**COUNCIL OF THE EUROPEAN UNION**

**Brussels, 24 September 2013**

**12981/13**

**LIMITE**

**SAN 303**
**SOC 723**

**NOTE**

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| from: | General Secretariat of the Council |
| to: | Working Party on Public Health at Senior Level |
| Subject: | Reflection process: Towards modern, responsive and sustainable health systems - *Discussion* |

1. At its meeting on 6 June 2011 the Council (EPSCO) adopted conclusions "Towards modern, responsive and sustainable health systems"[1], in which the Council invited Member States and the Commission *"to initiate a reflection process under the auspices of the Working Party on Public Health at Senior Level aiming to identify effective ways of investing in health, so as to pursue modern, responsive and sustainable health systems"* (paragraph 22).

2. The Working Party on Public Health at Senior Level (herein after "WPPHSL") has been requested to *"steer the reflection process, set up its roadmap and develop its modalities"*. At its meeting on 10 October 2011, the WPPHSL included the reflection process in its multi-annual work programme[2] and set up thematic subgroups[3] consisting of interested Member States to discuss as a priority those topics that had been identified in paragraph 22 of the Council conclusions, namely:

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1 OJ C 202, 8.7.2011, p. 10

2 14112/11 and 16270/11 (outcome of proceedings of the meeting on 10 October 2011)

3 The WPPHSL set up 4 subgroup at the meeting on 8 October 2011 and at the meeting on 8 February 2012 decided to split the former subgroup 3 into two separate subgroups (now 3 and 4).

1) Enhancing the adequate representation of health in the framework of the **Europe 2020 Strategy** and in the process of the European Semester.

2) Defining success factors for the **effective use of Structural Funds** for health investments.

3) Cost-effective use of **medicines**

4) **Integrated care** models and better **hospital management**

5) Measuring and monitoring the **effectiveness of health investments.**

3. At the WPPHSL meeting on 8 February 2012, the 'coordinators' of each subgroup gave a brief information about the first discussions within the subgroups.

4. At the WPPHSL meeting on 28 September 2012, the 'coordinators' of each subgroup submitted progress reports indicating a timeline and expected deliverables for sub-groups' work[4]. The Chair concluded that:
   - delegations welcomed the progress reports by sub-groups;
   - the sub-groups plan to conclude their work soon, within the given timelines and a final report to be presented by next year, so that some outcomes may be submitted to the EPSCO Council of December 2013;

5. The WPPHSL at its last meeting on 14 February 2013 noted the information from its Chair on the progress of the work[5] and concluded that "the WPPHSL would return in detail to the reflection process on modern, responsive and sustainable health systems at its next meeting in October 2013 under the Lithuanian Presidency and would discuss the final reports by the five sub-groups".

6. The five final reports by subgroups have been now submitted for consideration of the WPPHSL and are contained in Annexes I to V to this document. All reports are structured into five parts to give information about main findings, deliverables,conclusions and recommendations formulated by subgroups..

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4 13051/12

5 8057/13, part 1 (outcome of proceedings of the meeting on 14 February 2013)

7. Annexes to different reports are in the Addendum 1 to this document, which contains information and analysis that the subgroups want to bring to the attention of the WPPHSL.

8. The Presidency analysed the reports and, in order to frame the discussion, submits to the WPPHSL for consideration the following points:

   a. operational conclusions and recommendations formulated by subgroups in their reports (part III for subgrups 3 and 4 and part IV for subgroups 1, 2 and 5) could be accepted and they could be reflected in the Council conclusions submitted to the EPSCO Council in December 2013 for adoption;

   b. there are some outstanding deliverables identified by subgroups that should be finalised by the end of 2013;

   c. there are issues related to the further possible work beyond the end of 2013, where subgroups specifically asked the WPPHSL to address them, namely:

      i. continuation of the subgroup 1 activities and their extension with a specific view to assess (in full respect of Member States' competences in the organisation and provision of healthcare) observed trends in Member State reform processes, in interaction with the European Semester framework;

      ii. further EU-level dialogue on European Structural and Investment Funds as suggested by subgroup 2;

      iii. continuation of subgroup 3 work on external reference pricing and the policy mix for reimbursing medicinal products to be delivered in the first quarter of 2014;

      iv. "peer reviews" of integrated care models and self-assessment for interested Member States to identify best practices and "success factors" as suggested by subgroup 4;

      v. continuation of subgroup 5 work on concrete recommendations and suggestions on how coordination and harmonisation on the Health Systems Performance Assessment (HSPA) could be organised and on criteria to select priority areas for such HSPA.

9. Further process:

- Subgroups shall be allowed to conclude their on going work on outstanding deliverables by the end of 2013.
- In parallel, the Presidency will submit for discussion, via the Working Party on Public Health, the draft conclusions on this reflection process in order to ascertain a follow-up to the Council conclusions adopted on 6 June 2011 and clearly mark the Council's view on this process. The draft conclusions will build on recommendations of subgroups taking into account the discussion at the WPPHSL on 8 October 2013.
- Subgroups shall pursue work beyond the end of 2013 as indicated in sub-paragraph 8(c) above and report to the next meeting of the WPPHSL under Greek Presidency.

10. The Presidency invites the WPPHSL to:

– take note of the final reports by the subgroups as contained in annexes to this note and thank the coordinators and participating Member States for their valuable contribution to the reflection process;
– take note of the progress achieved in the reflection process, in terms of including health in other policies by implementing the strategy Europe 2020, of identification of themes for possible closer cooperation among Member States, exchange of best practices and progress towards more coordinated EU-level cooperation in order to support Member States, when appropriate, in their efforts to ensure that their health systems meet future challenges;
– agree that the subgroups may continue their work on outstanding deliverables, if necessary, with a view to conclude by the end of 2013;
– agree that the subgroups should pursue work as indicated in sub-paragraph 8(c) above and report to the next meeting of the WPPHSL under Greek Presidency.;
– consider appropriate working mechanisms to advance the reflection process, based on the experience of the subgroups and points raised by the Presidency in points 8 and 9 above.

**ANNEX I**

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| *Subgroup 1*: | Enhancing the adequate representation of health in the framework of the **Europe 2020 Strategy** and in the process of the European Semester |

Co-ordinator: European Commission

Members: Belgium, Estonia, Finland, Hungary, Italy, Lithuania, Luxembourg, Slovenia

## I. Introduction

For the purpose of the sub-group's activities "health" covers topics related to

- Member States' health systems, as regards fiscal reforms and relevant Europe 2020 headline targets, in particular employment by health systems, so-called "white coat jobs".
- Population health status, to the extent that this has an impact on the relevant Europe 2020 headline targets in terms of poverty reduction through better access to healthcare and employment rates through healthy a workforce (employability effects)

The purpose of the group's work is to:

1. Enhance the take-up of the "health" theme in the European Semester. This work is subdivided into topical assessments (related to fiscal impacts, poverty reduction and general population employability, etc.) as well as monitoring of the uptake of "health" by on-going European Semesters
2. Engage in a wider horizon scanning exercise looking beyond the European Semester and the Europe 2020 agenda, encouraging both a more long -term and a broader take on health-related outcomes for society.

On 31 January 2012, 4 September 2012 and 12 June 2013 there were three face-to-face meetings have been held between the meetings of the Council Working Party on Public Health at Senior Level on 10 October 2011, 28 September 2012 and 8 October 2013.

Working methods consisted mostly of Member State experts contributing in writing to various policy papers under preparation. This exchange took place by email and was coordinated by the Commission.

## II. Main findings

### *Main Conclusions*

The uptake of the health theme in the European Semester was assessed for the 2012 and 2013 Semesters (the 2013 assessment is attached to this report). It was found that, over the course of the first three European Semesters, the role of "health" has been consistently reinforced with a total of eleven Member States now having received country-specific recommendations advocating health system reforms. Also, the tone and context of references to health systems reforms have evolved, with access to healthcare now explicitly included as a policy aim in the Commission's Annual Growth Survey for 2013[6]. More generally, there has been an increase in references to social inclusion/access to healthcare. References to employment effects now focus on beneficial effects on workforce employability, resulting from health investments (fostering a healthy population of working age). The reform agenda emerging from the 2013 country-specific recommendations stresses the overall aim of increasing the cost-effectiveness of health systems. Specifically, the necessity to make health systems less hospital -centric is emphasized. This is complemented by a recognition of the need to strengthen eHealth tools / health information systems in the European Semester. However, the uptake of the health theme in future European Semesters could be improved by further stressing the role of health investments in terms of beneficial social inclusion and employability effects. These elements could be presented in a more systematic and methodologically convincing manner in National Reform Programmes.

Discussions in the sub-group confirmed that the role health investments can play to contribute to the Europe 2020 headline targets to reduce population poverty levels and to demonstrate increases in population employability can be substantiated in an objective manner. In this context, discussions on the good practice examples showcased in the European Commission Staff Working Document on "Investing in Health"[7] have proven very useful. A more technical discussion on methods using EU-SILC (Statistics on Income and Living Conditions) data to estimate[8] the full impact of public healthcare coverage in terms of poverty rates further corroborated this point. The sub-group agreed

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6 COM(2012) 750, see http://ec.europa.eu/europe2020/pdf/ags2013_en.pdf

7 SWD(2013) 43 , see http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf

8 Aaberge et al 2013, see http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-RA-13-009/EN/KS-RA-13-009-EN.PDF

that the relevance of considering the full impact of health system reforms as going beyond direct budgetary effects to account for direct and indirect impacts of health system reforms on poverty rates and employment rates was confirmed. Furthermore, it found that the technical feasibility of such a more in-depth assessment was demonstrated from available literature and existing policy examples. The uptake of more thorough health reform impact analyses in National Reform Programmes is therefore advisable. This advice is particularly timely given the increase in the number of Member States that have received a country-specific recommendation in this area.

***Tools/Cooperation Mechanisms***

The widest possible dissemination of the sub-group's work was sought in line with one of the initial objectives of the sub-group: "to ensure a wider horizon scanning exercise looking beyond the European Semester and Europe 2020 agenda and encouraging both a more long -term and a broader take on health-related outcomes for society."

First, a discussion paper entitled "Health, an investment, not a burden" (see appendices to document 13051/12 by the General Secretariat of the Council) sparked a debate in the Working Party on Public Health at Senior Level on 28 September 2012. This debate focused on the possibility of a more pronounced role for the WPPHSL in the process of the European Semester. Second, in respect of the invitation in the June 2011 Council Conclusions to ensure a sufficiently wide dialogue, the Commission (DG SANCO Directorate D, holding the Chair of sub-group 1) has presented selected relevant policy questions sparked by the sub-group's discussion in the Social Protection Committee of 19 September 2012. Third, a dedicated thematic summary on Health and Health Systems was drafted, the "Health Fiche". A preliminary version was circulated in the sub-group and comments were taken on board. The "Health Fiche" was formally submitted as part of the Europe 2020 Thematic Summaries[9].

[9] See http://ec.europa.eu/europe2020/making-it-happen/key-areas/index_en.htm

***Challenges***

There are two outstanding challenges as identified by the sub-group. First, there seems previously to have been no consensus in the WPPHSL on strengthening its role in the European Semester. This is deplored by the sub-group as the increase in Country Specific Recommendations addressing health system reform means a more prominent role, possibly in tandem with an extended mandate, for the WPPHSL would be relevant and timely. Second, there is a need to translate the concept of "access to high- quality healthcare" as presented in the 2013 Annual Growth Survey into operational assessment criteria.

## III. Deliverables

Three short papers have been produced by the subgroup. These documents were finalised before the meeting of the WPPHSL in September 2012:

- Two shorter papers, summarising relevant policy questions related to the link between health investments and a healthy workforce, as well as poverty reduction.

- A paper entitled "Health, an investment, not a burden" taking a broader perspective in order to highlight both health and healthcare, values and the economic added value of a healthy population, equity, cost effectiveness and investment, along a Health In All Policies approach.

In parallel, the Commission delivered two short reports analysing the presentation of health in the European Semester, both for 2012 and 2013. The 2012 assessment had previously been circulated (see appendices to document 13051/12 by the General Secretariat of the Council), whereas the 2013 assessment is attached as appendix to this report.
Further, a preliminary version of the Europe 2020 "health fiche" was circulated within the sub-group and comments taken on board. It should be noted that the sub-group will be consulted in a similar way on a forthcoming update of the health fiche, which is likely to integrate the concept of "access to high quality healthcare" in a forthcoming update of the "health fiche".

Two final points should be noted in follow-up to the sub-group's report to the WPPHSL of 28 September 2012.

First, a previously announced paper on how better to present budget reforms in health systems as part of the National Reform Programmes was not delivered. Given the existence of general (non-sector -specific) guidance by the Secretariat-General of the Commission as well as the publication of a dedicated "Health Fiche", the latter document was considered a more effective platform for disseminating the sub-group's findings. Further, the present note (specifically the "Main Findings" section) points Member States to useful external sources demonstrating how the presentation of health system reforms could also include direct and indirect impacts on population poverty and employment rates.

Second, as regards the self-assessment of the impact the sub-group's work has made, there can be no firm conclusion on this point. The uptake of the health theme improved in parallel to the timeline of the sub-group's activities and the sub-group tapped into various dissemination channels, but this in itself does not constitute sufficient proof of the sub-group's impact.

## IV. Conclusions/recommendations

In view of the sub-group's main conclusions, the sub-group recommends that:

1. Member States assess the possible impacts of health system reforms as presented in National Reform Programmes in terms of direct and indirect effects on population poverty and employment rates.
2. The Commission translates the concept of "access to good quality healthcare" into operational assessment criteria.
3. The Commission continues its monitoring exercise whereby the uptake of the health theme in successive European Semesters is assessed.
4. The sub-group continues its work until the end 2013 in order to deliver a written input to the Commission in preparation of a forthcoming update of the Europe 2020 "Health Fiche" with an eventual publication foreseen as late as by June 2014.
5. The WPPHSL delivers a clear opinion on the possible continuation of the Sub-Group's work beyond 2013.
6. The WPPHSL tables an annual discussion point to reflect on the Commission's assessment of the preceding European Semester (discussion to be tabled in the second semester WPPHSL).

Within the sub-group, arguments for and against a possible continuation of the sub-group's activities have been presented. The absence of a clear consensus on the role of the WPPHSL has been noted as an argument against . The growing relevance of the sub-group's work in view of the continued and growing uptake of the health theme in successive European Semesters was raised as an argument for . Consequently, and in line with Recommendation 4 above, should the WPPHSL show an interest further developing its involvement in the European Semester, the work of the sub-group could usefully continue after 2013. In the absence of such a commitment by the WPPHSL, the sub-group will discontinue its work after 2013.

## V. Annexes (see 12981/13 ADD 1)

*1. "Health" in the European Semester 2012*

**ANNEX II**

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| *Subgroup 2*: | Defining success factors for the **effective use of Structural Funds** for health investments |

Co-ordinator: Hungary

Members: Bulgaria, Croatia, Czech Republic, European Commission, Greece, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia

## I. Introduction

The Structural Funds regulations 2014-2020 will soon be adopted and partnership agreements will then be concluded between the Commission and Member States on the priorities for investments.

The EU Structural Funds (which will be called "European Structural and Investment Funds - ESIF" in the 2014-2020 period) provide an important resource for achieving health objectives, transforming services and enabling health to make a significant and measurable contribution to regaining economic stability.

This provided the rationale and context for the work of subgroup 2 of the Reflection Process on health systems, which aimed to achieve the following objectives within the time frame of 2012-2013 (see Council document 14114/11):

- "Sharing and analysing experiences and best practices;
- Identifying common sense "success factors", which should be present in advance as to guarantee effective investments from the Structural Funds in the health sector;
- Develop a tool box for the use of Member States on the effective use of Structural Funds for direct health investments and for programming investments in other sectors, which could increase health gains;
- Discuss opportunities to implement PPPs or other financial engineering instruments in the health sector."

Subgroup 2 held five formal meetings on 29 March 2012, 2 July 2012, 28 November 2012, 23 April 2013 and 11 July 2013. In addition to these meetings, working papers were prepared by the chair and by the subgroup members, which provided evidence-based fact-finding aimed at generating a deeper level of understanding of members' experience and outlooks. In addition, the subgroup received findings from earlier project reviews of use of the Structural Funds in the health sector.

## II. Main findings

The precondition for providing safe and effective healthcare is that it should be evidence-based, supported by good governance systems and delivered by a well-trained and competent workforce. Thus, effective operational and management systems and practice are paramount.

At the moment, shortcomings can be observed throughout the various stages of Structural Funds investment on health, i.e. in strategic planning and priority setting, integration and coordination with other priorities and needs, technical content and structuring of projects, programme implementation and project management, and financial affordability and sustainability. The problems remain evident despite the extensive (and growing) package of advice and guidelines on using the Structural Funds provided by the European Commission.

The work of the subgroup 2 has led to the identification of policy principles and good management practices to address these shortcomings in the form of a toolbox (see in document 12981/13 ADD 2).

The main message from the group is that there are ways to improve Member States' capacities and competencies for Structural Funds planning, negotiation, implementation and evaluation, and to build bridges between the EU 2014-2020 Structural Funds processes, procedures and expectations and the health ministries' internal planning and investment management processes.

This can take the form of a more systematic approach to the planning and management of health investment, which constitutes an important area in the application of the Cohesion Policy and European Structural and Investment Funds in the 2014-2020 period. Subgroup 2's toolbox is a contribution to that approach.

## III. Deliverables

Based on its mandate, subgroup 2's main output is a "toolbox", the primary purpose of which is to provide a source of reference for all Member States, regions and Structural Funds stakeholders to help improve the performance and effectiveness of Structural Funds investments in health. This toolbox has the primary function to make a start to help improve the quality and effectiveness of planning, decision-making and implementation of Structural Funds investment programmes and projects in the health sector. It also incorporates elements that identify and help develop "common sense success factors" that will contribute to successful Structural Funds investment outcomes.

The toolbox does not replace the existing guidelines but aims to supplement them with specific advice applicable to the health sector. It can enhance but obviously not replace Member States' internal systems and processes.

The toolbox helps ultimately to transform tacit and implicit knowledge into explicit knowledge that can be shared throughout the system. The toolbox should therefore contribute to reducing the risk of malfunctions in health systems and enhance overall effectiveness.

The toolbox will contribute to:

- Improving Member States 'administrative capacity' to make effective investments whilst providing a means of strengthening the response to ex-ante conditionalities;
- Providing consistency and continuity in the quality of planning and management actions, and technical decision-making, by Member States and regions;
- Establishing a generic basis for subsequent or parallel development of planning, procurement, implementation and evaluation processes within Member States.

The toolbox contains the following chapters:

1. Critical success factors
2. Key policy messages
3. 2014-2020 Structural Funds framework and mechanisms
4. Strategic planning

5. Financial planning
6. Implementation
7. Conclusion

## IV. Conclusions/recommendations/next steps

- *Dissemination and national work*

The EU-wide dissemination of the toolbox is of utmost importance.

At the EU level, a joint DG SANCO-DG REGIO workshop will be held at the Open Days (11th European Week of Regions and Cities) on 9 October 2013 where the work of subgroup 2 and the toolbox will be presented and Hungary and other Member States will share their experiences using this tool in supporting the programming (and implementation) of the ESIF 2014-2020.

At the national level, Member States participating in the work of subgroup 2 are committed to using the toolbox and disseminating it widely within the bodies involved in ESIF management.

The toolbox document will be hosted by Hungary (on the website of the National Institute for Quality and Organizational Development in Healthcare and Medicines).

All Member States are encouraged to disseminate the deliverables of subgroup 2 to relevant national departments and agencies dealing with ESIF and similar health investments.

- *Health Programme Tender*

Additionally, the work of subgroup 2 will be continued in a support action, funded by the Health Programme, on the effective use of European Structural and Investment Funds (ESIF) for health investments, which will start this autumn and last until early 2015. The tender aims to develop evidence and further guidance on the use of 2014-2020 ESIF to address health sector priorities and better management of the funds at national and regional level.

The action has three specific objectives:

1) Building knowledge about the use of ESIF for health in the new programming period 2014-2020;
2) Preparing managerial and technical tools for effective health investments; and
3) Providing practical support to Member States – with tailored tutoring and meetings – on the use of ESIF.

The action will, therefore, support Member States' and regional authorities (i.e. ministries and departments of health, managing authorities and other bodies involved in the programming and managing of Structural Funds in the health sector) to be more successful and effective in using funding as part of their overall health investment strategy.

- *Further EU level dialogue on ESIF in 2013 and 2014*

Subgroup 2 has expressed a strong interest in the continuation of the dialogue aimed at improving the relevance, effectiveness and sustainability of health investments under ESIF. The group would like to exchange good practices, with a view to developing better planning, more effective implementation and improved monitoring in the period 2014-2020 in particular through the use of the toolbox.

Taking into account the abovementioned interest, subgroup 2 would like to continue discussions in 2014. Therefore, Hungary, as the chair of subgroup 2, proposes to work with Member States to identify the most effective ways and means of continuing the collaboration, for example in a form of a network – open to all interested Member States – to review the use of subgroup 2 deliverables and to exchange experiences in the context of the start of the 2014-2020 ESIF programming period.

**V. Annexes (see 12981/13 ADD 2)**

*1. Toolbox for effective structural funds investments in health 2014-2020*

| *Subgroup 3*: | Cost-effective use of **medicines** |
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Co-ordinator: Netherlands

Members: Belgium, European Commission, Cyprus, Greece, Poland, Spain

## I. Introduction

1. During the Working Party on Public Health at Senior Level (WPPHSL) of 8 February 2012, it was decided to divide subgroup 3 into two separate subgroups. The new subgroup 3 (SG3) *on cost-effective use of medicines* was established to focus on the goal set by the WPPHSL: *to analyse possible ways to make cost-effective use of medicines through an exchange/ benchmarking of best practices on pricing and reimbursement methods, relative effectiveness assessment, and use of generics.*

2. Subgroup 3 had its first meeting in Brussels on 26 June 2012 and decided to formulate its goals as follows:

- look for financial sustainability in providing the populations of European countries with the pharmaceuticals they need;
- try to use work that is already being done in other working groups and thus avoid duplication of effort (e.g. generic substitution, use of biosimilars, conditional reimbursement, improving HTA);
- seek long-term oriented solutions; concrete results as well as long-term agenda-setting are welcome outcomes;
- feed the outcomes of this exercise into a more comprehensive process and involve all Commission services and Member-State bodies involved in policies concerning medicinal products;
- collect ideas and examples from different countries that can help to get better value for money in pharmaceuticals and make existing best practices available for wider use.

The discussions in this first meeting led to a key question that the subgroup would like to answer in the course of its discussions: *why are medicines so expensive?* The members decided to focus the group's work around five subjects based on possible causal factors that can be influenced by policy measures:

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| Subject 1: | *Can time to market be shortened without damaging the safety of pharmaceuticals?* |
| Subject 2: | *Are there lessons to be learned from other regulatory systems, especially from medical devices by which the price of medicines will be influenced?* |
| Subject 3: | *What is the effect of European Reference Price Systems on prices and availability of pharmaceuticals in the different Member States?* |
| Subject 4: | *What is the effect of reimbursement systems in the different Member States on prices and availability of pharmaceuticals in the different member states?* |
| Subject 5: | *Can parties other than the government assume responsibility for the use of pharmaceuticals, and if so what will be the effect on the cost-effective use of pharmaceuticals?* |

3. The second meeting of SG3 took place on 26 January 2013. The members were debriefed by the chair on the discussion of the first progress report at the WPPHSL meeting on 28 September 2012. The discussion in the subgroup, focusing on the position of the WPPHSL and the European Commission on the proposed subjects 1 and 2, led to a consensus in the subgroup that strategic thinking about regulation and market access of pharmaceuticals, as incorporated in subjects 1 and 2, can have an impact on prices and cost-effectiveness but that this is not part of the mandate for this subgroup. It was therefore decided remove subjects 1 and 2 from the agenda of this subgroup.

4. The tender specifications for the planned studies that will be carried out to answer the questions for subject 3 (*Study on External Reference Pricing for medicinal products)* and subject 4 (*Study on the policy mix on the reimbursement of medicinal products)* were also presented to the members. Related documents are included as annexes to this report. Suggestions by the members of the subgroup were included, and kick-off meetings took place on 4 and 6 February 2013 respectively. The first interim reports of both studies were planned for and delivered by July 2013. The interim reports were presented and discussed at the third meeting of the subgroup on 18 September 2013.

## II. Findings and expected deliverables

**Subject 3 –** External Reference Pricing of Medicinal Products

All but a few EU Member States currently apply "external reference pricing" (ERP), a form of international price linkage, in setting prices for medicinal products, especially for on-patent products. As such, this has become a widely established practice in EU health systems. However, at present little is known about how existing ERP systems influence each other. Such "feedback effects" may lead to unstable prices or other unwanted dynamic effects, eventually possibly hampering patient access to medicinal care. This rather technical area of work is underdeveloped at present, at least as regards literature available in the public domain. A support study under the European Commission's public health programme was launched in January 2013 to assess which cross-country coordination issues may be at play, influenced by/influencing the price setting of medicinal products through ERP-based systems. This assessment will be based on a simulation to make it possible to identify the main parameters that have an impact on medicinal product price pathways over time. Included in this study are consultations with national pricing and reimbursement authorities as well as industry representatives.

The deliverable for this agenda subject will be a set of policy conclusions by the subgroup on the study's final report. In doing this, the subgroup will also take into consideration the growing complexity of ERP systems in themselves as well as their interaction with e.g. managed entry agreements and price negotiations that a growing number of member states execute.

**Subject 4** - Policy mix for the reimbursement of medicinal products

Policy-makers grapple with the challenge of simultaneously reconciling the policy objectives of patient access and equity, budget control and rewarding high-value innovation in the domain of medicinal products. Given inherent trade-offs between the policy objectives at play and varying expectations by different stakeholder groups, the design of an optimal policy mix is not straightforward. A support study under the European Commission's public health programme was launched to approach the issue in a more methodical manner: selecting relevant policy tools and appropriate assessment criteria to deliver a multi-criteria analysis reflecting policy preferences by medicinal product category and stakeholder group. Finally, a set of policy recommendations will be established.

The deliverable for this agenda subject will be a set of policy conclusions by the subgroup on the study's final report.

**Subject 5** - Responsibility for the cost-effective use of pharmaceuticals

In order to gain more insight into trends and developments with regard to stakeholders assuming responsibility for more cost-effective health treatment, the subgroup decided at their meeting on 25 January 2013 to collect best practices from the different participating Member States. To expand the outreach, the Pharmaceutical Pricing and Reimbursement Information (PPRI) network has also sent out a query to its members requesting input for this deliverable. The deadline for providing input was August 2013. This has resulted in best practices from eight different countries showing various ways stakeholders (physicians, insures, as well as professional and patient organizations) can take initiatives themselves to improve the cost-effectiveness and quality of health treatments.

The subgroup has discussed the first results of the recorded best practices in its meeting of 18 September 2013. It concluded that the recorded examples merit a more systematic and analytical approach and will recommend to give follow up on such after the closing of the reflection process.

## III. Conclusions/recommendations

1. The subgroup only had its first meeting in June 2012. For some of the deliverables, in particular deliverables 3 and 4, final conclusions and recommendations can only be given after the completion of the studies on 1) External Reference Pricing and 2) the policy mix for reimbursing medicinal products. These results are expected in December 2013 and January 2014 respectively. The subgroup therefore asks the WPPHSL to provide the possibility of an additional meeting of the subgroup early 2014. The subgroup will then present its final conclusions to the WPPHSL in the first quarter of 2014 on these two deliverables. As regards the external price referencing agenda the subgroup, at this point in time, concludes that the subject will require further consideration not only on a technical level, but also in a more broad perspective as further debate is needed on accessibility and equity issues and related proposals on e.g. differential pricing.

2. On the subject of stakeholder involvement in taking responsibility for cost effective use of medicines the subgroup recommends to the WPPHSL to facilitate a more systematic and analytical approach of the subject in a follow up phase. The subgroup concludes that recent experiences in several member states points to opportunities to considerably improve the use of medicines, including its cost effects, by making stakeholders like physicians, pharmacists and patients more aware about their own responsibilities.

3. As the proposed agenda items 1 and 2, regulation and market access of pharmaceuticals, also have an impact on prices and cost-effectiveness, the subgroup recommends that the WPPHSL further examine appropriate mechanisms to continue the reflection of Member States in cooperation with the European Commission on aspects that may have an impact on the availability, costs and safety of, and innovation with regard to medical products in the Member States.

**IV. Annexes (see 12981/13 ADD 3)**

1. *Executive Agency for Health and Consumers: Tender specifications for requesting specific services (External reference pricing of medicinal products: simulation-based considerations for cross-country coordination)*
2. *Executive Agency for Health and Consumers: Tender specifications for requesting specific services (Policy mix for the reimbursement of medicinal products: proposal for a best practice based approach on stakeholder assessment)*
3. *Best practices by EU Member States*
4. *PPRI Network query*

| *Subgroup 4*: | **Integrated care** models and **better hospital management** |
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Co-ordinator: Poland

Members: Belgium, Croatia, European Commission, Denmark, Finland, France, Greece, Hungary, Italy, Latvia, Malta, Spain

## I. Introduction

1. In its conclusions of 6 June 2011 *Towards modern, responsive and sustainable health systems*[10], indicating a number of challenges facing healthcare systems, the Council of the European Union emphasised the need for smart and responsible innovation, including social and organisational innovation. One of the instruments mentioned for addressing these challenges was innovative approaches to models of healthcare, with the aim of moving away from hospital-centred systems towards integrated care systems.

2. Analysis of models of healthcare should take into account values and principles shared across Europe: *universality, access to good quality care, equity, and solidarity*, as stated in the Council conclusions of June 2006 on *Common values and principles in European Union Health Systems*[11]. The conclusions, while referring to those values, also emphasised another essential feature of all systems: financial sustainability as a safeguard for these values in the future.

3. The integrated care concept is perceived as an important, innovative and promising safeguard. In this approach, sustainability of the healthcare system is assured through smart investing in health by reshaping and reinventing healthcare systems' provision and delivery structures – these structures to a large extent determine the effectiveness of a healthcare system and value of healthcare services delivered.[12]

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10 OJ C 202, 8.7.2011, p. 10.

11 OJ C 146, 22.6.2006, p.1.

12 Michael E. Porter, Elizabeth Olmsted Teisberg: *Redefining Healthcare: Creating Value-Based Competition on Results*. Harvard Business School Press.

4. On the basis of the above considerations, the subgroup decided to focus its work on how the integrated care concept is understood and implemented within the EU context. Moreover, the subgroup analysed the available data on the role of integrated care as a game-changer in improving outcomes and the efficiency and sustainability of a healthcare system. The instruments employed by the subgroup to achieve these results were reports prepared by the European Observatory on Health Systems and Policies, the repository of good practices identified by European Innovative Partnership on Active and Healthy Ageing, and presentations given by and discussions with experts from both public and private healthcare sectors as summarised in the web depository.

## II. Main findings

**Background**

5. **Sustainability of healthcare**: Identification of innovative models of healthcare delivery and provision should not be perceived as a merely academic or theoretical exercise. Expenditure on healthcare had been growing, both in absolute and relative terms (as a percentage of GDP and of total government outlays) till 2008. Despite the recent drop caused by tightened public budgets, it is expected to continue growing over the coming decades, due to a number of factors, the most significant being: chronic conditions, ageing populations, new technologies and public expectations on the accessibility and quality of care. In this context the ongoing patterns of the functioning of healthcare systems' structures (in particular service delivery structures) may both hamper the above-mentioned values and principles and, to some extent, undermine the long-term sustainability of public finances. There are of course many supply and demand side factors affecting the shape and costs of healthcare system and, while the integrated care concept cannot be expected to solve all problems, it can help in reshaping the healthcare delivery systems which are the main drivers of cost – and efficiency – on the supply side.

6. **Fragmentation of delivery systems – need for paradigm shift to integrated care models:** The main operational feature of this reshaping is a perspective that tries to escape the hitherto dominant paradigm of fragmented and separated service delivery systems at different levels:

- vertical (preventive, primary, secondary and tertiary),
- horizontal (health and social) and
- areas of healthcare systems' functions (governance, financing, funding, pooling, delivery, organisational, clinical).

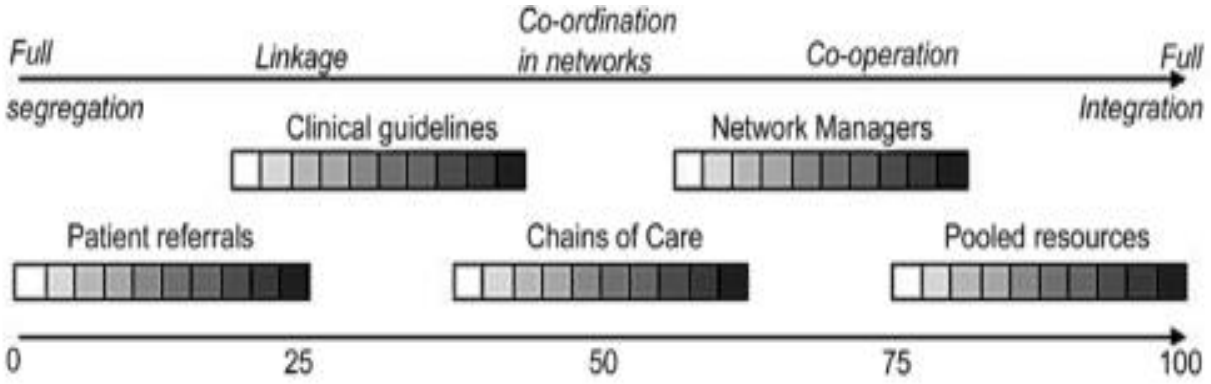
The broader point behind that kind of innovation is that the rapid changes in management and information and communication technologies, in the 20th and 21st centuries in particular, which transformed the way many sectors function, are not fully used in the healthcare sector. And despite numerous and fundamental changes that different segments of healthcare sector underwent during the 20th century, healthcare delivery is very often still frozen in two business models – the general hospital, and the physician's practice – both of which were designed a century ago, when almost all care was in the realm of intuitive medicine. So there may be a threat that 21st century medical technology is delivered with organisational structures that may prevent the healthcare system from taking full advantage (in particular in terms of health outcomes and the system's efficiency) of the rapid changes happening in the medical sector.[13] It is also to be noted that this structural environment was very well suited to a world dominated by communicable diseases but now, when the burden of diseases has shifted towards non-communicable conditions, it may need rethinking and reshaping.

**Rationale of integrated care models**

7. **Creating added value in healthcare:** The ideas of integration are not health-sector specific: actually the health sector may be one of the few that does not fully take advantage of this approach. In other sectors of the economy a synonym for integration is the idea of value chains and supply chains. What is crucial in the "chains" ideas is that each link in the chain adds some value to the one before . Creating, rescheduling and optimising these chains is crucial in terms of increasing the effectiveness of the whole system and organisation. On a large scale these ideas are employed by Health Maintenance Organisations / Managed Care Organisations.

8. **Continuum of integration and instruments:** Nevertheless, without a clear strategic approach, the healthcare sector employs a whole range of separate approaches aimed at integrating supply chains. Depending on the nature of the instruments employed, these approaches may be illustrated in the form of a type of continuum:

[13] Clayton M. Christensen: *The Innovator's Prescription: A Disruptive Solution for Healthcare*. McGraw Hill.




Source: Bengt Ahgren, Runo Axelsson: *Evaluating integrated healthcare: a model for measurement.* International Journal of Integrated Care, 2005 Jul-Sep.

9. The subgroup agreed that since the context of integrated care in the EU is mainly determined by the above-mentioned separate approaches, the integrated care concept , as it is, may be described as: *initiatives seeking to improve outcomes of care by overcoming issues of fragmentation through linkage or co-ordination of services of providers along the continuum of care*[14] These approaches use different instruments operating at different levels and addressing different system functions, as shown in the table below:

| **Functions** | **Instruments** |
|---|---|
| Governance | - consolidation/decentralisation of responsibilities and functions,<br>- inter-sectoral/inter-agency planning and/or budgeting,<br>- quality and outcomes frameworks; |
| Funding and pooling | - pooled resources (at various levels),<br>- prepaid capitation (at various levels); |
| Service delivery and payment mechanisms | - needs assessment incl. population (community) needs assessment,<br>- allocation chains,<br>- joint purchasing or commissioning,<br>- jointly managed programmes or services (chains of care),<br>- paying for performance,<br>- bundled payments,<br>- upfront fees; |

[14] Adapted from: "*Integrated care: assessing economic impact and payment methods",* the European Observatory on Health Systems and Policies.

| Functions | Instruments |
|---|---|
| Organisational | - patient referrals,<br>- consolidation, common ownership or merger,<br>- strategic alliances or care networks/network managers,<br>- centralised information, referral and intake,<br>- integrated information system,<br>- around-the clock (on call) coverage,<br>- discharge and transfer agreements; |
| Clinical | - care management,<br>- case management,<br>- disease management,<br>- clinical pathways (integrated care pathways),<br>- joint training,<br>- multidisciplinary /interdisciplinary team work,<br>- standardised diagnostic criteria,<br>- uniform, comprehensive assessment procedures,<br>- joint care planning,<br>- shared clinical records,<br>- continuous patient monitoring,<br>- common decision support tools (practice guidelines and protocols),<br>- regular patient/family contact and ongoing support; |

Source: Adapted from Dennis L. Kodner, Cor Spreeuwenber: *Integrated care: meaning, logic, applications, and implications – a discussion paper.* International Journal of Integrated Care – Vol. 2., 14 November 2002.

10. **Assessment and evaluation**. Because of the variety of these initiatives and the different instruments employed to incentivise coordination among different blocks and functions of healthcare systems, it is hardly possible, at this stage, to assess integrated care models as models *per se*. What is possible is the assessment of instruments integrating care within targeted programmes. And in this area there is a consensus among experts that such programmes appear to improve the quality of care. However it is difficult, if not impossible, to produce evidence supporting the thesis of substantial financial savings or efficiency gains – which seems to be a clear result of the fact that these programmes do not lead to systemic changes in delivery systems but to incremental ones in the provision of specific services.

**Early experiences with integrated care models**

11. **Initial approach to integrated care**: In the healthcare sector, fragmentation, decentralisation and lack of coordination in provision of healthcare services is also identified as a substantial obstacle to improving health systems' outcomes and efficiency in the short term, and sustainability in the longer term. So the idea of overcoming fragmentation by a more integrated approach is popular in many EU countries. There are a number of different approaches and instruments employed that are commonly labelled "integrated care" (see table above). Nonetheless, the common characteristic of most of these differences is that they usually start as disease-specific, targeted programmes; they concentrate on specific diseases and indications and usually they deal with chronic diseases.

12. Thus, if the main promise of integrated care models was to overcome fragmentation via system approach to service delivery and value/supply chains – that in result should generate value and effectiveness gains – it seems obvious that the present practices of targeted programmes do not live up to these expectations. But the main reason seems to be that we have not yet reached the integrated care phase – what we have is rather "instruments of integration / coordination" that *per se* cannot and do not constitute an integrated care model, and may even have some anti systemic side-effects: the whole is just greater than the sum of its parts.

13. **Need for further development:** As this continuum may indicate, most projects so far have only reached the phases of linkage or coordination, not integration. They try to incentivise coordination and linking of activities between blocks and functions of a healthcare system that are still separate. That is why they only use a few "integrating" instruments, i.e., only those essential for carrying out the particular programme, such as the "pay for performance" scheme, aimed at achieving set quality / outcome targets, or the "bundled payment" scheme for addressing chronic conditions. In effect, such an approach does not integrate blocks and functions at system level and does not change the system of healthcare delivery but only introduces incremental changes in the way the services are delivered in given conditions. And such attitude may also have important negative side-effects, by multiplying investments in parallel programmes, focusing on actions at the local level and jeopardising the implementation of long-term strategies.[15]

[15] Gilson L. *Health policy and systems research: a methodology reader*. Geneva: World Health Organisation; 2012.

**The way forward**

14. **Conceptual clarification:** The above-mentioned approach and description of integrated care needs revision: not all initiatives should be labelled as "integrated care". There is a need for such conceptual clarification, because without it both theory and practice could not be advanced and – what is even worse - may be lead astray, in particular in the context of research projects and financial investments in the healthcare sector.

15. **Broadened scope:** In the new approach and description, the integrated-care umbrella would cover only those projects that:

- try to integrate healthcare systems vertically, horizontally or functionally; and
- address the health needs of a population (community) rather than being disease-specific.

Through close integration of (some or all) of these vital healthcare functions, it may be possible to create value/supply chains by achieving strengths and synergies that – in particular in terms of quality and efficiency - may not be achievable in the fragmented, fee-for-service and non-systemic background of current healthcare systems. These strengths and synergies may be related to:

- sharing experience and expertise to identify and implement successful practices;
- sharing a vast clinical knowledge base that continuously supports quality improvement;
- coordinating care across disciplines to provide continuity of care and reduce duplication and waste and make optimal use of workforces;
- practising team-based care (physicians, nurses, care managers, technicians, and others);
- monitoring and reporting on the performance of service delivery, quality of care and equal access;
- investing in sophisticated quality improvement tools and strategies that are not available to a solo practice or to small groups of physicians.
- empowering patients and citizens and promoting self-care and informal care.

16. **Shift to 'second wave projects':** The approach proposed seems in line with the "second wave" projects relating to integrated care that are being conducted in some EU countries. While the "first wave" projects were mainly about disease-specific programmes, the "second wave" are projects that try to integrate and bring together functions of healthcare systems in a population-oriented, supply-chain manner. They also seem to have a strategic vision (rather than piecemeal, incremental improvements), with the ambition of reorganising delivery systems in the direction of the integrated delivery system. The ongoing second wave projects in this area identified by the subgroup are the following:

- the German *Gesundes Kinzigtal* integrated care initiative,
- the *Strategy for Addressing Chronicity in the National Health System in Spain*,
- the Basque *Chronicity Strategy,*
- the Northern Irish *Transforming Your Care* initiative,
- the Belgian Position Paper *Organisation of Care for Chronic Patients in Belgium,*
- the European Innovation Partnership on Active and Healthy Aging project headed by European Commission, DG for Health and Consumers and DG Communications Networks, Content & Technology.

This listing is illustrative only – in these cases there seems to be a clear shift from projects based on targeted programmes towards more systemic projects integrating separate functions and blocks of healthcare systems.

**III. Conclusions/recommendations**

The analysis developed by the subgroup concludes that there is a wide variety of strategies between Member States regarding the integration of care. Differences in healthcare system organisation and a vast myriad of actors involved: payers and reimbursement methods, multiple suppliers and levels of government have led to manifold solutions.

Nevertheless, some features have been identified on the basis of an EU comparison exercise, with a systemic approach that could constitute a common EU reference. Following the available evidence-based analysis, the subgroup recommends the following lines of action to advance towards integrated healthcare systems in the European Union:

**1. The Member States** should support the establishment and development of national policies and programmes on integrated care by:

a) Embedding integrated care as a priority in health policies and programmes at national, regional and local levels, including a specific commitment to promoting a systemic approach and population-based strategies.
This systemic approach is of the utmost importance both for research projects, financial instruments employed and service redesign. It is not targeted programmes with separate instruments of coordination but systemic projects integrating blocks and functions of healthcare systems that should be a driving force for the analysis and implementation of integrated care models. So Member States should move from a "disease-based" to a "population-based" approach when designing integrated care strategies, adopting a systemic perspective, making the patient the centre of the system and setting aligned objectives in terms of quality and cost. There seems to be a consensus about the potential benefits of integrated care, as experience from regional initiatives and other sectors shows. Member States should consider this option when discussing improvements in the efficiency and sustainability of healthcare systems.

b) Supporting the development of processes and tools, including the use of information and communication technology and financial instruments, and simultaneously promoting a cultural change in health organisations, based on professionalised managers and the involvement of professionals. Member States should therefore support the design of incentives to overcome obstacles in the system and to provide patients with healthcare on a care continuum basis by moving to modern management approaches based on key elements of integrated care based on scientific evidence (interoperable information systems; guidelines to steer decision-making; payment systems that prevent or minimise cross-costs and cost-shifting; enhancing the role of primary care as the coordinating axis of care integration; involvement of professionals in the management of integrated healthcare services). Member States are encouraged to use fully the tools devised by the subgroup on *Success factors for the effective use of Structural Funds for health investments* to support their systemic efforts to integrate blocs and functions of healthcare systems.

c) Encouraging health professional organisations to have an active role in integrated care.

d) Promoting the training of healthcare workers on integrated care by:
- encouraging multidisciplinary integrated care training of all health professionals, other healthcare workers and relevant management and administrative staff in healthcare settings;
- embedding integrated care in on-the-job training and the continuing professional development of health professionals.

e) Empowering and informing citizens and patients by involving patient organisations and representatives in the development of policies and programmes on integrated care at all appropriate levels.

f) Sharing knowledge, experience and best practice by working with each other and with the Commission and relevant European and international bodies on:
- the establishment of integrated care programmes, structures and policies, including reporting and learning systems, with a view to addressing the cost;
- effectiveness of integrated care interventions and solutions at the healthcare setting level and evaluation of their transferability, - reporting on the care integration situation in each Member State by working with each other and with the Commission to develop a performance assessment on the basis of the international available taxonomy and measurement tools.

g) Developing and promoting research on integrated care.

**2. The European Commission** should:

a) Use its financial and non-financial instruments to support those integrated care projects, including research, innovation and implementation projects, that are based on a systemic approach in integrating separate functions and healthcare system blocks. Evidence-based benchmarking and best practices should, when possible, be taken into consideration.

b) Provide specific attention to populations with chronic diseases, a major concern for the future with an eye to epidemiological trends in the population derived from the ageing process in the European Union. Specifically, building on the experiences of *the European Innovation Partnership on Active and Healthy Aging* and *the Reflection process on innovative approaches for chronic diseases in public health and health care systems*, create instruments and platforms for research, analysis, networking, and knowledge sharing for Member States, regional and local authorities and institutions interested, including collaboration with the Organisation for Economic Cooperation and Development and the World Health Organisation.

**3. The Working Group on Public Health at Senior Level** should continue its work on integrated care models. Instruments that may further that work could include integrated care models "peer-review" and self-assessment exercises for interested Member States with the aim of identifying best practices and success factors for systemic implementation.

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*Subgroup5:* Measuring and monitoring the **effectiveness of health investments**

Co-ordinator: Sweden

Members: Austria, Belgium, European Commission, Czech Republic, Denmark, Estonia, Hungary, Lithuania, Portugal, Slovenia, Spain, United Kingdom

## I. Introduction

In its conclusions "Towards modern, responsive and sustainable health systems", adopted in June 2011, the Council recognised that Member States face common challenges within this area and emphasised the need to join forces and enter into more coordinated EU-level cooperation in order to support Member States. Member States and the Commission were invited to initiate a ”reflection process” aimed at identifying effective ways of investing in health, so as to pursue modern, responsive and sustainable health systems.

The initial task of this sub-group was to specify objectives and consider policy actions for:

- Considering which recommendations in the Joint EC report should be taken forward,
- Developing common methodologies for collection of data and analysis of information, in cooperation with the OECD and the WHO,
- Sharing of best practices.

After the first meetings of the sub-group, and the feedback given by the Working Party on Public Health at Senior Level in spring 2012, the sub-group decided to fine-tune its brief and focus on improving the direct usefulness to policy-making of international comparisons of health systems by suggesting actions aimed at:

- Increasing the visibility, transparency and validity of comparisons
- Developing a basis for policy decisions by prioritising the areas for comparison and assessment
- Exchanging experience and knowledge

Members of the sub-group met five times to discuss the topic and elaborate conclusions and recommendations. The coordinator also met representatives of the OECD, WHO Euro and the Observatory.

## II. Main findings

Much has already has been done and is being done within the framework of the EU, the OECD and the WHO on measuring and monitoring quality and effectiveness within health and health care systems (see Annexes 1, 2, 6).

The initial work of the sub-group pinpoints the need to be more specific when comparing and assessing performance. General comparisons at a country-to-country level do not add enough policy value, since there are profound differences between how countries have structured their health care systems. Thus, the current comparisons cannot adequately steer the kinds of improvements in quality and effectiveness that are needed. From this perspective the sub-group concluded that there is a need to complement today's work on comparison and assessment with a more specific agenda of analysis and comparisons supporting and contributing to policy action.

There is potential for the EU to increase its activity and strengthen its role in the field of health system performance assessment (HSPA) in coordination and cooperation with other international organisations. To achieve this, the group has emphasised increasing the validity, transparency and visibility of comparisons and assessment.

Even though the challenges might differ to some extent, health care measurements and health system comparisons are currently performed in most countries for a multitude of purposes, including benchmarking, accountability, preparation for the introduction of new processes and procedures, and support for long-term quality assurance and improvement.

The sub-group decided to collect information from countries within the EU in order to get an "up to date" overview of the existing strategies on HSPA. A questionnaire was developed consisting of a series of questions concerning existing strategies for HSPA, the domains and indicators covered, whether, when and how reports were published, the process of indicator development, and so on. 17 countries have so far responded. The survey does not give a comprehensive picture for all EU Member States, but demonstrates some of the different national approaches to systems for HSPA.

To summarise, most of the responding countries state that they have a system for HSPA or are currently developing strategies and that they plan to publish indicator based reports. About two-thirds of the responding countries report that they have a set of national indicators in place. The number of national indicators varies immensely - from 30 or so to more than one thousand. A couple of countries report that they review the sets of indicators regularly, and about half involve researchers or health professionals in the process. Region is the most common background factor for disaggregated analysis, and a majority of the countries report that they also stratify the indicators for gender and age. Accessibility, quality and prevention are also covered in a number of the responding countries. Some of the respondents report that their reports are occasionally used for policymaking but it is not clear to what extent that is done systematically. Other countries state that their reporting system is mainly used for identifying areas of or for improvement in different parts of the health care system.

The sub-group can conclude that there is room for the EU to play an active and helpful role in the field of HSPA and the potential to bring added value to the field of HSPA.

**Cooperation mechanisms: a role to play for the EU**

The institutional architecture of the European Union is a valuable asset. Here are some of the key features of the European Union that can underpin effective action on HSPA:

- Effective decision-making mechanism: the three main EU Institutions – the Council, the Parliament and the Commission – can liaise with each other to develop and adopt actions in several fields, including health. The EU can therefore provide a broader dimension to HSPA, by its capacity to put actions in place.

- Policy relevance: There is already much on-going work but its direct usefulness for policymaking could increase. HSPA reports need to become more relevant to policymakers, e.g. by presenting a more continuous picture and enabling forward-planning. There is a need to provide a (unified) strategic framework to integrate the different existing measures; this would help bridge the gap between European actions and the decisions taken by of national policy-makers. Coordination and harmonisation are important elements that could be reinforced by the EU, in addition to placing a stronger focus on policy analysis with regard to existing data collection and reporting activities.

- Homogeneity: Even though there are major differences among EU countries, there are similarities amongst the problems and situations – it would therefore make sense to provide some body of evidence specific to the EU region, comprising data and figures, analysis, policy conclusions and recommendations.

## III. DELIVERABLES

The sub-group has produced a number of documents presenting the discussions and analysis conducted.

1. Health System Performance Assessment, a review (Annex 1)

   This document presents a brief review of current international assessment and comparison of the performance of health systems. The main international actors in this field are described and analysed; for each of them a short review of the most meaningful achievements and contributions is presented.

2. Visibility, validity and transparency of EU action in HSPA: problems and opportunities (Annex 2)

   This document describes problems and opportunities relating to the visibility, validity and transparency of EU action in the area of HSPA. The paper consists of three sections: 1) main challenges regarding the visibility, validity and transparency of EU actions; 2) opportunities for stronger EU involvement; 3) conclusions of the discussion held by the working group.

3. Possible criteria for selecting priority areas for comparisons and assessment (Annex 3)

   This document suggests criteria for selecting priority areas for comparison and assessment of health systems. The criteria are presented in a concise way, providing examples and source-based evidence wherever possible.

4. HSPA in EU Member States: summary of the survey (Annex 4)

   This document presents the main results of the survey sent to Member States on their use of HSPA.

5. The request to the expert panel (Annex 5) – see section 3.

   This is the request, presented to the panel of experts, for a scientific opinion on Annex 3, which concerns effective ways of investing in health. The opinion of the panel is expected by the end of 2013.

6. The full final report that summarises the analysis of the conclusions (Annex 6).

   The full final report summarises the work of the sub-group. It presents a longer and more detailed version of this report (including the main results of all documents produced).

## IV. CONCLUSIONS AND RECOMMENDATIONS

Health system performance assessment (HSPA) should be conducted with the ultimate goal of improving the performance of the health systems concerned. The sub-group identified several objectives that should be pursued by Member States and the Commission to address the challenges highlighted in the previous section of this report.

Overall objective: To make better use of HSPA, on a wide scale and in a harmonised and coordinated manner, within the Member States and at EU level with a view to creating dynamic and sustainable health systems responding to the needs of EU citizens.

Specific objectives:

- To establish a solid tradition on HSPA in the Member States and at European level;
- To identify useful methodologies and tools to support policymakers with taking decisions;
- To produce useful, coherent and timely evidence.

**Recommendations for action**

Taking into account the main conclusions of the work done, the sub-group recommends that:

Member States:

- Use HSPA for policymaking, accountability and transparency
- Streamline and prioritise data collection and analysis
- Contribute actively to the further development of international HSPA

Commission:

- Support Member States with using HSPA, by providing tools and methodologies
- Develop a tailored reporting system with clear objectives and a well-publicised launch

- Focus on specific areas of HSPA
- Support the Member States in their policy analysis
- Ensure consistency, harmonisation and coordination
- Coordinate the work on HSPA with other international organisations

Commission and Member States:

- Bring the issue of HSPA high on EU policy agenda
- Streamline the debate on the theoretical HSPA framework and facilitate consensus
- Focus on specific topics which are a priority for the Member States and for the EU policy agenda and develop criteria for selecting topics
- Improve the availability and quality of relevant data and information

**Further work by the sub-group**

There are some areas related to deliverables and recommendations which might require further work by this sub-group. These include.

- More concrete recommendations and suggestions on how coordination and harmonisation could be organised
- Finalisation of the choice of priority areas. This activity should be informed by the panel's opinion on the sub-group's suggestion concerning effective ways of investing in health (Annex 3); that opinion is expected by the end of 2013.

**V. Annexes (see 12981/13 ADD 4)**

1. *Health systems performance assessment: a review*
2. *Visibility, validity and transparency of EU action in HSPA: problems and opportunities*
3. *Possible criteria for selecting prioritized areas for comparison and assessment*
4. *Health systems performance in the EU: results from the Questionnaire*
5. *Request for a scientific opinion on criteria to identify priority areas when assessing the performance of health systems*
6. *Full report on measuring and monitoring the effectiveness of health investments*