CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

AUSTRIA

Answers provided by:
Mr. Nikolaus KOLLER, Federal Ministry of Health

	2000	2007	2012
1. Total health expenditure as % of Gross Domestic Product (GDP)	10.02	10.26	11.48
2. Percentage of public sector health expenditure on total health expenditure	75.64	75.82	75.56
3. Total expenditure on inpatient care as % of total health expenditure	39.1	38.9	40.2[1]
4. Private households' out-of-pocket payment on health as % of total health expenditure	15.14	15.34	15.2
5. All hospital beds per 100,000 inhabitants	794.78	775.23	767.73
6. Acute care hospital beds per 100,000 inhabitants	631.15	581.54	546.67
7. Acute care admissions/discharges per 100 inhabitants	24.66	26.63	25.94[1]
8. Average length of stay for acute care hospitals (bed-days)	7.55	6.79	6.55[1]
9. Practicing physicians per 100,000 inhabitants	385.33	453.79	489.75
10. Practicing nurses per 100,000 inhabitants	716.05	738.32	783.27

[1]*Data refers to year 2011*

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

The hospital sector has been affected by the growing budget constraints of the public sector as well as by governance measures towards restructuring and reorganization. Both led to resource conservation mainly in regard to human resources in hospitals and thus to high working pressure and continuous needs for internal reorganization. Hospitalization is getting shorter and the number of (acute-care) beds has been decreasing while the numbers of hospital patients has remained largely the same over the years. The promotion and incentives in order to increase the share of ambulatory care and day surgery in hospitals and the establishment of day clinics needed even more rethinking and reorganization (including new structural solutions). On a broader level, individual hospitals are increasingly being merged to multi-locational hospital associations, often combined with multi-locational care units, which require higher mobility of staff, especially physicians. These developments may be perceived as positive or negative effects depending on who is affected and on the given problem-solving potential (the smaller hospitals might face greater challenges than the larger ones). However, on the large scale and from a political point of view, respectively, the restructuring of the fragmented and small structured hospital sector has accelerated, thus contributing to the ongoing task to shape the Austrian healthcare system for the future challenges. A clearly positive development has been the intensification of the debate and focus on quality measures on all levels of healthcare, especially driven by the "Austrian Inpatient Quality Indicators (A-IQI)" project implemented three years ago which, for the first time in Austria, is dedicated to the measurement of the quality of care and its outcome.

- **What are the main challenges you are facing today?**

The still increasing scarcity of health professionals as well as financial resources constraints and the simultaneously increasing life expectancy combined with growing demands and expectations of patients and the population are major challenges not only for Austria but also for all European healthcare systems. Then, Austria needs to work on the implementation of the healthcare reform 2012/2013. Due to the EU Working Time Directive there are more physicians required for hospitals than the available ones. Many Austrian physicians migrated to other European countries, mostly Germany and Switzerland, due to the higher income. Currently, there are strong efforts undertaken to get them back by offering more attractive incomes, which, on the other hand, increases the constraints of public finances.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

A major trend can be observed as regards the rising demand for higher transparency on the quality of care. Another trend is the increasing specialization of health professionals, which requires centralization of complex care procedures. The current shortage of physicians will accelerate the process of structural adjustments in healthcare, affecting particularly smaller hospitals. Simultaneously, the provision of sufficient and adequate healthcare services of high quality on the local levels has to be maintained. What should happen is specified in the legal agreement between the major partners responsible for health and healthcare (the federal government, the regional governments – *Bundesländer* – and the social insurance) on the healthcare reform 2012/2013. The key element of the reform is a cooperative "governance by objectives" approach to achieve better coordination of the governance partners and to improve effectivity and efficiency in health care delivery while ensuring the long-term sustainability through expenditure containment. Therefore, accounting standards have been defined to better enable adherence to the budget cap. The goal of the agreed so-called "expenditure containment path" is to keep constant the ratio of public healthcare expenditures compared to total GDP which allows for continuous and steady expansion of services and avoid that tangible savings of public expenditure become necessary. One of the main topics of the reform is the strengthening of ambulatory care in general and primary healthcare in particular, regarding enhanced capacity as well as a larger scope of services with high (and measurable) quality. This should be achieved especially by establishing multi-professional and interdisciplinary outpatient care facilities, which are easily accessible (e.g. long opening hours) and are able to cover all kinds of basic healthcare from health promotion to acute care and rehabilitative care, with special focus on the care of chronic conditions. Another contribution to the implementation of this is the ongoing adoption of education and training curricula for health professionals in order to meet these requirements. Other elements of the reform are the standardization of care processes, the smoothest possible transition from one healthcare sector to another or to the social sector, and the establishment of pilot functions guiding patients as seamless as possible through the system. From the public health perspective, major tasks are the strengthening of health literacy and major improvements regarding the provision of independent and reliable information on health issues and the health system.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

DENMARK

Answers provided by:
Mrs. Eva M. WEINREICH-JENSEN, Danish Regions

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	8.7	10	11.2
2.	Percentage of public sector health expenditure on total health expenditure	83.86	84.4	85.54
3.	Total expenditure on inpatient care as % of total health expenditure	36.2[1]	37.2	37.9[5]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	14.68	13.96	12.62
5.	All hospital beds per 100,000 inhabitants	429.56	369.39	313.16[5]
6.	Acute care hospital beds per 100,000 inhabitants	350.46	299.23	253.61[5]
7.	Acute care admissions/discharges per 100 inhabitants	15.19	13.53	12.82[4]
8.	Average length of stay for acute care hospitals (bed-days)	3.8	3.5[2]	n.a.
9.	Practicing physicians per 100,000 inhabitants	291.17	340.4	348.44[3]
10.	Practicing nurses per 100,000 inhabitants	1,237.81	1,430.13	1,545.32[3]

[1] Data refers to year 2003; [2] 2005; [3]2009; [4]2010; [5] 2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

At the top of the list the global trend of demography has had an important say in how the health care has developed. More patients, living longer, having more complex and often chronic diseases, need more transparency and quality of care. These two factors combined together with the professionals' expectations enhanced the completion within providers and changed definitely healthcare and hospital environment. Over the last ten years, our answer in Denmark has been to increase centralization and specialization. This has had an effect on the numbers of hospitals, the structure of governance, quality, the role of the pre hospital system etc. Many hospitals were closed. This could be done because the professional argument became clear. Smaller hospitals did not match larger hospitals results generally. The outcome for patients was not always the best and changes were therefore required. At the same time, new hospitals were built. This choice suits better the current necessity on how health care services should be delivered as well as employees' job. For some years (long) waiting lists were a natural part of the Danish NHS and increasing the activity came as a natural response to this. The financial structure of hospital budgeting and the way Denmark reward the hospitals also paved the way for a higher activity. While hospitals were busy increasing the activity and reducing waiting lists, they somewhat lost sight of the actual outcome for the patients. But patient safety and patient rights, which now include the right to be diagnosed and treated within a specific timeframe, certain pathways for cancer, heart, psychiatric patients etc. are now a central piece for the new legislation and decision making: Denmark moved from a supply to demand focus, while increasing the activity and productivity at the same time.

- **What are the main challenges you are facing today?**

To integrate the health care with the social system is a main challenge that will demand a lot of efforts now and over the coming years. A small group of patients take up a large share of the health care system, and are also well represented in the social work departments. Inequality in health is a clear challenge and to solve or, at the least, reduce it, will occupy some resources in the future. The percentage of patients affected by cancer or chronic diseases is increasing, and hospitals and the healthcare system are challenged by this new reality. Denmark needs to find a solution for this new necessity. Furthermore, more and more treatments do not require hospitalization, but outpatient cares. This required more cooperation with other authorities. Patients' records should be digital and accessible in the whole health care system, not just in the hospital. At the same time it is necessary to protect the privacy and to grant transparency. This issue leads to a change in the culture: patients want to be more involved in their own treatment. And not just after the doctor has decided which is the right path to choose.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

The first action to put in place consists in involving more the patients. Personalized medicine and targeted treatment based on genome sequencing are now developing rapidly. Furthermore, patients are interested in having much more information on their own conditions after the treatments and, for this reason, it is important that they are involved in the decision making process. Their opinion could be used to learn and to develop new solutions. Another factor closely connected to this is how cares are integrated with the healthcare tasks the municipalities are in charge of. Patients expect to make the interacting work smoothly in one coordinated flow, where they do not have to pay too much attention to jurisdiction. A further challenge is the need to continue the development of the eHealth possibilities. Data play an important role because they allow professionals to register evidences and to implement standard procedures, independently from the hospital where the patient is treated. It is also desirable improving the connection between hospital and society in order to make the patients more active in the definition of their care as well as to prevent health problems.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

ESTONIA

Answers provided by:
Dr. Urmas SULE, Estonian Hospitals Association

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	5.28	5.1	5.94
2.	Percentage of public sector health expenditure on total health expenditure	77.42	76.46	79.92
3.	Total expenditure on inpatient care as % of total health expenditure	35.3	33.3	31.7
4.	Private households' out-of-pocket payment on health as % of total health expenditure	20	22.16	18.42
5.	All hospital beds per 100,000 inhabitants	717.63	547.75	566.38
6.	Acute care hospital beds per 100,000 inhabitants	554.94	375.87	363.82
7.	Acute care admissions/discharges per 100 inhabitants	18.66	16.67	15.81[1]
8.	Average length of stay for acute care hospitals (bed-days)	7.3	5.9	5.5[1]
9.	Practicing physicians per 100,000 inhabitants	319.16	325.71	336.54
10.	Practicing nurses per 100,000 inhabitants	595.32	639.87	632.17

[1] *Data refers to year 2011*

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

The health care workers collective agreement negotiations in 2012 were historic since this labour dispute led to the first Estonian health workers strike. Consequently, the Estonian Hospitals Association (EHA) and the Estonian Government had to offer solutions that meet the needs of health care professionals to resolve the dispute, but unfortunately this put hospitals in a difficult position. To end the strike EHA had to sign a collective agreement that included costs the Health Insurance Fund (HIF) did not include in the budget. The increase of health workers minimum wage was larger than the size of the input in the HIF health services price list. This meant increase of labour expenses without any financial support. A second element affecting hospital and healthcare services is hospital networking. This is an ongoing process necessary to ensure 24/7 readiness and availability of specialist care. Since it is expensive the organisation of the work has to be collaborative. According to Estonian HOPE Governor point of view, Estonia has one of the most efficient systems in Europe in the sense that despite the country has a lower health expenditure compared to other European countries it is also characterized by less health care workers than needed. In a situation where resources are not sufficient it is necessary thinking about optimal solutions. Health care providers have to collaborate on every level and use human and financial resources in the best possible way. Furthermore, EHA recognized the importance of e-health since it is collaborating on several projects on the topic. About ten years ago when the eHealth project was just starting the health system in Estonia was working mainly through paper document exchange. Today it is not a question of electronic exchange of documents between health care providers anymore, but processing patient data in IT systems. The objectives set ten years ago were reached, so now it is necessary to understand if and how the e-development process has to be updated and, to this extent, the involvement of health workers is fundamental.

- **What are the main challenges you are facing today?**

Social dialogue is a priority for Estonia. The agreement signed in December 2012 was valid for two years and now the country is in the middle of negotiations for the next agreement. The process of collective agreement negotiations is always difficult due to the fact that health sector employers are in a unique position compared to others. The money for the salaries of health care workers comes from the state budget through the Health Insurance Fund and hospitals themselves cannot decide the size of their salaries budget: this decision is made by Estonian Government. So to make an offer to raise the minimum wages of health care workers the employers need to have confirmation from the HIF and the Ministry of Social Affairs. Consequently collaboration between HIF and Estonian Government is crucial to stop the emigration of qualified health professionals. EHA set great value on Estonian qualified doctors and nurses and find it extremely important to have a productive social dialogue with all the parties. During these negotiations within EHA, the Ministry of Social Affairs, HIF, health care workers unions and the national conciliator it was found a common understanding, which brought to the signing of a pre-agreement. The pre-agreement states that the parties are willing to sign the new collective agreement for years 2015-2016, in respect of certain conditions. In the coming years EHA has a great challenge to achieve: all the HIF prices have to include real expenditure in the health services price list. The inputs for prices have to be adequate and have to consider also the increase of consumer price index. A topical issue in Estonia is hospitals networking. The Ministry of Social Affairs has prepared a development plan called "Health Care Development Trends 2020". Then, Government finds that well organised specialized health cares have to ensure quality, sustainability and access while using limited resources (in terms of workers, technology and finances). The close-to-home principal is important for primary health care and planning outpatient and inpatient specialist care it is substantial to find a reasonable and affordable balance between quality, rational use of resources and closeness to home. EHA´s challenge here is to find sufficient funds to develop IT systems for e-health databases. The state has to find a way to support IT and innovative solutions and science and development activities.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

Planning and implementing all the necessary changes in the hospital network have to take place in a balanced collaboration with competence centres, smaller hospitals and other specialist care providers. Hospital network developments have to be aimed at ensuring quality and safety of specialist care, rational use of resources and ensuring sustainability of the system. Hospital networking is a collaboration process of different types of hospitals to achieve uniform availability of health care services in the country. During hospital networking the two regional hospitals in Estonia ensure substantial efficiency for general and county hospitals to provide necessary specialist care services. EHA considers of great importance the evaluation of young doctors and the enabling of their skills into practice. EHA is planning activities in cooperation with the Tartu University, Estonian Medical Students Association and the Ministry of Social Affairs to give medical students the possibility to work legally as assistant doctors. Investing in young generation is the way to finding solutions to difficult problems.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

FINLAND

Answers provided by:
Mrs. Dr. Aino-Liisa OUKKA, Association of Finnish Local and Regional Authorities

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	7.22	8.04	9.16
2.	Percentage of public sector health expenditure on total health expenditure	71.26	74.38	75.42
3.	Total expenditure on inpatient care as % of total health expenditure	39.8	35.6	35.1[2]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	22.32	19.34	18.6
5.	All hospital beds per 100,000 inhabitants	753.97	673.3	531.47
6.	Acute care hospital beds per 100,000 inhabitants	352.24	319.73	293.08
7.	Acute care admissions/discharges per 100 inhabitants	20.77	18.11	17.05[2]
8.	Average length of stay for acute care hospitals (bed-days)	6.93	7.2	6.93[2]
9.	Practicing physicians per 100,000 inhabitants	249.91	268.87	272.05[1]
10.	Practicing nurses per 100,000 inhabitants	926.1	935.48	1,044.53[2]

[1]Data refers to year 2008; [2]2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

The elements that had a positive effect in the last years on hospitals and healthcare services were the introduction of the *Health Care Act* and the development of the *Finnish e-Health environment*, of the *national e-Archive* and of *e-Prescription*. On the contrary, the factors affecting negatively the healthcare sector in the country were the economic depression, the ageing workforce and shortage of some professional health categories (e.g. physicians specialized in some fields as well as nurses) especially in the rural areas.

- **What are the main challenges you are facing today?**

The biggest challenge is the reorganization of the social and health care sector. Finland is integrating primary and secondary care together with social care. The new legislation is in the Parliament at the moment and it should be approved by April 2015. The country is also facing problems due to the deterioration of hospitals' buildings, which were built 40-50 years ago. The estimated cost for their renovation and reorganisation is 5-10 billion of Euro in the next 10-15 years.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

One of the main challenges Finland envisages for the next five year is the integration between health and social care as well as the simplification of the new financing system. For this reason, patients will play a central role and consequently the organisation of services will be more patient-centred. This topic is crucial but at the same time represents a critical point in the political agenda. Furthermore, in the country there is the need to set the real value for the different treatments and to prioritise them accordingly.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

FRANCE

Answers provided by:



Mr. Yves-Jean DUPUIS, French Federation of Non-Profit Hospitals
Mrs. Pascale FLAMANT, UNICANCER (French Federation of Comprehensive Cancer Centers)
Mr. Gérard VINCENT, French Hospital Federation

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	10.08	10.88	11.76
2.	Percentage of public sector health expenditure on total health expenditure	79.38	77.26	76.96
3.	Total expenditure on inpatient care as % of total health expenditure	38.3	36.6	37.1[3]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	7.1	7.26	7.4
5.	All hospital beds per 100,000 inhabitants	822.27	727.23	648.57
6.	Acute care hospital beds per 100,000 inhabitants	419.07	369.03	347.27
7.	Acute care admissions/discharges per 100 inhabitants	16.62[1]	16.45	16.45[2]
8.	Average length of stay for acute care hospitals (bed-days)	5.6	5.3	5.1[3]
9.	Practicing physicians per 100,000 inhabitants	n.a.	316.08[3]	315.64
10.	Practicing nurses per 100,000 inhabitants	n.a.	n.a.	n.a.

[1]Data refers to year 2006; [2]2009; [3]2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

Transition from global budget to activity based payment through the Law 12/18/2003.

Introduced in 1983, the global budget was an annual and limited budgetary envelope that was calculated on the number of days in hospital and was re-defined each year. This system, which was deemed to be unbalanced and unrepresentative of institutions' activities, was replaced in 2004 by a new funding method: rating per activity (T2A). In this system, it is the medical activity (nature and quantity of the treatments performed) that determine the hospital's resources. Rate-setting per activity stems from a mixed funding system that differentiates between treatment and public interest assignments (research, teaching, etc.). Rate-setting per activity only concerns medical, surgical and obstetric procedures. Rehabilitation services, psychiatry and long-term care are, for now, funded on a different basis. Besides, block grants provide annual lump-sum funding, such as for emergency treatment, organ retrieval and transplants. Two separate lump sums are also defined by the regional hospital authorities on a contractual basis: one is for education and research related activities (general interest missions); the other is for activities carried out to meet national or regional priorities (for example, developing preventive care) or specific public missions (for example, providing care for vulnerable groups; contracting allowance). There are opportunities of rating per activity:

- It facilitates productivity gains as it encourages healthcare actors to reducing their costs and to develop their activity and thus rating per activity permits to cope with health needs;
- It permits greater predictability of expenditures;
- It allows hospitals to provide more meaningful information to physicians related to their care practices;
- It is very positive for the public sector which was penalized by the previous system (indeed, there was no possibility to develop hospital's activity when the annual budget was spent);
- It increases fairness for health providers;
- It gives more independence to hospital managers;
- It ensures better use of resources by rewarding efficiency and more transparency in the payment model.

But there are as well challenges of rating per activity:

- It could cause inflationary effects as it can lead to prescribe and thus realize medical acts, whose utility is not scientifically established;
- It does not (fully) permit to optimize healthcare circuits since this funding method is calculated on what is done when it is done;
- It fosters efficiency through cost cutting but this efficiency is attained out of any assessment of the cost/quality ratio;
- It does not value the relevant activities and cooperation actions as there are bias in choice of patient for profitability goal, excessive decrease in length of stay, cost of collect and audit of information, no incentive to increase the quality level.

Performance based payment introduction to reward better care quality.

The introduction of hospital governance reform has been implemented through two major texts:

- Ordinance 05/02/2005: this text introduces the medical pole's setting up in order to decentralize management issues and allows clinical managers nomination (pole's chief);
- Law 07/21/2009 "Hospital, Patients, Health and Regions" (HPST) renewed hospital governance and strengthened the hospital director.

These two texts have developed a balanced medico-administrative steering through the introduction of medical department (*"pole"*) as well as an effective relationship between the hospital chief executive and the elected chair of the hospital medical commission. Moreover, they have permitted doctors to get the voting majority inside the hospital executive board. The purpose of that reform was to encourage doctors to be part of the decision making process. Practitioners are better associated to what happens in their hospital while the decision-making ability of the hospital director is strengthened. These reforms create and foster a management culture for every medical actor. These reforms go with the introduction of the rating per activity's system, which

provides more meaningful information to physicians related to their care practices and allows them to make better decisions.

Regional Health Agencies creation to facilitate a regionalized policy of the health care facilities (health and social sectors).

The HPST law merged several regional institutions into a "one-stop shop" by creating the Regional Health Agencies (ARS) in order to coordinate ambulatory and hospital care, health and social care for the elderly and disabled. Setting up the regional health agencies was a way to stop diverse segmentations such as those between hospital and medicine in town, between uphill and downhill, and between health and medico-social sector. The introduction of the regional health agencies was seen, initially, as an independent regional authority promoting regional health and medico-social policies. The purpose of these agencies was perceived as a way to lead health policies fully docked in territorial reality. Moreover, these agencies should have been independent by national health policies implemented by the health ministry, but it is unfortunately not the case since the ministry still practices a large tutorship on these agencies.

Creation of the French NCI.

Cancer is the leading cause of death in France. For this reason, in 2002, the French President Jacques Chirac made the fight against cancer one of three priorities for his second term. In 2003, the 70 measures of the 2003-2007 Cancer Plan were launched. The French National Cancer Institute was created in 2004. Since then, two other Cancer Plans have been implemented (2009-2013 and 2014–2019).

- **What are the main challenges you are facing today?**

In France, socioeconomic disparities and geographic inequality in the density of health care professionals remain considerable challenges to provide a good level of equity in access to health care. For example, there are 237 practicing doctors per 100 000 inhabitants in Picardy region, compared with 375 in the Provence Alpes Côte d'Azur region. These disparities between regions are accompanied by significant variations within the regions themselves, with increasing gaps between major towns - where doctors still set up their practices when they complete their studies - and less populated areas.

The obligation for a GP to receive patients at night and during week-end when on call is not enough driven as it is based on practitioners volunteering. In this context, patients use emergency services a lot instead of resorting to liberal continuing care system. The central and the regional level share responsibility for capacity planning. At the regional level, the ARS were implemented to coordinate ambulatory and hospital care, and health and social care for the elderly and disabled through a regional strategic health plan that is based on population needs. Each sector's planning process will have to comply with this plan. This is a first attempt at regional planning of the ambulatory care sector, but it is not sufficient until the continuing health care procedure remain based on practitioners volunteering.

The main challenges France is facing today are listed as follows:

- The re-organisation of the healthcare system by coordinating ambulatory and hospital care, health and social care and develop care networks, which implies to build a new human resources management policy.
- The development of alternatives in order to reach full hospitalization standards such as hospital at home, hospital hotel, ambulatory medicine. Furthermore, the evolution of medical facilities and shorter hospital stays, especially in oncology. The GP's mission has to be considered during and after treatment in a new way with a close relation with specialized hospital professionals.
- The reduction of unnecessary prescriptions.
- The improvement of health democracy: build a common culture between patients and professionals through the creation of the Patient Institute.

Other actions like online participative consultations are implemented in order to take patients' expression into account and improve hospital care. They are listed as follows:

- The improvement of public and private non-profit hospital funding.
- The improvement in innovation financing: the French reimbursement process is very slow and does not fit with fast evolution of treatment. Pricing pressures make it a big issue for innovative acute care hospitals.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

In September 2013, the Government presented a National Health Strategy in order to improve the healthcare system. This strategy in developed an appropriate diagnosis, shared by all the actors. The public health law, currently under discussion, should have been a translation of the National Health Strategy but it leaves behind the real subjects and polarizes against it all the disagreements. Indeed, nothing is done to reform rating per activity payment, and everything is done to strengthen the regional health agencies as a supervisory actor instead of giving more autonomy to hospitals. However, this law has some positive aspects and promote interesting measures such as:

- Creating a real territorial public service by reinforcing cooperation between hospitals through the obligation to make a hospital group territory, which will gather a university hospital centre, proximity and local hospitals, social and medico-social structures. Indeed, it seems necessary to optimize the territorial healthcare organization. It should permit to adapt our structures to healthcare path and coping with economic and demographic constraints.
- Enhancing prevention (GP for children, anti-smoking campaign, etc.).
- Developing health democracy by creating the Patient Institute and allowing class actions.

Besides, an evolution of rating per activity payment will be necessary to optimize healthcare circuits, cooperation, investment, quality and healthcare relevance. The solution could be to define a fixed part, which would correspond to public service missions, and a variable part, whose purpose is to value the relevant activities, cooperation actions and quality.

Challenges France has to envisage for the next years are the following:

- Restoring the link between local communities and hospitals;
- Refocusing supervisory agencies on their strategic steering mission: RHA should propose a global viewpoint, support local actors and promote reorganisation;
- Regulating doctor's freedom of practice by penalizing practitioners who decide to settle in over-served areas;
- Improving healthcare relevance through:
  - Leading studies -in every region- on the different experiences related to non-explainable situations;
  - Tiding up the inspectors hierarchically linked to the statutory health insurance to the Regional Health Agency;
  - Using the tariff regression as a way to fight the unnecessary acts;
  - Establishing a second free medical advice for a certain number of acts and procedure.
- Fostering transparency in health open data and thus permitting to avoid the drug prescription's drift and therefore cope with unnecessary prescription;
- Enhancing the information system to become more efficient;

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

- Reaching efficiency in the field of funding innovation through:
  - Developing new ways to finance innovative treatments and practices, such as more targeted radiotherapy in oncology, oral treatment and tumour characterization;
  - Allowing hospitals to adapt to evolutions in developing ways to finance the new organizational models: ambulatory care, home treatment, care coordination;
  - Increasing investments in research activities.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

GERMANY

Answers provided by: Mr. Georg BAUM, German Hospital Federation

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	10.4	10.48	11.28
2.	Percentage of public sector health expenditure on total health expenditure	79.54	76.38	76.28
3.	Total expenditure on inpatient care as % of total health expenditure	35.3	34.3	34.8[1]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	10.44	12.4	12.06
5.	All hospital beds per 100,000 inhabitants	911.91	823.95	818.44
6.	Acute care hospital beds per 100,000 inhabitants	604.89	538.3	528.1
7.	Acute care admissions/discharges per 100 inhabitants	19.97	20.76	22.33[1]
8.	Average length of stay for acute care hospitals (bed-days)	10.1	8.5	7.9[1]
9.	Practicing physicians per 100,000 inhabitants	326.04	350.32	389.28
10.	Practicing nurses per 100,000 inhabitants	960	1,049.08	1,131.09[1]

[1]Data refers to year 2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

Germany's hospitals in the last ten years experienced a major change of the settings in which hospital care is provided. The implementation of the G-DRG-system (diagnosis related groups) at the beginning of 21st century's first decade, replaced the former reimbursement system with its per diems. The new scheme provides one flat payment for the whole treatment of a patient in a hospital from the admission till the discharge. This lead to an enormous increase of efficiency of care, e.g. the average length of stay declined from 8,3 days in the year 2003 to 7,1 days in the year 2013 for the acute care hospitals – a reduction of almost 15 % in ten years only. In parallel, the number of hospitals and beds were reduced by merging or closing structures. Since the year 2003 nearly 2.200 hospitals with almost 550.000 beds were shrinking to around 2.000 clinics with approximately 500.000 beds till the year 2013. At the same time, the shares of ownership were shifted considerably. While public and charity based hospitals suffered significant reduction, private-for-profit hospitals were able to essentially increase the number of hospitals and of beds.

- **What are the main challenges you are facing today?**

The reform of the reimbursement system was accompanied by major efforts to increase quality in hospital care. In the year 2004 the Federal Joint Committee started acting with the official participation of the German Hospital Federation and initialised several measures in order to enhance quality of care. For some years ago, hospitals have been compulsory required to continuously report data on approximately 400 quality indicators and are assessed and evaluated by external visitors in the frame of the so called "external quality assurance's structured dialogue". The whole process ends with an annual "quality report" for each hospital, which has to be public and is accessible to patients and sending doctors. With the fix prices by the G-DRG-system and the free choice for patients, hospitals can only compete by offering best quality thus the quality report is an important tool to ensure a high level of transparency. This intensive competition also leads to permanent efforts of hospitals to provide innovative care. On the other side of the coin, hospitals got under permanent and massive pressure to optimise the provision of care and to reduce costs where possible. Despite this pressure, hospitals since the year 2006 considerably and continuously increased the total number of full-time-equivalent of their staff. As such, labour costs remain the biggest percentage of hospital expenditures that increase permanently and faster than the rise of prices for hospital care. Furthermore, hospitals had to contribute to savings for the statutory health insurance funds in time of crisis and to accept cuts of their bills. As a result, the reimbursement of hospital healthcare services is leading to deficit in the hospitals' budgets. This effect is boosted as additionally the Bundesländer, Germany's federal states, which are in charge of financing the costs for the hospitals' infrastructure. After calculation of the German Hospital Federation the lack of financing hospital infrastructure is currently attending the mark of 6 billion Euros. Thus more and more hospitals have to invest the revenues generated by the treatments in necessary renovation or purchase of new goods. Consequently only a quarter of hospitals are generating profits. The reorganisation of hospital financing has become one of the most urgent challenges and has to be tackled with priority. The major hospital reform, which is awaited to by realised in 2015 would be a good opportunity.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

Besides struggling for adequate financial resources, Germany's hospitals are facing a lack of health workers. Already today, almost 6.000 vacancies for doctors' positions cannot be filled in due time as the labour market for doctors is characterized by an unemployment rate of only 1,5 %, representing almost a full level of employment. Additionally – due to demographic change and an increasing ageing population – more healthcare workers will be needed in the mid-term. Bearing in mind that also healthcare workers will get older in average too, the need for more junior staff will be even bigger. Thus the training capacities at the universities have to be increased and the access to medicinal studies have to be eased for those who are interested to become doctors. Consequently the necessarily widened training capacities at academic teaching hospitals have to be financed in order to produce more young professionals. German hospitals will have to further develop on family friendly working conditions which they started already to do, e.g. by supporting federal initiatives for better compatibility of career and family for doctors and for nurses. These rising needs for healthcare workers also could be matched by continuously overcoming the disruptive borders between primary and hospital care. Despite having already achieved more options for the provision of ambulatory care by hospitals in legal theory in the recent years, the execution of the options often is hindered in practice. The German Hospital Federation will further work on moving away the obstacles for the already existing permissions and to overcome still existing restrictions.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

ITALY

Answers provided by:
Mr. Dr. Domenico MANTOAN, Veneto Region

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	7.88	8.5	9.18
2.	Percentage of public sector health expenditure on total health expenditure	74.22	78.26	78.18
3.	Total expenditure on inpatient care as % of total health expenditure	43.7	45.4	46.6
4.	Private households' out-of-pocket payment on health as % of total health expenditure	24.94	20.44	20.24
5.	All hospital beds per 100,000 inhabitants	470.91	384.48	339.57
6.	Acute care hospital beds per 100,000 inhabitants	407.01	312.7	272.63
7.	Acute care admissions/discharges per 100 inhabitants	15.83	13.26	11.29
8.	Average length of stay for acute care hospitals (bed-days)	7	6.7	6.8
9.	Practicing physicians per 100,000 inhabitants	n.a.	367.54[1]	384.43
10.	Practicing nurses per 100,000 inhabitants	n.a.	n.a.	n.a.

[1]*Data refers to year 2009*

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

The main element, which affected negatively hospitals and healthcare services in the past years, was the economic crisis. On the contrary, the so-called "*Patto per la Salute*" (Pact for the Health) produced a positive impact on hospitals and healthcare services. It is an agreement signed by the Italian Government and the Regions on how to plan the healthcare services during the years 2014-2015.

- **What are the main challenges you are facing today?**

The main challenge that Italy is facing today is maintaining the sustainability of public NHS considering the increasing costs of therapies and diagnostic procedures. A recent example is the new anti-viral therapy for Hepatitis C (Sofosbudir): the cost of treatment is 65,000 Euros for 3 weeks of therapy (130,000 Euros in some cases needing 6 weeks of therapy). This means to realize many actions such as the update of *LEA* (Essential Levels of Assistance), which indicate the list of services the citizens have the right to receive by the NHS and for which they have financial coverage; and the update of co-payment system and actions to improve pertinence in the use of diagnostic procedures and therapies.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

In the next five years the challenges the Italian NHS envisages are: moving from Evidence Base Medicine towards Evidence Based Medicine and cost – effectiveness; moving towards a new organization of NHS more oriented on processes rather than on structures (less number of beds in acute care hospitals and need of increasing outpatients services, home care, intermediate care - e.g. country hospitals); moving towards an Health Promotion Approach, which is well described in *Ottawa Charter in Health Promotion of the WHO* that was adopted on the occasion of the international conference on health promotion "*The move towards a new public health*", held in November 1986 in Ottawa, Canada. According to this charter "*Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well*".

Furthermore "*Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility. Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy*".

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

LATVIA

Answers provided by:

Mr. Dr. Jevgenijs KALEJS, Latvian Hospital Association

	2000	2007	2012
1. Total health expenditure as % of Gross Domestic Product (GDP)	6	7.02	6
2. Percentage of public sector health expenditure on total health expenditure	54.4	60.7	56.74
3. Total expenditure on inpatient care as % of total health expenditure	29[1]	28	26.5[2]
4. Private households' out-of-pocket payment on health as % of total health expenditure	44.14	34.9	37.4
5. All hospital beds per 100,000 inhabitants	873.5	757.13	588.5
6. Acute care hospital beds per 100,000 inhabitants	610.79	525.33	359.43
7. Acute care admissions/discharges per 100 inhabitants	20.01	20.16	15.4[3]
8. Average length of stay for acute care hospitals (bed-days)	8.49	7.08	5.97[3]
9. Practicing physicians per 100,000 inhabitants	287.36	303.85	314.4
10. Practicing nurses per 100,000 inhabitants	456.89	534.86	486.01

[1]Data refers to year 2005; [2]2010; [3]2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

In the past years, Latvia was characterized by an economic crisis impacting on financial choices the Government had to implement to control the level of expenses in all sectors, including healthcare. One of the indicators to take into consideration to clarify the policy implemented is the total health expenditure as % of GDP. From 2000 to 2012, this figure was lower than the EU average of at least 2 percentage points, in particular in 2012, its value was around 6.0% against 9.6% in EU. A further aspect negatively affecting hospital and healthcare services is the high level of co-payments. Although all citizens are entitled to access universally health care services, equity is compromised due to high levels of Out-of-Pocket payments by patients and low incomes. From 2000 to 2012, the Out-of-Pocket payments as % of total health expenditure was more than the double compared to EU average. In 2012 this value was around 37% in the country against 16% in EU. According to the Poverty Reduction Strategy, adopted in August 2000, "low income" individuals are defined as people who earn less than 50% of the average monthly income. Despite rapid economic growth, poverty in Latvia is extensive with an increase degree of income inequality. This condition discourages professionals to work in the country and pushes them, especially the younger ones, moving abroad in search of better working conditions or salaries. As a consequence, in the previous years, there was a shortage in human resources working in healthcare sector although reliable data is limited. Within the aspects affecting positively hospitals and healthcare services it is possible to mention the high coverage of ICT tools (88% of Latvian GP practice use a computer; 85% of practices have an internet connection and broad band is used in 58% of GP practices) and the high quality of skills and competences of physicians.

- **What are the main challenges you are facing today?**

The Latvian healthcare system has experienced an important transformation in the last years since its independence in 1991 and is now in the process of consolidating its new structures and institutional arrangements. Having abolished the highly centralized system that prevailed during the Soviet period, it has focused on decentralization of health care delivery, administration and financing; full or partial privatization of some kinds of provider institutions; and the establishment of independent primary care practices, which have led to a wide variety of legal forms of health care providers and institutions. In May 2004 the country joined the European Union with a population reaching 2.3 million of inhabitants and since that year the integration in EU structures is an ongoing process that needs to be reinforced. For this reason, this is one of the main challenges Latvian institutions have to face. The educational system does not meet the growing needs of the health care system and the development of human resources in this sector and, for this reason, there is the perception that students tend to cross the border to be educated.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

As it was described in the previous paragraphs, one of the aspects affecting negatively the hospitals and healthcare services in Latvia was the professionals' migration to higher income countries and one of the main challenges the country has to face is the tendency of students to cross the border to be educated. The lack of professionals working in this sector is an obstacle that should be overcame through the introduction of measures aimed at motivating them to stay instead of to migrate.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

LITHUANIA

Answers provided by:
Mr. Dr. Dalis VAIGINAS, Lithuanian Hospital Association

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	6.46	6.22	6.66
2.	Percentage of public sector health expenditure on total health expenditure	69.72	72.98	70.82
3.	Total expenditure on inpatient care as % of total health expenditure	26.44[1]	24.78	24.08[2]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	26.12	26.56	28.54
5.	All hospital beds per 100,000 inhabitants	883.32	688.26	743.23
6.	Acute care hospital beds per 100,000 inhabitants	660.52	509.33	537.52
7.	Acute care admissions/discharges per 100 inhabitants	22.18	20.26	22.46[2]
8.	Average length of stay for acute care hospitals (bed-days)	8.4	6.94	6.42[2]
9.	Practicing physicians per 100,000 inhabitants	362.68	371.81	421.85
10.	Practicing nurses per 100,000 inhabitants	763.13	705.2	759.46

[1]Data refers to year 2004; [2]2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

The elements that positively affected hospitals and healthcare services in Lithuania in the past years were the decentralisation of hospital management and the introduction of a case mix financing system (since 2012 DRG based financing). The aspects that had a negative impact were the lack of long term strategic plan as well as scarcity of needs assessment of hospital care; and the problems of transition to DRG system and human resources planning due to the fact that there is a shortage of health professionals in rural areas.

- **What are the main challenges you are facing today?**

The main challenges Lithuania is facing today are the lack of financing; and the lack of human resources in rural areas and the necessity of implementing a strategic planning for the future.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

The changes the country has to be ready to face are the creation of a strategic plan; the increasing percentage of ageing population and the growing need of treatments for elderly people; the necessity of introducing a planning system for long term care.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

MALTA

Answers provided by:
Mr. Denis VELLA BALDACCHINO, Ministry of Health, the Elderly and Community Care

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	6.58	8.46	9.1
2.	Percentage of public sector health expenditure on total health expenditure	72.48	66.92	65.6
3.	Total expenditure on inpatient care as % of total health expenditure	n.a.	n.a.	n.a.
4.	Private households' out-of-pocket payment on health as % of total health expenditure	26.68	31.24	32.26
5.	All hospital beds per 100,000 inhabitants	547.68	780.26	478.42
6.	Acute care hospital beds per 100,000 inhabitants	375.06	269.38	256.73
7.	Acute care admissions/discharges per 100 inhabitants	7.88[2]	7.34	14.23[4]
8.	Average length of stay for acute care hospitals (bed-days)	4.63	4.8	6.3[4]
9.	Practicing physicians per 100,000 inhabitants	n.a.	303.63[3]	329.2
10.	Practicing nurses per 100,000 inhabitants	374.78[1]	583.49	668.64

[1]Data refers to year 2001; [2]2005; [3]2009; [4]2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

The main element that affected positively hospitals and healthcare sector is the increase of investments in the last ten years, which were used for new buildings (acute and oncology care) and refurbishment of old hospitals (Karen Grech, SVPR, and MCH). Resources were spent also in new equipment, machinery and tools. Furthermore, procurement has been centralised and professionalised. Within the aspects that negatively affected the hospitals and healthcare services there are: overinvestment in acute healthcare services with the result that primary care, community, and rehabilitation cares have suffered from underinvestment; pharmaceuticals and devices cost increase which caused budget cut elsewhere; migration issues and burden on services and, more in general, societal changes on hospital and healthcare services.

- **What are the main challenges you are facing today?**

There are specific challenges in primary care, rehabilitation and community care triggering issues with care for the elderly. Moreover, Malta will experience a lack of tangible and practical leadership and management skills and values across the whole healthcare sector.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

Within the challenges the country has to face it is possible to mention: major investment in primary, community and rehabilitation to shift emphasis and burden away from acute care; major public relations and education campaign running for years influencing perceptions and attitudes towards health and well-being; major investment in training for employees.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

POLAND

Answers provided by:

Mr. Dr. Jaroslaw J. FEDOROWSKI, Polish Hospital Federation

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	5.52	6.34	6.72
2.	Percentage of public sector health expenditure on total health expenditure	70.04	70.44	70.08
3.	Total expenditure on inpatient care as % of total health expenditure	29.1[1]	31.2	32[4]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	29.98	24.62	22.82
5.	All hospital beds per 100,000 inhabitants	668.06[2]	642.45	652.03
6.	Acute care hospital beds per 100,000 inhabitants	515.16	461.63	426.79
7.	Acute care admissions/discharges per 100 inhabitants	13.95[3]	14.25	15.86[4]
8.	Average length of stay for acute care hospitals (bed-days)	7.9[3]	7.4	7.1[4]
9.	Practicing physicians per 100,000 inhabitants	222.27	219.12	220.65
10.	Practicing nurses per 100,000 inhabitants	495.69	518.03	549.2

[1]Data refers to year 2002; [2]2003; [3]2005; [4]2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

Elements affecting positively hospitals and healthcare services in Poland during the last years were the access to EU funds for investments in the sector and the raise of competition in the healthcare market. On the other side, factors affecting negatively health sector were decision makers' expectations out of proportion of the actual level of reimbursement for services provided by hospitals and aging of healthcare personnel, especially nurses.

- **What are the main challenges you are facing today?**

Patients' expectations are higher for certain services compared to their costs. Lawyers are becoming more and more aggressive to earn profits on adverse events. Lately, advances in medicine are coming much faster than the financing to provide and to implement modern technologies.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

Patients should be more involved in their path of care rather than acting just as customers. On the professionals' side, it is necessary to make the nursing career more attractive. Stronger cooperation between public and private sector is necessary as well as between Government and stakeholders.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

PORTUGAL

Answers provided by:

Mrs. Prof. Ana ESCOVAL, Portuguese Association for the Development of Hospitals

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	9.3	10	9.46
2.	Percentage of public sector health expenditure on total health expenditure	66.58	66.68	62.64
3.	Total expenditure on inpatient care as % of total health expenditure	23.9	20.4	19.8[1]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	24.34	25.46	31.66
5.	All hospital beds per 100,000 inhabitants	370.9	343.55	338.04
6.	Acute care hospital beds per 100,000 inhabitants	302.6	280.59	284.98
7.	Acute care admissions/discharges per 100 inhabitants	10.71	11.24	10.62[1]
8.	Average length of stay for acute care hospitals (bed-days)	7.76	6.87	7.17[1]
9.	Practicing physicians per 100,000 inhabitants	n.a.	n.a.	n.a.
10.	Practicing nurses per 100,000 inhabitants	n.a.	n.a.	n.a.

[1] *Data refers to year 2011*

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

Some elements that positively affected hospitals and healthcare services are:

- The reform of the Primary Healthcare with its decentralization into the ACES (Health Centre Groups) and with the creation of the USF (Family Health Units);
- The increase of the scientific research associated with the management and organization of the Health care.

Despite the difficulties endured the NHS resisted and continued to function. But on the contrary, some aspects produced negative effects:

- Lack of human resources for health policies in the Portuguese NHS, including shortage of doctors;
- Crisis within the pharmacies sector, with many of them closing and the limited stock in many others (significantly reducing the people's access to medicines);
- Substantial increase in user fees (working as the system funding measure, rather than as an element for moderating the access to health care);
- Cuts in the health budget and specifically in hospital budgets;
- Patient transportation policies, which left in many occasions the problems in the hands of the hospital administrations.

- **What are the main challenges you are facing today?**

Within the challenges Portugal is facing today it is possible to mention:

- The analysis of the social and economic crisis and its impact in the Health of the populations, particularly for the more vulnerable groups, and in the mental Health (related with the crisis and the unemployment);
- The necessity of making the Portuguese NHS a sustainable system, and maintaining its purposes and values;
- Demographic changes (ageing population and its consequences, such as the growth in the chronic disease);
- The emigration of Health care professionals and shortage of human resources;
- The maintenance of the levels of access to the health care services, and to innovation.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

- The sustainability of the Portuguese NHS, from the economic and financial point of view and from the management strategy of the Health care professionals and of the human resources;
- Ageing population and management of chronic diseases – there is the need to develop well-adapted Health care policies and integrated management of chronic diseases. A common European policy for the rare diseases, innovation, costs and quality management would be an asset;
- Shortage of human resources – it will be necessary to develop and implement human resources' policies that would motivate the Health professionals to stay in the country and work within the Portuguese NHS;
- Possible deterioration of the Health indicators and of the Portuguese population as a medium and long term consequence of the economic, financial and social crisis. There is the need for measures within the health care area but also in all social areas that will create employment, housing, feeding and general wellbeing of the Portuguese population, thus contributing for the maintenance and/or improvement of the health indicators;
- Increase of mental health problems – it will be necessary to implement the national Mental Health Programme, adapted to the local realities and needs, in harmony with the local plans and local health strategies.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

SLOVENIA

Answers provided by:
Mr. Simon VRHUNEC, Association of Health Institutions of Slovenia

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	8.26	7.86	8.76
2.	Percentage of public sector health expenditure on total health expenditure	74.02	71.9	73.3
3.	Total expenditure on inpatient care as % of total health expenditure	33[1]	31.6	35.7[2]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	11.46	13.2	11.94
5.	All hospital beds per 100,000 inhabitants	539.88	466.18	454.66
6.	Acute care hospital beds per 100,000 inhabitants	445.57	376.74	361.87
7.	Acute care admissions/discharges per 100 inhabitants	16.04	17.2	16.07[2]
8.	Average length of stay for acute care hospitals (bed-days)	7.08	5.51	6.65[2]
9.	Practicing physicians per 100,000 inhabitants	215	238.39	254.25
10.	Practicing nurses per 100,000 inhabitants	684.98	771.76	816.72

[1]Data refers to year 2002; [2]2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

The most important element that affected hospitals drastically was a change of payment model in 2004. From *patient based payment* the country moved to *per case payment*, based on the Australian model, which caused the decrease of hospitals yearly budget. The implementation of the new system is an ongoing process that will last for the next 5 years. The second element was the intention of the Government to empower the role of private providers in public health sector. This idea raised a strong public debate involving the civil society but finally the process of reform stopped. The third element consists in the implementation of a new legislation on salaries of public system, introduced in This reform was implemented just a year before a strong economic recession in which prices of hospitals treatments paid by National Health Insurance Institute decreased of more than 8%. Hospitals faced at the same time challenges due to the increase of costs and the decrease of incomes.

- **What are the main challenges you are facing today?**

The main challenges of present years are linked to the price of treatments paid by the National Health Insurance Institute, which is not covering basic costs of the treatments. Secondly, the increasing demand of healthcare services does not correspond to an increase of the level of financing by insurance systems, which stays at the level of the year 2008. Due to this, the 5% of hospital admissions is unpaid. The third challenge consists in the reputation that hospital sector has on public opinion. The idea that people have is of a corrupted sector despite the costs of treatments are lower than in the neighbour countries. Moreover, it is important to consider the cooperation between primary and secondary healthcare as well. A further issue is the necessity to digitalise healthcare processes and to face problems related to funds shortage in an historical moment characterized by demographic changes leading to an increase in the demand of healthcare services.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

The main change the whole country expects is the organisation of public hospitals as well as the governance and management of the private ones. We are also expecting a public debate whether to decrease benefit package (basket) to suite the amount of financial resources that are available or to increase financial resources to cover the existing benefit package. If the second proposal will be decided there will also be the opportunity to decrease the regression of financing healthcare in Slovenia. The country is now characterized by high co-payments for almost all treatments on one side and the contributions are paid from only few incomes.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

SPAIN

Answers provided by:
Mrs. Asunción RUIZ DE LA SIERRA, Ministry of Health, Social Services and Equality

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	7.22	8.5	9.62
2.	Percentage of public sector health expenditure on total health expenditure	71.62	71.86	73.56
3.	Total expenditure on inpatient care as % of total health expenditure	28.2	28.1	30.2[1]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	23.58	20.46	20.26
5.	All hospital beds per 100,000 inhabitants	368.6	327.23	297.6
6.	Acute care hospital beds per 100,000 inhabitants	284.06	253.19	229.62
7.	Acute care admissions/discharges per 100 inhabitants	11.76	11.47	11.09[1]
8.	Average length of stay for acute care hospitals (bed-days)	7.1	6.6	6.1[1]
9.	Practicing physicians per 100,000 inhabitants	316.63	358.86	382.47
10.	Practicing nurses per 100,000 inhabitants	357.37	464.12	524.63

[1]*Data refers to year 2011*

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

Health spending has continued to fall in Spain. The Spanish Government has taken some measures to avoid a major impact of the crisis on the healthcare system and to contribute to the sustainability and improve the quality of the Spanish National Health System. The Spanish National Health System and access to healthcare in Spain underwent changes in 2012, in particular following the adoption of the Royal Decree-Law 16/2012 that came into force on 1 September 2012. The Ministry of Health, Social Services and Equality has created and implemented the Individual Health Card, based on a unique and life-long Personal Identification Code for the entire National Health System. In addition, it also means that the interoperable Electronic Health Record and electronic prescriptions can be implemented in the National Health System. The Electronic Health Record is an electronic register designed to make it easy to automatically note any observations, actions and instructions and which duly authorised professionals can access. At present, over 21 million citizens already have interoperable medical records and over 77% of prescriptions were dispensed electronically. At the same time, Spain has introduced a range of measures to curb pharmaceutical spending: price cuts (achieved through negotiations with the pharmaceutical manufacturers, introduction of reference pricing, application of compulsory rebates, decrease of pharmacy margins, reductions of the value added tax applicable for pharmaceuticals), centralised public procurement of pharmaceuticals, promoting the use of generics, reduction of package sizes, reduction in coverage (excluding pharmaceuticals from reimbursement) and increases in co-payments by households. Spain introduced a general rebate applicable for all medicines prescribed by NHS physicians in 2010. In addition, it mandated price reductions for generics, which is one of the factors explaining the growth in the consumption of generics.

- **What are the main challenges you are facing today? What changes do you envisage within the next five years: what will happen and what should happen?**

The Ministry of Health, Social Services and Equality is trying to introduce and implement the clinical management Units, to develop a standard of basic character that regulates the principles of clinical management throughout the national territory. It will make possible a greater involvement of the doctor and health workers in the governance of public health. This model will enable professionals to participate in a more direct way in the management of resources and decision-making, and will also be positive for patients, because it will result in an improvement of the quality of care.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

SWEDEN

Answers provided by:
Mr. Erik SVANFELDT, Swedish Association of Local Authorities and Regions

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	8.18	8.92	9.62
2.	Percentage of public sector health expenditure on total health expenditure	84.9	81.36	81.7
3.	Total expenditure on inpatient care as % of total health expenditure	4.6	29.4	28.4[1]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	13.78	16.5	16.14
5.	All hospital beds per 100,000 inhabitants	358.02	286.35	261.86
6.	Acute care hospital beds per 100,000 inhabitants	247.58	211.14	195.43
7.	Acute care admissions/discharges per 100 inhabitants	15.3	15.25	15.51[1]
8.	Average length of stay for acute care hospitals (bed-days)	5.89	5.5	5.13[1]
9.	Practicing physicians per 100,000 inhabitants	308.86	367.62	392.23[1]
10.	Practicing nurses per 100,000 inhabitants	n.a.	n.a.	n.a.

[1]Data refers to year 2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

In the last years, we have seen a continuing reduction of emergency hospitals and hospital beds, and at the same time an increase of health care centres (primary care). Although some people are negative towards this reduction of hospital care, this reflects a development from inpatient care to outpatient care and from hospital care to home care. Contributing factors are both limited financial resources and an increased focus on quality in health care, which manifests itself in an increased differentiation and specialization. Another significant change is the fact that today's patients are generally better informed. They have better education and also greater access to relevant information, not least thanks to the ongoing digitalization. Today's patients are more demanding and often want to get involved in their own care. This should be seen as a great asset. By letting the patients become co-creators, they can contribute to the further development of health and medical care. A third substantial change, at least in Sweden, is the increased opportunities for patients to choose – public or private – health care provider with public financing. This development has gone together with an increase of private providers, especially in primary care, working within the Swedish tax-financed health care system.

- **What are the main challenges you are facing today?**

Some of the challenges that Sweden is facing are:

- Comorbidity of chronic diseases: like in many other countries, Sweden has a growing proportion of elderly people. Many of them are active and healthy, but an increasing number of elderly persons have several chronic conditions.
- Creation of better pathways: efforts are made, and still have to be made, to improve cooperation between different healthcare providers, but also between healthcare providers and providers of social care.
- Long waiting times: although we have seen improvements in the last years, there are still queues. Too many patients still have to wait too long for medical examinations and treatments.
- Resistance to antibiotics: this is a global problem that already affects patients and health care systems all over the world.
- Recruitment of health care workforce: it is a challenge to have enough well-educated health care workers and use the collective skills in the best possible way.
- Equal access to healthcare: although all Swedish residents have the same rights to health care, surveys show that not all residents get the same services. There are differences due to geographic, gender-related and socio-economic factors.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

What we would like to see are shorter waiting times, more equal access to healthcare services, and an even larger focus on quality issues in health care – that we would really be able to develop based on all the quality measurements that are made.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

THE NETHERLANDS

Answers provided by:
Mr. Robbert SMET, Dutch Federation of Hospitals

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	7.96	10.76	12.44
2.	Percentage of public sector health expenditure on total health expenditure	63.08	78.24	79.82
3.	Total expenditure on inpatient care as % of total health expenditure	36.5	45.8	46.4[5]
4.	Private households' out-of-pocket payment on health as % of total health expenditure	8.98	6.06	5.58
5.	All hospital beds per 100,000 inhabitants	482.62	474.19	465.69[3]
6.	Acute care hospital beds per 100,000 inhabitants	305.34	317.49	332.38
7.	Acute care admissions/discharges per 100 inhabitants	8.97	10.76	11.52[4]
8.	Average length of stay for acute care hospitals (bed-days)	9	6.2	5.8[5]
9.	Practicing physicians per 100,000 inhabitants	n.a.	n.a.	n.a.
10.	Practicing nurses per 100,000 inhabitants	783.33[1]	830.19	840.35[2]

[1]Data refers to year 2002; [2]2008; [3]2009; [4]2010; [5]2011

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

In 2006, the Netherlands introduced a reform of its healthcare system that introduced market principles into Dutch hospital care: private organisations (health insurers and health care providers) together would define the demand and supply of healthcare services. On a yearly basis health insurers and hospitals negotiate the volume and quality of treatments contracted by insurers for their clients. Increasingly these negotiations lead to efficiency gains in hospitals, insight into the costs of treatments, improvement of the quality of treatments in hospitals and transparency. Both health insurers and hospitals are collecting data to provide information on variations in quality and costs between health providers. In 2014, the Dutch Association of Hospitals (NVZ) launched the "Quality Window" across the all country. The Quality Window is an online platform for patients sharing hospital's current and previous scores on ten quality indicators, from patient experience to employee satisfaction. The Quality Window therefore responds to the growing demand for information and transparency on hospital care and performance. The system helped in the recent years to contain the increasing hospital expenditures in the country but does not contribute to a decrease in the complexity of the registration and control system in hospital care. The Dutch Healthcare Authority (NZa) sets the rules to manage the relationship between insurers and healthcare providers, which are in some way forced to negotiate. At the same time this new system pushed health providers to merge within each other in order to counterweight the power of health insurers as well as to remain eligible for insurers' contracts (given the trends of ever increasing volume standards for, especially, complex treatments).

- **What are the main challenges you are facing today?**

From January 2015 medical specialists in Dutch hospitals will not be allowed to declare their treatments via the hospital. Non-employed medical specialists operating in partnerships within the hospital will not be automatically viewed by the tax office as entrepreneurs and eligible for tax deductions on their income. Instead, the board of Dutch hospitals will become responsible for both the care and salary component of hospital care treatments. This means that boards will have to negotiate with the non-employed medical specialists about the fee they will receive for each treatment. For the board the main concern is whether it will be able to act decisively on its responsibility for quality of care and control of costs in the hospital within the new organizational model. In February of this year the Dutch Healthcare Authority fined one of the largest general hospitals in the Netherlands (Sint Antonius Hospital) for faults in its declarations to the insurers. The total amount of the fine was 2,5 millions of Euro (1% of its total turnover) and the hospital had to repay 25 million of Euro to its insurers. In response to this verdict, all general hospitals in The Netherlands decided to use this ruling to investigate their own declaration for the years 2012 and 2013. Based on the outcomes of each individual investigation, hospitals and insurers will start negotiations on the amount that has to be repaid. On the positive side the process brought to a common understanding of the faults in the declaration system. On the negative side the verdict of the Dutch Healthcare Authority and the outcome of the investigation will lead to negative publicity.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

Hospitals in The Netherlands are constantly looking for ways to improve the efficiency of their services. Quality and transparency of treatments are priorities and for this reason hospitals increased the level of care to meet patients' expectations. At the same time, the level of out-of-pocket payments grew and hospitals feel pressure due to the fact that they have to justify what healthcare services they provide at that price. A further change is the concentration of high-complex treatment and dispersion of low-complex treatments to more and smaller hospitals (or locations). Where possible hospitals are urged to transfer (substitute) low complex treatments to the general practitioners as, given the quality of services provided, they are often cheaper. Besides, healthcare is sector characterized by economic growth. Companies tend to cooperate with hospitals to develop new technologies, products and services that will also bring down unit costs and can be commercially exported to other countries.

CHALLENGES AND CHANGES

WHICH ARE THE ELEMENTS AFFECTING HOSPITALS AND HEALTHCARE IN THE NEXT YEARS?

UNITED KINGDOM

Answers provided by:
Mr. Rob WEBSTER, NHS Confederation

		2000	2007	2012
1.	Total health expenditure as % of Gross Domestic Product (GDP)	7.02	8.5	9.44
2.	Percentage of public sector health expenditure on total health expenditure	79.12	80.16	82.52
3.	Total expenditure on inpatient care as % of total health expenditure	n.a.	n.a.	n.a.
4.	Private households' out-of-pocket payment on health as % of total health expenditure	11.12	11.48	9.94
5.	All hospital beds per 100,000 inhabitants	409.82	340.78	284.79
6.	Acute care hospital beds per 100,000 inhabitants	316.56	274.98	234.43
7.	Acute care admissions/discharges per 100 inhabitants	13.03	13.16	13.31[1]
8.	Average length of stay for acute care hospitals (bed-days)	8.08	7	6.49[1]
9.	Practicing physicians per 100,000 inhabitants	195.83	248.71	279
10.	Practicing nurses per 100,000 inhabitants	901.16	963.07	832.33

[1]*Data refers to year 2011*

- **Could you tell us the two or three main elements that have affected positively or negatively hospitals and healthcare services in your country for the past five/ten years?**

The NHS now faces the most challenging set of circumstances since it began over 65 years ago. These pressures are being felt right across the full continuum of care for patients, involving general practice, social care, mental health services and others. In terms of the specific pressures on acute sector, an excellent report by the Royal College of Physicians (RCP) a few years ago set out the magnitude of the challenges faced. Three of the key areas the report mentioned and which are routinely raised by the NHS Confederation's acute membership are quoted here below:

- *Increasing clinical demand: There are a third fewer general and acute beds now than there were 25 years ago, but the last decade alone has seen a 37% increase in emergency admissions. Hospitals have coped with this increase by reducing the average length of stay for patients. However, this fall in length of stay has flattened and in the past three years it has started to rise for patients over 85.*
- *Fractured care: Hospital doctors have reported the lack of continuity of care as their biggest concern about the current health service. It is not uncommon for patients, particularly older patients, to be moved four or five times during a hospital stay, often with incomplete notes and no formal handover. Every ward move puts at least one day on a length of stay and has a detrimental impact on patient experience.*
- *Changing patients, with changing needs: Nearly two thirds (65%) of people admitted to hospital are over 65 years old, and an increasing number are frail or have a diagnosis of dementia. The report also cites concerns with breakdowns in out-of-hours care provision and a looming workforce crisis in the medical workforce, both of which are important trends with direct implications for the hospital sector.*

The NHS Confederation worked with the RCP, and others, to follow up this report with a look across Urgent and Emergency Care more recently. What is clear is that while the challenges mentioned above are, quite literally, at the door of hospitals, to address them it is necessary to change the way care is delivered and organised across the whole system.

- **What are the main challenges you are facing today?**

There is a growing consensus that NHS Confederation will struggle to meet the needs of future generations unless it does more to help people be as well as possible for as long as possible, and reshape services to better support the growing number of people requiring ongoing care. The NHS Confederation has been seeking a coherent view of the future NHS from national bodies and politicians. Earlier this year it led the development of the 2015 Challenge, a powerful and comprehensive case for change produced by a partnership of national organisations representing health and care charities, local government, communities, staff and leaders, in advance of the UK General Election in May 2015. The fact that patient groups, professional bodies, all the nursing and medical royal colleges, public health, local government and NHS leaders have signed up makes it an unprecedented statement. The 2015 Challenge Declaration laid out the seven challenges facing the health, care and wellbeing system: needs, culture, design, finance, leadership, workforce and technology. In parallel to the 2015 Challenge, NHS England – responsible for commissioning around £90bn of health services across the NHS in England – published the Five Year Forward View, setting out its vision for the future of the NHS. It has been developed by the partner organisations that deliver, oversee and regulate health and care services and represents a clean break with the 'command and control' ethos of the past. The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how to achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Both these documents are consistent in their analysis of the challenges facing the NHS today. Despite this, the Five Year Forward View was silent on social care, which is an integral part of everyday health and care and certainly needs addressing.

- **What changes do you envisage within the next five years: what will happen and what should happen?**

The 2015 Challenge recognised that during the pre-election period, change in a politically sensitive area like health and care is difficult to achieve. After the General Election, however, and regardless of which party or parties form a government, it is expected a period in which the prevailing conditions accelerate the changes the health and care system needs to make. The central characteristics then of NHS Confederation vision of a new health and care system centre around: supporting people to stay as well as possible for as long as possible; reshaping care around the needs, aspirations and capabilities of people today; developing and supporting workforce to meet future needs; striving to continually improve quality and outcomes; and having adequate funding. Consensus is one thing, but delivering change will require two things to be in place. The first is under NHS Confederation control. The national bodies need a genuinely new relationship with local leaders. This means a national framework that is locally delivered and locally led. To successfully do this it is necessary to overcome ingrained behaviours like risk aversion

and intolerance of failure. Instead it is needed to stand together as we take the health service through unprecedented times and forge a new approach to what it means to lead in a 21st century NHS. The second is not in NHS Confederation control. Politicians need the courage to do what only they can do. They need to be facilitators of change. This means backing change.