Governance of health systems and the future of health care in Europe

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EUPHA President
Fifty million people watched, but no one saw a thing.

Who said this quote?
And when?

“The harsh economic climate is partly responsible, since it has exposed company reports and accounts to unusually close scrutiny.

It is, however, the continuing concern about standards of financial reporting and accountability [...] which has kept corporate governance in the public eye”
The Cadbury Report on Corporate Governance even in health care issues
The Cadbury Report, titled Financial Aspects of Corporate Governance, is a report of a committee chaired by Adrian Cadbury that sets out recommendations on the arrangement of company boards and accounting systems to mitigate corporate governance risks and failures. The report was published in 1992. The report's recommendations have been adopted in varying degree by the European Union, the United States, the World Bank, and others.
Governance in healthcare is a multi-faceted issue.

By ‘governance’, we mean all ‘steering’ carried out by public bodies that seeks to constrain, encourage or otherwise influence acts of private and public parties.

We also include structures that ‘delegate’ the steering capacity to nonpublic bodies (i.e. professional associations).

- By ‘steering’, we mean to include binding regulatory measures (laws) and other measures that are sometimes called ‘new governance’ measures – that is, ‘a range of processes and practices that have a normative dimension but do not operate primarily or at all through the formal mechanism of traditional command-and-control-type legal institutions’.
A Health System has 4 main targets

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good health outcomes</td>
<td>Reaching <strong>best possible health conditions</strong> for the population (e.g., increase life expectancy, decrease child mortality and prevalence of diseases), ensuring <strong>access</strong> to health services and public health interventions</td>
</tr>
<tr>
<td>Financial protection</td>
<td>Protection from financial consequences of <strong>health shocks</strong> that put households at risk of impoverishment</td>
</tr>
<tr>
<td>Responsiveness (patient satisfaction)</td>
<td><strong>Meeting appropriate patient</strong> (country-specific) <strong>expectations</strong></td>
</tr>
<tr>
<td>Country competitiveness</td>
<td>Ensuring <strong>competitiveness</strong> of a country through achieving health systems' financial sustainability and its contribution to overall fiscal and macroeconomic performance</td>
</tr>
</tbody>
</table>

Source: Team analysis, inspired by WHO, Worldbank, and ILO research
... that can be evaluated according to some metrics

<table>
<thead>
<tr>
<th>Objectives of health systems</th>
<th>Typical metrics (examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good health outcomes</td>
<td>▪ <strong>Life expectancy</strong> at birth</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Prevalence</strong> of major communicable diseases* or non-communicable diseases**</td>
</tr>
<tr>
<td></td>
<td>▪ Proportion of the population that is vaccinated</td>
</tr>
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<td></td>
<td>▪ <strong>Waiting times</strong> for health services</td>
</tr>
<tr>
<td>Financial protection</td>
<td>▪ <strong>OOP</strong>* expenditures compared to total health expenditures</td>
</tr>
<tr>
<td></td>
<td>▪ Frequency of health-related shocks to income compared to all income shocks</td>
</tr>
<tr>
<td></td>
<td>▪ Percentage of individuals falling below the poverty line due to illness</td>
</tr>
<tr>
<td>Responsiveness (patient satisfaction)</td>
<td>▪ <strong>Patient satisfaction</strong> surveys at in- and/or outpatient points of care</td>
</tr>
<tr>
<td></td>
<td>▪ Household surveys on satisfaction with government performance with respect to health policies</td>
</tr>
<tr>
<td>Country competitiveness</td>
<td>▪ <strong>Labor costs</strong> and tax rates</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Inflation</strong></td>
</tr>
<tr>
<td></td>
<td>▪ <strong>GDP</strong> growth</td>
</tr>
<tr>
<td></td>
<td>▪ Health care expenditures in relation to total GDP</td>
</tr>
</tbody>
</table>

* Such as AIDS, tuberculosis, malaria, etc.
** Such as diabetes, hypertension, obesity, coronary heart disease, metabolic syndrome
*** OOP expenditure = out-of-pocket expenditure

Source: Team analysis, inspired by WHO, Worldbank, and ILO research
Schematic model of health system

Supply

1. Service providers
   - Public or private service providers

2. Patients and population
   - Frequency of diseases, environmental factors, etc. determine demand for services

3. Benefit package

4. Financing
   - Revenue collection
   - Risk pooling
   - Strategic purchasing

5. Stewardship
   - Regulatory and legal oversight
   - System governance including fiduciary arrangements

6. Input markets
   - Personnel
   - Pharma
   - Medical equipment

Building human resources with respect to knowledge, training and health

SOURCE: McKinsey & Company HSFI team analysis
• Since 1992, Governance has literally ‘grown like topsy’ (in the English NHS, there are well over 40 different ‘types’ of governance) – from corporate to clinical, commissioning to research, and information to staff governance.

• Not all types of governance are necessarily governance in a strict sense, but are more appropriately described as ‘management’.
Clinical Governance

…"What is Clinical Governance?

Clinical Governance is a system through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”…

Why we need governance in healthcare?

- The complex ecology of National health Systems
Globalization

Mobility of goods, services & capital

Mobility of ideas & innovations

Mobility of individuals & microbes

Leadership & Governance

Financing

Service delivery

Information

Medicines & technologies

Human resources

National Health Systems

Patients/People

Tomson, 2010
Governance for health in the 21st century: a study conducted for the WHO Regional Office for Europe

- Governance for health and well-being includes ‘the attempts of governments and other actors to steer communities, whole countries or even groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches’.
- The entire society must be understood as being responsible for its health.

WHO, 2011
Good Governance = Governance for the Common Good?

• We define governance as the traditions and institutions by which authority in a country is exercised for the common good.

• This includes:
  
  – (i) the process by which those in authority are selected, monitored and replaced,
  – (ii) the capacity of the government to effectively manage its resources and implement sound policies, and
  – (iii) the respect of citizens and the state for the institutions that govern economic and social interactions among them.

The World Bank, 2011
Dimensions of Good Governance

UNDP, 1997
Five types of smart governance for health and well-being

• Governing through collaboration
• Governing through citizen engagement
• Governing by a mix of regulation and persuasion
• Governing through independent agencies and expert bodies
• Governing by adaptive policies, resilient structures and foresight

WHO, 2011
Five types of smart governance for health and well-being

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WHO, 2011
The Tallinn Charter (WHO, 2008)

- Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health.

- **Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.**

- [...] health systems are more than health care and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies.
Five types of smart governance for health and well-being

- Governing through collaboration
- **Governing through citizen engagement**
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- Governing through independent agencies and expert bodies
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WHO, 2011
Which is the best health system in the world?

It may be nice to find your country at the top of healthcare rankings, but the relevance to policymakers is strictly limited, explain John Appleby

John Appleby chief economist

King's Fund, London, UK
• The performance of healthcare systems is multidimensional; it may, in the end, be about health, but it is also about efficiency and effectiveness and affordability and acceptability.

• WHO and the EuroHealth Consumer Index recognise this (as do many such comparative surveys) and construct performance “dimensions” populated with varying numbers of statistics (six dimensions and 38 statistics in the case of the EuroHealth survey2).
Health Consumer Powerhouse

The Euro Health Consumer Index
# EuroHealth Consumer Index 2009

For more info please visit: www.healthpowerhouse.com

## Euro Health Consumer Index at a glance:
- **Winner:** Netherlands
- **Runner-up:** Denmark
- **Third place:** Iceland

### Sub-disciplines:
- **Patient rights and information:** Denmark, Portugal
- **e-Health:** Portugal
- **Waiting time for treatment:** Albania, Belgium, Germany, Switzerland
- **Outcomes:** Sweden
- **Range and reach of services provided:** Belgium, Luxembourg, Sweden

### Pharmaceuticals:
- **Denmark, Netherlands**

### Indicators:

#### 1. Patient rights and information:
- 1.1 Healthcare law based on Patients’ Rights
- 1.2 Patient organisations involved in decision making
- 1.3 No-fault medicare insurance
- 1.4 Right to second opinion
- 1.5 Access to expert medical record
- 1.6 Register of legal doctors
- 1.7 Web or 267 telephone HC info
- 1.8 Cross-border care seeking
- 1.9 Provider catalogue with quality ranking

#### 2. e-Health:
- 2.1 SRF penetration
- 2.2 Transfer of medical data between professionals
- 2.3 Lab test results direct to patients via e-health
- 2.4 On-line booking of appointments
- 2.5 On-line access to personal care costs (by insurers)
- 2.6 e-prescriptions

#### 3. Waiting time for treatment:
- 3.1 Family doctor same day access
- 3.2 Direct access to specialist
- 3.3 Major non-acute operations <60 days
- 3.4 Cancer therapy <31 days
- 3.5 CT scan <7 days

#### 4. Outcomes:
- 4.1 Infant & acute child mortality
- 4.2 Infant deaths
- 4.3 Ratio of cancer deaths to number of cancer cases
- 4.4 Preventable years of life lost
- 4.5 MRSA (resistant) infections
- 4.6 Rate of decline of suicide
- 4.7 % of people with high HbA1c levels

#### 5. Range and reach of services provided:
- 5.1 Equity of healthcare systems
- 5.2 Cataract operations per 100 000 aged 65+
- 5.3 Infant 4-disease vaccination
- 5.4 Kidney transplants per million population
- 5.5 Dental care included in public healthcare
- 5.6 Rate of mammography
- 5.7 Infant payments to doctors

#### 6. Pharmaceuticals:
- 6.1 Prescription drug subsidy, %
- 6.2 Layman-adapted pharmacopoeia
- 6.3 Novel cancer drug deployment rate
- 6.4 Access to new drugs (time to subsidy)

### Sub-discipline weighted score:

- **Patient rights and information:** 29 50 38 42 54 38 38 63 46 50 33 50 38 25 46 54 42 33 29 38 42 29 65 50 38 67 25 29 38 42 54 46 54
- **e-Health:** 187 173 187 120 160 133 120 93 172 160 147 147 173 120 120 120 173 120 120 120 173 120 120 120 123 155 155 173 155 172 234 172
- **Waiting time for treatment:** 95 190 155 143 190 202 143 226 202 107 214 190 119 226 202 214 131 131 231 126 226 131 155 107 95 155 172 234 172
- **Range and reach of services provided:** 64 107 136 57 93 100 121 121 139 134 114 88 100 79 86 114 93 71 99 136 88 107 60 107 107 136 134 112
- **Pharmaceuticals:**

### Total Score and Rank:

- **Rank:**
  - 1st: 542
  - 2nd: 795
  - 3rd: 428
  - 4th: 448
  - 5th: 446
  - 6th: 673
  - 7th: 487
  - 8th: 697
  - 9th: 813
  - 10th: 821
  - 11th: 778
  - 12th: 787
  - 13th: 600
  - 14th: 633
  - 15th: 631
  - 16th: 811
  - 17th: 701
  - 18th: 671
  - 19th: 512
  - 20th: 546
  - 21st: 777
  - 22nd: 555
  - 23rd: 863
  - 24th: 740
  - 25th: 585
  - 26th: 632
  - 27th: 489
  - 28th: 560
  - 29th: 686
  - 30th: 788
  - 31st: 630

- **Country Rank:**
  - Netherlands: 1
  - Belgium: 2
  - Switzerland: 3
  - Germany: 4
  - France: 5
  - Italy: 6
  - Spain: 7
  - Austria: 8
  - Denmark: 9
  - Ireland: 10
  - Portugal: 11
  - Luxemburg: 12
  - Britain: 13
  - Greece: 14
  - Sweden: 15
  - Croatia: 16
  - Belgium: 17
  - Finland: 18
  - Iceland: 19
  - Hungary: 20
  - Lithuania: 21
  - Turkey: 22
  - Romania: 23
  - Bulgaria: 24
  - Cyprus: 25
  - Estonia: 26
  - Latvia: 27
  - Malta: 28
  - Denmark: 29
  - Greece: 30
• **Fung C et al. Systematic review: the evidence that publishing patient care performance data improves quality of care.**

• ”Evidence is scant, particularly about individual providers and practices. Rigorous evaluation of many major public reporting systems is lacking. Evidence suggests that publicly releasing performance data stimulates quality improvement activity at the hospital level. The effect of public reporting on effectiveness, safety, and patient-centeredness remains uncertain.”
• Ketelaar N. **Public release of performance data is changing the behaviour of healthcare consumers, professionals or organisations**

• To release information about the performance of hospitals, health professionals or providers, and healthcare organisations into the public domain. However, we do not know how this information is used and to what extent such reporting leads to quality improvement by changing the behaviour of healthcare consumers, providers and purchasers, or to what extent the performance of professionals and providers can be affected.

• The small body of evidence available provides no consistent evidence that the public release of performance data changes consumer behaviour or improves care. Evidence that the public release of performance data may have an impact on the behaviour of healthcare professionals or organisations is lacking.
### Q7 All in all, how worried are you to suffer a serious medical error?

- **% county**

<table>
<thead>
<tr>
<th>Country</th>
<th>Worried</th>
<th>Not worried</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>LT</td>
<td>70%</td>
<td>25%</td>
<td>5%</td>
</tr>
<tr>
<td>EL</td>
<td>70%</td>
<td>29%</td>
<td>5%</td>
</tr>
<tr>
<td>LV</td>
<td>64%</td>
<td>32%</td>
<td>6%</td>
</tr>
<tr>
<td>IT</td>
<td>64%</td>
<td>34%</td>
<td>6%</td>
</tr>
<tr>
<td>CY</td>
<td>53%</td>
<td>46%</td>
<td>6%</td>
</tr>
<tr>
<td>PL</td>
<td>51%</td>
<td>43%</td>
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<tr>
<td>PT</td>
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<td>LU</td>
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<td>MT</td>
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<td>HU</td>
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<tr>
<td>ES</td>
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<td>UK</td>
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<tr>
<td>CZ</td>
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<td>IE</td>
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<td>AT</td>
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<td>NL</td>
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<td>13%</td>
<td>86%</td>
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<td>BG</td>
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<td>TR</td>
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<tr>
<td>RO</td>
<td>58%</td>
<td>32%</td>
<td>11%</td>
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<tr>
<td>CY(tcc)</td>
<td>53%</td>
<td>32%</td>
<td>6%</td>
</tr>
<tr>
<td>HR</td>
<td>41%</td>
<td>56%</td>
<td>5%</td>
</tr>
</tbody>
</table>
Q4 Have you or a family member suffered...? - % Yes

- A serious medical error in a local hospital
- A serious medical error from a medicine that was prescribed by a doctor

Medical Errors

Fieldwork: September – October 2005
Publication: January 2006
Five types of smart governance for health and well-being

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WHO, 2011
Chronic disease management. This is defined as a population-based approach to the treatment of chronic illness using evidence-based clinical guidelines, multidisciplinary management and information systems to produce good outcomes at reasonable cost.

Typically, chronic disease management programs pay physicians and providers for putting in place appropriate structures and processes of care (e.g. better information systems), including paying for changes in the way that physicians and providers provide care.

Nolte, 2008
Financial flows related to paying for chronic care

- Financial pooler → Payer/purchaser
- Population/patients
- Providers (GPs, nurses, specialists, hospitals)

(C) (Re-)Allocation

(B) Resource generation: taxes, contributions, premiums

Financing of chronic care / disease management

(D) Provider payment/reimbursement

(A) Cost-sharing & direct payments

Nolte, 2008
Pay-for-performance.
Pay-for-performance has tended to focus on paying for the delivery of specific patient-based outcomes of care, not necessarily exclusively in the field of chronic care. Thus it refers to “financial incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to payer, and improving quality and patient safety” (McNamara 2006).
Quality-based payment

McNamara (2006) defines quality-based payment (or quality-based purchasing) as a narrower concept than pay-for-performance, since it does not generally include an economic component (i.e. incentives for cost savings or efficiency gains); instead it “focuses only on financing schemes that embody explicit financial incentives to reward and penalize providers based on the level of quality of care they deliver”.

Quality can be pegged to structural benchmarks (e.g. information technology investments), processes of care (e.g. compliance with clinical guidelines), and outcomes, including technical outcomes (lower mortality following surgery) and patients’ satisfaction with their care experiences, but not costs.

Nolte, 2008
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WHO, 2011
We want to see better health and well-being for all, as an equal human right. Money does not buy better health. Good policies that promote equity have a better chance. We must tackle the root causes (of ill health and inequities) through a social determinants approach that engages the whole of government and the whole of society.”

Dr Margaret Chan, Director General of WHO
Governance in health in the XXI Century

Health and Well Being

Social Determinants of Health

21st Century Determinants of Health – TRANSNATIONAL

WHOLE OF SOCIETY

SMART GOVERNANCE

Whole of Government
Health in All Policies

Shared Value – Corporate Social Responsibility

Community and Consumer Engagement

Government Action

Business Action

Citizen Action

HEALTH is created in the context of everyday life – where people live, love, work, play, shop, google, travel...
Dear prime minister, minister, mayor or member of parliament:

- Good health underpins social and economic development and strengthens policies across all sectors. However, the economic and fiscal crisis facing many countries presents serious challenges and potentially risks undermining the positive progress that has been made. Nevertheless, it also presents an important opportunity to refocus and renew our efforts to improve the health of all people.

- All sectors and levels of government contribute to health creation. **Your leadership for health and well-being can make a tremendous difference** for the people of your country, state, region or city and for the European Region as a whole.

- Your support for **Health 2020** is truly essential.
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WHO, 2011
<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>Examples</th>
<th>Core comparisons</th>
<th>Special features</th>
<th>Analogies outside health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting</td>
<td>Women's health, Men's Health</td>
<td>Regions, population groups</td>
<td>(In)Equality, (In)Equity</td>
<td>Environmental R.</td>
</tr>
<tr>
<td></td>
<td>Health situation 2020, 2040</td>
<td>(external, internal comp.)</td>
<td>Forecasting</td>
<td>Generic: Human Devel. R.</td>
</tr>
<tr>
<td>2. Health needs</td>
<td>Polish migrants in UK</td>
<td>Observed vs. nominative</td>
<td>Prioritization</td>
<td>Educational NA</td>
</tr>
<tr>
<td>Assessment (HNA)</td>
<td>Mental HNA of Lesbian, Gay, Bisexual, Transgender population</td>
<td>Regions, population groups</td>
<td>Potentially leading to health targets</td>
<td>Community NA</td>
</tr>
<tr>
<td>3. Health Impact</td>
<td>European Emplyment Strategy</td>
<td>Policy-plan-program-project</td>
<td>Prospective or contemporary</td>
<td>Specific: Environmental IA</td>
</tr>
<tr>
<td>Assessment (HIA)</td>
<td>Drinking water privatization</td>
<td>option A vs. B vs. etc.</td>
<td>Social IA, Sustainability IA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Airport extensions (runways)</td>
<td>Population groups</td>
<td>Participation and modeling</td>
<td>Generic: EC-type IA</td>
</tr>
<tr>
<td>4. Health Technology</td>
<td>Pharmaceuticals</td>
<td>Health technology innovation</td>
<td>Medical, economic social, ethical implications</td>
<td>TA of energy, transports etc. technologies</td>
</tr>
<tr>
<td>Assessment (HTA)</td>
<td>Robotic-assisted surgery</td>
<td>vs. previous status</td>
<td>&quot;Horizon scanning&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New-born hearing screening</td>
<td>Population groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Health System Performance</td>
<td>Estonia HSPA</td>
<td>Temporal</td>
<td>Quality, Equity, Efficiency</td>
<td>Technical Systems PA</td>
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<tr>
<td>Assessment (HSPA)</td>
<td>Georgia HSPA</td>
<td>Regions, population groups</td>
<td>Micro-, Meso-, Macrolevel</td>
<td>Security Systems PA</td>
</tr>
<tr>
<td></td>
<td>&quot;Health Systems in Transition (HiT)&quot;</td>
<td>(external, internal comp.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Health-related evaluation</td>
<td>Drug prevention evaluation</td>
<td>Intervention vs. no</td>
<td>Formative or summative evaluation</td>
<td>E. of social interventions</td>
</tr>
<tr>
<td></td>
<td>Health care evaluation</td>
<td>intervention</td>
<td>Study designs</td>
<td>E. of business strategies</td>
</tr>
<tr>
<td></td>
<td>Screening program evaluation</td>
<td></td>
<td></td>
<td>E. of any policies, programs</td>
</tr>
</tbody>
</table>
The European social model

• A system of transfers
  – From rich to poor
  – From young to old
  – From employed to unemployed
  – From healthy to ill
Free health care – no thanks.... We’d rather die
Daniel Hannan MEP on the NHS

“A 60 year mistake”
A Greek tragedy

Correspondence

Health effects of financial crisis: omens of a Greek tragedy

Greece has been affected more by the financial turmoil beginning in 2007 than any other European country. 15 years of consecutive growth in the Greek economy have reversed; in 2009, unemployment rose from 6.9% in May 2008, to 16.1% in May 2013. (Youth unemployment from 18% to 43% in 2010). The official growth between 2007 and 2010 from 45.4% to 14.2% of the gross domestic product (GDP) was followed by a sharp decline in GDP of 21.5% (2007-2010). The average change in the EU-15 (the 15 countries that were euro members before May 2010) from 66.4% to 29.4% of GDP in the same period (6.8% to 1.8%).

Greece’s options were limited, since its government resorted to leaving the Euro, predicting them from one of the most common solutions in such scenario: recession, depression, and financial crisis, the crisis continued to evolve in Greece; industrial production fell by 8% in 2007.

Michael Burton has asked whether anyone is looking at the effect of the economic crisis on health and health care in Greece, in light of the adverse health effects of previous recessions. Here, we describe changes in health and health care in Greece on the basis of our analysis of data from the EU statistics on income and living conditions, which provide comparable cross-sectional and longitudinal information on social and economic circumstances and living conditions. The results show that the economic crisis has had a profound impact on the health and health care system. In particular, there has been a significant decline in the number of hospital beds and doctors, and an increase in the number of patients waiting for treatment.

Although people were less likely to use health care and are more likely to report they are unable to afford medical care, they are also more likely to report that they are unable to afford medical care. The increase in the number of patients waiting for treatment is also evident, with a significant decrease in the number of hospital beds and doctors, and an increase in the number of patients waiting for treatment.

Figure 1: Changes in self-reported health and access to health care are linked to financial stress. The percentage of people who report financial stress increased from 30% in 2007 to 2010, while the percentage of people who report financial stress decreased from 20% in 2007 to 2010. The percentage of people who report financial stress decreased from 30% in 2007 to 2010, while the percentage of people who report financial stress increased from 20% in 2007 to 2010.

Figure 2: Changes in self-reported health and access to health care are linked to financial stress. The percentage of people who report financial stress increased from 30% in 2007 to 2010, while the percentage of people who report financial stress decreased from 20% in 2007 to 2010. The percentage of people who report financial stress increased from 30% in 2007 to 2010, while the percentage of people who report financial stress decreased from 20% in 2007 to 2010.

Figure 3: Changes in self-reported health and access to health care are linked to financial stress. The percentage of people who report financial stress increased from 30% in 2007 to 2010, while the percentage of people who report financial stress decreased from 20% in 2007 to 2010. The percentage of people who report financial stress increased from 30% in 2007 to 2010, while the percentage of people who report financial stress decreased from 20% in 2007 to 2010.
“A service for the poor is a poor service”

Richard Titmuss
We stand at a critical point

• So far, the European welfare state, and with it universal health coverage, has withstood shocks and attacks
• But this time, the forces against it are stronger than ever
• Will it survive?