A complementary approach to reducing waiting times is to implement demand-side policies by introducing tools to improve clinical prioritisation. They have been used in New Zealand, with some success. Implementation can be difficult, as it is necessary to set a clinical threshold in a valid and reliable manner. In Norway, clinical prioritisation is linked to waiting-time guarantees, with guarantees varying according to need. This appears to be a promising approach, but requires better tools for clinical prioritisation that reliably measure clinical need and the benefit of the elective procedures.

References

Summary: In the post-crisis era, EU health policy increasingly risks to be overshadowed by a patchwork of competing processes and policies, such as the European Semester and Health System Performance Assessment. This re-focusing poses challenges for the collection of necessary health system data and could threaten the ownership of health issues by health actors. In the current climate of fiscal and economic coordination the public health community must be vigilant in safeguarding EU health policy and protect the achievements made in recent decades.

Keywords: Economic Governance, Health System Performance Assessment, Better Regulation, Health Systems, Health Data

Background
Health policy at European Union level has entered a new era. The revised economic governance framework which was introduced in the wake of the crises of the late 2000s challenges traditional processes and adds a new dimension to policy-making at European level. This dimension is macroeconomic – it scrutinises the budgets and financial commitments of national governments sector by sector, identifying in each the policies and developments which present a threat to sustainability and thus to the economic stability of the region. The macroeconomic dimension of health catalogues the people, institutions and resources of the health sector in terms of their fiscal and economic impact. Though it focuses primarily on expenditure, it has prompted debates about financing models, service delivery and how to ensure universal access to high quality care. As such, the European Union (EU) is increasingly engaged in analysing and evaluating health policies, trying to identify, quantify and target specific areas of value or concern.
Two early observations can be made about this ‘new era’ of health policy and the future development of the field. Firstly, monitoring, comparison, guidance and control require access to comprehensive, coherent and comparable data. This will be the next governance challenge for the EU. Secondly, the context of the new health policy mandate risks the potential loss of ownership by health actors. This presents a much deeper political question.

Contemporary challenges

Each era of EU health policy is defined by its challenges. In the 1960s and 1970s, the free movement of workers exposed diverging occupational health and safety practices, forcing the establishment of common standards and providing the foundation for a series of EU social policy measures. In the 1980s, the battle to present a ‘People’s Europe’ and a ‘human face’ of economic and monetary union was fought using the Europe Against Cancer programme, which offered genuine EU ‘added value’ and stimulated significant activity in the public health field. In the 1990s and 2000s, the free movement of services and patients was brought to the fore, raising important questions about the balance between economic and social priorities in the EU project and promoting the recognition of health as an issue inherent in all policies. Furthermore, throughout this period health policy has responded to and been shaped by sporadic crises; scandals involving thalidomide, BSE, blood contamination and breast implant products have each made their mark upon the structure and content of contemporary EU health policy.

Financial crisis has necessitated a shift in focus to fiscal sustainability and led, in some countries, in some countries to implementation of an austerity agenda, further exacerbating anti-European sentiment. These challenges have forced the EU to, once again, re-evaluate its approach in health, as embodied in the Better Regulation agenda and the proliferation of activity which assesses, evaluates and structures health policy.

It might be argued that the EU has gone as far as it can go in health under the current Treaty – competences have been stretched, provisions creatively interpreted and opportunistic extensions made into many unforeseen areas. Put less theatrically, the EU is now engaged in an impressive range of health policy activities and increasingly faces, with each new undertaking, a tougher ‘sell’ with regard to the necessity and appropriateness of its actions. As such, there is some logic to the new Commission’s notion of ‘being big on the big things and small on the small things’, whilst political will and public support is lacking, it is perhaps natural to turn to improving the efficiency of existing activities rather than seeking further expansion. For health, this could mean that the immediate future would be characterised by ongoing processes of audit and revision. The risks here are significant – the Better Regulation agenda has already labelled important public health policies, such as those protecting workers from exposure to dangerous chemicals, as ‘regulatory burdens’, whilst limiting new policy initiatives and fostering an increasing reliance on soft law.

EU Health policy in the ‘new era’

In addition to turning its attention inwards to improve the efficiency of its health policy activity, the EU has also redirected its focus in response to the political priorities of the post-crisis Union. The financial crisis and economic recession forced an overhaul of the economic governance framework, the most notable innovation of which has been the European Semester. The Semester embraces all policy areas and applies the same fiscal-sustainability framework to each, generating recommendations which set the parameters of subsequent policy decisions. As one of the largest areas of public expenditure, health is a central focus of this process and recommendations have commonly targeted the cost-efficiency of national spending on pharmaceuticals, the balance between primary and secondary care provision and health and long-term care sector reforms. Though the recommendations are non-binding for most Member States, the issues they identify and the analysis upon which they are based increasingly define the parameters of national reforms and European policy.

In aid of the Semester process, the new Health Commissioner was charged with further developing the EU’s competence in health system performance assessment (HSPA). This involves establishing methodologies and indicators to assess how health systems are performing, which in turn feed into the evaluations and analyses undertaken in the Semester and other processes. An expert group has been established to map the national activity in this area, based on the understanding that ‘knowing how health systems work is the precondition to design effective health system reforms for the benefit of citizens’. Policy-makers now face the challenge of ‘measuring’ health and assigning value to the outcomes that health systems produce, whilst ensuring that these outcomes reflect patient experience and societal wellbeing, and not simply clinical or financial end-points.

Finally, and also prompted by the post-crisis focus on financial sustainability, the role of the EU in health systems policy has become at least tacitly recognised. Last year DG Santé published an ‘agenda’ for effective, accessible and resilient health systems and, whilst this is far from a coherent, stand-alone policy strand, it reflects a broader understanding that addressing sustainability issues and implementing health reforms efficiently requires some central coordination of health systems policy. For the moment, activity is centred on issues such as cross-border health care, professional

* The legal character of the recommendations differs for members of the euro area, for states which rely heavily upon EU funds and again for those countries subject to economic adjustment programmes. See also (5).
mobility, patient safety and pricing and reimbursement of medicines but the potential scope for this new avenue of EU policy is substantial.

Implications for the future

Two important observations can be made about the implications of these ‘new era’ undertakings – the European Semester, HSPA and the early fragments of an EU health systems policy – for the future of EU health policy. Firstly, each of them will require consistent, comprehensive and comparable data. This is both the silver bullet and, arguably, the third rail of EU health policy; whilst vital to perform the kind of policy activities which seem likely to characterise health policy in the coming years it is notoriously difficult to acquire. One of the most critical elements is the presence of reliable eHealth systems, such as electronic prescriptions and health records, which can collect vast quantities of data without putting excessive burden upon health care professionals, administrators or patients. Sufficient systems are in place in only a handful of Member States and are particularly weak in the poorer health systems, immediately creating a data bias. Within those countries which, via eHealth or other systems, do collect health system data, there is substantial variation in the kind of information recorded and the methodologies used. This makes comparison difficult and often precludes thorough assessment of specific features. Moreover, even where reliable systems collect the appropriate data, national governments have historically been reluctant to transmit health system data beyond national borders. When the World Health Organization published its World Health Report in 2000, producing for the first time a ranking of health systems, a significant backlash was experienced, particularly from the poorer-performing countries. Since this episode, national governments have remained wary of international comparison and its power to impact upon policy agendas.

A second implication is far more concerning: if the ‘economisation’ trend continues the latest era of health policy might see a loss of ownership for health actors. The European Semester, and renewed focus on HSPA and health systems policies target the infrastructure of national health policy and scrutinise some of its most fundamental elements. This shift is not exclusive to health – all-encompassing ‘economisation’ introduced by the Semester is forcing most policy areas to engage in some form of streamlining. This progression could be read positively; a policy area has to reach a certain level of institutionalisation and success before it can undertake the kind of efficiency-drive and internal-stocktaking which DG Santé is currently unofficially engaged in. This might be interpreted as an achievement in itself.

In practice, however, it the importance of health has become so well recognised that it can no longer be entrusted to the DG Santé. Its role risks being confined to a technical and analytic role and ‘in support’ of those colleagues in the Commission responsible for the Semester and the policy recommendations it makes. This is made clear in the mandate given to the Health Commissioner, which outlines how he should develop expertise to ‘inform’ national and EU level policies and contribute to the European Semester, leaving leadership and substantive development of health systems policy to the economic and finance officials in DG ECFIN and their colleagues from the Member States. The Better Regulation agenda looks set to perpetuate this ‘streamlining’ work programme, reducing active leadership and policy initiatives and instead investing resources in implementation of legislation, review of existing directives and production of technical reports. As such, characterisations of decline seem increasingly apt – the EU health community must be vigilant in safeguarding the progress made over the past decades and vocal in supporting the continued role of the EU in health protection and promotion.

References