, through State budget.

Investment in primary care and proximity care, with strengthening of the role of the family doctor and the biggest concern with the prevention, health promotion and health education, supporting the efforts of the non-profit sector with vulnerable populations is important. To solve the problem of waiting lists for consultations and surgery is proposed the publication of the rights of users and the wait timeouts, redefinition of professional profiles and better planning of human and material resources in addition to the already mentioned strengthening of primary care.

Citizen empowerment implies the strengthening of existing social contract and to involve citizens, well informed, on their choices and in the management of their own health process, adapting their expectations to the possibilities of state, with the support of information and communication technologies.

To promote the efficiency of NHS, the categories relate to a better utilization and mobilization of human and material resources and with the professional and organizational development. Mobilization of resources through taxation must be maintained, however as a measure of greater social justice, higher taxes for large economic and financial groups are pointed out. The public debate in the percentage of tax spending on health would also be important.

With a view to possible reduction of health spending, medicine policy is one of the priorities. The decrease of costs allocated to inefficiencies and waste also involves better information management policies and negotiations with suppliers of the Ministry of Health, centralized, with longer term and involving public contracts.

Better use of human resources can be done through measures such as adequacy of professional skills to basic and continuous training, redefinition of health professionals roles and appointment of senior management and administration according with principles of competence and professional profiles.

In conclusion, the debate on improving the effectiveness and efficiency of healthcare system in Portugal generates new forms of governance that take into account how the problems are thought, what solutions are idealized, what are the objectives to achieve and how, through which concrete actions that incorporate a tactical and strategic vision. The dominant discourse on health expresses the challenges and costs of change, in a context where risk arises as a social construction that legitimizes certain government practices.

## Bibliographical references

- Bardin L., (2008), *Análise de Conteúdo*, Lisboa: Edições 70.
- Bilhim J.A.F., (2008), *Teoria Organizacional. Estruturas e Pessoas*, Lisboa: ISCSP.
- Deloitte, (2011), *Saúde em Análise: uma visão para o futuro*, Lisboa: Deloitte.
- Ebner Y., (2010), *The impact of Economic Crisis on Health inequalities*. An AER Background paper for AER Conference on health inequalities, October 2010: Assemblée des Regions d'Europe.
- European Commission, (2010), *The Social Situation in the European Union 2009*. Eurostat, Luxemburg: European Union.
- Foucault M., (2000), *Microfísica do Poder*, Rio de Janeiro: Graal.
- Huysmans J., (2006), *The Politics of Insecurity. Fear, Migration and Asylum in the EU*, UK: Routledge.
- Marinker M., (2006), "Health Policy and the constructive conversationalist", in: Marinker M. (ed.), *Constructive Conversations on Health. Policy and Values*, London: Radcliff.
- Marques F. & Torgal J., (2002), "Contributo para a Definição de uma estratégia da cooperação portuguesa para o desenvolvimento no sector da saúde", in: *Revista Portuguesa de Saúde Pública*, 20(1): 21-26.
- O'Malley P., (2008), "Governmentality and risk", in: Zinn Jens (ed.), (2008 a), *Social theories of risk and uncertainty – an introduction*, Oxford: Blackwell Publishing: 52-75.
- OECD, (2009), *Health at a Glance OECD Indicators*, Paris: OECD.
- OECD, (2010), *OECD Health Data 2010: Statistics and Indicators*, Paris: OECD.
- OPSS, (2011), *Relatório de Primavera 2011. Da depressão à crise: Para a governação prospectiva da saúde*, Lisboa: Observatório Português dos Sistemas de Saúde.
- Paulo A., (2010), SNS: Caracterização e Desafios, Artigo 09/2010. Lisboa: GPEARI-Ministério das Finanças e da Administração Pública: January 2012, [www.gpeari.min-financas.pt/analise-economica/publicacoes/ficheiros-do-bmep/dezembro-de-2010/artigos/artigo-9-sns-caracterizacao-e-desafios](http://www.gpeari.min-financas.pt/analise-economica/publicacoes/ficheiros-do-bmep/dezembro-de-2010/artigos/artigo-9-sns-caracterizacao-e-desafios).
- Rose N., O'Malley P. & Valverde M., (2006), "Governmentality", in: *Annual Review of Law and Social Sciences*, 2, 83-104.

United Nations, (2011), *The Global Social Crisis. Report in the World Social Situation*, Department of Economic and Social Affairs. New York: United Nations.

WHO, (2010), *Portugal Health System Performance Assessment*, Geneva: WHO.

### **Websites**

Eurostat, (2012), Unemployment rate, annual average, by sex and age groups (%) [http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=une\\_rt\\_a&lang=en](http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=une_rt_a&lang=en) (13/03/2012).

European Union, (2011), Memorandum of understanding on specific economic policy conditionality [http://aventadores.files.wordpress.com/2011/05/2011-05-18-mou-portugal\\_en.pdf](http://aventadores.files.wordpress.com/2011/05/2011-05-18-mou-portugal_en.pdf) (13/03/2012).



ΣΕΙΡΑ: ΚΟΙΝΩΝΙΟΛΟΓΙΑ & ΕΡΓΑΣΙΑ

## “Κοινότητες” μεταναστών και εργασιακή αντιπροσώπευση

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- ▶ Τι είναι οι «κοινότητες» των μεταναστών και τι μορφές λαμβάνουν;
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**Η** κοινωνιολογική έρευνα στο παρόν βιβλίο υπογραμμίζει ότι η απουσία μόνιμης απασχόλησης και ο περιορισμός των μεταναστών σε περιστασιακά, χαμηλού κύρους επαγγέλματα τους απομακρύνουν τόσο από συλλογικότητες όσο και από ατομικές ή οργανωμένες διεκδικήσεις. Η μελέτη, εισάγοντας μια νέα οπτική στην πραγμάτευση του μεταναστευτικού φαινομένου στην Ελλάδα, συνεισφέρει σημαντικά στην αντίστοιχη διεθνή έρευνα και βιβλιογραφία για τη συλλογική οργάνωση των μεταναστευτικών πληθυσμών και τις επιπτώσεις των σύγχρονων μορφών εργασίας. Καθίσταται έτσι ένα εξαιρετικά χρήσιμο εγχειρίδιο για ερευνητές και φοιτητές, δημόσιες υπηρεσίες ή οργανισμούς και για όσους ασχολούνται με το φαινόμενο της μετανάστευσης και τη μεταναστευτική πολιτική.

Στο πρώτο μέρος του βιβλίου, επιχειρείται η θεωρητική αποσαφήνιση των εννοιών της «κοινότητας», της εργασιακής-επαγγελματικής κοινότητας και της χαμηλού κύρους εργασίας στο πλαίσιο της μετανάστευσης· εξετάζονται οι τύποι των μεταναστευτικών κοινοτικών οργανώσεων καθώς και η στάση των συνδικάτων των χωρών υποδοχής απέναντι στους μετανάστες.

Στο δεύτερο μέρος του βιβλίου, ερευνώνται οι περιπτώσεις των Αιγυπτίων, Αλβανών, Μπανγκλαντεσιανών, Παλαιστινίων και Φιλιππινέζων μεταναστών και των «εργασιακών» συλλόγων τους. Ειδικότερα, αναλύονται οι επιπτώσεις της απασχόλησης και της εργασίας στις μορφές συλλογικής εκπροσώπησης. Επίσης, διερευνάται η κοινωνική ταυτότητα που απορρέει από την οικονομική δραστηριότητα καθώς και οι ρόλοι και τα πρότυπα που διαμορφώνονται στο χώρο της εργασίας.

# Privatisation and profitisation in health care. A comparative study of Sweden and the Netherlands

Ines Verspohl, *Advisory Council on the Assessment of Developments in the Health Care System*

## Ιδιωτικοποίηση και επιδίωξη κέρδους στη φροντίδα υγείας. Μια συγκριτική μελέτη Σουηδίας και Ολλανδίας

Ines Verspohl, *Advisory Council on the Assessment of Developments in the Health Care System*

### ABSTRACT

During the last 20 years, privatization became an issue in health care. The neo-liberal market idea promised to increase efficiency and responsiveness, while at the same time relieving public budgets. European countries have introduced all kind of market instruments, reaching from internal markets, over DRGs, to increased co-payments. However, the welfare state literature currently lacks a detailed explanation of these different reforms.

All health care systems in the European Union are affected by the same problem pattern: demographic change, raising demand, medical-technical innovations and labour intensive services. Nonetheless, the degree and form of privatization varies a lot. This paper studies the power of ideas within the framework of structural reform pressure and institutional path-dependency. The causes for privatization reforms are studied in two countries representing the two ideal types: the Netherlands for Social Health Insurance and Sweden for the National Health Service.

**KEY WORDS:** Privatisation, profitisation, healthcare, institutional path-dependency, Netherlands, Sweden

### ΠΕΡΙΛΗΨΗ

Κατά τα τελευταία 20 χρόνια, η ιδιωτικοποίηση αναδείχθηκε σε σημαντικό ζήτημα στον τομέα της υγείας. Η νεο-φιλελεύθερη ιδέα της αγοράς υποσχέθηκε να αυξήσει την αποτελεσματικότητα και την ανταπόκριση, μειώνοντας συγχρόνως την επιβάρυνση των δημόσιων προϋπολογισμών. Διάφορες Ευρωπαϊκές χώρες έχουν εισάγει όλα τα είδη των εργαλείων της αγοράς, τα οποία κυμαίνονται από την εφαρμογή εσωτερικών αγορών, μέχρι τις Ομοιογενείς Διαγνωστικές Κατηγορίες (DRGs) και την αύξηση των συν-πληρωμών. Ωστόσο, η υφιστάμενη βιβλιογραφία για το κράτος πρόνοιας δεν διαθέτει μια αναλυτική επεξήγηση αυτών των μεταρρυθμίσεων. Όλα τα συστήματα φροντίδας υγείας στην Ευρωπαϊκή Ένωση αντιμετωπίζουν παρόμοια προβλήματα: δημογραφική αλλαγή, αύξηση της ζήτησης, ιατρο-τεχνολογικές καινοτομίες και υπηρεσίες έντασης εργασίας. Παρ' όλα αυτά, ο βαθμός και η μορφή ιδιωτικοποίησης διαφέρει πολύ. Η παρούσα εργασία μελετά τη δύναμη των ιδεών στο πλαίσιο των πιέσεων για διαρθρωτικές μεταρρυθμίσεις και υπό την οπτική της θεωρίας της θεσμικής εξάρτησης. Οι αιτίες για τις μεταρρυθμιστικές διαδικασίες ιδιωτικοποίησης εξετάζονται σε δύο χώρες που εκπροσωπούν τις δύο ιδεατούς τύπους συστημάτων υγείας: την Ολλανδία η οποία έχει σύστημα κοινωνικής ασφάλισης υγείας και τη Σουηδία η οποία διαθέτει Εθνικό Σύστημα Υγείας.

**ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ:** Ιδιωτικοποίηση, επιδίωξη κέρδους, φροντίδα υγείας, θεσμική εξάρτηση, Ολλανδία, Σουηδία

## 1. Introduction

The first reaction to the current economic crisis is a call for cut-backs. The same pattern could be observed after the oil crisis of the 70s. However, the crisis was also the source of a new discourse: neo-liberalism. In the 90s and 2000s the new paradigm was also applied to health care. Privatisation and profitisation should increase efficiency and contain costs. Neo-liberalism as the dominating economic theory and 'cost-explosion' as the major concern of health policy makers emerged simultaneously in the mid-80s on the agenda. Since 1990, the fall of the iron curtain, the Single European Market and afterwards the introduction of the Euro increased the need for structural reforms (Verspohl, 2012). The time frame for analysis spans from 1990 to the recent financial and economic crisis (2009). During these years neo-liberal market orientation has been the leading reform idea on the European stage.<sup>1</sup> However, these privatization/profitization reforms took place in different forms and degrees in different countries. Two forerunners in market oriented reforms are selected as case studies: the Netherlands and Sweden. The two countries represent the two different systems Social Insurance and National Health Service. This paper studies the power of ideas within the framework of structural reform pressure and institutional path-dependency.

## 2. Structural reform pressure and Institutional path-dependency

The first welfare state researchers explained the expansion of the welfare state as a function of economic development (Wilensky 1975). Inversing the argument, economic slow-down or crisis should therefore lead to welfare state retrenchment. Following the oil-crises of the 70s, a race-to-the-bottom has been expected. While the economic means for welfare are decreasing, costs are increasing. The reasons are demographic change, increasing demand due to post-modernism, medical-technological innovation and the cost-driving nature of the labour intense sector (Moran 1999; Powell et al. 1999; Freeman 2000; Blank, Bureau 2004). Out of these, demographic change is the most quoted reason for raising costs. From 1986 to 2006 the life-expectancy within the EU rose by more than four years. Older people are more fragile and therefore have higher health care needs. In post-industrial societies, increasing levels of education and urbanisation of the population result in higher expectations towards health status. Furthermore demand rises for quality and availability of services as well as choice and self-determination on behalf of the patient. These developments on the demand side are met by increasing costs on the supply side. Apart from a few innovations like key-hole surgery, progress results in increasing costs in health care.

From a functionalist point of view, we would therefore expect retrenchment and convergence towards one – most efficient - health care system.

However, this retrenchment could not be observed in pension and unemployment. The new institutionalism explained persisting differences in the light of common challenges by inherited structures of the welfare state and path-dependency (Pierson 1994; Hall, Taylor 1996). Especially the continental social insurance systems were regarded as "frozen landscapes" (Esping-Andersen 1996).

Institutions are defined as the "rules of the game". In the welfare state literature 'institution' refers to the rules of redistribution and risk-sharing in a society. Welfare programs are institutionalized historical decisions. Their existence confines and restrains the policy options available. Once the path-way is chosen, welfare states become highly path-dependent (Pierson 1996, p. 311).

For health care, just two ideal types can be distinguished: National Health Service (NHS), invented by Beveridge, and Social Health Insurance (SHI), invented by Bismarck (Moran 1999;

Freeman 2000). Solidarity and actuarity are the underlying principles of social health insurances (SHI). The members of the insurance pay a regular contribution, which is based on income rather than reflecting health status or risk. Membership is based on employment. Children and spouses have derived rights to care. Contributions are paid both by employers and employees. The variety of social insurance system reaches from universal, meaning just one public insurance covers all citizens (in the Central and Eastern European Countries) to highly particularized with several occupational funds and substitutive private health insurances for the well-off (in Germany).

The social insurance funds and the medical profession play a central role in the governance of health care. The government just sets a regulatory framework for the insurances. Goods and services are provided by private and public hospitals and doctors in private praxis. At least some choice is available to patients and satisfaction with the system is generally high.

The typical problems of social insurance systems lie in the inability to maintain costs and the pressure to lower non-wage labour costs. None of the two central actors - social insurance funds and the medical profession - has an overwhelming interest to cut expenditures. Increasing contribution rates, directly translate into higher labour costs for companies, making investment in the country unattractive.

In countries with a national health service (NHS) the right to health care does not derive from contributions, but from citizenship. Health care is a public good and therefore financed by taxes out of the general budget. The responsibility for health care lies with the municipalities, the central government or the regions – but it is always a public obligation. The provision of goods and services is governed by central planning. Hospitals are owned by the responsible state level. Ambulatory care is provided in local health centres and in private praxis – the relation varies among the countries. The central planning allows for budgetary control and easy cost-containment. However, tight planning tends to result in under-provision and waiting lists. Notwithstanding its effectiveness, the NHS has been criticized as unresponsive to individual needs and its bureaucratic style.

Following an institutionalist approach, the state governed NHS should be easier to reform than the SHI with their strong position of interest groups.

Immergut stressed the importance of political institutions for health care reforms (Immergut 1992). In some countries, the state had the power to replace existing market or corporatist arrangements by an NHS, while in others, political institutions allowed the medical association to block the introduction of a public system. Hence, taking political institutions and especially veto-points into account is also salient for the analysis of privatization reforms in health care.

### 3. Neo-liberal ideas

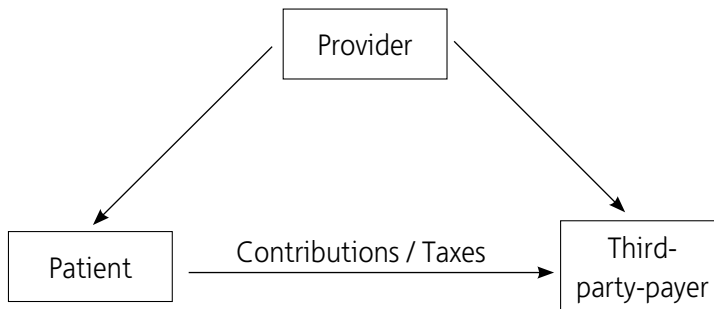
**T**he newest theoretical approach concentrates on the power of ideas. The objective, structurally and institutionally shaped world still leaves a lot of room for uncertainty, where ideas are needed to fully understand the world and formulate legitimate responses (Parsons 2007). Actors follow their personal beliefs about the world and the most suitable action to take. Policy actors, organizations, and the population at large are interpreting facts. The glasses they are wearing are grinded by cognition, experiences and values (Harrison 2004). These interpretations about the world are also labelled policy paradigms or discourse. Ideas play a crucial role throughout the whole process of reform. They are needed to recognise a problem, find a solution and organise support for it.

Following the oil crisis, neo-liberalism replaced Keynesianism as the dominant idea. In this interpretation, reducing state spending, in particular welfare state spending, was not just

commanded by raising public deficits, but also morally necessary to liberate entrepreneurship and welfare state dependents. The new market ideology was first translated into labour market and pension reforms. In health care reforms, the balance between “freedom” and “solidarity” is re-adjusted under the influence of the new policy paradigm. Markets have not just been promoted to ensure freedom, but also to increase efficiency in the delivery of health care. The American public health professor Alain Enthoven developed the concept of “managed competition” for health care maintenance organisations in the US (Enthoven 1978). The providers should not compete for patients, but the insurances for members. The insurances would then contract providers. Although the US generally serve as the example of the least efficient and most unjust system in the western world, his ideas figured prominently in European reform debates.

The modern health care systems have been developed to eliminate direct markets between patients and doctors and to ensure that questions of life and death are not decided by money. All countries introduced third-party-payer systems (see Graphic 1). Theoretically, markets, competition, or market instruments can be introduced in all three sides of the triangle to set economic incentives for rational use.

**Graphic 1: Third-party-payer scheme**



To categorize health care systems, traditionally three dimensions have been suggested: finance, provision, including remuneration, and regulation. Ferrera adds the category of access (Ferrera 1996). These four dimensions provide also the adequate framework to study change in health care systems. In the ideal model of a NHS all four dimensions are dominated by the state, in an ideal SHI by corporatism. Privatisation and profitisation can take place in all of the four dimensions of health care systems (see table 1). By scrutinizing all four dimensions the degree and direction of change can be detected.

<b>Table 1</b>	<b>Social Health Insurance</b>	<b>National Health Service</b>	<b>Privatisation</b>
governance	Self-administration	Hierarchical state governance	Competition rules
Funding	Social contributions	taxes	Decrease of public funding, increase of either <ul style="list-style-type: none"> <li>• <i>private insurance</i></li> <li>• <i>out-of-pocket payments</i></li> <li>• <i>charity</i></li> </ul>
Provision	Private	Public employees	<ul style="list-style-type: none"> <li>• <i>Increase of private praxis</i></li> <li>• <i>Privatisation of public hospitals</i></li> </ul>
Access	Membership	Citizenship	<ul style="list-style-type: none"> <li>• “going private” to skip waiting lists</li> </ul>

## 4. Netherlands

The new Dutch health care system from 2006 often serves as the prime example of a market based system in Europe. The transformation was enabled by a coherent policy paradigm. All parties agreed in principle to a plan drafted in the 80s and implemented the “regulated competition” in incremental steps. However, as shown below, the radical path-break took mainly place on a discourse, not on an institutional level. That means, the system is officially based on competition between private insurances, but tight regulation brought the social health insurance de facto closer to a NHS than to a market model.

### 4.1 Causes for reform: Institutional legacy and ideas

As in all European countries, demographic change and medical-technological innovations were driving up health care costs. Expenditures rose constantly in real terms. In percentage of GDP, they could be maintained during the 90s. Especially the population projections called for reforms. By 2030, every fourth Dutch will be in retirement age. The means to finance the expenditure growth became rare. At the end of the 1970s the Dutch disease was diagnosed. Real economic growth rates were very low. Social insurance contributions rose to 45% of wage costs, and the competitiveness of Dutch companies in the open economy became a serious issue of debate (Andeweg, Irwin 2009). In the early 90s, structural reforms begun. At the turn of the millennium the Dutch economy experienced a boom (4.1 and 5.1 in 2000 respectively 2001) (Eurostat), which allowed for the final step of the radical reform in 2006. In reform debates it is often forgotten, that all reforms are expensive, as consent has to be bought.

The Dutch health care system has not been planed from the scratch, but is rather the result of an organic process. It is separated into three compartments, with different governance and funding principles. The first compartment, the AWBZ, is a universal insurance. It covers the whole population against high risks, especially long-term care. Furthermore, the AWBZ covers public health, and maternity and child care.

The second compartment is a SHI and covers the actual costs of medical care. Just the second compartment was subject to the radical reform. In the old system, social and private insurances existed parallel to each other. As the income threshold was relatively close to the average income, a third of the population was privately insured. Civil servants were insured in a special system. Just employees under the income threshold and civil servants were obliged to have a health care insurance. The rest of the population could be voluntary insured, which resulted in 2% of the Dutch not obtaining health insurance in 2001.

The third and tiniest compartment includes the private complementary insurances, which cover medical care excluded from the standard insurance. The reasoning for supplementary care is that it is either affordable or a luxury good. Over 90% of the population are covered by supplementary insurance for dental care, physical therapy, and optic and hearing aids (Helderman 2007).

Table 2: The Dutch health care system prior to the reform

Private complementary insurances (90%)		
ZfW (social insurances) (66%)	Private Insurance Voluntary (27%)	civil servants (5%)
AWBZ (100%)		

The insurances, social as well as private, and the medical association had a strong role in the management of the second compartment, which allowed them to block reforms. The health care insurances and in particular the private companies constituted the main opposition against any structural reform.

Even when health care is managed by corporatism, the state has the legal power to change the terms of governance. Traditional pillarization, fluctuate ten party parliament, and coalition governments, often without a majority in parliament, led to a political culture of consent. The bicameral parliament with strong parliamentary committees, decentralisation, corporatism, a society of minorities, and nowadays the increasing policy-making by the courts are further veto-points (Andeweg, Irwin 2009). As a result of the high fragmentation within the parliament the incoming government rarely replaces all the parties from the old coalition. This allows for a great deal of political stability (Vaillancourt Rosenau, Lako 2008). The same few parties are to be found in government continuously: Christian-Democrats (CDA), Labour Party (PvdA), and Liberals (VVD). This enforces a continuous strive for consensus. On the one hand, the compulsion for compromise offers a variety of veto-points, on the other hand, policies are continued by the following government, which allows for incremental, but radical change.

The idea of competition is the core of the Dutch reform. The health care system was discredited as violating the principle of solidarity, first, by separation into social and private insurances and, second, by differentiated premiums according to age, gender, and health status in by the private insurances (van Ginneken et al. 2006). The new neo-liberal ideas were not presented as opposing the old value of solidarity, but as reinforcing it.

The recession in the early 80s did not just lead to top-down cost-containment measures, but also to the establishment of a committee to propose a new health care system, which assembled in 1986. The choice of the chairman set the direction for the proposed solution: Dr. Wisse Dekker, chairman of the board of Philips was a convinced market proponent. The final plan suggested a system of regulated competition, inspired by the concept of "managed competition" by Enthoven (Commissie Dekker 1987). The Dekker plan served as blueprint for reforms throughout the 90s until its final implementation in 2006. The core elements were:

- One insurance market for social and private funds
- Competition between the insurances on a defined basic package of goods and services
- Expansion of the market for private, complementary insurances
- free market of providers, insurances conclude selective contracts with providers
- insurances and providers are allowed to merge, following the example of health maintenance organisations in the US
- a central fund collects the employer contributions and redistributes them via a risk-adjustment scheme
- additional flat-rate premiums to be paid directly by the insured; the main element for competition among insurances
- strengthening patient rights and their groups to ensure quality

In combination these elements should ensure universal access, quality and efficiency. In the public debate the new market system could successfully be linked to the old and the new values of health care. The abolition of the parallel private system increases solidarity, while competition between insurances should render them more efficient. Hence, the plan presents a classical Dutch compromise. The Dekker-plan constitutes the common basis for all following health care reforms, surviving all changes of government. Among the three major parties, CDA, PvdA, and VVD "it was the normative conviction that liberalizing reform was necessary and appropriate, regardless of the

electoral consequences for party self-interest" (Castles 2000, p. 288). An electoral alternative to privatisation and quasi-markets was not available.

In 2006 a reform clearly based on the Dekker-Plan was finally ratified. The ministry named as the main maladies of old system:

- Too many different schemes: social health insurance, private health insurance, civil servants
- Little or no choice for insured parties
- Ineffective or no competitive incentives for insurers
- Little or no pressure on suppliers to achieve better performance
- Unfair premium and income effects (Ministerie van Volksgezondheid, p. 7)

The problem interpretation already frames the solution; three out of the five points are to be solved by market elements. Competition is not presented as a remedy to exiting problems, but as a goal in itself. However, the other two goals – the first and the last one – refer to solidarity in the system. The two aims: competition and solidarity co-exist in the discourse and are presented as mutually reinforcing.

## ***4.2 Change: governance, funding, provision and access***

The first attempt to introduce the Dekker-plan failed in 1994. Despite contrary interests, private and social insurances, as well as trade unions and employers had aligned in a veto-coalition. To allow for the radical reform in 2006 to succeed, the institutional patterns of the health care system had to be altered. The corporatist bodies of self-governance have been staffed with crown advisors. As outlined above, the political institutions allow for change in the welfare institutions.

The old system was a Bismarck-system with self-administration. However, the government had always obtained a role in the governance of health care. Several corporatist bodies were rather advisory councils for the government, then regulatory bodies. The reform of the governance dimension took place in two steps: during the 90s, the social partners, insurances and medical associations in the bodies of self-administration and advice were replaced by representatives of the crown. In a second step, the agencies changed their task from governing to market supervision.

For example, social insurances and association of general practitioners negotiated the prices and remuneration system for ambulatory care under the supervision of the National Board for Tariffs in Health Care. The later was merged with the Supervising Board for Health Insurances to the new Dutch Healthcare Authority (NZa). The NZa resembles an anti-trust board and should ensure that prices are found on the free market.

The introduction of markets in health care called for state re-regulation, resulting in a very densely institutionalised framework (Götze et al. 2009).

The legal scope for competition for selective contracts with insurances has constantly been improved since 1992, but remains still small. It is further limited by the shortcut of providers. Price negotiations between insurances and individual providers are just allowed for 34% of hospital services. For the remainder of hospital care and for all ambulatory care, the NZa sets the prices by hierarchical state governance (De Nederlandsche Bank 2009). It has to be asked, if the high administrative costs of selective contracting are worth the outcome.

Contrary to the neo-liberal idea, health care costs have not been privatized. Despite the far reaching market-oriented reforms, the burden on private households decreased from 51% to 42% of total health care expenditures. The share of employers increased slightly from 21% to 22%. Expenditures have been shifted to public budgets. The share of state, provinces and municipalities increased from 23% to 32% (Centraal Bureau voor de Statistiek).



Low premiums have already been introduced in 1989, but insurances seemed to have come to a gentlemen's agreement not to compete on prices. Thus variations in the flat premiums were negligible, and so were the actual switching rates.

Since 2006, premiums completely replaced the employee contribution of former 1.3%. They amount to approximately 1.100€. Although the real price difference just increased slightly, from 200€ to 265€, in the first year of the new health insurance system 18% of all insured changed their insurance. However, this was a one-time effect. Employer contributions and thereby non-wage labour costs decreased from 6.75% to now 6.5%<sup>2</sup> (de van Ven et al. September 2009).

Despite contrary expectations, the premiums made the system more equal. 38 percent of the population receive allowances to finance their health insurance premiums. Furthermore, the state directly pays the premiums for children up to 18 and students (circa 20 percent of the population). Military personal is covered by the ministry of defence and imprisoned people by the ministry of justice, respectively (Ministerie van Volksgezondheid 2005).

Health care services are offered by private providers and remunerated by a common fee schedule. The 2006 reform had no significant impact on the provision of care. The important changes – reduction of beds, hospital mergers, group praxis for general practitioners – happened already in the 90s as a result of hierarchical (cost) pressure and technological innovations.

Although not directly visible to the patient, the 2006 reform fundamentally changed the underlying logic of access to care. Whereas the old ZfW was an employee insurance with derived rights for spouses and children, the new ZVW is based on citizenship. Health care insurance is an individual right and obligation. The reform therefore adapts to the changing social realities, praising individuality.

In the 1990s, a special fund for the specialities with the longest waiting lists was established to decrease the lists. This was the result of a typical hierarchical regulation, no market solution (Harrison 2004). The gate-keeper system is fully accepted.

### ***4.3 Concluding remarks***

The idea of regulated competition was the driver of reform. It linked solidarity and competition. The radical reform was facilitated by the political institutions. Consecutive governments incrementally prepared the basis and implemented the Dekker-Plan. However, more emphasis is laid on regulation, then on competition. Although the new system is widely perceived as market based, the impact of competition is very limited. In the governance and funding dimension, state governance and taxes replaced the corporatist self-administration and wage-related contributions. To sum it up: the Dutch health care system was incrementally transformed to new kind of NHS with competition and private providers.

## **5. Sweden**

**I**n the late 80s, Sweden came closest to the ideal public health care service. Health care is the responsibility of the county councils, which experimented with private providers to increase efficiency and meet societal demands for choice. The political institutions allowed for inconsistent reforms at the national level. As a result, the counties employed different systems and privatization is mainly a Stockholm issue.

## ***5.1 Causes for reform: institutional legacy and ideas***

Ageing population, medical-technological innovations, and rising expectations on behalf of the public are also named in the Swedish reform debate (Federation of Swedish County Councils 2002).

In the early 90s, Sweden experienced an economic crisis, which was met by tight state and county budgets. Sweden managed to maintain its health care costs as share of GDP during the 90s, during the 2000s they slightly rose from 8% to 9% of GDP.

The share of the population aged 65+ was 17.3 in 2006 and is expected to further increase. The share of the very old, aged 80+, rose to 5.3% of the population and is now the second highest in Europe (Eurostat).

In the welfare state literature, Sweden presents the ideal model of the social democratic welfare state and is the ideal National Health Service, described by state governance, funding by taxes and universal access. In Sweden, even the doctors were public employees. However, since the 90s, the socialist system, allocating patients by post-code to their doctors and hospitals, did not fit the new post-modern values any more. People demanded choice and accused the old system of its bureaucratic style.

Although Sweden is not a federal country, responsibility for health care is devolved to the 21 counties and governed by the county council. The counties are in charge of health care, but the national level sets the legal framework and can at any time withdraw competences from the counties. Policy making at the country level is marked by two central features: political responsiveness, as health care reforms are salient issues in the regional election campaigns and pragmatism, as in all regional governments. The decentralised system allows for experimentation at the county level.

At the national level, the complete absence of veto-points allowed rapid course changes and partisan politics can be observed. The shift to a one-chamber system in 1970 increased responsiveness, but undermined institutional stability.

Universalism, the core value of the Swedish welfare state, was challenged by the new value of self-determination. Post-modern individualism also found its way into the Swedish culture. Standardised procedures and paternalistic decisions were no longer accepted. At the beginning of the 90s "something had to be done" to meet increasing complaints about waiting lists and unresponsiveness. The neo-liberal discourse offered a competing interpretive framework (Enthoven 1989). The market idea promised to render the health care system more efficient, patient-oriented, and at the same time help to decrease public debts.

These new ideas were embraced by both sides of the political spectrum. In their program for the 90s, the Social-democrats favoured internal markets in health care to give the individual health care centre or clinic incentives to increase efficiency and responsiveness. The Moderates, on the contrary, favoured private provision in competition to the public system. They furthermore embraced the ideology of markets on an ideological level, whereas the SAP saw it just as a tool to rescue the universal welfare state. Out of these conflicting views no coherent discourse emerged.

## ***5.2 Change: governance, funding, provision and access***

The change in Swedish health care in the last 20 years is best described by modernisation. The process is marked by learning and pragmatism. Free choice has been introduced and private providers challenged the public health bureaucracy. The new times called also for new forms of governance and management: global budgets for hospitals, capitation for family doctors and DRGs, as well as health technology assessment and prioritisation guidelines, replaced the traditional planning. Change took place on the county level, according to regional needs and demands.

Health care policy at the national level was marked by reforms, which were redrawn by the next government. The real privatisation process was driven from below. The mode of governance itself was not changed.

Some county councils had already experimented with purchaser-provider splits in the late 80s. In the early 90s, the Federation of County Council had recommended to fill gaps in the provision with private providers. In 1994, the Moderates obliged the county councils to include private providers into the public system. In the following year, the SAP revoked the reform law.

After the privatization of the first public hospital in Stockholm, the national SAP government prohibited further privatizations in 2004 – the stop-law. In 2006, the new moderate government enacted the start-law, encouraging further privatisations of public hospitals.

In 2005, the Federation of County Councils recommended to offer free choice in the whole country, including private and public providers alike. With the exception of the Northern region, all county councils followed the recommendation. In 2010, the national moderate government embraced the recommendation (Olsen forthcoming).

Also for quality assurance, we observe a constant rebalancing between regional and national level. Due to the technical developments, health care technology assessment, guidelines for practice and prioritisation became ever more detailed and strengthened the national level. Since 2001, the Federation of County Councils publishes its own quality reports to counterbalance this development (Sveriges Kommuner och Landsting 2002).

Swedish health care is funded by income taxes on the county level. A national income and risk equalisation scheme evens out regional differences. The national subsidies rose from 15% in 1994 to 20% in 2009. However, these are average numbers, the percentage per county varies widely (Swedish Association of Local Authorities and Regions 2008).

Next to tax-funding, high co-payments and a social insurance finance health care. The share of private funding out of total health expenditure nearly doubled from 10% in 1990 to 18% in 2007(OECD 2010). This is mainly the result of the complete privatisation of dental care. The Social Insurance finances just sick-leave and dental care subsidies for adults. Just 4 percent of the population obtain a private health insurance (OECD 2004). Hence, increasing co-payments increase the risk of social imbalances.

In the late 80s, nearly all doctors were public employees. In the early 90s, the Federation of County Councils recommended to fill gaps in the provision structure by private contracts. The counties concluded contracts for private practice with their own employees. The standard working week allowed the public employees to practice privately in their extensive free-time.

In 1994, the Family Doctor Reform established competition within the public system and allowed patients to choose their family doctor, instead of being treated by the doctor on duty. Private and public providers have to be treated on equal terms. The counties had to introduce a remuneration system, where money follows the patient. The result was provider induced demand. In 1995, the social democratic government revoked the reform, as it accelerated costs and threatened the new approaches of integrated care. Some counties maintained the capitation for family doctors, others returned to salaried doctors in public health care centres. The regional systems became more diverse (Harrison, Calltorp 2000).

Despite the privatization reforms, health care is still predominantly provided by public employees. In 2006, just 16% of all physicians, 12% of the nurses, and 10% of midwives worked in the private sector (Socialstyrelsens 2010). Privatisation is concentrated in ambulatory care. Nationwide, in 2005, already 30% of primary care visits were paid to private practitioners.

However, the degree of privatisation differs widely between the counties. Stockholm had 129 private practitioners within the public system per 100.000 inhabitants, in contrast to an average of 31 in the other counties (Sveriges Kommuner och Landsting 2010). Privatisation was the answer to the quest for self-responsibility and responsive providers by the urban middle class. In rural areas a natural monopoly exists.

In the hospital sector, the huge public and political privatisation debate obscures the negligible significance of private clinics within the public system. So far, just one public hospital was sold to a private investor. Furthermore 20, private non-profit clinics exist. Out of the 941 private hospital beds, 645 were under contract in Stockholm in 2008 (Sveriges Kommuner och Landsting 2009).

The only exception to the principle of public provision is dental care. More than 40% of the dental care personnel work in private for-profit practice.

Access to health care goods and services has been and still is universal in Sweden. In a public system demands from providers and patients are unlimited and some kind of rationing has to take place. In Sweden, clear guidelines for prioritization are followed. The most dominant issue in the public debate are the waiting lists for elective surgery. Different approaches have been tried to cut them down. Investments in specialities and hospitals with the longest lists were combined with financial penalties. Under the waiting time guarantee, competition between counties is established. The patient can seek care in a private clinic or in another county, if the hospital of the catchment area is unable to provide the treatment within the three months. The costs are born by the home hospital.<sup>3</sup>

The slight tendencies to a dualisation of the system, with a parallel private market for insurances and private clinics, could be kept at a very low level.

Again, dental care is the exception. Costs and risk are born by the patient. As a result, patients from lower income classes visit the dentist less often, despite higher needs (Calltorp, Larivaara 2009; European Commission 2007, p. 396).

### *5.3 Concluding remarks*

Reform pressure in Sweden stemmed mainly from increasing demands of a new urban middle class. The neo-liberal discourse offered an alternative. The pragmatism and simple institutional design allowed for reform by the county councils. The most salient shift was the introduction of private providers – although in international comparison still at a low level. The devolved responsibility resulted in pragmatic, but also fragmented solutions. Markets were introduced as instruments and maintained in counties, where they provided added value to meet societal demands.

## **6. Conclusion**

**B**oth the Netherlands and Sweden introduced market elements into their public systems. However, the detailed analyses revealed, that these took place in different dimensions of the systems. Whereas the Netherlands established competition in the funding dimension, Sweden between providers. In the governance dimension, Sweden experimented with markets, without questioning the supremacy of state governance. The Netherlands replaced their corporatist bodies under the heading of “markets” by state agencies. State governance is the most efficient mode to maintain costs. Table 3 gives a comparative overview of the two systems. The changes are highlighted.

<b>Table 3</b>	<b>Netherlands</b>	<b>Sweden</b>
Governance	<i>Market with tight regulations</i>	State (counties)
Funding	<i>Premiums + taxes + contributions</i>	Taxes + co-payments
Provision	Private	<i>Public and private</i>
Access	Membership; gate-keeper	Citizenship; <i>choice of physician</i>

The structural challenges were quite similar between the two small countries: demographic change and a post-modern society. The institutional heritage determined in which dimensions they introduced choice and competition. In the Netherlands the provision dimension was already market by competition – also in a corporatist setting. In Sweden, choice between third-party-payers is inhibited by the regional principle. The governance structure of health care determined the pace of reform. Whereas Swedish county councils could already in the late 80s experiment with internal markets and private providers, the Netherlands first had to alter the institutional framework of health care governance.

The reform outcomes differ also as a result of the different impact of the neo-liberal idea. Whereas the concept of Enthoven was prominent in both countries, in the Netherlands, competition became a value itself. In Sweden, the conservatives could not establish such a common discourse, and competition was just employed at the instrument level. Markets are seen in concurrence to solidarity, whereas the two are conceptualised as mutually reinforcing in the Netherlands. To sum it up, a coherent neo-liberal idea is the precondition for market oriented reforms. The welfare state institutions define the dimension, in which competition is the easiest introduced and the political institutions define the feasibility. For the future, research in countries with more veto-point is needed.

## Notes

1. During the first years of the crisis, there seemed to be the possibility of a new paradigm shift Hemerijck, 2009.
2. Officially all contributions are paid by the insured, however the reimburseable wage-related contribution is in reality a employer contribution.
3. This guarantee was first introduced in 1992, withdrawn in 1997 due to scientific critic and reintroduced in 2005. However, since 2005 nearly all counties offer free choice of provider in the whole country.

## Bibliographical references

- Andeweg R.B., Irwin G.A., (2009), *Governance and politics of the Netherlands*, 3. ed., fully rev. and updated. Basingstoke, Hampshire: Palgrave Macmillan.
- Blank R., Burau V., (2004), *Comparative Health Policy*, Basingstoke, New York: Palgrave Macmillan.
- Calltorp J., Larivaara M., (2009), "Changing perceptions of equity and fairness", in: Magnussen J., Vrangbæk, Karsten S., Richard B. (Hg.), *Nordic health care systems. Recent reforms and current policy challenges*, Maidenhead: Open Univ. Press, 214-232.

- Castles Fr.G., (2000), "The dog that didn't bark: economic development and the postwar welfare state", in: *European review: interdisciplinary journal of the Academia Europaea*, 8 (3) 313-332.
- Centraal Bureau voor de Statistiek: Statline. [www.cbs.nl](http://www.cbs.nl), last access 22.09.2010.
- Commissie Dekker (1987), *Bereidheid tot verandering. Advies van de Commissie Structuur en Financiering Gezondheidszorg*, Den Haag: Distributiecentrum Overheidspublicaties.
- De Nederlandsche Bank (2009), Quarterly Bulletin March 2009. Online verfügbar unter [http://www.dnb.nl/en/binaries/DNBmar09\\_tcm47-216272.pdf](http://www.dnb.nl/en/binaries/DNBmar09_tcm47-216272.pdf).
- Enthoven AL., (1978), "Consumer-choice health plan. Inflation and inequity in health care today: alternatives for cost control and an analysis of proposals for national health insurance A national-health-insurance proposal based on regulated competition in the private sector", *New England Journal of Medicine*, 298 (12) 650-658, 709-720.
- Enthoven AL., (1989), *Management Information and Analysis for the Swedish Health-Care System*, Swedish Institute for Health Economics. Lund. (IHE Working Paper, 7).
- Esping-Andersen, G., (1990), *The three worlds of welfare capitalism*, Princeton N.J.: Princeton University Press.
- Esping-Andersen, G. (Hg.), (1996), *Welfare States in Transition. National Adaptations in Global Economies*, London: Sage.
- European Commission, (2007), *Joint report on social protection and social inclusion, 2007*. Luxembourg: Office for official publications of the European Communities.
- Eurostat: Employment and Social Policy Indicators. [http://epp.eurostat.ec.europa.eu/portal/page/portal/employment\\_and\\_social\\_policy\\_indicators/introduction](http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_and_social_policy_indicators/introduction), last access 14.01.2011.
- Federation of Swedish County Councils, (2002), *Swedish health care in the 1990s*. Trends 1992-2000. Stockholm.
- Freeman R., (2000), *The politics of health in Europe*. Manchester: Manchester University Press (European Policy Research Unit series).
- Ginneken Ewout van; Busse R., Gericke Ch., (2006), "Das neue Krankenversicherungssystem in den Niederlanden: erste Erfahrungen mit der Mischung aus Kopfpauschalen, Bürgerversicherung und einem zentralen Fonds", *Gesundheits-und Sozialpolitik*, 60 (7-8) 10-18.
- Götze R., Cacace M., Rothgang H., (2009), "Von der Risiko- zur Anbieterselektion. Eigendynamiken wettbewerblicher Reformen in Gesundheitssystemen des Sozialversicherungstyps", *Zeitschrift für Sozialreform*, 55 (2) 149-175.
- Hall P., Taylor R., (1996), *Political Science and the Three New Institutionalisms*. MPIFG Discussion Paper 96/6. Köln.
- Harrison M.I., (2004), *Implementing change in health systems. Market reforms in the United Kingdom, Sweden, and the Netherlands*. London: Sage Publ.
- Harrison M.I., Calltorp J., (2000), "The reorientation of market-oriented reforms in Swedish health-care", *Health Policy*, 50, 219-240.
- Helderman Jan-Kees, (2007), *Bringing the Market Back In. Institutional complementarity and hierarchy in Dutch housing and health care*. Proefschrift Erasmus Universiteit Rotterdam. Rotterdam.

- Hemerijck A., (2009, December 10), *Aftershocks: Economic Crisis and Welfare State Transformation*. Florence.
- Immergut E.M., (1992), *Health politics. Interests and institutions in Western Europe*, Cambridge: Univ. Press (Cambridge studies in comparative politics).
- Ministerie van Volksgezondheid, Welzijn en Sport (2005), *Health Insurance in the Netherlands. The new health insurance system from 2006*. The Hague.
- Ministerie van Volksgezondheid, Welzijn en Sport: *The new care system in the Netherlands. durability, solidarity, choice, quality, efficiency*, The Hague.
- Moran M., (1999), *Governing the Health Care State. A Comparative Study of the United Kingdom, the United States and Germany*, Manchester: Manchester University Press.
- OECD (2004), *Private health insurance in OECD countries*, Paris: OECD (The OECD health project).
- OECD (2010), SourceOECD Health Data 2010. Statistics and indicators for 30 countries. [http://0-lylsander.sourceoecd.org/biblio.eui.eu/vl=1370227/cl=13/nw=1/rpsv/statistic/s37\\_home.htm?jnlissn=99991012](http://0-lylsander.sourceoecd.org/biblio.eui.eu/vl=1370227/cl=13/nw=1/rpsv/statistic/s37_home.htm?jnlissn=99991012), last access 23.2.2011.
- Olsen J., (forthcoming): *Privatisation in health care*.
- Parsons Cr., (2007), *How to map arguments in political science*, Oxford: Oxford Univ. Press.
- Pierson P., (1994), *Dismantling the welfare state. Reagan, Thatcher, and the politics of retrenchment*, Cambridge: Cambridge Univ. Press (Cambridge studies in comparative politics).
- Pierson P., (1996), "The New Politics of the Welfare State", *World Politics*, 48 (2).
- Powell Fr.D., Wessen Al.F. (Hg.) (1999), *Health care systems in transition. An international perspective*. Thousand Oaks: Sage Publ.
- Socialstyrelsens (2010), statistikdatabaser.
- Sveriges Kommuner och Landsting (2002), *Verksamhet och ekonomi i landsting och regioner 2001*. Verksamhet.
- Sveriges Kommuner och Landsting (2009), *Statistik om hälso- och sjukvård samt regional utveckling 2008*. Verksamhet och ekonomi i landsting och regioner.
- Sveriges Kommuner och Landsting (2010), *Statistik om hälso- och sjukvård samt regional utveckling 2009*. Verksamhet.
- Swedish Association of Local Authorities and Regions (2008), *Local government financial equalisation. Information about the equalisation system for Swedish municipalities and county councils in 2008*. Stockholm.
- Vaillancourt R., Pauline L., Christiaan J., (2008), "An Experiment with Regulated Competition and Individual Mandates for Universal Health Care. The New Dutch Health Insurance System", *Journal of Health Politics, Policy and Law*, 33 (6) 1031-1055.
- van Ven, W.P.M.M. de; Schut F.T., Hermans H.E.G.M., Jong J.D. de, van der Maat M., Coppen R., et al (september 2009), *Zorgverzekeringswet en Wet op de zorgtoeslag. Evaluatie*. NIVEL, Instituut Beleid & Management Gezondheidszorg (iBMG), Universiteit Rotterdam. Den Haag.
- Verspohl I., (2012), *Health care reforms in Europe: Convergence towards a market model?* Baden-Baden: Nomos.
- Wilensky H., (1975), *The Welfare State and Equality. Structural and Ideological Roots of Public Expenditure*. Berkeley: University of California Press.

# Assessing the value of medicinal innovation in an era of increasing austerity

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## Η αποτίμηση της αξίας της φαρμακευτικής καινοτομίας σε μια εποχή αυξανόμενης λιτότητας

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### ABSTRACT

In this paper an overview of the rewarding innovation pharmaceutical regulatory systems has been presented, focusing on the emerging role of innovation and health technology assessment (HTA). In a time of political and financial turmoil, benefits could be obtained through the pooling of resources and experiences among various countries. For this purpose, recent major pharmaceutical reforms in Greece have been critically discussed taking into consideration the dynamic and complex environment among cost containment measures and the recent implementation of HTA in combination with some of the critical factors that influence today's key decision makers, such as the economic crisis, increasing austerity as well as political and international pressures.

**KEY WORDS:** HTA, innovation, pharmaceutical pricing and reimbursement, Greece.

### ΠΕΡΙΛΗΨΗ

Το άρθρο παρουσιάζει τα επικρατέστερα συστήματα ρύθμισης της αγοράς φαρμάκου διεθνώς, δίνοντας έμφαση σε αυτά που επιβραβεύουν την καινοτομία και αναδεικνύουν το σημαντικό ρόλο της Αξιολόγησης της Τεχνολογίας Υγείας (ΑΤΥ). Η ανασκόπηση των διεθνών προτύπων κρίνεται ιδιαίτερα σημαντική για την παρούσα πολιτική και οικονομική συγκυρία που αντιμετωπίζει η χώρα. Γι αυτό το σκοπό, στο άρθρο επιχειρείται κριτική προσέγγιση των πρόσφατων μεταρρυθμίσεων στην Ελλάδα, πρώτον ως προς την επίτευξη ή μη των στόχων των πολιτικών συγκράτησης και ελέγχου των δαπανών υγείας, και δεύτερον ως προς τα δυνητικά οφέλη που θα προκύψουν από την εφαρμογή της ΑΤΥ στη χώρα.

**ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ:** Αξιολόγηση Τεχνολογίας Υγείας (ΑΤΥ), καινοτομία, τιμολόγηση και αποζημίωση φαρμάκων, Ελλάδα.

## 1. Introduction

The varying nature and emerging complexity of health technologies, in combination with limited healthcare resources, have resulted in efforts to deliver cost-effective healthcare, improve Research and Development (R&D) and sustain the entrepreneurship and manufacturing by maintaining the societal benefit of the healthcare sector. Growth in demand for healthcare is strong and expenditure is increasing due to the continuing increasing demand for health technologies and especially for pharmaceuticals.



In Europe, the research-based pharmaceutical industry is one of the leading high technology industries, amounting to about 19% of global business R&D investments and about 3.5% of the total EU manufacturing added value (EFPIA, 2011). The European pharmaceutical market is highly fragmented and strictly driven by cost containment and regulatory policies that many times prevent rewarding innovation. This refers as the reason behind the US pharmaceutical market dominates over the European, given that 65% of sales of new medicines marketed since 2002 are generated on the US market, compared to 24% on the European market (IMS, 2011).

In an era of increasing austerity, the fact that pharmaceutical industry is one of Europe's best performing high-technology sectors should always be taken into consideration. It is increasingly important to achieve a balance between affordable healthcare and the use of innovative health technologies, at national, European and international level. In this context, the aim of paper is to make an overview of the value-based regulatory systems rewarding innovation, widely used in the EU. The increase in the use of health technology assessment (HTA) and its impact on today's key decision makers are also discussed. Finally, a critical review is made regarding the major pharmaceutical reforms taken place in Greece, giving emphasis in the reasoning behind the failure or the success of the policies implemented.

## 2. The value of pharmaceutical innovation

**I**nnovation in pharmaceuticals plays a critical role in both the industrial and health fields. A drug can be considered a pharmaceutical innovation only if it meets otherwise unmet or inadequately met health care needs. Pharmaceutical innovations create value to society by generating improvements in patient health (net of treatment risks) that were previously unattainable (Morgan et al., 2008). There is growing evidence at macro and micro-economic level regarding the added value of medicines in the healthcare sector, not only in terms of global cost savings but also in terms of increasing the quality of care. Medicines not only improve health status, but also generate savings by substantially reducing costs through the substitution of hospital care etc. Therefore, decision makers should take into consideration the overall therapeutic and economic value of medicines

Medicines remain the prime target of cost containment policies, despite the fact that on average pharmaceutical spending accounts for only 16.6% of total health expenditure in Europe (EFPIA, 2011). Although rises in pharmaceutical spending are observed, recent increases in health spending are not primarily caused by increases in spending on pharmaceuticals. Since 2005 the contribution towards total increases in health spending attributed to pharmaceuticals is 17.3% in Canada, 13.8% in France, 15.1% in Germany, 5.6% in Italy, 14.0% in Spain, 5.4% in the United Kingdom and 10.9% in the United States (US Department of Trade, 2004; OECD Health Data, 2010). Hence, reforms or cost containment policies focusing on pharmaceutical expenditure alone are unlikely to achieve significant cost savings and achieve their targets.

Innovation remains a predictor for increasing healthcare expenditures. Rational criteria in terms of safety, efficiency, effectiveness and equity, used in the pricing and reimbursement mechanisms should provide incentives and reward innovation. Certainly, it is very difficult to measure spill over effects of medical technology in economic terms, despite the fact that a number of studies have demonstrated the health gains and cumulative benefits of such innovation (Kanavos et al., 2010). The benefits of pharmaceutical innovation should include clinical/therapeutic benefits, quality of life benefits, and socio-economic benefits. According to the international literature, there are

different criteria required by EU regulatory authorities in order to assess new technologies for pricing and reimbursement purposes. The benefits should be evident, since achieving incremental innovation requires significant investments that can be seen as a challenge for healthcare systems. Some countries like the United Kingdom, Finland and the Netherlands refer to cost-effectiveness and patients' quality of life criteria to determine the real value of a medicine while other countries, such as Austria, Belgium, Denmark, Ireland, Italy and Portugal take into account a variety of socio-economic criteria. But there are still some European countries, such as Greece, in which healthcare policies are short term and they do not yet take into consideration the overall therapeutic and economic value of the use of new technologies (Abel-Smith and Mossialos, 1994; Dickson, 1992; Jonsson, 1994; Kanavos, 2002; Valasco-Garrido et al., 2008; Mousiama et al., 2001; Liaropoulos and Kaitelidou, 2000; Geitona and Kanavos, 2010).

### 3. Pricing and reimbursement practices in EU countries

**I**n most countries, the pharmaceutical market is one of the most heavily regulated sectors, since governmental regulation takes into consideration healthcare market failures related to the safety, equity, accessibility and cost containment concerns. The rationale behind state intervention is focused on the fact that health policy decision makers attempt to ensure the efficient and equitable access to medicines, provide adequate incentives for innovation, and control total health /or and pharmaceutical expenditure. Measures taken for controlling the performance of pharmaceutical markets are complex and often conflicting since they are usually targeting at different and multiple actors such as the manufacturers, wholesalers, physicians, pharmacists, patients and the third-party-payers. Pharmaceutical market regulations are mainly focusing on the improvement of the effectiveness, safety and quality of pharmaceuticals, in combination with their rational use and control expenditure. Alternative regulation mechanisms include well-defined, structured and systematic actions induced by regulators in order to affect the rules and the functioning of the pharmaceutical market by changing the multiple agents' behaviour (Chen, 1999; Kanavos et al., 2010).

In economic theory terms, governmental regulation refers to the measures taken usually distinguished between the supply and demand-side. The demand side of pharmaceuticals refers to the patient/consumer, the prescriber and the pharmacist and takes into consideration that the respective healthcare provision is paid by third party payers. It is evident that in the EU countries, the share of drugs' expenditure financed by third-party payers accounts for over 75% of the total market (Mrzcek, 2002). The supply side of pharmaceutical markets is determined absolutely by all agents involved in the drugs' production.

The demand side interventions are aimed at changing the behaviour of healthcare professionals and patients. Clinical and prescription guidelines focusing on the monitoring and changing of prescribing patterns, the implementation of pharmaceutical budgets for reinforcing cost-consciousness and generics substitution are the most common measures taken for controlling the cost of prescribed treatments, promote a more rational use of medicines while maintaining the quality. As far as demand side interventions aiming at affecting patients' behaviour, cost-sharing, co-payments and co-insurance practices are included. It is noteworthy to mention that patients' and health professionals' behaviour change is primarily affected by third party payers and the reimbursement status of each product category. The definition of the amount of the price to

be paid by the third-party payer, already mentioned as reference pricing system, as well as the adoption of positive and negative lists are practices closely associated with patients' cost-sharing and co payments reimbursing mechanisms (Lopez- Casanovas and Puig-Junoy, 2000; Kanavos, 2002; Helin-Samivaara et al., 2003; Gray, 2006; Espin and Rovira, 2007; Tsiantou et al., 2009; Geitona and Kanavos 2010).

In most EU countries, supply side interventions include price regulation, direct expenditure and profit control as well as tax benefits. More analytically, price regulation refers to the administrative or statutory pricing, such as price caps, positive or negative reimbursement lists, etc. In situations of information asymmetry, as in the case of pharmaceutical products, the exercise of the price setting is complicated compared to the other goods whereas perfect information dominates in the consumption process. When price regulation is based on the product's cost plus a certain profit margin of the manufacturer's, refers to the cost-plus pricing system. Additionally, price regulation can be referred to the referencing pricing system which is based on the prices for the same product in other countries or for the same indications of similar treatments. Another price regulation mechanism derives from economic evaluations and is usually used for pricing and reimbursement decisions (Espin and Rovira, 2010; Kanavos et al., 2010).

Direct expenditures controls are also introduced in order to contain pharmaceutical expenditures through the set up of mandatory or negotiated discounts in the drug's price, as well as rebates related to a specified proportion of the sales made by a manufacturer to the purchaser over a given time period (i.e Germany, Ireland, Spain). Similar is also the payback control system which serves as a risk-sharing mechanism requiring manufacturers to return a part of their revenue, if sales exceed a previously determined target. Additionally, price-volume agreements are applied to specific new products, where the price agreed is conditional to the expected number of units sold. (i.e France, Spain). Profit control refers to a system applied in the UK for the sales of branded medicines to the NHS and tax benefits are related to the manufacturer's investment in R&D (i.e Belgium) (Kanavos, 2002; Simoens et al., 2005; Espin and Rovira, 2007).

Among other systems of supply-side regulation for price setting, the Value Based Pricing (VBP) and the External Price Referencing (EPR) systems are currently used extensively to inform decisions on pricing and reimbursement of pharmaceuticals. VBP integrates the value into the price of medicines in order to reward products that have better outcomes and to encourage future innovation in the development of new therapeutic agents. VBP can serve as a validation mechanism of new technologies, enable governments to make decisions driven by value and provide health professionals and patients the information needed to make the best treatment choices (Sorenson et al. 2008; Kanavos et al., 2010; Espin and Rovira, 2010).

External or International Price Referencing (EPR) system involves the selection of a basket of countries, which can change over time, to compare pharmaceutical prices and create a reference price (RP) for a country. It can be used for price negotiation and setting within a country as well as for reimbursement and market authorisation purposes. In addition, it provides a benchmark for negotiations between industry and health insurance organisations. Combination of both systems (VBP and EPR) can be applied for setting pharmaceutical pricing and reimbursement within a country. It is important to note that the process of selection of the above mentioned pricing systems is complex. In VBP the definition of value is the key factor and the value determination should be based on the cost effectiveness analysis (CEA) and more precisely, on the incremental cost effectiveness ratio (ICER). The greatest difference between VBP and EPR, is that VBP relies on a combination of scientific and social value judgements to inform pricing and reimbursement decisions, whereas EPR borrows these indirectly from other countries (Kanavos et al., 2010).

## 4. The emerging role of HTA

**H**ealth Technology Assessment (HTA) has come under focus in the last three decades and has become a crucial part of the decision making process in the healthcare sector. HTA is a multidisciplinary process that summarises information about the medical, social, economic and ethical issues related to the use of a health technology in a systematic, transparent, unbiased, robust manner. Its aim is to inform the formulation of safe, effective, health policies that are patient focused and seek to achieve best value ([www.eunetha.eu](http://www.eunetha.eu)). HTA networks at EU level are aiming to contribute to the generation of HTAs to inform policy and healthcare decision making in European countries so that new health technologies can be adopted and obsolete technologies abandoned in a well-informed and robust manner, hence bringing about high quality, safe, accessible, sustainable, ethical and efficient health care for citizens across Europe. The partners in the EUnetHTA Collaboration share the overarching values of the European Union for health systems such as universality, access to good quality care, equity and solidarity (Valasco-Garrido et al., 2008).

In practical terms, the role of HTA is to provide informed decisions aiming at allocating resources within the healthcare sector in order to improve the efficiency in healthcare. There are many variations in the practice of HTA. In some cases, HTA is linked to reimbursement and third party payers' decision making; in others to clinical guidelines and disease management, etc. HTA is also carried out at different levels of government, and there are considerable variations in the level of stakeholder involvement, in the methodology used and in the quality of studies. In addition, in most countries economic evaluations studies are increasingly included in HTA despite their differentiations observed in the methodologies used, the type of the analysis and the data used. For this purpose specific guidelines are also available in economic evaluation studies.

HTA bodies are responsible for assessing the economic, social, organisational and ethical implications of a given technology which usually refers to drugs, medical devices and procedures. They aim to improve the quality and safety of healthcare in a context of continuous medical progress, by advising decision makers, producing guidelines for health professionals, certifying healthcare organisations, developing diseases' management and informing health professionals, patients and the public. Today, HTA is used to assess new technologies before or after their establishment on the market. The challenges that lie ahead include the need to provide advice in a timely and transparent manner, by using multi-disciplinary approaches and taking into consideration stakeholders' issues. HTA analyses must not be restricted to individual product medical added value but they should make reviews beyond it. HTA studies on innovative technologies should be used at the national level in the formulation of national health policies, given that costs and values differ among countries.

It is well known that most European Union member states have established responsible bodies for publishing pricing and reimbursement (P&R) guidelines, since price setting remains a national health policy issue. In this context, the establishment of HTA agencies worldwide is targeting to inform decisions aimed at allocating resources within the healthcare sector (Zentner et al., 2005; Yfantopoulos, 2008; Kanavos et al., 2010a; Wilsdon and Serota 2011). Decisions about third party payers and stakeholders are the most important target for HTA agencies in order to improve the allocative efficiency of healthcare. The criteria used for assessment and the role of global HTAs in P&R as well as in market access decisions are presented in the Table 1.

Table 1. Criteria used in global HTA

Country	Relative Effectiveness	Budget Impact	Cost-Effectiveness	Cost/QALY	Cost/QALY with threshold	Influence on price, reimbursement & market access*	Pharmaceutical innovation
<i>Australia</i>	•	•	•	•		Price & access	•
<i>Brazil</i>	•	•	•			Access only	
<i>Canada</i>	•		•	•		Access only	•
<i>England</i>	•		•	•	•	Access only	•
<i>France</i>	•					Price, reimbursement & access	•
<i>Germany</i>	•		•			Reimbursement & access	
<i>Italy</i>	•					Price & reimbursement (limited)	
<i>Netherlands</i>	•	•	•	•		Price, reimbursement & access	•
<i>New Zealand</i>	•	•	•	•		Price & access	
<i>Poland</i>	•	•	•	•		Price & access	
<i>Scotland</i>	•		•	•	•	Access only	•
<i>South Korea</i>	•	•	•	•	•	Price & access	
<i>Spain</i>	•		•	•		Access only	
<i>Sweden</i>	•		•	•		Reimbursement & access (limited on price)	
<i>Turkey</i>	•	•	•	•		Price & access	

Source: Wilsdom and Serota, 2011.

\*Market access refers to restrictions imposed on the product

In the UK the National Institute for Clinical Excellency (NICE), established in 1999, undertakes a more-rigorous approach to economic evaluation. The role of NICE is to make recommendations to health professionals on the economic appraisal of new and existing technologies, the development of clinical guidelines and the specification of audit technologies. Nowadays, NICE contribution is very significant, since it has made restrictive or negative rulings on 63% of all drugs examined data. In 2003, the Institute for Quality and Efficiency in Health Care (IQWiG) was established in Germany aiming to evaluate the current state of medical knowledge on diagnostic and therapeutic schemes for selected group of diseases, the quality and efficiency of services provided by the statutory health insurance and drugs' effectiveness. IQWiG is also responsible for the development of evidence based guidelines and recommendations for disease management as well as for the dissemination of information on evidence-based therapies. IQWiG contribution is substantial since it reported no proven benefit in 73% of all drugs examined.

Adversely, the role of the SBU in Sweden, established in 1987 and in 1992 commissioned as an independent public authority, does not make any decisions concerning approval or reimbursement of drugs, and does not have a supervisory function. However, despite its relative lack of power, SBU has made a substantial contribution to improvements in the healthcare system. In a survey carried out in 2002, 81% of physicians stated that they obtained a practical benefit from SBU reports. Additionally, SBU projects on the pre-operative routines and the management of mild head injury led to annual savings of about €24 million and €4 million respectively. Furthermore, the report concerning the non evidence that calcium and vitamin D supplements prevent osteoporosis among women under the age of 80, revealed a potential saving of €3.2 million ([www.sbu.se](http://www.sbu.se)).

Nowadays, a number of countries in Europe actively use health economic evaluations and have established HTA bodies. They have also set up pharmaco-economic guidelines to be used in the decision-making process. Some of these countries are the UK, Netherlands, Finland, Portugal, Sweden, Denmark, Ireland, Switzerland, France, Italy, Estonia, Poland, Hungary etc. The administrative structure of the healthcare system affects significantly the type and the function of HTA in each county. In highly de-centralised countries, such as in Sweden, there are more than one body while in others HTA decisions are taken at national level. It is worth to mention that the lack of a systematic process for the selection of technologies for evaluation as well as the no evident link between regulatory and HTA bodies refer among the most significant drawbacks.

In summary, a global perspective of HTA may offer a predictable environment for long-term investment to the industry, clarity of roles & responsibilities to decision makers and assessments based on the added therapeutic value to patients. International collaboration among various HTA agencies should be reinforced through the already existing network of competent national and international agencies. The enforcement of the EUnetHTA Collaboration is very useful since it provides systematic information on the use of best available evidence, common methodological and process standards as well as common review processes.

## 5. Medicinal market regulation in Greece

**D**rugs' market regulation operates under the guidance of the Ministry of Health and Social Solidarity (MoH) in accordance to the EU legislation. The process regarding drugs' market authorisation is operating under the responsibility of the National Drug Organization (EOF), and pricing process under the responsibility of the Pricing Committee at the MoH. For drugs' approval, pharmaceutical companies are required to submit the product's dossier to the National Drug

Organization (EOF) and for pricing setting to the Ministry's respective Committee. The pricing Committee is responsible for the price determination as well as for the drugs' price bulletins publication. Prices' setting takes into account the wholesale prices of imported and locally manufactured or packaged products as well as various other criteria.

In Greece, health authorities have always applied regulatory controls on the supply-side with emphasis on prices' reductions targeting to control the growth of pharmaceutical expenditure. Short-term measures taken to reduce pharmaceutical expenditure failed to deal with rising healthcare budgets and most importantly hampered innovation. In that sense, technology up to now has been considered as a cost driver increasing health service intensity, excess inflation and the cost of treatment, since the overall benefits of pharmaceutical innovation are not yet taken into consideration.

Last two decades, three major reforms (1998, 2006 and 2010) have been implemented targeting at pharmaceuticals' control. The first reform refers to the introduction of a positive reimbursement list and a reference pricing system based on the lowest price among the 15 EU countries. Although based on legislation the principle criterion for the inclusion of a drug in the list was its therapeutic value, which was based on the severity of the disease, the product's effectiveness/safety ratio, the availability of alternative treatments and the target population, the only inclusion criterion was the daily treatment cost. In order for a product to be included in the positive list, its average cost of daily treatment should be equal to or lower than the reference price of each therapeutic category. Both measures didn't achieve their goals and the country reference pricing system has been judged by the Council of State as unconstitutional. More importantly, positive list failed because it restricted patients' access to new and more effective drugs, given that it took years to update the list with negative impact on long-term innovation. Drugs withdrawals from the market and shortages have been reported while parallel trade and exports increased. Also, patients' co-payments had not a significant impact on controlling expenditures due to low prices of pharmaceuticals in the country.

The second major reform, in 2006, refers to the abolishment of the existing positive list aiming at the reimbursement of all medicines except OTCs and lifestyle drugs (not defined till 2011). In addition, a new pricing system was introduced based on the average of the three lowest European prices, of which two were calculated from the former 15 European Member States plus Switzerland and one from the new EU members (Yfantopoulos, 2008). Also, the 2006 reform introduced a rebate system paid by the pharmaceutical companies to the Social Security Funds (SSF). Again, the above cost containment measures didn't achieve their goals since the rebate system partially operated and pharmaceutical expenditures were continuously increasing due to the inability of controlling the volume of prescribed drugs as well as changing physicians' prescribing behaviour (Geitona and Xaplanteris, 2010).

It is worth mentioning that the 1998 and 2006 reforms appeared inefficient given that pharmaceutical expenditures were continuously increasing, regardless of the introduction or the abolishment of the positive list. The reasoning behind the expenditure rise is that the supply side measures taken were solely focused on prices' control and measures targeting at the demand side were totally missing.

In 2010 and Greece being under the economic crisis and EU and IMF inspection, the government adopted tough austerity measures in order to:

- Cut government spending,
- Reduce the size of the public sector,
- Decrease tax evasion - increase tax collection,

- Control health spending - reform healthcare and pension systems
- Improve competitiveness through structural reforms to the labor and product markets.

In this context, the government legislated in 2010 a third reform on pharmaceuticals. This time the government implemented both supply and demand side measures in order to reduce pharmaceutical spending. Again, a new positive reimbursement list was introduced by classifying the drugs in ATC4 clusters and the drug's daily treatment cost should not exceed the average cost of each therapeutic category which was comprised by branded and generic products. Any excess would be paid back as a rebate for enlistment. More importantly, in the criteria of the reimbursement list there was a provision for accepting a 20% price premium for innovative medicines with the submission of pharmacoeconomics studies. In addition, this reform included numerous cost-containment measures targeting to control NHS hospitals' pharmaceutical expenditure through the introduction of hospital formularies, therapeutic protocols/guidelines, patients' electronic prescribing, drug tenders, changing of physicians' prescription patterns and generic substitution. Also, the creation of an integrated information technology (IT) system intra and across hospitals as well as the establishment of a HTA body have been announced. More analytically, a set of measures have been legislated targeting at hospital spending control such as the centralised public procurement of medical supplies, the modernisation of hospital accounting and billing systems, bookkeeping of medical supplies and monitoring activity in NHS facilities, timely invoicing etc. As about the establishment of the HTA body it aimed to evaluate new technologies in health, therapeutic interventions, clinical practices, and disease management.

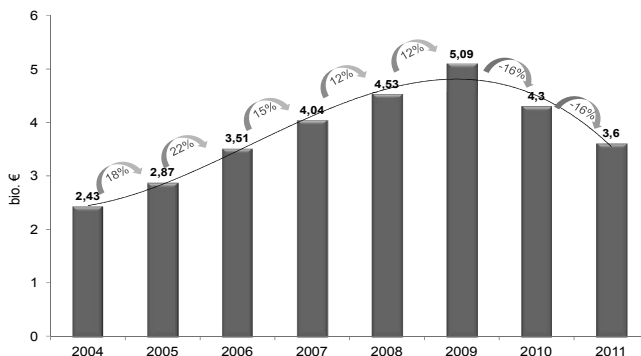
Similar measures have also been applied to social security funds (SSF) for the reduction of their expenses with emphasis given in the creation of an integrated electronic processing system for controlling the prescriptions and diagnostic tests within all SSFs. As of 2011 the 4 key SSFs covering 90% of the Greek insured population were unified to form EOPYY with increased negotiating power.

It should be mentioned that although the implementation of these measures has not yet been completed, it seems to be successful in controlling spending (figure 1), since total pharmaceutical expenditure decreased more than € 2 billion in 2010-2011, both outpatient and hospital, exceeding the troika target which was €2 billion . However, other cost drivers within the hospital sector remained uncontrolled and offset major savings coming from drugs and other supplies (Figure 2).

#### Outpatient drug spending evolution

2004-2009: Average increase of € 0,5bn per year

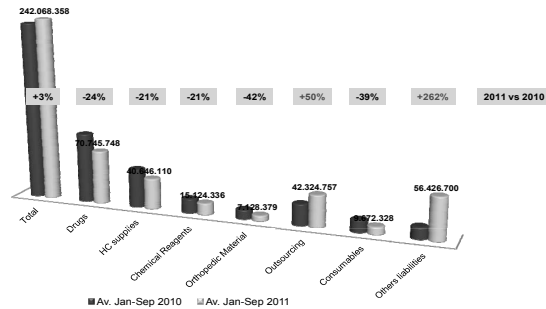
2010-2011: Average decrease of € -0,7bn per year



Source: Ministry of Health, ESY.net, 2011



Average Hospital Spending per cost category  
 2011 drug savings vs 2010 are squandered due to increased costs of outsourcing and other liabilities



Source: Ministry of Health, ESY.net, 2011

In addition, the price premium never operated and cost-effectiveness criteria have been excluded from the list, although they had already been announced by the MoH. Hopefully, in November 2011 the Greek HTA agency began to operate, the so called National Centre for Evaluation of Quality and Technology in Healthcare. It is expected that investment in HTA would offer long term benefits related to improvements in healthcare access and outcomes as well as rationality in resources allocation. Potential benefits of the HTA in Greece should be:

- Establishment of cost-effective prescribing policies
- Reinforcement of decision making based on costs and benefits rather than cost cutting
- Help purchasers to set priorities
- Providers' choice of the most cost-effective treatment techniques -practices
- Recommendations can be used as criterion for reimbursement acceptance
- Maximization of health gains from a finite budget or/and maximize of outcomes to input constraints
- Reallocation of resources from less to more productive uses.

Furthermore, the Greek HTA Centre may provide consultations regarding the short- and long-term social and economic consequences of the use of new technologies and make recommendations on their effective and efficient use mainly for reimbursement purposes. It is believed that with the 2010-11 measures taken, the government will meet IMF proposed targets and savings, rationalize healthcare investments and ensure economic sustainability especially of the insurance organizations. By this way, the NHS primary goals such as the improvement in the quality of healthcare delivery, the universal access and the increase in the productivity of healthcare sector will be achieved

## 6. Concluding remarks

**I**n a time of political and financial turmoil, benefits could be obtained through the pooling of resources and experiences among various countries. In this paper an overview of the rewarding innovation regulatory systems has been presented, systems that are widely used in the EU and specific OECD countries based on the assumption that clinical and social value judgements among countries could be suited in another country. However, it has been seen that each EU country has

a specific set of requirements and local adaptations of HTA which are not as straight forward, as they seem. Different countries utilize different levels of complexity and processes as well as different advantages, limitations and impact key variables such as price/reimbursement, coverage and access, assessment of value and rewarding of innovation (Kanavos et al.,2002).

For this purpose, recent major pharmaceutical reforms in Greece have been critically discussed in this paper, taking into consideration the dynamic and complex environment among cost containment measures and the implementation of health technology assessment in combination with some of the critical factors that influence today's key decision makers, such as the economic crisis, increasing austerity as well as political and international pressures.

In brief and critically thinking, it should be mentioned that the implementation of cost containment measures were necessary in the country in order to stabilize or/and reduce health care & pharmaceutical expenditure. The above measures applied were usually short term and based on price cuts rather than on value assessment and volume controls, and were mostly restricted to medicinal products.

The traditional criteria in terms of safety, efficiency, effectiveness and equity are almost always used in the pricing and reimbursement mechanisms but they very seldom provide incentives and reward innovation. If a product offered superior or/and marginal therapeutic benefit, it was difficult to justify a price premium relative to its competitors. In that sense, the allocation of health resources was always based on the maximum investment required with unknown or never assessed benefits, since reimbursement price was negotiated on the basis of a variety of factors, excluding pharmacoeconomic criteria. By this way, the therapeutic value of a product could not be rewarded, since economic evaluation and HTA was out of any consideration.

The 2010 -11 reform regarding the creation of HTA agency in Greece seems to be very promising since it would speed up decision making and lead to the development of evidence based policies. Hence the existence of real-world evidence would demonstrate the value of medicines and other new technologies in the real world. It is believed that Greek government and IMF expectations will be fulfilled due to long term targeting and acceptance of value based pricing and reimbursement practices. Hence, long-term economic accountability may sustain entrepreneurship and reinforce innovation and employment which are imperative at a time of economic recession and uncertainty that Greece is facing nowadays.

## Bibliographical references

- Abel-Smith B. and Mossialos E., (1994), "Cost containment and health care reform: a study of the European Union", *Health Policy* 28(2):89-132.
- Chen P., (1999), "Setting price controls while facing variable or uncertain market conditions", *International Economic Review* 40(3):617-634.
- Dickson M., (1992), "The pricing of pharmaceuticals: an international comparison", *Clin Ther* 14(4):604-610.
- EFPIA (European Federation of Pharmaceutical Industries and Associations) (2011) <http://www.efpia.org>.
- Espin J., and Rovira J., (2010), "External Reference Pricing", *WHO/HAI*, December.
- Espin J., and Rovira J., (2007), "Analysis of differences and commonalities in pricing and Reimbursement systems in Europe", *Escuela Andaluza de Salud Pública*, Granada, Spain.

- EUnetHTA Collaboration (2011), *www.eunetha.eu*.
- Geitona M., Kanavos P., (2010), "Coloctal cancer management and prevention policies in Greece", *Eur J Health Econ*, 10(1):27-33.
- Geitona M., and Xaplanteris L., (2010), "Data Collection and Conduction of Pharmacoeconomic Studies in Greece", *European Psychiatric Review* 3(1):21-5.
- Gray J., (2006), "Changing physician prescribing behaviour", *Can J Clin Pharmacol* 13(1):81-84.
- Helin-Salmivaara A., Huupponen R., Klaukka T. and Hoppu K., (2003), "Focusing on changing clinical practice to enhance rational prescribing-collaboration and networking enable comprehensive approaches", *Health Policy* 66(1):1-10.
- IMS Health 2011, *www.imshealth.com*.
- Ioannides-Demos L.L., Ibrahim J.E. and McNeil J.J., (2002), "Reference-based pricing schemes: effect on pharmaceutical expenditure, resource utilisation and health outcomes", *Pharmacoeconomics* 20(9):577-91.
- Jonsson B., (1994), "Pricing and reimbursement of pharmaceuticals in Sweden", *Pharmacoeconomics* 6(1):51-60.
- Kanavos P.,(2002), "Pharmaceutical regulation in Europe", *Commonwealth Fund Harkness Report*, Harvard Medical School and London School of Economics.
- Kanavos P., Nicod E., van den Aardweg S. and Pomedli S., (2010a), "The impact of health technology assessments: an international comparison" *Euro-Observer*, 12:4.
- Liaropoulos L., Kaitelidou D., (2000), "Health Technology Assessment in Greece", *International Journal of Technology Assessment in Health Care* 16(2): 429-448.
- Lopez-Casasnovas G. and Puig-Junoy J., (2000), "Review of the literature on reference Pricing", *Health Policy* 54(2):87-123.
- Morgan S., Lopert R. and Greyson D., (2008), "Toward a definition of pharmaceutical innovation", *Open Medicine* 2:1.
- Mousiama T., Ioakimidou S., Largatzi E., Kaitelidou D.,and Liaropoulos L., (2001), "Health Technology Assessment in the area of prevention" *International Journal of Technology Assessment in Health Care* 17(3): 338-357.
- Mrazek M.F., (2002), "Comparative approaches to pharmaceutical price regulation in the European Union", *Croat Med J* 43(4):453-61.
- OECD Health Data, (2010) Directorate for Employment, Labour and Social Affairs, *http://www.oecd.org*.
- Simoens S., De Bruyn K., Bogaert M. and Laekeman G., (2005), "Pharmaceutical policy regarding generic drugs in Belgium", *Pharmacoeconomics* 23(8):755-66.
- Tsiantou V., Zavras D., Kousoulakou H., Geitona M., Kyriopoulos, J. (2009) "Generic medicines: Greek Physicians' perceptions and prescribing practices", *Journal of Clinical Pharmacy and Therapeutics*, 34, 547-554.
- US Department of Trade, (2004), "Pharmaceutical Price Controls in OECD countries: implications for U.S consumers, pricing, research, development and innovation", *International Trade Administration*, Washington DC. *www.ita.doc.gov*.

- Valasco-Garrido M., Kristensen B., Nielsen C., Busse R., (2008), "Health Technology Assessment and Health Policy-Making in Europe", *World Health Organization, Observatory Studies Series No 14*.
- Vogel R.J., (2002), "Pharmaceutical patents and price controls", *Clin Ther* 24(7):1204-1222.
- Wilsdon T., and Serota A., (2011), "A comparative analysis of the role and impact of Health Technology Assessment", *CRA report*, London.
- Yfantopoulos J., (2008), "Pharmaceutical pricing and reimbursement reforms in Greece", *Eur J Health Econ* 9:87–97.
- Zentner A., Valasco-Garrido M. and Busse R., (2005), "Methods for the comparative evaluation of pharmaceuticals", *GMS Health Technol Asses 1: Doc09* PMID: PMC3011319.

# δια-ΛΟΓΟΣ

ΕΠΕΤΗΡΙΔΑ ΦΙΛΟΣΟΦΙΚΗΣ ΕΡΕΥΝΑΣ

#1  
2011

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ΕΚΔΟΣΕΙΣ ΠΑΠΑΖΗΣΗ

# Restructuring the hospital sector in Greece in order to improve effectiveness and efficiency

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## Αναδιάρθρωση του νοσοκομειακού τομέα στην Ελλάδα προς βελτίωση της αποτελεσματικότητας και της αποδοτικότητας

Λυκούργος Λιαρόπουλος, Όλγα Σίσκου, Νίκος Κοντοδημόπουλος, Δάφνη Καϊτελίδου, Παναγιώτα Λαζάρου, Μαρία Σπινθούρη, Κωνσταντίνος Τσαβαλιάς, *Πανεπιστήμιο Αθηνών*

### ABSTRACT

This paper discusses the study focused on the reform of Greek Hospital Sector, also known as "hospital mergers". The aim of the study was to propose a new pattern of organizing hospitals in groups based on the reform of emergency care and the management of five main chronic diseases (AMI, Stroke, Cancer, Diabetes Mellitus and COPD). The proposals in general concern the creation of a national network of health services provided mainly by primary healthcare units and the largest hospitals of the groups in each health region. In the context of improving the hospital sector efficiency, ways of collaborations between private and public sector and expenditure containment measures are presented. The restructuring of the public hospital sector relied on six specific criteria including the population criterion, catchment area, hospital size, infrastructure age, utilization of hospital facilities and cost. Due to its nature, the study was exposed to various factors such as the diversity of actors being involved, collection and compilation of the relevant data in a short term of three months, last minute adjustments and the variety of audience.

**KEY WORDS:** Restructuring hospital sector, hospital mergers, cost-efficiency criteria

### ΠΕΡΙΛΗΨΗ

Το άρθρο αυτό παρουσιάζει τη μελέτη που αφορούσε στην αναδιάρθρωση του Ελληνικού Νοσοκομειακού Τομέα. Σκοπός της μελέτης ήταν να προτείνει ένα νέο πρότυπο οργάνωσης των νοσοκομείων σε ομάδες με βάση την αναμόρφωση της επείγουσας φροντίδας και τη διαχείριση των πέντε κύριων χρόνιων νοσημάτων (Οξύ Έμφραγμα του Μυοκαρδίου, Αγγειακό Εγκεφαλικό Επεισόδιο, Καρκίνος, Σακχαρώδης Διαβήτης και Χρόνια Αποφρακτική Πνευμονοπάθεια). Στο πλαίσιο της βελτίωσης της αποτελεσματικότητας και αποδοτικότητας του νοσοκομειακού τομέα παρουσιάστηκαν προτάσεις όπως η συνεργασία ιδιωτικού και δημόσιου τομέα καθώς και μέτρα περιορισμού των δαπανών. Η αναδιάρθρωση του δημόσιου νοσοκομειακού τομέα στηρίχθηκε σε έξι διακριτά κριτήρια τα οποία συμπεριελάμβαναν το πληθυσμιακό κριτήριο, τη συγκέντρωση του πληθυσμού, το μέγεθος του νοσοκομείου, την παλαιότητα των υποδομών, την ένταση της αξιοποίησης της νοσοκομειακής υποδομής και την οικονομική αποδοτικότητα του νοσοκομείου.

**ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ:** Αναδιάρθρωση νοσοκομειακού τομέα, συγχωνεύσεις νοσοκομείων, κριτήρια κόστους-αποδοτικότητας

## 1. Introduction

**O**n January 5, 2011 the Minister of Health announced that Prof. L. Liaropoulos of the Athens University was commissioned to conduct a study on restructuring the Greek Hospital Sector. The study was part of the obligation Greece had undertaken to contain health care costs, under the MoU between Greece on the one hand and the IMF, the ECB and the E.U Commission (also called the “Troika”) on the other. Prof. Liaropoulos was free to form his own study group, which was subsequently formalized by a decision of the Secretary General of the Ministry of Health, and a budget of €65.000 was agreed upon by the chief investigator and the Minister. The Study was to be completed in a period of three months. The time schedule was kept, and, beginning with Athens in April 10, the study was presented in public hearings in the various Regional Health Administrations. The task of hospital sector restructuring, also known as “hospital mergers” implies the reorganization of two or more hospitals, with the aim of lowering the total costs of the services they provide, and does not necessarily result in the closure of one hospital and the extension of another, nor does it imply that a new investment replaces two or more older hospitals. A “merger” may mean that hospital services are reduced in one hospital and concentrated in another in such a way that the former hospital retains only a limited number of specialties or services.

The inefficiencies and shortcomings of the Greek NHS, since its establishment in 1983, are well known and have been covered extensively in the literature (Davaki & Mossialos, 2005; Mossialos & Allin 2005, Mossialos et al., 2005). Legislative initiatives undertaken in the 1990s to confront these inefficiencies were not successful due to political particularism, fiscal constraints and administrative weaknesses, thus resulting in either partial implementation or total abolition of the attempted reforms (Kristensen, 2010). Hospital mergers captured the public eye and became the center piece of health policy reform at the time of serious fiscal and debt crisis faced by Greece during the last two years. The reason why health has been targeted is the fact that Greece at the end of the previous decade came to spend about 10% of GDP [OECD Health Data, 2011] and at the same time it has been widely published that corruption, under-the-table payments and tax evasion are rampant (Liaropoulos et al., 2008). Despite the widespread interest and the high level of exposure given by the mass media, the fate of hospital restructuring four months after the completion of the study is not promising. The political will and the determination to face up to the proposed changes, although these are not very radical, do not seem to be very firm. Obstacles are also posed by the arcane administrative system, the complexity of the legal status of many hospitals and the understandable resistance to change inherent in major social re-engineering projects.

## 2. Study presentation

### 2.1 *The hospital sector in Greece*

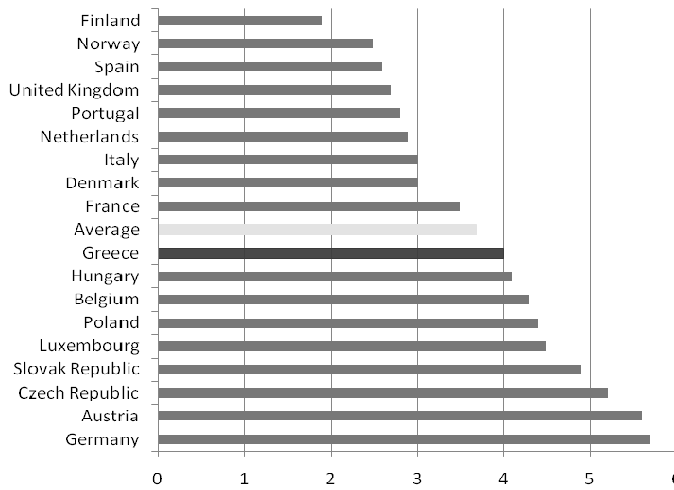
Greece has currently 158 Public Hospitals and 84 private hospitals and small clinics. The main characteristics of public hospitals which are the subject of this study are the small bed capacity, the age of the infrastructure, and their uneven distribution along historical lines and patterns of political patronage. Considering hospitals per 1,000 inhabitants (Fig. 1), Greece is at the high end of the scale.

Beds per 1000 population

Doctors /bed

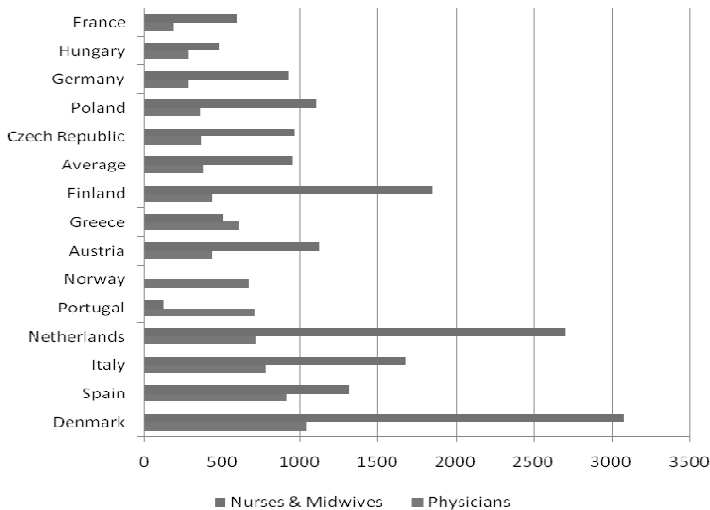
Nurses/bed

**Figure 1: Curative care beds / 1,000 pop in 2008**



Source: OECD Health Data, 2010

**Figure 2: Hospital Physicians and Nurses & Midwives per 1,000 hospital beds, adjusted with occupancy rate in 2008**



Source: OECD, Health Data 2010

## 2.2 The aims of the study

What the study attempted to do was to propose a new pattern of organizing hospitals in order to achieve better productivity, higher quality of care, and greater efficiency both at a sector level and at the level of groups of hospitals or even individual hospitals. Greece has a great number of doctors, but few nurses. It has a surplus of high-end diagnostic and curative technology, but the majority is



in the private sector. Finally, the public hospital sector has two very serious management problems. First, hospital managers are political appointees with all the serious drawbacks of cronyism.<sup>1</sup> Many writers have located party plutocracy as the main source of corruption in Greek public administration (Mouzelis, 2005). Second, the main drawback in public administration is the total lack of functional supervising mechanisms independent of government direct control. Despite the widespread and persistent reference to corruption and wasteful behavior in hospitals for at least 20 years, there are still no reliable computer-assisted financial reporting mechanisms, pharmaceutical consumption is almost unchecked and the, often fraudulent, misuse of medical technology widespread. Merging hospitals, has always been seen as a means to achieving economies of scale, better utilization of resources, and the application of new management techniques. It is for this reason that the main building block of our analysis and our main proposal is the creation of hospital groups of two to six hospitals as a framework in which such productivity improvements can be realized.

### **3. The main branches of the analysis**

#### ***3.1 Emergency care***

The main problems in the hospital sector in Greece centers around emergency care and the way patients are admitted. Emergency care in the two Metropolitan Areas of Athens and Thessaloniki is organized on a rotating basis where only a few hospitals admit patients on a given day, while all other hospitals are essentially “closed for business” in terms of new admissions. The result is overcrowding every 3-4 days, in every hospital on this rotating “emergency duty” schedule. The problem with patient admissions is also related to this. Since patients can only be admitted into a hospital when it is on emergency duty, hospital doctors arrange for “their” essentially private patients to come to the emergency department, and the patient is admitted on bogus emergency admission orders by the “attending” physician. Of course, this means that an actual emergency case may find needed hospital beds already occupied, if brought to the hospital at a late hour, while non-emergency cases admitted before will probably wait for 2-3 days until the necessary tests and probable surgery can be scheduled. The end result is a waste of resources and money, patient dissatisfaction, often resulting in negative media coverage, and on rare occasions, adverse effects on a patient’s health.

Our proposal to deal with this situation is the creation of independent Emergency Care Units in selected large hospitals, operating on a 24 h/7 days basis. These hospitals are usually the largest in a group of hospitals.

#### ***3.2 Small hospitals - hospitals in Islands***

Another area where intervention in the form of hospital mergers is required has to do with the small size of Greek hospitals. Greece features a vast number of islands and islets, ranging between 1,200 and 6,000 depending on the definition, 227 of which are inhabited, although only 78 of those have more than 100 inhabitants. This particular form of insularity does not exist in any other European country. The population of many of the islands may increase by ten times or more during the summer as a result of tourism. Thus for the larger islands which have either a general hospital or an expanded health center, and taking into consideration that obviously no other health facilities are available in close proximity, it would be violating the important social criteria of equity and accessibility to propose any “reducing” restructuring of these particular hospitals,

and all efforts should be directed to enhancing their role in their respective catchment areas. Thus, by excluding these island hospitals (and the respective populations) from the analysis, the number of general hospitals in Greece per 100,000 inhabitants falls below 1.98 calculated previously and suggests an abundance of approximately 30 (and not 40) hospitals compared to the OECD average of 1.62 general hospitals per 100,000 inhabitants.

### ***3.3 The five main clinical areas of interest***

We focused our interest on re-organization of the hospital sector concerning the effective management of the five main chronic diseases: Acute Myocardial Infraction (AMI), Stroke, Malignant Neoplasms, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease (COPD). We analyze the status quo concerning the provision of health services for facing the above mentioned diseases and also we submit specific proposals for improving the provided services.

#### **3.3.1 Cardiovascular diseases**

Cardiovascular diseases consist the first cause of death both in Greece and in Europe, as they are related with half of deaths and moreover they consist the first cause of inpatient admissions in Greece (OECD Health Data Base). According data derived from Eurostat, the standardized mortality ratio concerning ischemic heart disease and cerebrovascular diseases (for the period 2006-2008) is higher in Greece than in the other EU countries since they were estimated to 72.2 and 86.8 per 100,000 pop respectively, when the corresponding European ratios were 70.4 and 43.5 per 100,000pop., the same period.

##### ***3.3.1.1 Strokes***

Strokes consist the third cause of death and the first cause of chronically disabled people in Greece, where the incidence is 310 new cases per year per 100,000 pop (30.000-35.000 in total). About one-third of these patients (approx. 10.000) are dying within the first year, and 35% become permanent disabled. Patients suffering from stroke occupy 15% of in patient beds, with often extended length of stay due to insufficient development of rehabilitation units (Vemmos et al., 1999 & Ntaios et al., 2011).

##### ***Managing patients suffering from Stroke: status quo and problems***

- Population is not sufficiently informed about the preliminary symptoms of stroke due to the lack of health promotion programs. However, thanks to the effective emergency ambulatory services, the time between the onset of symptoms and the admission to the emergency care services of the hospital is estimated to less than 3 hours for the 45% -60% of patients.
- The majority of patients suffering from stroke are admitted in internal medicine departments and only few of them are admitted in neurological departments (mainly younger patients less than 50 years old), while the existing specialized stroke units are very few, with only 25-30 beds in total. Moreover, those few stroke units are facing staffing problems especially in nurses, physiotherapists and logo therapists.
- There are serious problems concerning the access to rehabilitation services for these patients, since few public centers operate, located mainly in Attica. Consequently, after the acute phase of the disease, the majority of patients are hospitalized either in private rehabilitation centers, where the cost is partly covered by Social Security Funds, or return to their homes without actually participating in any specific rehabilitation program.

### *Proposals for improving provided services to patients suffering from Stroke*

Our main proposal for managing patients with stroke was the development of a *national network of specialized stroke units* all over the country, in a way that each patient suffering from stroke could reach one, in less than 90 minutes according to the Austrian model. According to those assumptions it can be easily estimated that taken into account the incidence of the disease and the average length of stay approximately 650 beds are needed. However, due to the economic recession of the country, the development of all these units in the near future is not considered as a realistic aim. Therefore our proposal is, in a pilot phase, to be developed 17 units in big public hospitals all over the country, at which the majority of needed resources already exist (CT, MRI, ICU, specialized health professionals etc). Each hospital in which a stroke unit is operating would be considered as a specialized referral center for strokes, where the complicated cases will be hospitalized. Each one of these specialized stroke units could be considered as a referral center for its catchment area. Moreover, the adoption of a common *clinical protocol* concerning the management of stroke patients at their arrival at emergency departments should be a priority along with the development of telemedicine services in order to support physicians (both at diagnostic and therapeutic phase) in remote areas.

#### *3.3.1.2 Acute myocardial infraction*

According to the results of HELIOS study conducted in the years 2005-2006 in 31 Greek hospitals, the incidence of AMI is 18.5 patients /10,000 pop (which mean 20,000 new cases in total per year) without remarkable variances, between the various geographical areas. The corresponding ratio in other EU countries varies from 9-31.2 patients /10,000pop. The inpatient fatality of AMI in Greece is estimated to 7.7%, while in Europe varies from 4.2-13.5% (Andrikopoulos et al., 2007).

#### *Managing patients suffering from AMI: status quo and problems*

- There is a remarkable number of patients who would be potentially eligible for receiving *reperfusion therapy*, but in practice they don't receive. The pre-hospital beginning of reperfusion therapy (in Health Centers and in ambulances) is not applying in Greece, although the advantages it provides.
- The percentage of *acute* Percutaneous Coronary Interventions (PCI), is limited because of the lack of a well organized emergency transportation system to hemodynamic laboratories.
- Moreover the time between the onset of symptoms (pain) and arrival to hospital is high, due to delays from the beginning of symptoms to call for help from the emergency ambulatory services.

#### *Proposals for improving provided services to patients suffering from AMI (and other heart diseases)*

Our proposal for managing patients suffering from severe heart diseases, includes the determination of already existing hospitals in each health region that would be considered as *specialized referral centers* for these patients. These hospitals should have at least a cardiology department, AMI unit, hemodynamic laboratory and in some cases a cardio surgery department.

Moreover, as the development of many new hemodynamic laboratories (for performing PCI), is not considered as a realistic aim (due to geographical particularities of the country and the high cost of development) we proposed to increase the rates of *acute reperfusion therapy* that in some cases should be performed even in pre-hospital units (e.g health centers, emergency ambulance services etc). In order to achieve the previous purpose, the modification and adaptation of the European Society of Cardiology clinical guidelines is necessary.

However, we considered as necessary the development of one new *hemodynamic laboratory* in the area of Peloponnesus, where none exists, in order to be covered a population of 600,000 inhabitants.

Finally, we proposed the creation of a *Coordinating Center in Emergency Ambulatory Services*, in order to manage in an effective way the transfer of acute heart diseases patients to the appropriate health units. This center should be supported by telemedicine services and also could be staffed by transferring existing personnel, from other units (which are under operating).

### 3.3.2 Malignant neoplasms

Malignant neoplasms constitute the second cause of death both in Greece and in Europe. According the European Cancer Observatory (Country Report) the age standardized incidence rate per 100,000 pop in 2008 was estimated in Greece to 235.3 (38,229 new cases in total) while in EU-27 countries the corresponding ratio was estimated to 374.1. The same year, the age standardized mortality rate per 100,000 pop was estimated to 153.5 per 100,000 pop (26,815 deaths in total), while the corresponding ratio was estimated to 172.5 per 100,000 pop in EU countries (OECD Health Data Base, 2010). In a study conducted in 2004 by Tountas et al. (2007), was reported that 25% of all deaths were related to cancer. Even though Greek morbidity statistics are not very reliable, it has been revealed from various surveys that ten percent of patients discharged from a hospital have been hospitalized due to cancer disease.

#### *Managing patients suffering from Malignant Neoplasms: status quo and problems*

- In general, geographical imbalances concerning the provision of oncological services are reported both for screening and therapeutic interventions. Some patients are late diagnosed due to insufficient development of mass screening programs and generally because of the under development of Primary Health Care.
- There is a limited number of specialized Oncological inpatient departments even in territory hospitals and insufficient number of some kind of biomedical devices (3.5/million pop. linear accelerators while in a study conducted from the EC in 2005, the needs for Greece was estimated to 5.5/million pop.)
- Even the few operating oncological departments are facing staffing problems and more over in the majority of hospitals the oncological boards are not performing in practice.
- Hospices and generally Palliative care services are also under-developed in all country.

#### *Proposals for improving provided services to patients suffering from Malignant Neoplasms*

As health care delivery system in Greece is hospital oriented, services related to patients with cancer are characterized by structural and allocation problems, understaffing and low patients' accessibility.

Patients with cancer need a multidisciplinary approach. Health services for these patients in Greece are totally fragmented. The suggestion is to create an *oncology health services network per health district* in order to facilitate services and health workers coordination to a more integrated model *with compliance to national or international clinical guidelines for cancer treatments*. The network will consist of a specialized oncology centre and three graduate units. All these services should be in direct coordination with primary health services of the region. Health region after examination of criteria set fulfilment will be able to certify specialized health units for a specific neoplasm or group of neoplasms. This will give the region an outstanding position in the cross border care services mosaic at the South - East Europe.

The suggestion also includes the reinforcement of early diagnosis and treatment units of primary and secondary health services and the increased staffing with oncologists, radiation physicists, nurses and other specialties at all health regions. Also it is suggested to reorganize small hospitals *per health district to cancer palliative care and end-stage patients centres*. An investment in new health care technologies such as adequate number of linear accelerators per health region is also part of the suggestion. The ultimate purpose of all these is more oncology patients have an easier access to a more integrated and quality health services network.

### 3.3.3 Diabetes mellitus

Diabetes mellitus constitutes the 12th cause of death all over the world. The probability of a patient suffering from diabetes mellitus to die is double compared to the general population. According data from the European Observatory on Health Systems and Policies, the prevalence of diabetes mellitus in Greece was estimated to 0.15% in 2004; while in 2000 the percentage of population over 20 years suffering from diabetes mellitus was estimated to 10.3%.

#### *Managing patients suffering from Diabetes Mellitus: status quo and problems*

- Some patients are late diagnosed due to insufficient development of Primary Health Care (especially lack of organized diabetes prevention and screening programs). This is a common phenomenon especially for patients suffering from diabetes mellitus type II.
- There has been developed an insufficient number of clinics relevant to diabetes (obesity clinics, smoking cessation clinics, etc).
- No clinical protocols concerning disease management at the emergency departments of hospitals have been adopted.
- Although there is a sufficient number of internal medicine and endocrinology departments in hospitals, there hasn't been developed a sufficient number of specialized diabetes mellitus departments. Even the few ones, are facing staffing problems mainly for nurses and for specialized physicians on diabetes.
- According data derived from the National Center of Diabetes, only 14 diabetes centres have been developed in the country (11 in Attica, 2 in Thessaloniki and 1 in Patras).
- The average waiting time in order a diabetes mellitus patient to arrange an appointment at a specialized unit of Attica hospitals is estimated from 3.5 to 4 months. This time could be reduced, in case that some patients were referred for follow-up at out patient units.

#### *Proposals for improving provided services to patients suffering from Diabetes Mellitus*

Preventing diabetes is the most effective way to reduce morbidity, mortality and health care expenditures. It includes the modification of dietary habits, regular physical activity, achieving and maintaining normal body weight and avoiding smoking. Therefore and considering the fact that diabetes is one of the main causes of mortality in Greek population, the expected increase in the prevalence of the disease during the coming decades and the urgent need for rational and efficient allocation of resources in the health system, we concluded that it would be necessary to create *an organized National Action Plan to address, control and prevent diabetes* in order to reduce its impact both on the population and on the NHS. Key objectives of the National Action Plan for diabetes should be the early prevention, diagnosis, treatment and management of the disease and the effective, timely, organized and continuous patients' monitoring at all levels of care.

Patients with diabetes need regular monitoring and care by trained health professionals at primary health care level and specialized diagnostic and therapeutic care by specialized health professionals at secondary and tertiary health care level. Our proposal *is to create a regional*

*network for diabetes at each Health District* as to facilitate cooperation among health services and health professionals and the consolidation of services where appropriate. In addition, networks for diabetes will enable the harmonization among all health services and health professionals with the creation of national (and global) standards of prevention, treatment and rehabilitation of diabetic patients. Special units of each diabetes network will be able to qualify for specific range of services, upon approval by the competent Health District. This certification will also give a significant advantage both on national and on cross-border health care and will strengthen the medical tourism in the country.

Our detailed report includes specific detailed suggestions according to predefined operating criteria for each Health District and each hospital in the country concerning the reallocation of services, staff, departments and clinics, etc. in order to create both a district and a national network for diabetes and to facilitate the coordination of services for diabetic patients across the country.

Our main suggestions for each Health District include:

- Creation of Diabetes Units in all hospitals with pathological sections > 20 beds.
- Strengthening Diabetes Centers with specialized health personnel (mainly nurses and dietitians but also psychologists, GPs, etc).
- Creation of diabetes clinics in primary health care organizations (IKA, OTA, etc).
- Creation of more clinics for obesity, smoking cessation hyperlipidemia, hypertension, etc. in all health regions.
- Development of home care services in many hospitals and health centers.

### 3.3.4 Chronic Obstructive Pulmonary Disease (COPD)

COPD constitutes the fourth cause of death both in Greece and in Europe. In Greece, the prevalence of COPD is higher than in other EU countries due to the high rates of smoking habit (WHO, Centers of Disease Control and Prevention). It is estimated that 70% of the total burden of the disease is attributed to tobacco smoking (which is the cause of death that can be almost entirely prevented). In a study conducted in 2004 (Tzanakis et. al., 2004) was found that among Greek smokers over 35 years old, 8.4% were suffering from COPD. The prevalence was higher in rural areas and among men.

Main cost driver of the COPD treatment, is inpatient care, in case of severe exacerbation. According the results of a study conducted in 2011 from Geitona et al., the cost for COPD patients hospitalized at ICU was estimated from € 1.711 to €2.614 /patient/exacerbation.

#### *Managing patients suffering from COPD: status quo and problems.*

- In general, geographical imbalances are reported concerning the provision of specialised respiratory services to patients suffering from COPD. Some patients experience repeated exacerbations due to the lack of a well organized referral system to specialized centers.
- Even the few specialized (on COPD) respiratory departments are facing staffing problems mainly concerning nurses.
- There are very few respiratory rehabilitation units operating (apart from Attica and Central Macedonia) and because of this, serious shortages of respiratory rehabilitation beds are reported.

#### *Proposals for improving provided services to patients suffering from COPD*

COPD can not be cured but can be prevented. Since the main cause is smoking (including passive exposure to it) the *effective prevention of COPD depends entirely on the effective tobacco control*. Preventing COPD is therefore the most effective way to reduce morbidity, mortality and related health expenditures. It includes smoking cessation and modification of conditions that contribute

to the occurrence of exacerbations of the disease through education, systematic physical motivation and learning self-care techniques. Therefore and considering that COPD is one of the main causes of mortality, a large increase in the prevalence of COPD is expected in the next decades in the country since Greece reports the highest proportion of heavy smokers and tobacco consumption in Europe, we concluded that it would be necessary *to create an organized National Action Plan to address, control and prevent COPD in order to reduce its impact both on the population and the NHS.*

Key objectives of the National Action Plan for COPD should be the early prevention through effective and systematic prevention programs, the early diagnosis, treatment and management of the disease, the effective, timely, organized and continuous patients' monitoring at all levels of care and the continuity of care and rehabilitation for all COPD patients.

Patients with COPD need regular monitoring and care by trained health professionals at primary health care level and specialized diagnostic and therapeutic care specialized health professionals at secondary and tertiary health care level. Our proposal *is to create a regional network for COPD at each Health District* as to facilitate cooperation among health services and health professionals and the consolidation of services where appropriate. In addition, networks for COPD will enable the harmonization among all health services and health professionals with the creation of national (and global) standards of prevention, treatment and rehabilitation of COPD patients. Special units of each COPD network at every health district will be able to qualify for specific range of services, the providers. This certification will also give a significant advantage both on national and on cross-border health care and will strengthen the medical tourism in the country.

Our detailed report includes specific detailed suggestions according to predefined operating criteria for each Health District and each hospital in the country concerning the reallocation of services, staff, departments and clinics, etc. in order to create both a district and a national network for COPD and to facilitate the coordination of services for COPD patients across the country. Our main suggestions for each Health District include the creation of more clinics for smoking cessation in all health regions, the creation of pulmonary clinics in primary health care organizations (IKA, OTA, etc), the development of home care services in all hospitals and health centers *and the strengthen of respiratory Rehabilitation Centers* with specialized health personnel (mainly nurses and physiotherapists, but also GPs, psychologists, etc)

### ***3.4 Improving the efficiency in hospital sector: partnerships and cost containment measures***

The two sectors of in patient care, public and private, have been grown with different aims and problems in their financing and provision of care. Our proposals for possible areas of joint practices, in a way of mutual benefits, include the following:

- The exploitation of the opportunities of Public Private Partnerships (PPP), in the Health Sector. Possible areas of joint action in the hospital area can range from construction ventures to hospital management and outsourcing.
- The partly usage of public inpatient care facilities from private health insurance, by disposing a number of beds and other special services- a practice which has already been announced and ministerial decision taken (19.08.2011), (until now 560 beds are provided for private use).
- The strengthening of the practice expected to be instituted by the new organization EOPYY regarding the contracted work with private providers: medical doctors, diagnostic centers and also private hospital services.

Moreover, apart from partnerships, it is necessary to be taken some expenditure containment measures such as:

- Completing the application of *double-entry* accounting system for the effective economic and financial management of hospitals and the implementation of analytical accounting systems.
- Upgrading the practice of publication of *economic statements* (income and expenditure) at hospital level, through ESY.net for evaluation and benchmarking. Enhancing and improving the Supply System for medical provisions and drugs, utilizing the “Prices Observatory” (observe.net) and promotion of the already proved as a success case the e-Auction and tendering.
- Developing and formalizing best practices for rational use of resources and economies of scale, in the networks of hospitals which have been emerged by applying the new structural change instituted by the Minister (re-organization and rationalization of the operation and management of hospitals).

### ***3.5 The criteria for restructuring the public hospital sector***

Most of the studies reviewed in a recent hospital merger study (Kristensen, Bogetoft, Pedersen, 2010) primarily used a pre-merger parametric, semi- or non-parametric DEA-approach to investigate the effect of mergers on productivity and cost efficiencies. In Greece, no empirical studies of potential economic gains from hospital mergers have been conducted, although the available evidence regarding hospital efficiency indicates that significant efficiency gains can be achieved (Aletras, 1999; Athanasopoulos et al., 1999; Athanasopoulos et al, 2001; Giokas, 2001; Kontodimopoulos et al., 2006; Aletras et al., 2007; Flokou et al, 2010). Whilst efficiency is obviously the predominant criterion in resource allocation and in the merging process as well, the sensitive nature of health and healthcare dictates that policy-makers equally value the usually contradicting (to efficiency) criterion of access equity. Moreover, in light of the current economic crisis in Greece, it is extremely important that any suggestions, which may eventually lead to hospital merger policy decisions, be fair, well justified and based on transparent criteria. For example, it would be contradicting the criterion of equity to limit the medical specialties available on a small island or to decrease the number of hospital beds, despite the fact that efficiency analyses results might be pointing in this direction. It is taken as axiomatic that the role of health care is to improve health and reduce access inequalities and that policy-makers concurrently seek the twin goals of efficiency and equity (Manyard, 1999; Sheldon & Smith, 2000). Although international experience is indeed an important factor to guide decision-making, the existing political and economical situation in Greece, in conjunction to an intense social turmoil, made it evident that the restructuring criteria adopted in the present study should rely less on technical and analytical tools, and more on various social, political, geographical and other peculiarities existing nationally and locally in Greece. Six distinct criteria, covering all aspects of hospital functioning, were considered. More specifically:

- i. The *population* criterion. International experience, with adjustments, was the starting point. According to 2008 data (OECD Health Data, 2010 & 2011), the average number of general hospitals per 100.000 inhabitants in Europe, and in Greece separately, was 1.62 and 1.98 respectively, revealing a 22.2% difference. At that time the number of general hospitals in Greece was 222 (including small rural hospital-health centers, IKA and military hospitals and private hospitals / mixed clinics). These figures suggest an abundance of approximately 40 hospitals compared to the OECD average. By comparing only with “Mediterranean”



countries, i.e. countries with similar social, cultural, and geographic aspects, i.e. Italy, Spain, Portugal, Turkey and France, the above mentioned difference decreases to 10%, which is still considerable and suggests an abundance of approximately 20 general hospitals in Greece after adjustment for population differences. These figures are only a crude approximation of the number of general hospitals justified by the population criterion.

- ii. The *catchment area* criterion. Greece is characterized by an extremely high population density in the greater Athens area, where approximately 40% of the country's population resides. A second densely populated area is Thessaloniki region with approximately 10% of the country's population. The rest of the population lives in smaller urban, semi-urban and rural areas. The average number of general hospitals per 100.000 inhabitants in the Athens area is 2.16, approximately exceeding the national average by +9.6%, in Thessaloniki 1.66 (-15.7%) and in the rest of the country 1.94 (+1.6%). Catchment area refers to the geographical area of permanent residents from which a hospital is expected to draw its patients and in a sense reflects accessibility as well. Twelve regions designated by EKAB, i.e. the National Service for Medical Transport, were adopted in the present study as respective catchment areas. This division is based solely on geographical and transportation criteria, as opposed to a recent legislative reform with an administrative division into 13 peripheries. To understand a hospital's contribution within its catchment area, a "coverage" index was calculated. Specifically, the percentage of cases handled by a hospital annually in respect to the cases handled in its catchment area was divided by the percentage of its beds in respect to the total beds of the catchment area. For example, if a hospital handled 33.8% of the cases in its catchment area, while accounting for only 28.4% of the beds in that area, the coverage index is  $33.8\% / 28.4\% = 1.19$ . In other words, that hospital "carried" 19% more weight in its catchment area (i.e. more patients) than would be expected from the proportion of beds it owns. Hospitals with a coverage index  $< 0.90$  were scored with -1, those between 0.90-1.10 with 0, and those exceeding 1.10 with +1, thus roughly forming tertiles, i.e. three evenly sized groups.
- iii. The *size* criterion. Hospital size is typically measured by the number of beds available for treating inpatients. It is generally expected that larger general hospitals can more effectively cover the needs of the population in their catchment area. They attract patients with more complex conditions and expand the scope of their activities. It is also likely that larger hospitals tend to treat patients with more advanced and complex equipment. Producing services on a larger scale, though not necessarily linked to scale efficiency which is a different concept not addressed in this study, might imply that that a hospital is better prepared to serve its patients. For example, lower mortality can be expected for patients treated with coronary disease in a larger hospital which handles many similar cases, compared to a smaller hospital in which there might be an experience deficit. Furthermore, larger hospitals can attract specialized physicians and offer more medical specialties as well as better medical training. They typically provide better isolation of medically contagious cases due to the availability of specialized units, thus reducing in-hospital infections. Other advantages include fewer referrals to other hospitals and better management of outpatients and emergencies. Generally, hospital size is determined by considering factors such as catchment area, epidemiological profile, transportation infrastructure, proximity to other health facilities and local health hazards. With an aim of again forming tertiles in terms of the size criterion, hospitals with less than 125 beds were scored with -1, those with 125-300 beds with 0, and those with +300 beds with +1.
- iv. The *infrastructure age* criterion. Hospital infrastructure in Greece was developed over the years according to historical, geographical and, to a large extent, political criteria. This, in

part, may explain the increased age of most public hospitals and the unsuitability of a large proportion of the respective facilities. It is noteworthy that the average age of the 117 public hospitals included in this study is 45 years, whereas the average age of a US hospital building is 27 years (Guenther & Vittori, 2007). Following the establishment of the Greek NHS, via the introduction of Law 1397/1983, there was an increase in and upgrading of infrastructure (buildings and medical equipment) and staffing, as well as improvements in quality and access to health care, especially in rural areas. Since then, new regional university hospitals in large urban areas, many prefectural hospitals in smaller cities and more than 200 health centers in rural areas have been built, while many existing facilities have been renovated or extended. The rationale in the present restructuring effort was to further strengthen the newer and more modern hospitals, and concurrently exploit the useable infrastructure of older ones. The latter were not to close down, but in many cases could be used differently, e.g. care units for patients with long-term illnesses or for elderly, and other such services currently provided by general hospitals, thus relieving them of the respective physical and financial burden. Infrastructure age was determined via a questionnaire sent to the regional health authorities supervising the hospitals. Response rates were slow and large portions of the data were missing and incomplete, hindering the process. Furthermore, most hospitals had undergone multiple renovations in some of their facilities over the years, making it extremely difficult to designate a unique age for each. Eventually, 46 hospitals were classified as "relatively new" (opening after 1985), 37 hospitals as "middle-aged" (1960-1985) and 34 hospitals as "old" (before 1960), and were scored +1, 0 and -1 respectively.

- v. The *utilization* criterion. The purpose of this criterion was to measure how well each hospital exploited its facilities and resources for treating inpatients. Two commonly used indices for measuring hospital utilization and capacity were selected:
- Patient *throughput* which is expressed as the average number of patient discharges per available hospital bed per annum.
  - Bed *turnover interval* which is the average number of days a hospital bed remains unoccupied between admissions.

Both indices were given equal weight and patient throughput and bed turnover interval were calculated for each hospital. For each index, hospitals were sorted from best to worst (i.e. descending throughput and ascending turnover) and were categorized into tertiles scored respectively +1, 0 and -1. Hence, each hospital was allocated two marks which were summed to provide an overall score between -2 and +2. This was regarded as an "intermediate" score and was transformed for comparability with the other criteria mentioned previously as follows: an intermediate score of -2 or -1 was given a final score of -1, an intermediate score of 0 was given a final score of 0 and an intermediate score +1 or +2 was given a final score of +1.

- vi. The *cost* criterion. Although consensus on the appropriate unit of hospital output (hospital case vs. patient days) is not always apparent, efficiency of hospital services has traditionally been measured by simple economic indices of both outputs (i.e. cost per day and cost per patient). Despite providing straightforward information about performance such indices are indeed limited by some obvious shortcomings, such as one input and output, the need to incorporate relative weights and the difficulty to explain the behavior of individual hospitals when ranking efficiency across many hospitals. For these, and other, reasons multiple input-output parametric and mostly non-parametric methods have prevailed in efficiency analyses. Moreover, hospitals provide services to cases that differ in terms of complexity and severity of illness and to deal with this, researchers have typically incorporated general diagnostic groups

(such as Diagnosis Related Groups -DRGs) in their models. In Greece, the ministry of health plans to change the hospital payment method in the future; however, it has not yet been decided how the change will be introduced or whether it will involve the expansion of DRGs or the introduction of global budgets [17]. In the present study, the two abovementioned indices and cost per bed were used as three crude approximations of the economic performance of each hospital. All costs incurred in hospital functioning were considered, e.g. pharmaceuticals, consumables, reagents and all other materials, for inpatients and outpatients (including day surgeries, dialysis, chemotherapies). However staff salaries, despite constituting the largest portion of hospital cost, were not included as they are covered centrally by the state budget and do not burden the hospitals themselves. Furthermore, as hospital management has no control over staff hiring (or firing), a basic principle of the present restructuring effort was that proposals would only involve some staff reallocation and not in any case reductions. Therefore, we decided to focus only on controllable costs. Cost per case, cost per day and cost per bed was calculated for each hospital and given equal weight. Hospitals were sorted from best to worst by each index (i.e. ascending costs) and were categorized into tertiles scored respectively +1, 0 and -1. Hence, each hospital was allocated three marks which were summed to provide an overall score between -3 and +3. As in the previous criterion, this was regarded as an "intermediate" score and was transformed as follows: an intermediate score of -3 or -2 was given a final score of -1, an intermediate score of -1, 0 or +1 was given a final score of 0 and an intermediate score +2 or +3 was given a final score of +1.

The scores for criteria ii to iv were summed and each hospital was allocated a final score ranging from -5 to +5. It should be noted that the overall score serves the purpose of informing on possible weaknesses encountered in each hospital, which should be seen as priorities by management for potential improvements. It also assisted the study group in the formulation of reasonable suggestions for improving the health services in each hospital. It is emphasized that no restructuring suggestions were based solely on the individual score of a particular hospital.

## 4. A novel way to conduct a study

**F**rom the very beginning it was clear that a study of this nature was going to be used for wide public debate among the many stakeholders in the health system, regional stakeholders, professional interested parties, and ultimately for policy formulation. It, therefore, had to answer to certain preconditions in order for it to be useful. As hospital mergers have been known by European experience to be rather sensitive political subjects on a regional basis (Tsavalias et al., 2011), the study parameters could be disseminated early and widely, but the detailed proposals by health region should not be made public until the time of public debate by region. Second, the difficulties of collecting the relevant data, which in many cases were not readily available, compiling them, creating the necessary indices, and come up with policy suggestions in the time frame of 3 months, made the presentation of a printed document impossible. Third, the need to have many people, from different parts of the country, working on different sections simultaneously made distance working essential. Fourth, the need to have as much time available for last-minute adjustments and/or corrections, made it essential that the "text" could be changed even on the last day before presentation. Lastly, the study audience was understood to be very diverse, and the desire to go into detail could vary considerably. The Report, therefore, should

make it easy for everybody to go to the results or proposals of their interest immediately, and print anything, but, at the same time make all the information by which the given results or proposals were obtained, available to the interested party. All these considerations pointed to the need for the Study to be conducted in the form of a website, to which the study team could add information continuously, under the exclusive approval of the study coordinator who had the exclusive right of publication. In this way, we were able to finish the study in the period of 3 months, to present the results in a very functional way, and to use and present information, data, and analysis which, if printed, would require more than 400 pages. The website <http://platon.cc.uoa.gr/~reconweb/new2/> is available (in Greek) at the main site of the Department of Nursing, University of Athens, where most of the Study team members teach or collaborate with the Center for Health Services Management and Evaluation (CHESME).

## Notes

1. The only occasion on which hospital directors were appointed by a board of high-ranking public servants, on the basis of a CV, was during the period 2001-2004 under Law 2889/2001, passed by Minister Al. Papadopoulos, who also introduced the Regionalization of the Public hospital sector.

## Bibliographical references

- Aletras V., (1999), "A comparison of hospital scale effects in short-run and long-run cost functions", *Health Economics* 8:521-30.
- Aletras V., Kontodimopoulos N., Zagouldoudis A., Niakas D., (2007), "The short-term effect on technical and scale efficiency of establishing Regional Health Systems and General Management in Greek NHS hospitals", *Health Policy* 83:236-45.
- Andrikopoulos G., Pipilis A., Goudevenos J., Tzeis S., Kartalis A., Oikonomou K. et. al., (2007), "Epidemiological Characteristics, Management and Early Outcome of Acute Myocardial Infarction in Greece: The Hellenic Infarction Observation Study", *Hellenic J Cardiol* 48: 325-334.
- Athanassopoulos A.D., Gounaris C., Sissouras A., (1999), "A descriptive assessment of the production and cost efficiency of general hospitals in Greece", *Health Care Management Science* 2:97-106.
- Athanassopoulos A., Gounaris C., (2001), "Assessing the technical and allocative efficiency of hospital operations in Greece and its resource allocation implications", *European Journal of Operations Research* 133:416-31.
- Davaki K., Mossialos E., (2005), "Plus ça change: Health sector reforms in Greece", *Journal of Health Politics, Policy and Law*, 30:143-67.
- Economou C., (2010), "Greece: Health system review", *Health Systems in Transition* 12:1-180.
- Flokou A., Kontodimopoulos N., Niakas D., (2010), "Employing post-DEA cross-evaluation and cluster analysis in a sample of Greek NHS hospitals", *Journal of Medical Systems*, 35(5): 1001-1014. [Epub ahead of print].

- Geitona M., Hatzikou M., Steiropoulos P., Alexopoulos E.C., Bouros D., (2011), "The cost of COPD exacerbations: a university hospital-based study in Greece", *Respir Med. Mar* 105(3):402-9.
- Giokas D.I., (2001), "Greek hospitals: how well their resources are used?", *Omega* 29:73-83.
- Guenther R., Vittori G., (2007), *Sustainable Healthcare Architecture*, 1st ed. Sussex, UK: Wiley.
- Kontodimopoulos N., Nanos P., Niakas D., (2006), "Balancing efficiency of health services and equity of access in remote areas in Greece", *Health Policy* 76:49-57.
- Kristensen T., Bogetoft P., Pedersen K.M., (2010), "Potential gains from hospital mergers in Denmark", *Health Care Manag Sci* 13:334-345.
- Liaropoulos L., Siskou O., Kaitelidou D., Theodorou M., Katostaras T., (2008), "Informal payments in public hospitals in Greece", *Health Policy*, Jul 87 (1):72-81.
- Maynard A., (1999), "Rationing health care: an exploration", *Health Policy* 49:5-11.
- Mossialos E, Allin S., (2005), "Interest groups and health system reform in Greece", *West European Politics*, 28:420-44.
- Mossialos E., Allin S., Davaki K., (2005), "Analysing the Greek health system: A tale of fragmentation and inertia", *Health Economics*, 14:151-68.
- Mouzelis N., (2005), "Why reforms fail" in Pelagidis T. (ed.), *The involvement of reform in Greece: An evaluation of modernization*, Athens: Papazisis.
- Ntaios G., Vemmou A., Koroboki E., Savvari P., Saliaris M., Spengos K., Vemmos K.N., (2011), "Long-term mortality and stroke recurrence in patients with ischaemic stroke and atrial fibrillation are associated with the type of atrial fibrillation", *20th European Stroke Conference*, Hamburg Germany.
- OECD, *Health Data Base* 2010 & 2011.
- Sheldon T.A., Smith P.C., (2000), "Equity in the allocation of health care resources" *Health Economics* 9:571-4.
- Tragakes E., Polyzos N., (1998), "The evolution of health care reforms in Greece: Charting a course of change", *International Journal of Health Planning and Management* 13:107-30.
- Tountas J., (2007), "Health of Greek population 1997-2006. Center for Health Services. Epidemiology Department", *Medical School of Athens*. Available at <http://www.neahygeia.gr/index.php>.
- Tsavalias K., Siskou O., Liaropoulos L., (2012), "Hospital Merges in Europe: The experience of Greece and future prospects", Accepted for publication in *Archives of Hellenic Medicine* (in Greek).
- Tzanakis N., Anagnostopoulou U., Filaditaki V., (2004), "Prevalence of COPD in Greece", *Chest* 892-900.
- Vemmos K.N., Bots M.L., Tsiouris P.K., Zis V.P., Grobbee D.E., Stranjalis G.S., Stamatelopoulou S., (1999), "Stroke incidence and case fatality in southern Greece: the Arcadia stroke registry", *Stroke* Feb 30(2):363-70.

# Tomorrow's public hospital in Greece: Managing health care in the post crisis era

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## Το δημόσιο νοσοκομείο του αύριο στην Ελλάδα: Η διαχείριση της φροντίδας υγείας στην μετά την κρίση εποχή

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### ABSTRACT

The management of the hospitals (defined as the attempt for optimum performance via appropriate cycles of planning, deciding, evaluating, and reviewing), transcends all the functional parameters of the production and provision of health services. Tomorrow's public hospital in Greece demands a new managerial approach. This approach would sufficiently answer to the main four problematic conundrum of today: the perverse unaccountability of medical subjectivity, the obsolete management model, the lack of human resources management tools and the unhealthy financing of hospitals. Tomorrow's hospital would respect the autonomy of the medical profession while at the same time would demand scientific accountability, would utilize modern organizational tools to manage its human resources in order to produce effectively and efficiently quality services and finally would measure its performance on a case by case basis.

**KEY WORDS:** Hospital administration, micro-level management, Greece

### ΠΕΡΙΛΗΨΗ

Η νοσοκομειακή διοίκηση (οριζόμενη ως η προσπάθεια για την βέλτιστη απόδοση μέσω κατάλληλων κύκλων σχεδιασμού, αποφάσεων, αξιολόγησης και επανελέγχου) τέμνει όλες τις λειτουργικές παραμέτρους παραγωγής και προσφοράς υπηρεσιών υγείας. Το δημόσιο Ελληνικό νοσοκομείο του αύριο θα πρέπει να απαντήσει στις τέσσερις προβληματικές ενότητες του σημερινού συστήματος: τον ιατρικό υποκειμενισμό, το απαρχαιωμένο μοντέλο διοίκησης, την έλλειψη εργαλείων διαχείρισης ανθρώπινου δυναμικού και την προβληματική χρηματοδότηση των ελληνικών νοσοκομείων. Το νοσοκομείο του αύριο θα πρέπει να σέβεται την αυτονομία του ιατρικού επαγγέλματος ενώ ταυτόχρονα να απαιτεί επιστημονική λογοδοσία, θα πρέπει να χρησιμοποιεί μοντέρνα εργαλεία επιχειρησιακής οργάνωσης ώστε να διαχειριστεί το ανθρώπινο δυναμικό του με απώτερο στόχο την αποδοτική και αποτελεσματική παραγωγή υπηρεσιών υγείας και τέλος θα πρέπει να μετράει την απόδοση του σε κάθε περιστατικό. Σε αυτή την κατεύθυνση θα κατευθυνθούν τα νοσοκομεία τα επόμενα χρόνια.

**ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ:** Διοίκηση νοσοκομείων, διαχείριση σε μικρο-επίπεδο, Ελλάδα

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## 1. Introduction: Modernizing the management of the system as a catalyst for change

Greece faces a multi-level crisis which in so far as the healthcare arena is concerned, presents the country with a window of opportunity not simply for reviewing its problems but for a complete transformation of its management practices. Modernizing the health care system is critical for three reasons: (a) health care expenditures have largely contributed to the derailment of state finances, (b) the crisis and the continuing recession subtracts funds and other resources from the health care system and (c) health care services can assist the population to cope with the overall consequences of the crisis (Matsaganis, 2011). In the international literature, there is much talk about how to reform health systems (Braithwaite et al., 2004; Oliver et al., 2005; Schmid et al, 2010; Maarse, 2006; Nikolentzos et al, 2008). The discourse invariably focuses on topics such as political leadership, organizational transformation, clinical improvement etc. The vacuity of generalization notwithstanding, three categories of reform cover most of the relevant territory. The first is “system-improving” measures, such as the accumulation and analysis of data, electronic medical records, disease management. The second are “system transforming” policies such as explicit priority setting and institutional realignment; what analysts tend to mean by “real” reform because they change the workings of the system not incrementally but “fundamentally”, though not of course completely. It can and most likely encapsulates system improving measures. The third category, which most often is unnoticed, is “system-sustaining” reform. It may sound oxymoronic (reforms are after all supposed to alter the status quo not preserve it), but, nevertheless is of utmost importance in maintaining the viability of health care systems (Brown, 2006). The main, if not only virtue of this typology is to underline the centrality of politics in health care reform. The point is that reform attempts suffer from a large and widening gap between policy analysis and policy practice. Health policy in Greece is increasingly an elaborate structure of ideas set atop rather fragile pillars of political comprehension, and institutional capacity. Put differently, the main argument is that Greece has to both design health policy which can be expected to improve efficiencies and at the same time alter the existing decision making mechanisms of the system in such a manner that will allow such policies to be implemented.

The consensus of analysts about the Greek health care system is that its main characteristic is fragmentation (Oikonomou et al, 2011; Mossialos, 1995; OECD, 2010; Minogiannis, 2003, Tountas, 2006; Tountas et al., 2002; Tountas et al, 2005; Liaropoylos et al., 1998; Kyriopoulos et al., 1993 ). It does not practically offer single coverage and has multi-fragmented funding and delivery mechanisms (Siskou et al., 2008). It is characterized by its regressive financing with many disparities in access, supply and quality of services. Inefficiencies arise from excessive dependence on expensive inputs. The oversupply of specialists and the lack of nursing staff in Greece is well documented (OECD, 2008; OECD, 2010). The allocations of scarce resources is a result of historical and often political processes and has never been linked to performance standards leading to a system that presents no incentives to providers for effective and efficient health care delivery (Mossialos, 2005; Economou, 2010).

This fragmentation develops in three levels which interact with one another: (a) the structure of the system (funding, staffing, development units, etc.), (b) the management (decision making) and (c) the flow patients and the lack of disease management networks. The reduction of fragmentation in these three levels will most likely result in a modern administration system that is properly institutionalized and has adequate resources to achieve both economic viability and improve population health indicators (Mossialos, 2005).

In this article we will focus on hospital administration, where these three levels converge and reveal all the pathologies of the Greek Health Administration. The first part of the chapter attempts to highlight the problematic aspects of management of public hospitals in Greece in the period prior to the economic crisis. This is followed by an admittedly cursory look to reform efforts of the last two years and their immediate results. We conclude this chapter with a series of further reforms that are necessary in order to establish a clear management structure aimed at improving the quality of services, namely improving clinical effectiveness, efficiency in use of available resources but also patient satisfaction.

## 2. Before the crisis

**T**he main problem, not only in the management of socially sensitive services like health care, but in terms of the overall Greek public management system is that it has never tried to be financially self-sufficient, through a funding system that would reward the “good players” at either the health professionals and employees level or at the institutional-hospital level. These problems are largely due to the structure of the health system but even more to its problematic administration. Multiple decision-making centers, overregulation, extensive party penetration of public management as well as a truculent and irrational co-management of the system by labor unions are just some of the parameters that lead to inefficient administration of all levels (strategic, supervisory, tactical-operational) (Economou, 2010). The problematic command occurs at two levels: (a) at the macro-level of the administration or what is called the political management of the system and (b) at the Micro-Level administration level at hospitals and other service units. The key point is that policy makers (macro level) must understand the basic principles of health management and aim at a balanced market whereas health services managers (micro level) should understand the constraints within which they have to manage their institutions (Minogiannis, 2003). In this paper, we do not concentrate on the political management of the system but rather focus on the micro level management parameters. Suffice it to say, however, that any attempt for meaningful reform on the problematic micro level management parameters would require substantial political capital.

## 3. Problematic parameters at the micro level

### *3.1 There are four main categories of management issues, one has to consider:*

#### 3.1.1 Medical subjectivity

A generation ago, the remarkable variation in the delivery of health care across populations was brought to light (Wennberg, 1973). Since then, numerous articles have documented variations across small and large areas in surgical procedures, health system capacity, use of pharmaceuticals, intensity of diagnostic testing and others (Wennberg, 1998; Dartmouth Atlas, 2011; Fiscella et al, 2000; Archer, 2009; Freburger, 2005; Clance, 2009; IOM, 2000). The principal finding of these studies has not changed: for medical care, geography is destiny. Each medical encounter is characterized by four basic parameters: the physician, the patient, the disease and the timing of the encounter. Each one differs if only one of these parameters is different. This is what creates



the great knowledge imbalance between management and the physician community in a hospital setting. Whereas it is important to underline the importance of such differences, one cannot avoid examining the question of medical subjectivity. This medical subjectivity leads in turn to an imbalanced services consumption (via physician agency) which on occasion cannot be justified and leads to elevated costs and inefficiencies. Practically speaking, the same and on occasion better clinical results can be achieved in cheaper ways by certain physicians. This does not negate the fact that each patient is different and hospital management tools must take that into consideration. And it is also rather obvious that the best clinical result may also be the most expensive. The key point is that this is not axiomatic. In Greece, however, this is a discussion that has not even begun both due to professional resistance but also due to the lack of both clinical and until recently even financial information which would have allowed such a discussion to take place based on actual data. The medical community at best is indifferent and at worst promotes medical subjectivity and reformist voices within medicine are often overheard.

### 3.1.2 Obsolete management model

The Organizational charts of Greek hospitals are governed by a 1987 static statute called the Single Organizational Hospital Framework. If the management system of a hospital cannot follow the scientific developments that have occurred in the past twenty five years, then it is not an exaggeration to call such a system obsolete. The current organizational charts provisions for staffing needs are based on the number of beds of each hospital (rather than its output). Departments that are no longer in existence are still officially part of the organization, whereas others that have come to existence are not provided for. Fundamental operational procedures as well as written open ended job descriptions are nonexistent. Policies and procedures need to be in tandem with the law but also need to be specialized at the hospital level since they are affected by parameters such as the nature of the hospital, the structure of the facility, organizational culture. A single framework could only be used as a guide. Hospital managers should be allowed to adjust their organizational charts in order to achieve their budgetary goals, create networks with other hospitals and other providers, and to achieve economies of scale and speed, in so far as hospital managers are capable to do so. We will return to this point.

Devolving such "power" to the hospital level brings up a relevant management problem which has to do with the existing co-management square in Greek public hospitals. In all world renowned hospitals, there is an open dialogue between management and the leadership of the medical community. These two sides of the square, which exist in all hospitals, share common organizational values and goals and strive for clinical excellence within a financially disciplined environment. This discussion is necessary due to the knowledge imbalance discussed earlier. It is a cliché but it is also true that hospitals are not factories vis a vis they cannot standardize their production processes the same way that a car manufacturer can. Improved coordination, however, is still required in order to achieve economies of speed in hospital output. At the same time, a physician cannot practice medicine the same way his/her predecessors did half a century ago. A modern hospital environment is needed and such an environment needs sustainable financial health. This discussion is being developed in many Greek public hospitals as well. As a result of political party penetration in almost every aspect of Greek public management, however, one also observes the two other sides of the co-management square; unionized physicians and unionized employees. In fact, representatives of both entities have a seat on each governing board by law. The penetration of public management by both party and union interests is the norm in Greece

(Carpenter, 2003). The consequences of this penetration are evident in the lack of accountability in performance results throughout the health sector prior to the memorandum with the troika.

Party penetration is however, evident not only in the union movement but also in selecting hospital managers and members of governing boards. The problem exists when the criterion of party membership supersedes the criterion of proven management ability. In these cases, one is not accountable to one's Board or to society but to the party.

In sum, due to the problematic operational parameters that were mentioned, the organizational model of Greek hospitals is characterized by very little horizontal coordination, and very little standardization of procedures. Problems are not solved as close to the level where they are created but rather are forwarded to the highest hierarchical levels in order to avoid accountability. Finally, staff gets addicted to this non accountability culture of not servicing internal or external clients which eventually leads to an overall decline of the entire institution.

### 3.1.3 Human resources management

The most efficient utilization of human resources is of paramount importance in achieving any desirable result in health care management, especially during an economic crisis where the available financial resources for health care are rather scarce. Analysts have shed light to the *"black box" relationship between HR and firm performance, always emphasizing the integration of strategy implementation as the central mediating variable in this relationship (Becker and Huselid, 2006). The evaluation of human resources, however, seems conspicuously absent from the Greek health policy agenda.* The problems in human resources management focus on the following four parameters: delayed processes of choosing staff, lack of substantive staff evaluation, a culture of non-accountability, and a steamroller horizontal approach to reward or punishment. Further analysis of the parameter is not required. The management of human resources is a broader issue that should concern not only the health care sector but the entire public sector.

### 3.1.4 Hospital financing-Hospital cash flow

Until recently, the structure of the financing scheme of the Greek health care system was a source of bureaucracy costs since there were more than thirty social security funds, numerous ministries involved in the pricing and costing of different goods and services, as well as many others in the approval of ordering, purchasing and paying for such goods and services. It is self-evident that timely and adequate financing is the engine of any corporation (public or private). And since resources are rather scarce, an appropriate cash flow must be ensured which would in turn lead to cost savings from the current waste without jeopardizing the quality of care. Hospitals are not allowed to charge freely for their services following negotiations with insurance funds. At the same time, many medical procedures remain without central prices and the ones that had been priced had not even adjusted for inflation since the early 1990s. Couple that with the huge bureaucracy cost of submitting payment forms in different ways for different social security funds, of the numerous relevant inspections as well as of the convoluted and strict procurement process which in turn leads to delays in finalizing the different tender procedures and signing contractual agreements with suppliers, and the bleak picture is complete. The norm is that the hospitals (which are closely monitored by the Ministry) frequently face financial difficulties due to delays in payments by social insurance funds. Even during periods of economic growth, such payments were delayed up to five years from certain funds. This lack of liquidity led in turn to delays in the payments of suppliers who in turn overpriced their goods and services to account for the financing cost. This entire business

relationship is unhealthy, allows much room for corruption, is systemically flawed and needs to be fundamentally altered. Many reforms of the past two years aimed at this target.

## 4. The memorandum with the troika

**I**n the past two years, the global economic crisis has led to intense and negative ramifications on the Greek economy overall and its health care sector in particular. The sector was not however prepared in any fashion to face such a crisis and therefore health care has been a core focus of the troika's agenda. Under the pressures of the memorandum signed by the country and its lenders, many reforms have taken place greatly improving the overall conditions, especially in terms of the economic survey and the financial result of hospital management. Measuring the financial performance of the system was in fact the immediate priority since the achievement of this self-evident goal was the only means to promoting further improvements to the system. It is not therefore surprising that in terms to the four themes analyzed earlier, the Ministry's efforts focused primarily on the fourth theme dealing with the financial management and cash flow of hospitals.

### 4.1 Medical subjectivity

The cultural transformation that the medical profession needs to undergo to overcome medical subjectivity and practice medicine in a collaborative fashion requires both financial and clinical information. There has not been a significant and systematic effort to either collect the clinical data required or to engage the medical community in such a process. Overall, one can safely conclude that given the surrounding financial environment, such a project was not a top priority. From a normative perspective, one could safely argue that there was enough waste in the system to allow for policy makers to ignore this parameter in the first instance. It remains, however, the key reform necessary in moving forward.

### 4.2 Obsolete management model

There were a number of reforms that took place between 2010 and 2012. The main goals were the optimum allocation of inputs, the most effective utilization of scarce resources and finally the more efficient performance of hospitals. There were a number of mergers - the 131 hospitals in 2010 were reduced to 81, the hospitals that were run by the main social security fund IKA also merged into the NHS, hospital beds were reduced from 46,783 to 36,035 and new organizational charts were proposed by hospitals (MHSS, 2011). These actions, however, neither changed the single organizational hospital framework nor increased the management autonomy of hospitals. The co-management square which we analyzed earlier was also not targeted by any actions and is to date one of the main problems in the daily routine of a public hospital.

### 4.3 Human resources management

Given the economic crisis, the social tensions that arose from it and the political history of the current political system, human resources issues were handled in two basic ways: (a) Horizontal wage cuts for salaried personnel of all levels and (b) attempts to replace as many of the staff that left the system due to retirement.

And whereas 600 physicians and 4,000 nurses entered the workforce in 2011 (MHSS, 2011), the difficult and pressing questions in human resources management were not tackled. No actual measures were taken towards introducing personnel accountability, measure performance, and link such performance to a rewards (positive or negative) system. It is yet another piece of evidence both of the ways that the political development of public management in Greece has led to great imbalances that require major changes and of the institutional resistance to such changes.

#### ***4.4 Hospital financing-hospital cash flow***

As mentioned earlier, this is the one area that was a priority on the political agenda and where most reforms took place. Admittedly, positive results can be claimed in this area. In terms of both the financial but also the operational management of hospitals, targets were set, a data standardization and evaluation process was introduced, and most importantly the communication between the ministry and hospitals were based on data and actual hospital performance. Some of the systems improving reforms in this arena, as reported by the Ministry of Health (MHSS, 2011) include: (a) The publications of balance sheets for all hospitals and the introduction of the double-entry accounting system, alongside the settlement of hospital debts for the 2005-2009 period, (b) the improvement of the procurement process with new public tenders being held for the first time in the past five years, (c) the introduction of unified diagnosis coding (ICD-10) and a new system of hospital reimbursement based on diagnosis related groups. Perhaps, the most significant measure was the development of a database at the Ministry (ESY.net) where financial information from all hospitals was analyzed on a monthly basis.

These efforts resulted in overall reductions in the main hospital expenditures by 21.22% in 2011. The greatest decrease was observed in surgical materials (-40.8%), followed by the reduction of hospital pharmaceutical expenditures (-23%), laboratory agents (-16%) and finally consumables (-14.7%). At the same time, and to a great extent because of the economic crisis, the number of patients who entered the public health care system increased by close to 10% in both years (2010 and 2011 compared to the previous year). Average cost per patient decreased from 1,228 Euros in 2010 to 1,057 Euros in 2011 (ESY.net, 2011). A criticism has been raised that in the context of recession and austerity, efficiency (measured as health spending per life-year saved) will generally increase as spending is lower and hospital admissions rise, making it an incomplete measure of the performance of the health-care system. Such criticisms, however, miss the key point. The key point has to do with the ability or the lack thereof of the management to even collect primary data, let alone reach measurement of analytical variables. Analysts have often pointed out the marginal role and the low significance that accounting has had in the operations of the Greek national Health System and attribute it to the historically high politicization that characterized the system that placed emphasis not on the managerial dimensions of running public bureaucracies but rather favored political evaluation criteria for public management (Ballas et al, 2004). A strong foundation has therefore been laid that the system can build upon in the future. When one compares the lack of management information systems, the enormous amounts of hospital debts, the lack of public tenders, the overall non-accountability culture that hospital management exhibited up to 2010, these reforms can be judged as the most significant ones in health care in the past twenty years.

A final note should be added for the introduction of DRGs in late 2011. A number of technical problems have characterized this effort. It is essential to understand that the movement from a fee for service system to a DRG system is essential for the financial health of the system. It allows room for hospitals (public and private) to compete with one another for more efficient production

of quality services. It is critical in any attempt to level the playing field. The direction has to be towards improving these DRGs, adjust them to the true costs of Greek health care and utilize them to promote accountability in the system.

## 5. Moving forward

**A**s important as streamlining the financial performance of hospitals is, it is not merely enough and it is certainly not sustainable if it is not accompanied by interventions in the other three areas of consideration.

### 5.1 Medical subjectivity

Overcoming medical subjectivity and moving towards a more collaborative fashion of medical practice is the direction that the system needs to move towards (Lee, 2010). This requires the collection of both clinical and financial data, the creation of links between the two and the measurement of performance of each provider. For all practical purposes the system needs to move towards a system of dynamic clinical case management whereby a collaborative process of assessment, planning, facilitation, care coordination, and evaluation of medical treatment is instituted. In such a model, hospitals will have to develop ways to measure clinical effectiveness and to link it to financial information on a case by case basis. International clinical protocols should be utilized and scientific accountability for treatment needs to become the norm. Medical boards, especially in areas such as oncology need to be instituted which in turn should assist in compliance of indications in terms of diagnostic procedures, interventional procedures and pharmaceutical treatment.

Such protocols need to be dynamic because medical care is highly innovative, and medical innovation generates considerable uncertainty. That famous gold standard, the randomized controlled trial, is the beginning, not the end of definitive evidence, much of which accumulates in the course of clinical applications (Gelijns and others, 1998). While researchers meticulously gather the evidence on which evidence-based medicine reposes, myriad new drugs, devices, and procedures make their appearance, and evidence on existing ones changes with clinical experience, leaving clinical managers perpetually a chapter or two behind the class. Evidence – and evidence-based medicine – have indeed grown and continue to do so dramatically, but uncertainty grows faster (Brown, 2006). Equally important is that the way doctors think needs to encapsulate the possibility of the exception to a well-known best practice that is based on evidence (Groopman, 2008). Therefore, a new equilibrium must be formed which would allow on the one hand for the flexible application of these protocols and at the same time would account for scientifically justified exceptions to such protocols.

### 5.2 Obsolete management model

The reduction of medical subjectivity is closely linked with improved efficiencies and clinical effectiveness. This will not, however, suffice if the management paradigm of Greek hospitals does not change to a paradigm of quality. Such a paradigm would in turn require amendments to hospitals' organizational charts that will not utilize the number of a facility beds but rather the output of each facility (Ronen, 2006), clear operational manuals with policies and procedures that will be binding at the hospital level alongside job descriptions which cannot be a matter of negotiations with unions.

The selection of Hospital managers must be performed by either a headhunter or by a special task force which will not be prone to party politics and these managers will in turn create two management teams. The first will be comprised by the Chief Executive Officer (CEO), the Quality controller, the Chief operations Officer (COO), the Chief Financial Officer (CFO), the Chief Medical officer (CMO), the Facility Manager, the Chief Nursing Officer (CNO) and the Chief Information Officer (CIO) and will be responsible for the strategic plan of the organization. The second will be the scientific committee of the hospital and would be comprised of section heads under the leadership of the CMO. It should not be a result of election procedures and will serve as an advisory Board to the executive team in scientific matters.

### ***5.3 Human resources management***

As mentioned earlier, human resources management transcends all arenas of Greek public management and is in the core of any kind of substantive reform effort. The required actions need to aim towards a new work ethic where performance evaluation and the creation of incentives and disincentives for staff would be the norm. In short, the selection and allocation of staff should be dependent on a clinic's productivity and clinical effectiveness and not based on a static number of allocated beds. The merger of low productivity departments needs to also be considered. The hospital hierarchy must be restored both within the individual department level but also in the entire organization. "Business Contracts" with explicit goals that are measurable ought to form the basis of human resources management. Staff evaluation, granting of tenure as well as participating in reward programs should be linked to the employee performance within such contracts. Furthermore, each hospital should be responsible for extending and/or removing "admission rights" from physicians that are non-tenured.

### ***5.4 Hospital financing-Hospital Cash Flow***

As mentioned earlier, the engine to any operation including the production of health care is the financial stability of the institution vis a vis the sufficient financing in a timely manner. This can be based on the introduction of information systems in all operational aspects (Procurement, Diagnosis, Pricing etc.), the transformation of the public procurement process towards a centralized model with a well-developed logistics system and last but not least the improvement of DRGs alongside the introduction of "pay for performance" schemes.

Numerous studies dating back even to the mid 1980s have shown that the introduction of DRGs must be closely monitored since it can potentially lead to an exacerbation of hospital cost inflation (Wennbero, et al., 1984; Rosenthal, 2007). Losses in hospital revenues resulting from the DRG payment system could be offset if physicians and providers in general modified their admission and practice policies to produce more profit, well within the current limits of medical appropriateness. There are a number of analyses in the literature in relation to medical upcoding, changes in admission practices (Wennbero, 1984), and decreased quality of care (Rosenthal, 2007). Effective control of such parameters must be on the radar of health policy makers moving forward with the DRG system. Furthermore, this system is a dynamic one and the DRG costs must be adjusted annually to account for risk, utilization rates etc. Moreover, if a procedure is not covered, the cost should be passed on to the patient (either via private supplemental insurance or out of pocket). Finally, the gradual introduction of pay for performance bonus system whereby hospitals with good quality (both clinical and financial) indicators would receive additional funds should enhance hospital efficiency in the utilization of scarce resources.

Many analysts have presented the need for the introduction of such quality measures both in the Greek health care system (Theodorakoglou et al, 2000) and abroad (Jencks et al, 2009; Widner et al, 2008). The gradual introduction of quality measures which would range anywhere from simple measures such as aspirin or beta inhibitors at arrival all the way to more complex ones such as 30-Day All-Cause Risk Standardized Readmission Rate Following Heart Failure Hospitalization (Hospital Quality Alliance, 2012) should go a long way to altering the management culture of Greek hospitals. And since public hospitals will continue to be pressured to improve their operations both in terms of resources they use and also in terms of the quantity of their outcomes, a pay for performance bonus system should account for improved efficiency results. The assessment of "good players" should entail both the notions of technical and allocative efficiency as they yield complementary information about the management effectiveness of individual hospitals (Athanasopoulos and Gounaris, 2001). Such information would refer to the degree of utilization of production factors, to the particular weight of each factor of production in the formation of the relative efficiency score, to the utilization level of each factor of production, and to those hospital units that utilize their factors of production in an optimal way and constitute models for the exercising of effective management (Katharaki, 2007).

## 6. Conclusion

The management of the hospitals (defined as the attempt for optimum performance via appropriate cycles of planning, deciding, evaluating, and reviewing), transcends all the functional parameters of the production and provision of health services. Tomorrow's public hospital in Greece demands a new managerial approach. This approach would sufficiently answer to the main four problematic conundrum of today: the perverse unaccountability of medical subjectivity, the obsolete management model, the lack of human resources management tools and the unhealthy financing of hospitals. Tomorrow's hospital would respect the autonomy of the medical profession while at the same time would demand scientific accountability, would utilize modern organizational tools to manage its human resources in order to produce effectively and efficiently quality services and finally would measure its performance on a case by case basis.

## Bibliographical references

- Archer K., MacKenzie E., Bosse M., Pollak A., Riley L., (2009), "Factors Associated With Surgeon Referral for Physical Therapy in Patients With Traumatic Lower-Extremity Injury: Results of a National Survey of Orthopedic Trauma Surgeons", *Physical Therapy* vol. 89 no. 9 893-905.
- Athanasopoulos A., Gounaris C., (2001), "Assessing the technical and allocative efficiency of hospital operations in Greece and its resource allocation implications", *European Journal of Operational Research* vol. 33, Issue 2, p.p. 416-431.
- Ballas A., Tsoukas H., (2004), "Measuring Nothing: The Case of the Greek National Health System", *Human Relations* vol. 57(6), 61-69.
- Becker B., Huselid M., (2006), "Strategic Human Resources Management: Where Do We Go From Here?", *Journal of Management* vol. 32 no. 6 898-925.
- Braithwaite J., Goulston K., (2004), "Turning the health system 90° down under" *The Lancet* vol. 364, Issue 9432, p.p. 397-399.

- Brown L.D., (2006), "Policy fixes, public funds, and political frustration", *Revue française des affaires sociales*, 2006/6 no 6, p.p. 315-329.
- Carpenter M., (2003), "On the Edge: The Fate of Progressive Modernization in Greek Health Policy" *International Political Science Review* vol. 24 no. 2 p.p. 257-272.
- Clance C., (2009), "One Decade after To Err is Human" *Patient Safety and Quality healthcare*, p.p. 8-10.
- Dartmouth Atlas of Health Care, [www.dartmouthatlas.org](http://www.dartmouthatlas.org).
- Economou Ch., (2010), "Greece: Health System Review. Health Systems in Transition" *European Observatory on Health Systems and Policies* vol. 12, no. 7.
- Ellerbeck E., Engelman K., Williams N.J., Nazir N., Markello S., (2004), "Variations in Diabetes Care and the Influence of Office Systems", *American Journal of medical Quality* vol. 19 no 1 12-18.
- Fiscella K., Franks P., Gold M., Clancy C., (2000), "Inequality in Quality" *JAMA* 2000;283(19): 2579-2584.
- Freburger J., Holmes G., (2005), "Physical Therapy Use by Community-Based Older people", *PT Journal* 85:19-33.
- Gelijns A.C., Rosenberg N., Moskowitz A.J., (1998), "Capturing the Unexpected Benefits of Medical Research" *New England Journal of Medicine* vol. 339(10):693-698.
- Groopman J., (2008), *How Doctors think*, Boston and New York. A Mariner Book, Houghton Mifflin Company.
- Hellenic Ministry of Health. Esynet health data 2012. Athens: Ministry of Health, 2012.
- Hospital Quality Alliance (2012), [www.hospitalqualityalliance.org](http://www.hospitalqualityalliance.org)
- Institute of Medicine, (2000), *To Err is Human*, Washington DC National Academy Press.
- Jencks S. et. al., (2009), "Rehospitalizations among Patients in the Medicare fee for Service Program", *New England Journal of Medicine* vol 360, 1418-1428.
- Katharaki M., (2007), "Approaching the management of hospital units with an operation research technique: The case of 32 Greek obstetrics and gynaecology public units" *Health Policy* vol. 85 (1), 19-31.
- Kyriopoulos J., Tsalikis G., (1993), "Public and Private Imperatives of Greek Health Policies" *Health Policy* vol. 26(2):105-17.
- Lee T., (2010), "Turning Doctors into Leaders" *Harvard Business Review* vol. (4) p.p. 51-58.
- Liaropoulos L., Tragakes E., (1998), "Public/private financing in the Greek health care system: Implications for equity" *Health Policy* vol. 43, Issue 2, Pages 153-169.
- MHSS (2011), *Report to Troika*, Athens, Ministry of Health and Social Solidarity.
- Maarse H., (2006), "The Privatization of Health Care in Europe: An Eight-Country Analysis Journal of Health Politics" *Policy and Law* 31(5): 981-1014.
- Matsaganis M., (2011), "The Welfare State and the Crisis: The case of Greece" *Journal of European social Policy* vol. 21 no. 5 501-512.
- Meredith B., Rosenthal M.B., (2007), "Nonpayment for Performance? Medicare's New Reimbursement Rule" *N Engl J Med*, 357:1573-1575.



- Minogiannis P., (2003), *European Integration and Health Policy: The Artful Dance of Economics and History*, Transaction Press. New Brunswick NJ.
- Mossialos E., Allin S., Davaki K., (2005), "Analyzing the Greek health system: A tale of fragmentation and inertia" *Health Economics* 14:151-168.
- Nikolentzos A., Mays N., (2008), "Can existing theories of health care reform explain the Greek case (1983-2001)?" *Journal of European Social Policy* vol. 18 no. 2 163-176.
- OECD, *OECD health data 2010*, Paris: OECD, 2010.
- OECD, *OECD health data 2008*, Paris: OECD, 2008.
- Oikonomou N., Mariolis A., (2009), "Three trends that undermine the Greek health system: is there a way out?", *Eur J Gen Pract*, 15: 67-68.
- Oikonomou N., Tountas Y., (2011), "The Greek economic crisis: a primary health-care perspective" *The Lancet*, vol. 377(9759), p.p. 28-29.
- Oliver A., Mossialos E., (2005), "European Health Systems Reforms: Looking Backward to See Forward?", *Journal of Health Politics, Policy and Law*, vol. 30, Number 1-2: 7-28.
- Ronen B., (2006), *Focused Operations Management for Health Services organization*, Jossey-Bass. San Francisco.
- Schmid A., Cacace M., Götze R., Rothgang H., (2010), "Explaining Health Care System Change: Problem Pressure and the Emergence of "Hybrid"" *Health Care Systems Journal of Health Politics, Policy and Law* 35(4): 455-486.
- Siskou O., kaitelidou D., Papakonstantinou V., Liaropoulos L., (2008), "Private health Expenditures in the Greek health care system: Where truth ends and the myth begins", *Health Policy*, vol. 88 (2-3), 282-293.
- Theodorakioglou Y., Tsiotra G., (2000), "The need for the introduction of quality management into Greek health care", *Total Quality management* vol. 11 (8), 1153-1165.
- Tountas Y., Karnaki P., Pavi E., (2002), "Reforming the reform: the Greek national health system in transition" *Health Policy* vol. 62 (1), 15-29.
- Tountas Y., Stefansson H. and Frissiras S., (1995), "Health reform in Greece: Planning and implementation of a national health system" *Int. J. Health Plann. Mgmt.*, 10: 283-304.
- Tountas Y., Karnaki P., (2005), "The "unexpected" growth of the private health sector in Greece" *Health Policy* 74: 167-180.
- Weiss K., Wagner R., (2000), "Performance Measurement Through Audit, Feedback, and Profiling as Tools for Improving Clinical Care" *CHEST* vol. 118 no. 2 suppl 53S-58S.
- Wennberg D., (1998), "Variation in the Delivery of Health Care: The Stakes Are High", *Ann Intern Med* vol. 128:866-868.
- Wennberg J., Gittelsohn A., (1973), "Small Area Variations in Health Care Delivery A population-based health information system can guide planning and regulatory decision-making" *Science* vol. 182 (4117), p.p. 1102-1108.
- Wennbero J., John E. McPherson K., Caper P., (1984), "Will Payment Based on Diagnosis-Related Groups Control Hospital Costs?" *N Engl J Med* 311:295-300.
- Widner T., Gallant M., (2008), "A Launch to Quality" *Quality Progress* vol. 2, p.p. 38-43.

**Dermot Hodson,**  
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Oxford University Press , Oxford 2011

Since the onset of the sovereign debt crisis in Europe, some observers and policy makers alike have argued that the solution to the current crisis may be to deepen economic policy coordination in order to save the euro while other observers are much more negative and they argue that the euro is doom to fail. This book sheds some light to this debate by assessing the governance of the Economic and Monetary Union (EMU) from the launch of the Euro in 1999 until the emergence of the sovereign debt crisis in 2010.

The author starts by reminding readers that EMU represents a significant departure point from the traditional EU decision making process, the Community method, in which the Commission makes a proposal and the Council and the European Parliament debate on it. Under EMU, monetary policy is delegated to a newly created supranational institution, the European Central Bank (ECB), which has the first and final say over the definition and implementation of monetary policy. By contrast, economic policy relies on a decentralized approach in which Member states are ultimately responsible for implementing their own economic policies. Member state must, however, follow the broad economic policy guidelines (BEPG) set out by the Commission and the Stability and Growth Pact (SGP). However, countries that breach these goals face no more than non-binding recommendations for the most part, although financial penalties and fines can be employed in extremis.

The book aims to answer three specific questions surrounding the current debates about the governance of the euro area in particular and the EU in general: Is the single currency sustainable in the absence of a more centralized approach to economic policy? What conclusions can be drawn from EMU about the search for alternatives to the Community method? What lessons can be learned from the euro area's external relations for the EU's ambitions to be a global actor in its own right? To answer these questions the book starts by first focusing on the role of the ECB and the Eurogroup. It then analyzes the role of the Stability and Growth Pact and the BEPG. Finally, it looks at the external impact of EMU in the G20 and IMF decisions and in EU bilateral dialogues on macroeconomic policy with emerging economies.

Regarding the ECB the author finds that, contrary to some rational choice literature that argues that EU institutions are "competence maximizers" and thus would prefer more Community method in policy making, the ECB has proved to be reluctant do so. The reason for this, it is argued, is that the Bank's preference for "more Europe" is contingent on its overriding commitment to price stability. The author justifies these findings by looking at the cases of anti-fraud policy, the ECB views on the debates for establishing a Constitution for Europe between 2002 and 2003 and the role of the bank towards financial supervision and further economic policy coordination. Regarding the latter, one of the most interesting findings is that ECB officials appear to be against further economic governance where this is perceived to be a threat to price stability. This is consistent with the author's findings regarding the other institution tailor-made for the euro-area, the Eurogroup, composed of euro area finance ministers. In this case, the ECB has been systematically against providing this group with more oversight on economic policy coordination because of fear that this would threaten price stability.

While the findings regarding the ECB and the Eurogroup are interesting, the author does not clearly explain his selection of the cases used to illustrate the findings. This may lend itself to some questions regarding the applicability of the findings.

The chapters dedicated to the Stability and Growth Pact and the Broad Economic Policy Guidelines are one of the most interesting in the book as the author challenges some well-established institutional analyses that claim there is a specific link between electoral regimes and budget outcomes. Specifically, analysing the Stability and Growth Pact, the author finds that while political institutions affect budget institutions, it is not always true that member states electing single-party majorities that tend to “delegate” control of the budgetary process to powerful finance ministers have a harder time to comply with fiscal discipline than countries that elect broad coalition governments and that must rely on numerical rules or other types of “contracts” to enforce fiscal discipline.

While the author agrees that, in general “contract” states fare better in respecting the rules of the Stability and Growth pact, as he shows in the case of the countries that triggered an Ecofin recommendation to end excessive budget deficit, he argues that some cases do not fit nicely in this picture. He illustrates this point by highlighting the cases of Spain, Ireland and Austria, typical “delegation” states that achieved a remarkable degree of compliance with the Stability and Growth Pact rules from the late 1990s until the onset of the current financial crisis in 2007. The author argues that a possible explanation to this “puzzle” is that “delegation” states that had more stringent fiscal rules had a better time to comply with the Stability and Growth Pact. Using data from the Commission’s index of fiscal rules he finds some support for his claim as the data shows an increase in the scores for the three countries since the late 1990s, especially in the case of Spain.

One insight from this chapter, and that the author forgets to mention, is that there could be room for further econometric analyses, which could better test his assumption that domestic stringent fiscal rules may have an impact on member state compliance with the EU fiscal rules. This would provide further evidence and insight for the growing literature on domestic institutions and budget outcomes.

The chapter on the Broad Economic Policy Guidelines (BEPG) is equally significant regarding the insight that it provides. The author finds that such economic guidelines, which are overarching objectives for the economic policies of member states adopted by the Economic and Financial Affairs Council (Ecofin) upon recommendation from the European Commission, suffer from serious structural shortcomings. First, they lack a credible sanctioning institution. While the treaty article regulating the BEPG stipulate that member states should exercise “peer pressure” and make non-binding recommendations to other members who breach the BEPG, in practice policy makers have not wanted to issue such recommendations for fear of triggering a political backlash. Similarly, there is quite a lot of uncertainty regarding the specific content of such non-binding recommendations. Finally, BEPG sanctions may have little currency in domestic political arenas unless the Government’s opposition forces support such sanctions.

The author illustrates his findings by using the case of Ireland in 2001, when the Ecofin criticized the Irish budget for pushing tax cuts and capital expenditure increases that were seen as not necessary given the benign economic environment. This move generated a political backlash in Ireland with the finance minister criticising the move and receiving strong popular support. Equally, the Commission’s reprimand of Greece for breaching the BEPG in February 2010, unleashed a significant wave of strikes and protests. However, in this latter case, it is not completely clear whether the wave of strikes and protests were generated by the Greek Government’s decision to freeze wages or by the Commission’s actions.

Notwithstanding some shortcomings, the main insight of this chapter is that other “peer pressure” mechanisms, most notably the Open Method of Coordination, lack from the same problems regarding sanctioning criteria and lack of participation by key stakeholders for fear of generating a political backlash. This may point towards the need for more comparative research that illustrates on cases in which the BEPG and the OMC have been used.

The last two chapters analyse the role of the EMU at the international level. The main issue here is that the treaties that led to EMU are unclear in specifying who is in charge for EMU’s external representation. The main finding of the chapters is therefore that in cases in which there is agreement among member states in international forums, EU members states have been successful in forging an international consensus on policy responses to the current financial crisis, such as in the meetings of the G20. By contrast, the case of Greece since 2010 illustrates that deep disagreement among euro-area members made necessary to call the International Monetary Fund (IMF) to rely on its “expertise” in dealing with countries’ fiscal crises. While the author is right in pointing out that euro-area members, especially France and Germany, have had a significant degree of influence in the package of measures negotiated since 2010 with Greece, this case also marks the limits of EMU influence at the international level.

The author is perhaps too quick to conclude that EMU’s decentralised approach to economic policy coordination is here to stay. In this sense, it may be interesting to discuss further the European Commission’s proposals on EU economic governance drafted in 2010. While this is still a subject of negotiation, the author is right in pointing out that the proposals do not alter the EMU’s decentralised approach to economic policy since member states will still be in charge of implementing economic policies. The main difference is that the proposals set out more stringent budget requirements than in the SGP. In addition, they even contemplate some pecuniary sanctions against non-complying member-states. However, given the recent failure of some member states to comply with the SGP and the reluctance to use peer pressure mechanisms such as those contemplated in the BEPG and the OMC, as illustrated in the book, how likely is that the new set of rules for economic policy coordination will work? More broadly, how likely is EMU to weather successfully the current financial crisis that has affected some of its members and put them on the verge of exiting the Euro?

Overall, this book is well structured and the chapters seem to address well the research questions set out at the beginning. The author relies on a significant amount of well selected primary and secondary sources and the book is a good contribution to the academic literature on the functioning of the EMU since the launch of the Euro. As such, it will be of interest to academics and practitioners interested in the role of EMU institutions and economic policy coordination in euro-area countries.

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of anti-poverty policies in France and Germany,*  
VS Verlag Fuer Sozialwissenschaften, Wiesbaden 2008

**I**n the context of the current economic and financial crisis, the debate at EU level revolves primarily around the economic governance architecture, crisis management and prevention in the euro-area, while the 'Europe 2020' strategy and its social goals have been put on the side-lines. Yet, it was only a decade ago –with the launch of the Lisbon strategy- when EU leaders were inaugurating a new era for European social policy. A basic component of the (then new) strategy was the Open Method of Coordination (OMC), a new governance tool based on the moral and political commitment (in contrast to the traditional Community method) and the voluntary collaboration of actors participating in the process. Despite the concerns raised in relation to its actual impact at national level and its strength as an instrument of Europeanisation, the significant number of publications on the subject –inversely related to its actual weight one could argue- allow us to draw conclusions on the method itself. More importantly, though, these analyses provide useful insights as to the future direction of social policy which could be of particular relevance and importance in the present context.

The book of Sandra Kröger focusing on the OMC in the field of social inclusion provides an insightful contribution to the OMC literature. Based on extensive variable-based research, Kröger aims at assessing the extent at which the OMC/inclusion has contributed to the goals of effectiveness (through mutual learning and monitoring) and legitimacy (through the participation of all relevant stakeholders) in France, Germany and at EU level through an examination of its implementation. The book comprises seven chapters. The first –introductory- one presents the poverty debate at EU level and the way this has been framed over the years through a narrative of the major steps in the development of European social policy, while placing particular emphasis on the Lisbon process and the OMC. A brief reference is also made to the main actors involved in the process (both state and non-state ones). The second chapter discusses questions of effectiveness and legitimacy (central to the book's analysis) by placing them in the framework of the different theories regarding the evolution of the European integration process. The third chapter presents the research framework of the book. It starts by highlighting the shortcomings of the OMC literature and proceeds in the operationalization of effectiveness and legitimacy (in the context of the OMC) through a set of evaluation criteria (namely the precision of information; the organizational capability building; monitoring; receptivity of the OMC by involved actors; representation; accountability). The chapter also provides a justification for the choice of policy field and of the countries under study. In relation to the latter, Kröger supports her choice –which has been missing from the introductory chapter- on the basis of the 'most different case design'; as argued by the author 'France and Germany are guided by different rationales, norms and institutions, rendering the comparison of the two member states a worthwhile enterprise'.

The following three chapters-constituting the core part of the book- focus on the implementation of the OMC/inclusion at national and EU level as well as its evaluation by the actors involved in the process. An in-depth analysis is provided based on the evaluation criteria set in the previous chapter. Notwithstanding the differences found in the implementation of the OMC/inclusion in the countries under study, the analysis leads to a rather pessimist conclusion with

regard to the method's capacity in the Europeanisation of anti-poverty policy, leaving negative integration unchallenged while foreclosing the possibility of supranational learning, despite its intentions. The final, concluding, chapter summarises the main findings drawn from the previous analysis. The resistance on the part of member states regarding the development of a European anti-poverty policy (corroborating the findings of other research regarding the limitations of the OMC) helps to explain the limited dynamics and the draw back during the revision of the Lisbon strategy. As Europeanisation is a two-way process limited uploading also meant limited downloading, even though EU-level dynamics have been stronger when compared to those at member state level. Overall, the book offers a well-researched comparative analysis of the OMC in France, Germany and EU-level.

With the benefit of the hindsight, as the book has been published in 2008, the issues raised in relation to the political economy of the OMC/inclusion and the EU more broadly acquire particular importance. The concern expressed by the author regarding the OMC's inability to contribute to the Europeanisation of anti-poverty policies, thereby diverting the attention away from a discussion on the structure of welfare states have resulted in social issues being further marginalised in the context of the current crisis and the dominance of the economic discourse at a time when Europeans are in need of a stronger and not weaker welfare state.

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**Δημοσθένης Β. Παναγιωτάκος**  
**Μεθοδολογία της Έρευνας**  
**& της Ανάλυσης Δεδομένων**  
**για τις Επιστήμες της Υγείας**  
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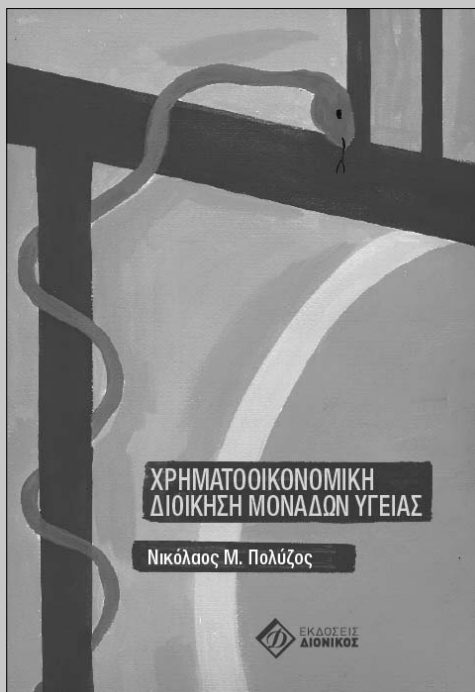
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Ο σωστός σχεδιασμός μιας έρευνας αποτελεί πλέον μια αναγκαιότητα παρά μια πολυτέλεια για τους επιστήμονες που ασχολούνται στο χώρο της Υγείας. Συγκεκριμένα, αποτελεί την σπονδυλική στήλη της σύγχρονης ιατρο-βιολογικής επιστήμης. Η μεθοδολογία της έρευνας υποστηρίζει την πρακτική εφαρμογή και προσφέρει νέες κατευθύνσεις, διευρύνοντας τους επιστημονικούς ορίζοντες και τη γνώση στο επιστημονικό πεδίο μια και επιτρέπει αντικειμενικές μετρήσεις από πολύπλοκα επιστημονικά πεδία και ποσοτικές εκτιμήσεις από τα αποτελέσματα των ερευνητικών διαδικασιών. Μέσω μιας μεθοδολογικά σχεδιασμένης έρευνας μπορούν να ελεγχθούν κλινικές και βιολογικές υποθέσεις, αλλά και να αξιολογηθούν τα προγράμματα της δημόσιας υγείας. Ο μεθοδολόγος της έρευνας μπορεί να χρησιμοποιηθεί για να τεκμηριώσει την πρακτική εφαρμογή, να καταγράψει τις ερευνητικές δραστηριότητες, να εγγυηθεί για την ποιότητα της έρευνας, καθώς και να μειώσει το οικονομικό της κόστος.



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**Η** απουσία εγχειριδίου ή άλλης μονογραφίας για το ζήτημα της Χρηματοοικονομικής Διοίκησης των Μονάδων Υγείας είναι ο κύριος λόγος που επέβαλε τη συγγραφή και έκδοση του παρόντος βιβλίου. Είναι πράγματι εκπληκτικό ότι σε μια χώρα όπου κυριαρχεί το κρατικό σύστημα υγείας και τα νοσοκομεία παίζουν πρωτεύοντα ρόλο δεν αναλήφθηκε έως σήμερα κάποια σοβαρή προσπάθεια να εκπονηθεί ένας αναλυτικός επιστημονικός οδηγός της χρηματοοικονομικής υποστήριξης του τομέα. Με αυτή την έννοια, ο παρών τόμος είναι το πρώτο βιβλίο του είδους του που κυκλοφορεί στην Ελλάδα.

Το βιβλίο έχει σχεδιασθεί για να συμβάλει στην οικονομική ανάλυση συστημάτων υγείας και κυρίως στην οικονομική διοίκηση των υπηρεσιών υγείας, με έμφαση στα νοσοκομεία. Αξιολογούνται οι βασικές αρχές, οι διαδικασίες και η γενικότερη λειτουργία και εφαρμογή προϋπολογιστικών, λογιστικών, κοστολογικών, τιμολογιακών, διαχειριστικών και πληροφοριακών συστημάτων και εργαλείων, για την πιο αποτελεσματική και αποδοτική οργάνωση των υπηρεσιών υγείας. Στόχος του είναι να συγκεντρώσει γνώση και εμπειρία, με σκοπό την ενημέρωση των σπουδαστών του αντίστοιχου αντικειμένου, των επαγγελματιών της Υγείας, γενικότερα όσων λαμβάνουν αποφάσεις στον τομέα αυτό, καθώς και όσων διαμορφώνουν σχετικά προγράμματα εκπαίδευσης.



## **ΟΔΗΓΙΕΣ ΠΡΟΣ ΤΟΥΣ ΣΥΓΓΡΑΦΕΙΣ**

Τα κείμενα υποβάλλονται στα ελληνικά ή στα αγγλικά. Οι συγγραφείς δεσμεύονται ότι δεν έχουν δημοσιεύσει ή υποβάλει προς κρίση τα άρθρα τους σε άλλο έντυπο. Σε περίπτωση δημοσίευσης παρόμοιου άρθρου, αυτό δηλώνεται από τον συγγραφέα. Υποβάλλονται τέσσερα ταυτόσημα κείμενα και ένα σε ηλεκτρονική μορφή στην επόμενη διεύθυνση του εκδότη.

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Τα άρθρα αξιολογούνται από δύο τουλάχιστον ανώνυμους κριτές. Το όνομα και τα άλλα στοιχεία του συγγραφέα, καθώς και ο τίτλος του άρθρου πρέπει να υποβάλλονται σε ξεχωριστή σελίδα από το κυρίως σώμα (τίτλος, κείμενο, βιβλιογραφικές αναφορές). Τα υποβαλλόμενα άρθρα πρέπει να συνοδεύονται από δύο περιλήψεις, όχι μεγαλύτερες των 100 λέξεων, και πέντε λέξεις-κλειδιά στα ελληνικά και τα αγγλικά. Η έκταση των άρθρων πρέπει να κυμαίνεται μεταξύ 6-8.000 λέξεων, συμπεριλαμβανομένων των περιλήψεων και αναφορών. Τα χειρόγραφα των άρθρων που απορρίπτονται δεν επιστρέφονται.

Για τις αναφορές χρησιμοποιείται το σύστημα Harvard. Οι αναφορές στο κείμενο περιλαμβάνουν το επώνυμο του συγγραφέα και το έτος έκδοσης της δημοσίευσης, π.χ. (Esping-Andersen, 1990, Kleinman and Piachaud, 1993). Οι άμεσες αναφορές πρέπει να δίνουν και τον αριθμό της σελίδας ή των σελίδων, π.χ. Ferrera et al., 2002: 230. Σε περίπτωση περισσότερων αναφορών του ίδιου συγγραφέα για το ίδιο έτος, πρέπει να χρησιμοποιείται η διάκριση με α, β, γ κ.λπ. για το έτος. Οι βιβλιογραφικές αναφορές (όχι βιβλιογραφία) καταχωρούνται αλφαβητικά στο τέλος του κειμένου. Παρακαλούνται οι συγγραφείς να επιμελούνται την ακριβή αντιστοίχιση των αναφορών του κειμένου με τον αλφαβητικό κατάλογο των βιβλιογραφικών αναφορών στο τέλος του κειμένου και το αντίστροφο. Η αναφορά σε βιβλία πρέπει να δίνει το όνομα του συγγραφέα, το έτος έκδοσης, τον τίτλο του βιβλίου, τον τόπο έκδοσης και την επωνυμία του εκδοτικού οίκου. Π.χ. Scharpf F., (1999), *Governing in Europe: Effective and Democratic?* Oxford: Oxford University Press. Η αναφορά άρθρων σε περιοδικά πρέπει να δίνει τόμο, τεύχος, σελίδες, καθώς και τον τίτλο του άρθρου σε απλά εισαγωγικά. Για παράδειγμα: Atkinson A.B., Marlier E. and Nolan B., (2004), "Indicators and Targets for Social Inclusion in the European Union", *Journal of Common Market Studies* 42: 47-75. Αναφορές σε κεφάλαια συλλογικών τόμων καταχωρούνται με τον τίτλο του κεφαλαίου σε απλά εισαγωγικά, ακολουθούμενο από τον συγγραφέα και τον τίτλο του συλλογικού τόμου. Π.χ. Leibfried, S. and Pierson, P. (1995) "Semi-sovereign Welfare States: Social Policy in a multitiered Europe", in: Leibfried S. and Pierson P., (eds), *European Social Policy: Between Fragmentation and Integration*, p.p. 43-77, Washington D.C.: The Brookings Institution. Οι τίτλοι των βιβλίων και περιοδικών γράφονται με πλάγια γράμματα. Συνιστάται οι επεξηγηματικές σημειώσεις να είναι οι ελάχιστες δυνατές. Εάν κρίνονται απαραίτητες, τότε πρέπει να αριθμούνται στο κείμενο και να παρατίθενται στο τέλος του άρθρου. Επίσης, στο τέλος παρατίθενται και οι τυχόν ευχαριστίες. Άρθρα που δεν συμβιβάζονται με τις παραπάνω οδηγίες επιστρέφονται στον συγγραφέα για την ανάλογη προσαρμογή.

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