Editorial: Universal Health Coverage - UHC

The 1978 Declaration of Alma Ata adopted the concept of universal healthcare and the unrealized slogan “health for all by 2000”.

More recently the concept has become an important part of WHO’s agenda under Margaret Chan’s direction. The Director-General of the WHO has reaffirmed the primary healthcare approach as the most efficient and cost-effective way to organize a health system. Thus, in 2010 the WHO launched *Health Systems Financing: the Path to Universal Coverage*, a tool to help countries to move more quickly towards this goal. This has led to more than 60 middle-income and low-income countries requesting technical assistance and advice to achieve universal health coverage. Even the United States; the only wealthy, industrialized nation that does not ensure all its citizens have access to health care is studying a health reform to provide the universal coverage.

The literature produced on this theme is vast and we cannot avoid mentioning the latest news on the subject. We present today two articles concerning UHC in Turkish and in the USA and an interesting study by Joseph Kutzin published in WHO Bulletin. According to Mr. Kutzin “Strictly interpreted, UHC is a utopian ideal that no country can fully achieve”. He also gives some indications to set the direction of health financing reforms in any country.

All these articles refer to an ideal that has lasted 35 years. Can we still do it?

IHF News

Informal dialogue with relevant NGOs on the development of draft terms of reference for a global coordination mechanism for non-communicable disease...

The International Hospital Federation (IHF), as a non-governmental organization in official relations with the World Health Organization (WHO), was invited to attend the “Informal dialogue with relevant NGOs on the development of draft terms of reference for a global coordination mechanism for non-communicable diseases (NCDs)”, which was held on Wednesday 14 August 2013 in the Executive Board Room of the World Health Organization (WHO) in Geneva. Representatives from over 20 Country Missions and 27 International NGOs attended the meeting.

WHO Global NCD Action Plan 2013-2020


The WHO Global NCDs Action Plan 2013-2020 is the result of the commitments made by Heads of State and Government in the United Nations Political Declaration on the Prevention and Control on NCDs (Resolution A/RES/66/2).
The main focus of the WHO Global NCDs Action Plan 2013-2020 is on four types of NCDs (cardiovascular, cancer, chronic respiratory and diabetes) and on four shared behavioral risk factors (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol).

The WHO Global NCD Action Plan 2013-2020 comprises a set of actions which, when performed collectively by Member States, WHO, other UN and intergovernmental Organizations, NGOs and private sector, will support governments in their national efforts to contribute to the attainment of nine voluntary global targets:

- 25% relative reduction in the overall mortality from NCDs;
- At least 10% relative reduction in the harmful use of alcohol (within the national context);
- 10% relative reduction in prevalence of insufficient physical activity;
- 30% relative reduction in mean population intake of salt/sodium;
- 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years;
- 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances;
- Halt the rise in diabetes and obesity;
- Receipt by at least 50% of eligible people, of drug therapy and counseling to prevent heart attacks and strokes;
- 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities.

The above voluntary targets and the 25 indicators (see Appendix 2 of the WHA66.10 Resolution) are part of the global monitoring framework which provides overall directions for the implementation of the Action Plan.

Dr. Kim Kwang Tae new President of the IHF
The last Governing Council meeting in Oslo was the opportunity to transfer the power to the designated president, Dr. Kim Kwang Tae. Dr. Kim is a honorary president of the Korean Hospital Association and also a former president of the Asian Hospital Federation.

He is a graduated from the Catholic University of Korea College of Medicine and currently he is chairman of Daerim Saint Mary’s Hospital, Seoul, and director of the Catholic Education Foundation.

Dr. Kim expressed his wishes to develop better health and medical treatment for people around the world and appealed to the members of the federation by proposing a mission that entails a “bigger, stronger and financially sustainable IHF.”

He replaces Dr. Tom Dolan who held the position beginning in 2011.
38th World Hospital Congress - Oslo 2013

Post Oslo congress
Top Healthcare and Hospital leaders came together in the city of Oslo, Norway 18-20 June 2013 to share information on the challenges and opportunities of future healthcare.

Thank you all participants, partners and staff for your contribution to the 38th World Hospital Congress in Oslo!

Our goal was to create a forum in which leaders, policy makers and clinicians from all over the world would share their experiences and best practices in healthcare delivery:

- More than 1000 delegates from 42 countries met for 3 days of inspiration.
- 44 sessions and 5 hospital visits gave new knowledge.
- 3 social events and the dynamic expo gave opportunities for networking.

We hope we reached our goal to improve the premises for Future Healthcare.
Winners Best posters
The prize giving ceremony of the posters awards was held the closing day of the 38th World Hospital Congress. The jury in charge of choosing the best posters was composed by: Dr. Lawrence Lai, Prof. Helen Lapsley and Anita Lyssand.

The winners were:

**Best scientific quality**: Bror Just Andersen, Norway

**Best Presentation**: Rajani, Sohail, Tasneem, Baig and Khan, Pakistan

**Best poster overall**: Andy Hyde and Anders Frafjord, Norway
The following posters received Commendations:

*Integration of prehospital emergency teams in the emergency department, Soares, Portugal

*Decrease in average length of stay after implementation of the Coordination Reform– an observational study in South East Regional Health trust in Norway, Tjomsland, Norway

*The role of availability and access in modern obstetric care, Engjom, Norway

*Does legal protection increase reporting rates?, Eiras, Portugal

*Multifaceted campaign aimed at increasing influenza immunization rates among hospital personnel, Smith, Norway

*To strengthen staff competency for chemotherapy administration in medicine areas, Mulji, Pakistan

*A Study of Apply Taiwan Medication Educational Resource Center Network as the Model of Community Medication Literacy Promotion, Lee, Taiwan

*Use of Electronic Health Records in Spanish hospitals, Ortiga, Spain

*Your Safety, Our Priority, Mohd Zain, MalaysiaA study of cleanliness, utilization, and operational problems of automated floor Scrubber Machines in a tertiary care hospital of India, Singh, India

View and download all the posters at Oslo 2013

From Our Partners

**IAPO supports WHO’s recommendations on patient involvement in priority medicines**

Access to treatment and medication is a serious concern to patients all over the world regardless of the status of national healthcare systems. IAPO supports WHO’s recommendations on patient involvement in priority medicines WHO has recently published an update to its 2004 report: Priority Medicines for Europe and the World. This report explores the changes in global health and pharmaceutical innovation since 2004. It provides recommendations on how pharmaceutical innovation can better meet current and future patients’ needs.

This report analyses pharmaceutical innovation from a global public health perspective for Europe and the world, based on the principles of equity and efficiency. The report contains a set of recommendations to further facilitate patient and citizen involvement in priority setting in pharmaceutical innovation.

IAPO welcomes the recommendations outlined in the report to prioritise research on:

**Frameworks and models for patient and citizen involvement** - strong frameworks can promote transparency and equity
**Capacity building for patients and citizens** - provides support which enables patients and citizens to be meaningfully involved in priority setting for pharmaceutical innovation.

**Assessing the outcomes of initiatives to involve patients and citizens** - monitoring and evaluation helps to develop an evidence-base for patient and citizen involvement and further improve patient involvement initiatives.

IAPO welcomes the recommendations in the report and will work with WHO to facilitate the involvement of patients in priority setting in pharmaceutical innovation.

Read the full report.

**Call for abstracts - Geneva Health Forum (GHF2014)**

The International Hospital Federation (IHF) is pleased to announce its collaboration as Thematic Partner of the fifth edition of the Geneva Health Forum (GHF2014) - to be held 15-17 April 2014, Geneva, Switzerland. The theme of the Forum is Global Health: Interconnected Challenges, Integrated Solutions, with thirteen thematic health tracks - http://ghf.globalhealthforum.net/tracks/.

The Geneva Health Forum (GHF) is an international conference, held biannually, which brings together practitioners, frontliners, researchers, policy makers, civil society and the private sector. It is a joint initiative launched by the University Hospitals of Geneva and the Faculty of Medicine of the University of Geneva in partnership with leading Swiss public institutions engaged in Global Health and the major international organizations and institutions active in health in Geneva and around the world.

The aim of the GHF is to:

- Link policy with practice
- Address health issues through an interactive approach
- Promote global health as a field of study, research and practice
- Engage contributions of health and non-health sectors to ensure policy coherence and synergies between policies
- Ensure human rights, including the right to health, equity, sustainability and empowerment of key elements are placed/maintained at the centre of all policies

IHF partnership with this event has as aim, engagement of hospitals and their associations with practitioners and policy makers from the arena of Global Health to collaborate with each other and forge alliances that harness their respective powers so as to advance access to health around the world.

We therefore encourage your active participation by positive response to this call for abstracts http://ghf.globalhealthforum.net/submission/. The extended deadline for abstract submission is 30 September 2013.

**Communication Material**

We have put together resources on this page that will help users disseminate information about the Geneva Health Forum.

No permission is required for disseminating this material. Follow this link

For any assistance from the IHF Secretariat, please contact, Sheila Anazonwu, IHF Partnerships and Project Manager: sheila.anazonwu@ihf-fih.org / Tel: +41 (0) 22 850 94 22

---

**WHO Round Up**

**Using TRIPS flexibilities to facilitate access to medicines**

Abstract The problem of how to mitigate the impact of pharmaceutical patents on the delivery of essential medicines to the world’s poor is as far from being resolved as it has ever been. Extensive academic commentary and policy debate have achieved little in terms of practical outcomes. Although international instruments are now in place allowing countries to enact legislation that permits the generic manufacture of patented pharmaceuticals, many countries have not yet enacted appropriate legislation and most of those that have yet to make use of it. One major problem is that the requirements of international instruments and implementing legislation are seen as being so stringent as to be unworkable. This paper calls for fresh attempts to enact workable legislation that fits within the prescribed requirements of international law without going beyond them. It argues that high-income nations should refocus on their moral obligation to enact appropriate legislative mechanisms and provide appropriate incentives for their use. Draft legislation currently being considered in Australia is used to illustrate how workable legislative frameworks can be developed.

TRIPS and access to medicines

When the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) was annexed to the Agreement Establishing the World Trade Organisation (WTO) in 1994, it set minimum standards for intellectual property (IP) protection that must be observed and enforced by all WTO Member States. TRIPS negotiations were long and complex, as documented by many commentators. Many low- and middle-income countries (as classified by the World Bank) resisted the inclusion of an IP regime in the WTO system because they feared that it might obstruct development goals and access to important goods such as essential medicines. Ultimately, however, they were constrained to accept the “TRIPS package” as an indivisible component of the WTO system. Since TRIPS came into force, bilateral and regional trade agreements have tended to set even higher standards for IP protection, in what Peter Drahos refers to as “the global ratchet” for IP rights.

An extensive body of commentary has been generated on the potentially detrimental effects of various aspects of the TRIPS package on public health and development, particularly in low- and lower-middle-income countries. Inadequate provision of basic public health care continues to afflict many of these countries. The United Nations (UN) clearly recognizes this. In 2001, the Committee on Economic, Social and Cultural Rights stated that national and international IP regimes must be consistent with the human rights obligations of states. In 2011, the United Nations General Assembly recognized the need to preserve TRIPS flexibilities to facilitate measures for improving access to health care, and United Nations Member States agreed that IP rights provisions in trade agreements should not undermine these flexibilities.

The World Health Organization (WHO) has taken several measures to counteract the potentially adverse health impact of IP protection. In particular, in 2008 the sixty-first World Health Assembly adopted Resolution 61.21, which endorsed the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property. This Global Strategy aims, among other things, to improve the delivery of and access to health products and medical devices by effectively overcoming barriers to access. Adoption of the Global Strategy followed an 18-month period of deliberations and meetings of the WHO Intergovernmental Working Group on Public Health. More recent measures by the WHO include an intensive study on access to medical technologies and innovation, conducted in collaboration with the World Intellectual Property Organization (WIPO) and the World Trade Organization (WTO), as well as release of its Zero Draft Global Plan for the Prevention and Control of Non-communicable Diseases 2013–2020. Various forms of technical assistance have been provided by WIPO to low- and lower-middle-income countries in formulating IP laws and policies using the TRIPS flexibilities.

Read the full article

Development assistance for health in Africa: are we telling the right story?
Nathalie Van de Maele, David B Evans & Tessa Tan-Torres, Article published in WHO bulletin, July 2013.

Objective: To describe the different types of data sets on aid flows, what they capture and the types of questions they answer, and to explore the extent of variation in levels and trends between these data sets at the regional and country levels.

Introduction
The amount of research on donor financial assistance to health, commonly called development assistance for health (DAH), has increased substantially over the last decade. One focus of this research has been the extent to which DAH increased after 2000, when the Millennium Development Goals, in which health features so prominently, were established. Others have explored the allocation of aid flows to particular health problems or geographical regions, on the basis of the argument that some health problems or countries have been neglected.
This work suggests that aid flows for health have more than doubled since 2000. Private foundations, particularly the Bill & Melinda Gates Foundation (equivalent to about 20% of the development aid for health supplied by the Government of the United States of America for the period 1999–2010), assumed greater importance relative to the traditional bilateral and multilateral donors. Half of the additional funding between 2000 and 2009 targeted only two diseases – infection with human immunodeficiency virus (HIV) and malaria. Some countries (e.g., Botswana, Zambia) benefited a great deal, but others (e.g., Cameroon, Guinea, Nigeria) were less fortunate and came to be called “aid orphans”.

Attention then turned to how recipient countries have reacted to increased financial inflows for health. The results of this suggest that they reallocated some of their own domestic resources away from health to other sectors following DAH inflows. Other work shows, on the other hand, that aid flows impose substantial costs on recipient countries, partly because each donor has a different application, monitoring and reporting requirement.

Other questions include how increases in DAH affect macroeconomic stability (e.g., inflation) and health outcomes and whether DAH will fall as a result of the continuing global financial crisis. Preliminary results suggest that official development assistance (ODA) has remained stable since 2008 (in constant prices), whereas DAH by foundations and nongovernmental organizations (NGOs) has decreased since 2010. ODA is: “flows provided by government official agencies, and administered with the promotion of the economic development and welfare of developing countries as its main objective”. ODA represents about 70% of total DAH.

These questions are undoubtedly interesting. However, the peculiarities in the way financial flows are reported and collated means that the data used to answer them are not always the most appropriate. The fragmented reporting of DAH precludes the availability of a comprehensive source of data capturing all sources of aid. In addition, the different ways in which aid flows are reported can cause confusion. Some of the studies above have based their analyses on information on donor commitments; others have done so using data on disbursements. Still others have used data on health expenditures in recipient countries that are financed from external sources.

Read the full article

Health financing for universal coverage and health system performance: concepts and implications for policy

Since the publication of The world health report 2010, universal coverage (also often referred to as universal health coverage or UHC) has received increased attention. Like having a “sustainable health financing system”, it is something that sounds very good. But what does it mean, exactly, and why is it something worth pursuing?

Introduction
The world health report 2010 contains the following definition of health financing for universal coverage: “Financing systems need to be specifically designed to: provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; [and to] ensure that the use of these services does not expose the user to financial hardship.” Some of the debates around recent reform experiences, particularly those related to the interpretation of what is meant by “insurance”, suggest that there remains a lack of common understanding about the concept portrayed in The world health report 2010. This is not merely an academic debate; conceptual differences create operational differences in terms of the health financing policy choices made by countries, what they are advised to do, and how reforms are assessed. This paper aims to clarify what is meant by health financing for universal coverage; how UHC embodies specific health system goals and intermediate objectives, what is the appropriate unit of analysis for these, and, broadly, the ways in which health financing can influence progress towards UHC. An assessment of specific policy options or recommendations for reform is beyond the scope of the paper, although some illustrations are provided.

“Financing systems need to be specifically designed to: provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; [and to] ensure that the use of these services does not expose the user to financial hardship.”

The next section of this paper derives a set of generic policy objectives for health financing policy from the framework for health system performance of the World Health Organization (WHO). The third section justifies UHC, as defined above, as an aim of health policy by linking it explicitly to the goals of the health systems framework. This is followed by a discussion of the three dimensions of coverage. Next is a further specification of both UHC goals and intermediate objectives, followed by an illustration of the types of health financing reforms that can influence progress towards UHC. The sixth section contains a discussion of the unit of analysis for UHC and of the practical importance of understanding the distinction between schemes and systems. The final section of the paper summarizes the core messages arising from this conceptual approach.

Health financing and system performance
The starting point for the approach used goes back to *The world health report 2000*, on health system performance. The framework used for that report identified three generic goals and four generic functions of all health systems (WHO reconfigured these four functions into six “building blocks”, but the framework is the same, as is the application to health financing policy used here). The aim of any health system is to maximize the attainment of the goals (adjusted for the relative importance that a country attaches to each), conditioned by contextual factors from outside the health system that influence the level of goal attainment that can be reached (e.g. a country’s income, education levels, political factors, etc.). A simplified depiction of this framework is shown in Fig. 1.

Read the [full article](#).

**Living with Disability & Disasters - take the survey**

Persons living with disabilities have unique contributions, often overlooked, to help reduce the risk of disasters. IDDR 2013 intends to switch on and amplify this critical issue of including the needs of persons living with disabilities now and for the post 2015 framework for disaster risk reduction.

* A disaster resilient planet means everyone must be part of the solution.
* Decisions and policies to reduce disaster risks must reflect the needs of persons living with disabilities
* Investment in disaster risk reduction must provide for the needs of persons living with disabilities

The on-line survey is now available in seven languages at the following site: [http://www.unisdr.org/2013/iddr/#.UhHTp6zzlGM](http://www.unisdr.org/2013/iddr/#.UhHTp6zzlGM)

Visit and complete the survey!

**From international Organizations**

**Universal Health Coverage in Turkey: “Pearls” Emerging from the Pressures of Ambitious Reforms**

Article by Tim Evans, published in Investing in Health, blogs.worldbank.org

Two days after joining the World Bank, I traveled to Turkey to attend the government’s ministerial meeting on universal health coverage (UHC), which corresponded with The Lancet publication of an independent 10-year assessment of Turkey’s Health Transformation Program (HTP).

The Lancet authors—led by Professor Rifat Atun—demonstrate convincingly the tremendous progress Turkey has made towards UHC in the last decade in three key areas: 1) increased spending on health together with decreased out of pocket expenditures and impoverishment arising from health care expenditure; 2) steep improvements in access to a more comprehensive set of services, especially maternal and child health; and 3) a sharp reduction in geographic (East-West), rural-urban, and socio-economic inequities in health.

To get a better idea of how the HTP managed to produce results, a group of us spoke with Professor Recep Akdağ, who was the Minister of Health during the HTP. Recounting the past 10 years, he stressed a number of points that in my opinion went well beyond the contextual specificity of Turkey. And just as the best professors of clinical medicine offer “pearls” of wisdom to medical students, Professor Akdağ provided seven UHC “pearls” distilled from his experience leading the HTP in Turkey.

1. **UHC is about the right to health.** Professor Akdağ first acknowledged that UHC is about realizing the right to health: “Access to health services is a fundamental human right,” he said. Realizing these rights requires multi-pronged strategies that ensure that no citizen is left behind.

2. **Short-term wins build buy-in for longer-term reforms.** In order to retain full political alignment with the UHC reforms among the Cabinet of Ministers and the Prime Minister, Professor Akdağ knew that an early “win” was critical. As such, he issued a “decree” on the first day of the newly elected government in 2002, outlawing the involuntary incarceration of patients (or the deceased) in hospital facilities for reasons related to non-payment of hospital bills. This and other subsequent popular decisions demonstrated the tangible benefits of the HTP to the people and secured political support for the longer-term—and in many cases, the tougher decisions related to the reforms.
3. “Adapt” rather than “adopt” the lessons from other countries. Early on in his tenure as Minister, Professor Akdağ visited other countries in Latin America, Africa, Asia and Europe to learn about their efforts to achieve UHC. These visits provided rich insights, but not a blueprint for reform. In Turkey, he stressed that just as a good clinician must understand the patient before treating the disease, the same is true for UHC: The Turkey context must drive the UHC reforms. Professor Julio Frenk echoed this experience at last week’s Ministerial meeting, where he stressed the value of cross-country comparative analysis but emphasized that the learning needed to be “adapted” not “adopted” to local context.

4. UHC reforms are both technical and political and must be managed with finesse. The HTP in Turkey made a number of major changes in the functioning of the health system that required both technical and political competencies. One of the toughest challenges—that very few health systems have been able to manage—is the problem of “dualism,” whereby health workers in the public sector also spend significant time working in the private sector. The strategy to stem this problem was nothing short of ingenious. The government began with a program of higher salaries and performance incentives to lure hospital physicians back into the public sector on a full-time basis. Over time this program moved the number of specialists working full-time in the public sector from less than 20% to more than 80%. It was only when the large majority of physicians were working in the public sector that a law was passed forbidding dual practice. The sequencing of this reform—incentives to persuade practitioners to work full-time in the public sector followed by a change in the law—worked in such a way to insure that the law would succeed. Should the law have changed at a time when the majority of physicians were engaging in dual practice, it would have most certainly met with insurmountable resistance.

Read the full article

Hospitals and Health Services Worldwide News

Reverse innovation in global health systems: learning from low-income countries
Edited by Dr Shamsuzzoha Syed; Ms Viva Dadwal, and Dr Greg Martin, Published in Globalization and Health, August 2013.

Can "developed" countries learn from the lessons of "developing" countries? How can we move away from the fatuous ideas associated with being labelled a 'developed' or 'developing' country? These are but a few questions that Globalization and Health new thematic series, ‘Reverse innovation in global health systems: learning from low-income countries’ will address to enhance our understanding in this subject. The series aims to move beyond the narrow constraints of traditional thinking to promote bi-directional learning that challenges and rethinks traditional practice within global health systems. Submissions are being accepted for on-going publication.

The global flow of knowledge, skills, and ideas has been a defining feature of human progress. Different regions and peoples have contributed to and, indeed, led innovation development at various times in human history. From Africa to Asia, Latin America, and the Middle East, the current body of knowledge on these diverse contributions to human science and medicine is expanding. For example, written a thousand years ago in the Middle East, the Qanun fi-l-tibb (Canon of Medicine) of Ibn Sina is an immense encyclopaedia of medicine that served as the chief guide to medical science in Europe for over six centuries. Prior to vaccination, eighteenth century Europeans were eager to learn about and adopt innovative ideas to combat smallpox, including through variolation, which was long practiced in Africa and Asia. The current global use of artemisinin anti-malarials as a standard treatment saving millions of lives is based on knowledge harnessed from Chinese medicine. Indeed, it is hard to imagine a world without such noteworthy contributions; the health systems of today represent the culmination of centuries of global innovation flow.

The development paradigm in recent history has chiefly focused on promulgating ideas and health systems solutions that have been developed in rich countries with the expectation that a grateful and deferential “South” blithely adopt them. In contrast, there has lately been a growing realization that the prodigal and often extravagant “North” has something to learn from innovations that emerge from resource-challenged settings. Out of necessity, poorer countries have had to rethink processes, interventions, and overall systems to ensure the best value for money is attained at every turn. In a time of global austerity there is a growing appreciation of the need for bidirectional exchange of ideas to be the new adage of global dialogue.
The view that businesses in “developed” countries could create opportunities from innovative products and services arising from emerging economies was highlighted by John Hagel III and John Seely Brown, through a term defined as “innovation blowback”. Govindarajan and colleagues advanced this concept a few years later, coining the term “reverse innovation” to refer to any innovation “likely to be adopted first in the developing world before spreading to the developed world”. Dominant business thinking posits a number of drivers behind the innovation imperative of resource-challenged developing countries, including affordability; use of ‘service ecosystems’; robust product development; creative application setting; and leapfrog technologies. Since Hagel and Brown, a set of related terms, such as frugal and disruptive innovation, have accompanied the discourse on the subject. At the same time, the phenomenon of two-way flow of knowledge, ideas, and products has had significant bearing on the field of global health, a field that naturally interacts with both the medical and social sciences disciplines and has its fair share of interdisciplinary partnerships, networks, and collaborations. Only recently has attention turned to focusing on “developing” country collaborators and innovators as partners, rather than just potential consumers.

Download the full article

Americas

Wielding the Carrot and the Stick: How to Move the U.S. Health Care System Away from Fee-for-Service Payment


The U.S. health system is plagued by fragmented care, variable quality, and high and rapidly growing costs. Underlying these problems is the prevalence of fee-for-service payment, in which health care providers are paid per visit, test, or procedure. Not only does fee-for-service payment fail to provide incentives for efficiency, quality, or outcomes, it encourages the provision of unnecessary care and often discourages coordination of care and management of patients across providers and settings.

A broad range of policy experts have called for the adoption of alternative approaches to paying for health care. But how do we move our $2.9 trillion health system from fee-for-service payment to other approaches?

Three elements are key to successfully moving toward alternative payment approaches:

- **The carrot**—Implement policies that reward high performance and encourage changes in the organization and delivery of health care.
- **The stick**—Reduce and eventually eliminate the option of remaining in the fee-for-service payment system.
- **The muscle**—Coordinate policies across public programs and private payers so they are applied consistently and their impact is maximized.

**The carrot.** Instead of tying payment to the volume and intensity of services, policies should be put in place that employ both financial and nonfinancial incentives to reward high quality and effective care. The U.S. health care system gets what it pays for, but it pays for the wrong things. Alternative approaches that redirect payment toward desired outcomes—and are structured to engage providers in developing and implementing more productive relationships with their patients—are needed to achieve improved outcomes and more efficient use of resources.

Health care providers and payers are increasingly recognizing the need for new approaches to organizing, delivering, and paying for care. The federal government is undertaking innovative initiatives in Medicare and Medicaid, as well as in partnerships between the two programs and between public and multiple private payers. These initiatives include the development of patient-centered medical homes to help patients more easily obtain needed care, bundled payment to promote better coordination of care across acute and postacute settings, and accountable care organizations to reward providers for increasing quality and reducing costs.

The Center for Medicare and Medicaid Innovation’s State Innovation Models initiative provides resources to state governors to engage in multipayer payment reform and innovative service delivery models. Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont have received grants to test their models. Many other state-level initiatives to pursue payment and delivery system reforms are under way. Private sector organizations such as Geisinger Health System in Pennsylvania, Appleton Medical Center and Theda Clark Medical Center in Wisconsin, Virginia Mason Medical Center in Washington, and the Blue Cross and Blue Shield plans in Massachusetts and Michigan are also engaged in innovative efforts to improve care and reduce costs.

It’s important to be flexible in adapting this array of initiatives to local circumstances. Areas may differ along several dimensions, including their population, the availability and mix of providers and the degree to which they are consolidated, and the regulatory environment—these and other factors can affect the success of alternative approaches.

**The stick.** The potential benefits of improved incentives cannot be realized as long as the current fee-for-service system, with its distorted incentives, is an available option for providers. Several recent proposals include policies that would diminish the attractiveness of fee-for-service payment over time, usually by making provider participation in alternative payment and delivery system models a prerequisite for future payment increases.
Two Americas

Economists at Harvard University recently reported that geography is a particularly powerful predictor of economic mobility in the United States. For those of us who work in health care, this should not be surprising: we already have abundant evidence that where you live matters a lot when it comes to health and the quality of care you receive. Increasingly, the U.S. is not one country, but two—divided geographically by persistent, troubling differences in people’s access to affordable, high-quality health care.

This is a clear message of The Commonwealth Fund’s state and local scorecards on health system performance, which have documented these divisions over much of the past decade. And the message will be reinforced in our newest health system scorecard, which focuses on low-income populations in the U.S. (look for it next month). Certain regions of the country—the Northeast and Northwest, parts of the Midwest, the North-Central states—regularly perform well. Other regions—generally the South, Southeast, and Southwest—perform poorly. The former have health outcomes that are among the best in the industrialized world. Results in the latter look more like those of developing countries in South Asia, South America, and Latin America.

Troubling as these findings are, geography is not destiny. Particular areas within the worst-performing states do relatively well. Austin, Texas, scored in the top half of regions in The Commonwealth Fund’s local scorecard—an outlier in a state that ranked 46th in our last state scorecard. Similarly, the Greensboro and Hickory areas of North Carolina ranked among the top half of regions of the U.S., much better than the state as a whole, which placed in the bottom fifth of states. But these oases of high performance in otherwise poor-performing regions are not sufficient to change the overall patterns.

And while we can take some comfort in positive outliers, the sheer variation in cost, quality, and overall health system performance across the country is reason for significant concern. Our recent local scorecard documented consistent 10- to-20-percentage-point differences between high- and low-performing regions on a host of measures related to health care access, quality, and costs. Gaps between the best- and lowest-performing areas are staggering.

For example, the proportion of adults with health insurance in the leading regions is more than 50 percent higher than in the lagging areas, while the rate of potentially preventable mortality in the best region is one-third of that in the worst.

The reasons for regional disparities in health and health care are not yet fully understood, and we must understand them before we can address them. Poor-performing regions tend to have much higher proportions of uninsured citizens. This could get somewhat better because of the Affordable Care Act (though not if states in those areas don’t take advantage of the law). Other explanations undoubtedly lie outside the realm of health care, in education, poverty levels, diet, and lifestyle.

Unfortunately, many of the states that lag in health care performance are choosing not to expand eligibility for Medicaid under the Affordable Care Act. We know that insurance coverage, including Medicaid, improves access to care and results in improved health for previously uninsured people. States skipping expansion will also miss an opportunity to lower the costs of uncompensated care for their hospitals and forgo an infusion of federal dollars for traditionally underserved and rural areas. Uneven implementation of the ACA, therefore, could increase preexisting disparities in the health and health care available in high- and low-performing areas of the U.S.

Persistent differences in health care across the country matter for all of us. In the end, we are one nation and one people. When some of our citizens suffer, we all suffer. If some regions lag economically because of health care deficits, we will all feel the downward tug on employment, tax revenues, GDP, and our international competitiveness. We are stronger as a country when all of us are strong.

The U.S. health care divide deserves much more attention than it has received. The Commonwealth Fund remains committed to tracking the two “health care Americas,” an undertaking that will continue next month with the release of our new scorecard on health system performance for low-income populations. Bringing the troubling variation in health outcomes within our country to light is a crucial step toward closing the chasm between these two Americas and ensuring that everyone has the opportunity to live a long, healthy, and productive life.

Latin American countries crack down on junk food
While several Latin American nations have introduced healthy food laws to try to combat childhood obesity, implementation has proved trickier. Barbara Fraser reports from Lima, Peru. Sergio Escalante got a shock at lunchtime on the first day of school this year. His school’s food kiosk no longer offered the usual fare—potato crisps, cookies, sweets, soft drinks, and sandwiches dripping with creamy sauces. “He came home and said there was nothing to eat”, his mother, Miriam González, a nurse, recalled with a chuckle. “They were selling fruit and chicken sandwiches without mayonnaise—to him, that meant ‘nothing to eat’.” The food concession was lining up with Peru’s new healthy food law, which aims to tackle the country’s rising obesity rate by getting children onto a healthier diet.

Peru’s law is the latest in a series of efforts by Latin American countries to tackle a public health problem that has accompanied the economic boom of the past two decades—more overweight kids and an increase in non-communicable diseases such as diabetes and cardiovascular problems.

But although several countries have passed laws, implementing regulations have lagged, and some public health experts are calling for international measures—such as the ones used to tackle cigarette sales—to counter what they say is powerful lobbying by the food and advertising industries. Peru’s law immediately drew criticism from legislators, advertisers, and even the Catholic archbishop of Lima, who said that shaping children’s dietary habits was a job for parents, not the government.

But the entire country will benefit if the government can head off future health problems by reducing children’s consumption of salty, sugary, and high-fat processed foods, according to Luis Fernando Leanes, who heads the Pan American Health Organization (PAHO) office in Peru.

“Being able to decrease children’s exposure to these foods will mean more hospital beds free in the future to care for people with other illnesses”, he said on July 9 at a conference in Lima on public policy for promoting healthy foods. Peru, Chile, Colombia, Costa Rica, and Brazil are among the Latin American countries with healthy food legislation. Uruguay’s Senate recently approved a law and Ecuador is considering one. The Latin American Parliament, an inter-governmental group, is drafting non-binding recommendations for countries that are considering legislation.

In Latin America, efforts to redirect children’s food choices have taken several approaches. Most have focused on controlling the food offered and advertised in schools. Some countries have added labelling regulations, while others have tried limiting advertising, especially on television. In 2011, PAHO issued a series of recommendations on the regulation of marketing of food to children, in the wake of a series of studies showing that television channels in some countries bombarded children with more than a dozen ads per hour for foods high in salt, fat, and sugar.

The Peruvian law, signed by the president in May, calls for nutrition education in schools; information campaigns by the education and health ministries; a system for monitoring nutrition, overweight, and obesity among children and adolescents; healthy food in school kiosks or cafeterias; more physical activity; and controls on advertising aimed at children and adolescents younger than 16 years. The law prohibits advertising that encourages “immoderate consumption” of food and non-alcoholic beverages that contain trans fats or high levels of sugar, salt, and saturated fat; shows “inappropriate portions”; appeals to children’s naiveté or emotions; claims products are natural when they really are not; or uses testimony from real people or fictitious characters whom the children might admire. It also forbids adverts that suggest that a parent is “more intelligent or more generous” if he or she purchases a particular product.

Studies have shown the power of advertising. In São Paulo, Brazil, 85% of parents said advertising influenced their children’s demands, and three-quarters said prizes or free food were strong incentives, according to a 2010 study commissioned by the Alana Institute, a Brazilian non-profit organisation that advocates for children’s rights.

The Peruvian law will not take effect until implementing regulations, being drafted by a multi-agency commission, are approved. Those regulations will flesh out the details and ultimately determine how strong the law will be.

Click to view the full article

Europe

The Twenty-Year War over England’s National Health Service: A Report from the Battlefield

This article analyzes the latest battle in the twenty-year war to change England’s National Health Service (NHS), starting with the internal market reforms introduced by the Thatcher government and now carried one step farther by David Cameron’s coalition government.
The government's program of change is characterized by (1) its wide scope and the organizational upheavals involved and (2) the fact that it is being introduced at a time when the NHS faces unprecedented fiscal pressures. The legislation faced strong political, public, and professional hostility both from those who saw it as a crime against the founding principles of the NHS and from those who saw it as a disruptive blunder that created more problems than it solved. This article asks three questions. Why did the coalition government embark on a policy course guaranteed to lose it votes? How will the much-amended legislation work out in practice: what are the risks and uncertainties? What will be the program's impact: will it, like previous waves of change, disappoint both the prophets of doom and the visionaries of transformation? The conclusion drawn is that the essential, defining characteristics of the NHS are not under threat. It continues to be a publicly funded service, freely available to all. It is not being privatized. But it is moving toward the kind of pluralistic system that would have been established by Britain's last, wartime coalition government, had not Aneurin Bevan nationalized the hospital service in 1948.

To see the full article

**The Keogh Mortality Review outcome reports**

Article published in NHS website [www.nhs.uk](http://www.nhs.uk)

On February 6 2013, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators.

A total of 14 hospital trusts were investigated as part of this review.

Although the 14 hospital trusts covered by the review were selected using national mortality measures as a "warning sign" or "smoke-alarm" for potential quality problems, the investigation looked more broadly at the quality of care and treatment provided within these organisations. The review considered the performance of the hospitals across six key areas:

- mortality
- patient experience
- safety
- workforce
- clinical and operational effectiveness
- leadership and governance

Mortality data reviewed was from the NHS Information Centre, the Care Quality Commission, Dr Foster, the Imperial College and Healthcare Evaluation Data (HED). The HSMR (Hospital Standardised Mortality Ratio) and SHMI figures (Summary Hospital-level Mortality indicator (SHMI) contained within the evidence packs are re-based and with the latest information to provide the most reflective picture of current performance at the 14 organisations. For ease, the SHMI figure has been reported as an "expected of 100", rather than the Information Centre's "expected of 1.00".

**Findings and recommendations of the Keogh Mortality Review**

The review of all 14 trusts has been completed. At both a local and national level, key findings have been collated and examined and recommendations have been made.

As well as the national overview report (PDF, 1.18mb), which outlines all key findings and recommendations, you can also download final reports for each individual hospital trust in the section below. These include:

-Rapid Responsive Review (RRR) report. This report details the findings from the announced visits, the unannounced visits and other hard and soft data collected on the trust.

-Risk Summit action plan. This report details the actions and recommendations that were agreed at the Risk Summit. It also details the next steps in the process.

-Risk Summit video. This shows the first part of the Risk Summit where members of the RRR panel summarised the results of the review to the Risk Summit panel.

Read the full article
Is it possible to incorporate quality into hospital pricing systems?
By Janet Sansoni et al., article published in AHHA website. August 2013.

Australia has recently implemented an activity-based funding system for public hospitals. Policymakers and providers are keen to ensure that the price paid for health care services stimulates improvements in quality and safety, but some remain sceptical that this can be achieved through pricing mechanisms.

There are four main ways of linking quality and safety to hospital pricing in the context of activity based funding:

- **Best-practice pricing**: This involves making evidenced-based decisions on what constitutes ‘best-practice’ for the treatment of a particular condition, then paying health services a set price when they provide best-practice care.

- **Normative pricing**: This involves using price to influence the delivery of care (for example, providing incentives to deliver more care in the home for certain conditions or to provide day surgery options where appropriate).

- **Structural models of pricing quality**: This involves linking funding to meeting accreditation standards or participating in benchmarking activities or clinical quality registries.

- **Payment for Performance (P4P) or quality pricing**: This involves using financial incentives and/or disincentives to encourage providers to behave in certain ways that will improve quality and safety.

This paper briefly examines the strength of the evidence for each of these pricing models. It considers both peer-reviewed research as well as non peer-reviewed material, such as program evaluations and government reports.

**What does the evidence say?**

There is a rich literature arguing that health care pricing models should reward quality and safety. Many of the arguments are inherently appealing. However while strong on argument, overall the literature is weak on evidence.

**Best-practice pricing.** Very little peer-review research has examined whether best-practice pricing models stimulate improvements in quality and safety, but there are some studies that provide useful information. One study was conducted in Michigan through a Participating Hospitals Agreement with Blue Shield Blue Cross. In this study, researchers examined how closely clinicians adhered to best-practice guidelines for the treatment of acute myocardial infarction and congestive heart failure when guidelines were tied to an incentive tariff. They found that over a three year period (from 2000 to 2003), the rate of appropriate aspirin use increased by 8 per cent, beta-blockers by 12 per cent and ACE inhibitors by 10 per cent. Overall, the researchers estimated that more than 24,000 patients received better care during this period because of the incentive program.

While the incentive program improved compliance with best-practice guidelines, it came at a cost of more than US$22 million (including administration costs). Because there was no adequate baseline data prior to implementation, and no control group or data from hospitals that did not participate in the program, it is impossible to tell how effective the incentives really were. Likewise, it is impossible to tell whether the high cost of the program was worthwhile. Some researchers have also criticised the study, suggesting that estimations of the effectiveness of the program were overstated.

Several other small studies on best-practice pricing incentives have also been undertaken: one in the US and one in Taiwan. The US study looked at improvements in adherence to best-practice guidelines for coronary artery bypass graft surgery, and the Taiwanese one looked at management of breast cancer patients. Both studies reported that best-practice pricing led to modest improvements in the quality of care provided. However both of the studies also had serious methodological flaws (for example, no control group or poor descriptions of the program), which means the evidence is suggestive rather than conclusive.

**Normative pricing.** Just as with best-practice pricing models, there has been very little peer-review research done on normative pricing schemes and their impact on quality and safety. Under these schemes, incentives are provided to encourage certain desired outcomes, for example more day surgery, reduced readmissions, shorter patient processing times or more home based care. Some research on the impact of normative pricing has been done in the radiology field. It shows substantial improvements in radiology reporting times following the introduction of normative pricing. Due to weaknesses in the research design – for example, there was no concurrent control group – it is impossible to draw strong conclusions from these studies...

Read the [full article](#)
Asia

Forecasting the absolute and relative shortage of physicians in Japan using a system dynamics model approach
By Tomoki Ishikawa et al., Published in Human Resources for Health, August 2013.

In Japan, a shortage of physicians, who serve a key role in healthcare provision, has been pointed out as a major medical issue. The healthcare workforce policy planner should consider future dynamic changes in physician numbers. The purpose of this study was to propose a physician supply forecasting methodology by applying system dynamics modeling to estimate future absolute and relative numbers of physicians.

Introduction

Health policy planning for human resources has become an internationally high priority. In Japan, a shortage of physicians, who serve a key role in healthcare provision, has been pointed out as a major medical issue. The Ministry of Health, Labour and Welfare (MHLW) reported that there is lack of absolute and relative numbers of physicians, as well as maldistribution among regions and medical departments. To ease the personnel shortage in Japan, the MHLW estimated that hospitals need a further 24,000 physicians.

It has been suggested that the policy of decreasing medical school enrolment quotas is a major factor behind the absolute shortage of physicians. In 1982 and 1999, the policy was approved by the Japanese Government to prevent future oversupply. The medical school enrolment quota had decreased from 8,280 students in 1984 to 7,625 in 2007. However, the number of physicians per unit of population in Japan is low compared with other developed countries. According to Organization for Economic Co-operation and Development (OECD) data, the number of medical doctors per 1,000 persons in Japan was 2.2 in 2008; this number was 2.4 in the US in 2009 and 2.7 in the UK in 2010. The number of physicians in Japan has always been lower than the OECD average. In 2008 the MHLW identified the physician supply issue, and recognized that there is not only maldistribution, but also a shortage of absolute numbers of physicians. To address the shortage, the Japanese Government decided to immediately increase the medical student enrolment quota. The Democratic Party of Japan (DPJ), which was elected into government from 2009 to 2012, promised to increase the quota to 1.5 times what it was in 2009 in order to raise the number of physicians per unit of population to the OECD average level.

Maldistribution of physicians at both the regional and departmental level has been reported by the MHLW. Regional maldistribution is identified as a factor contributing to the generation of areas that fail to meet the basic healthcare needs of their community. Maldistribution among medical departments causes insufficient provision of some medical care. In Japan, obstetrics/gynaecology (OB/GYN) and emergency departments are especially mentioned as being in need of more physicians than other departments. Specifically, the number of OB/GYN physicians is decreasing, and the department is facing future shortages. In Japan, medical school graduates determine their own speciality and location, so physician maldistribution may worsen. To address regional maldistribution, a bonding scheme has been proposed to ensure that graduates work in specified regions. No comprehensive measures have been proposed to address medical department-level maldistribution, and it is at risk of worsening in the future.

The healthcare workforce policy planner should consider future changes in physician numbers. Effective planning for the future medical workforce has become increasingly necessary in Japan because of changes in and uncertainty of physician supply in the face of the populations requirement for their services. Accurate forecasting of the workforce supply is essential for effective planning. Forecasting methods include the need-based model, the demand-based model and benchmarking. These methods are limited by assumptions about changes in physician availability across incomparable communities or areas. We argue that the forecasting approach used should be able to describe the dynamic variables involved in the physician supply system and have utility even if the needs of the community and health system differ.

Read the full article

International Events

IAPO Latin America Network Programme - 23-25 September 2013 - Mexico City, Mexico
This September IAPO will be holding a number of events in Mexico City with the purpose of strengthening the networks of patients' organizations in the region and highlighting the value of patient engagement in a number of areas including health technology assessments (HTA) and biological and biosimilar medicines.

IAPO's activities in Mexico include:

- A half day meeting for local Mexican patients' organizations
A half day multi-stakeholder seminar and reception entitled ‘Patient-centred access to healthcare in Latin America’ which will focus on mechanisms for accessing healthcare such as health technology assessments (HTAs) and biological and biosimilar medicines.

A two day workshop for patients’ organizations from across Latin America with the purpose of further strengthening the network in Latin America and developing an action plan for the remainder of 2013 and into 2014.

More information will be shared soon, if you have any questions about IAPO’s upcoming activities please email Rebecca Johnson at rebecca@patientsorganizations.org or on +44 20 7250 8281.

USA - University HealthSystem Consortium (UHC) annual Conference 2013
October 17 - 18, Hyatt Regency Atlanta, Atlanta, Georgia

USA - American Nurses Credentialing Center: ANCC National Magnet Conference
October 2-4, 2013, Orlando, Florida

At the ANCC National Magnet Conference®, more than 7,000 nurses and nursing executives from top hospitals celebrate Magnet Recognition and gather to share evidence-based practices. This is the official annual conference of the prestigious Magnet Recognition Program®, serving as both a celebration of accomplishment for newly designated Magnet® organizations and a showcase of best nursing practices for the Magnet community. All those interested in improving their institution’s nursing program and learning about Magnet are invited to register. Attendees will return to their hospitals energized to improve their nursing programs and equipped with proven methods to do so.

For more information: [http://www.anccmagnetconference.org/](http://www.anccmagnetconference.org/)

Switzerland - Congres 2013 H+
November, 7, 2013, Bern

Le Congrès 2013 de H+ sera consacré aux ressources humaines. Car un personnel bien formé est indispensable pour prodiguer des soins de qualité. Il est le garant de l’avenir des hôpitaux. Mais comment attirer et fidéliser de bons collaborateurs dans un marché du travail toujours plus tendu?

[click to learn more](#)

Korea - Healthcare Congress

Germany - German Hospital Day (Deutscher Krankenhaustag)
November 20 - 23, 2013, Düsseldorf (on the occasion of the fair MEDICA)

Luxembourg - 24th EAHM Congress
28 - 30 November, 2013, Kirchberg, Luxembourg

“Hospital Management in times of crisis - constraints, challenges and opportunities” at the New Conference Centre (NCCK), Luxembourg - Kirchberg

Il s’agit de l’événement phare de l’AEDH, organisé tous les deux ans dans une grande ville européenne, et rassemblant plus de 600 participants de toute l’Europe. Pour la première fois, ce congrès se tiendra à Luxembourg, du 28 au 30 novembre 2013. Ce sera l’occasion d’accueillir les CEOs et Managers des hôpitaux ainsi que les représentants de la presse spécialisée du monde de la Santé dans le prestigieux Centre de Conférences de Luxembourg-Kirchberg (NCCK) nouvellement inauguré.

**Second Joint European Hospital Conference**  
**22 November 2013 Düsseldorf, Germany.**

The 2nd Joint EUROPEAN HOSPITAL CONFERENCE (EHC) takes place as part of MEDICA 2013 and the 36th Congress of German Hospitals.

The EHC will address different political, medical and economic topics from across all of Europe. As a separate event the EHC is directed by the Gesellschaft Deutscher Krankenhaustag (GDK) and will be held in the Congress Center East (CCD-East) on the trade fair grounds of Messe Düsseldorf.

In addition, high-ranking speakers from the European Hospital and Healthcare Federation (HOPE), the European Association of Hospital Managers (EAHM) and the Association of European Hospital Physicians(AEMH) will take a detailed stance on the following topics:

> Implementing the EU Directive on patients’ rights
> Innovation access in Europe's hospitals

Approximately 150 – 170 top decision makers from Europe’s hospitals are expected to attend. All presentations will be translated simultaneously into English, French and German.

Congress Time: 10.00 h – 16.00 h

For more information download the [Programme](#)

**39th World Hospital Congress - Chicago 2015**

The next World Hospital Congress "Advancing Global Health & Health Care" will be held in the City of Chicago, USA from 6 to 8 October 2015.

Save the date !
International Hospital Federation
39th World Hospital Congress

Mark Your Calendar

ADVANCING GLOBAL HEALTH & HEALTH CARE
October 6–8, 2015 Chicago, USA

Exchange ideas and best practices with visionary health care leaders from around the world.

Come to Chicago—A World-Class City

Home to a vibrant health care market with 116 hospitals in the greater metropolitan area, including 15 teaching hospitals. Congress attendees will get a behind-the-scenes look at several leading health care organizations.

Enjoy top-rated restaurants, museums, entertainment and a shopping district known as The Magnificent Mile.

The Hyatt Regency Chicago—the program site—is a prime location with breathtaking skyline and Lake Michigan views.

More information will be forthcoming at www.ihf-fih.org, but for now, save the date!

Corporate Partners