Public health

Europe

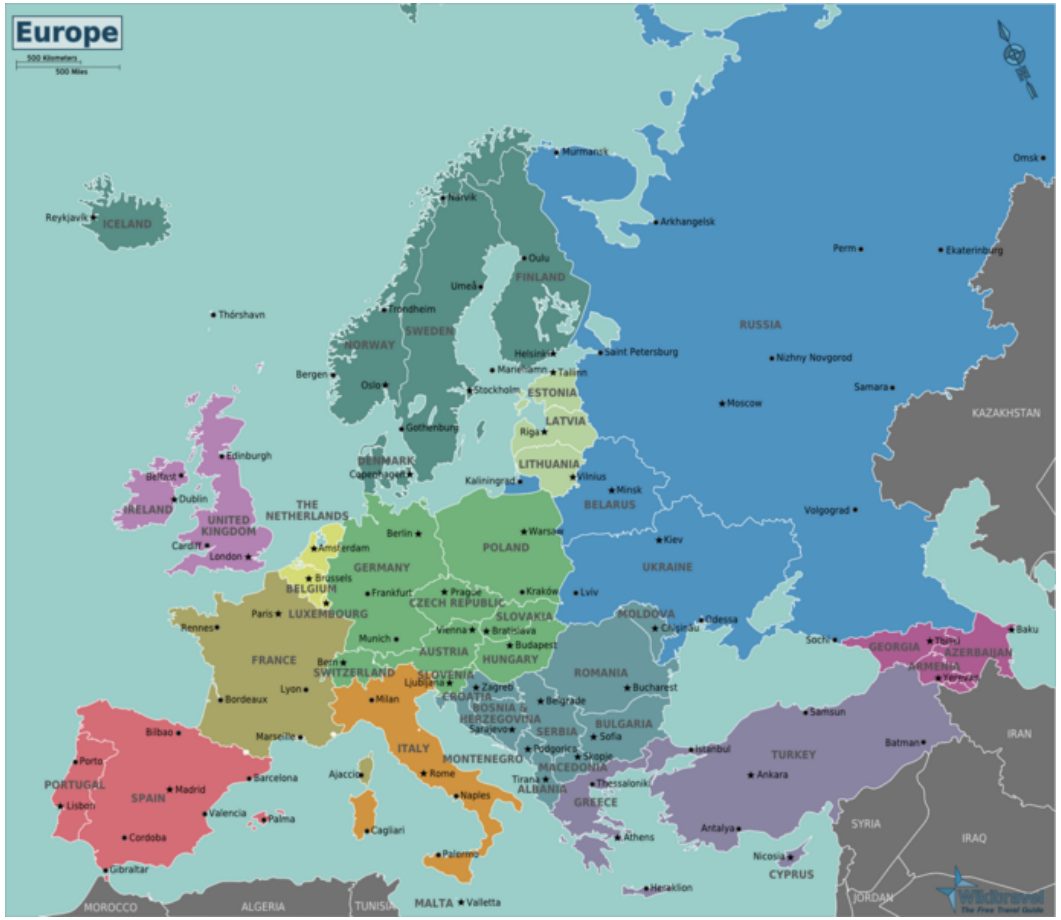
EU

Czech

perspective

European perspective

EUROPE



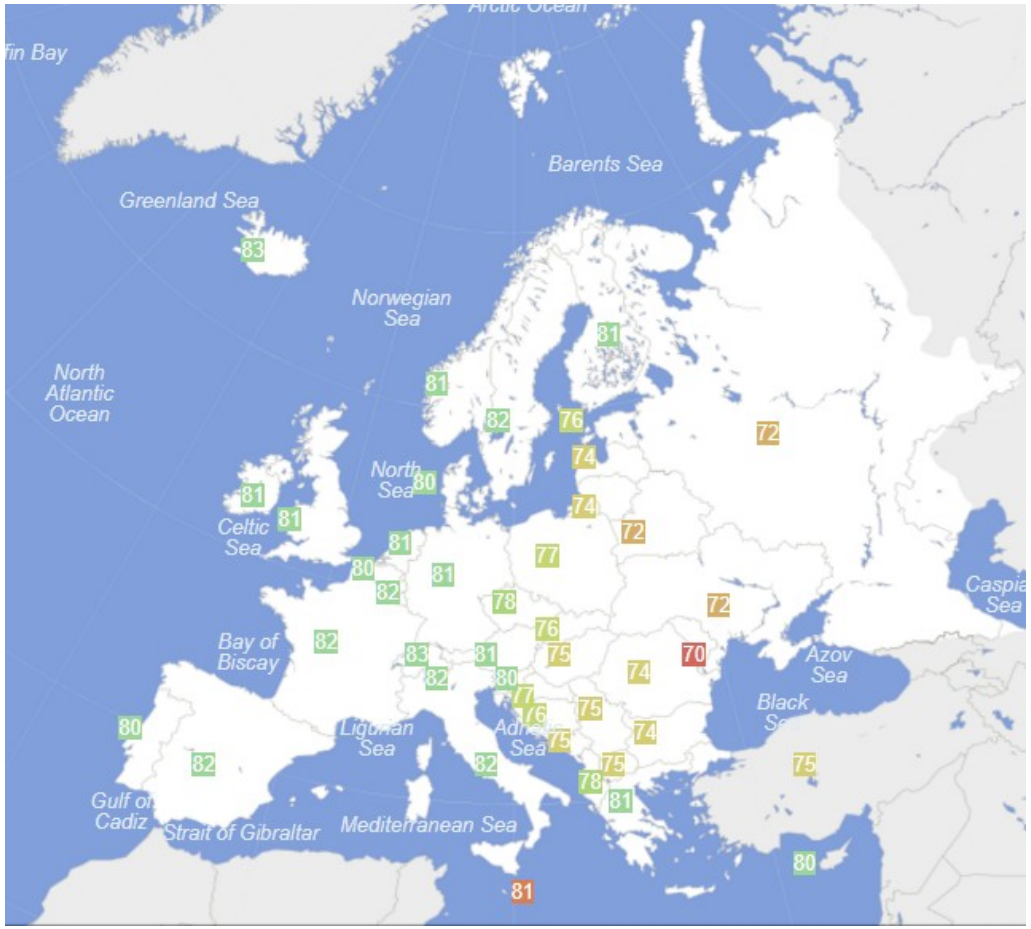
Basic facts

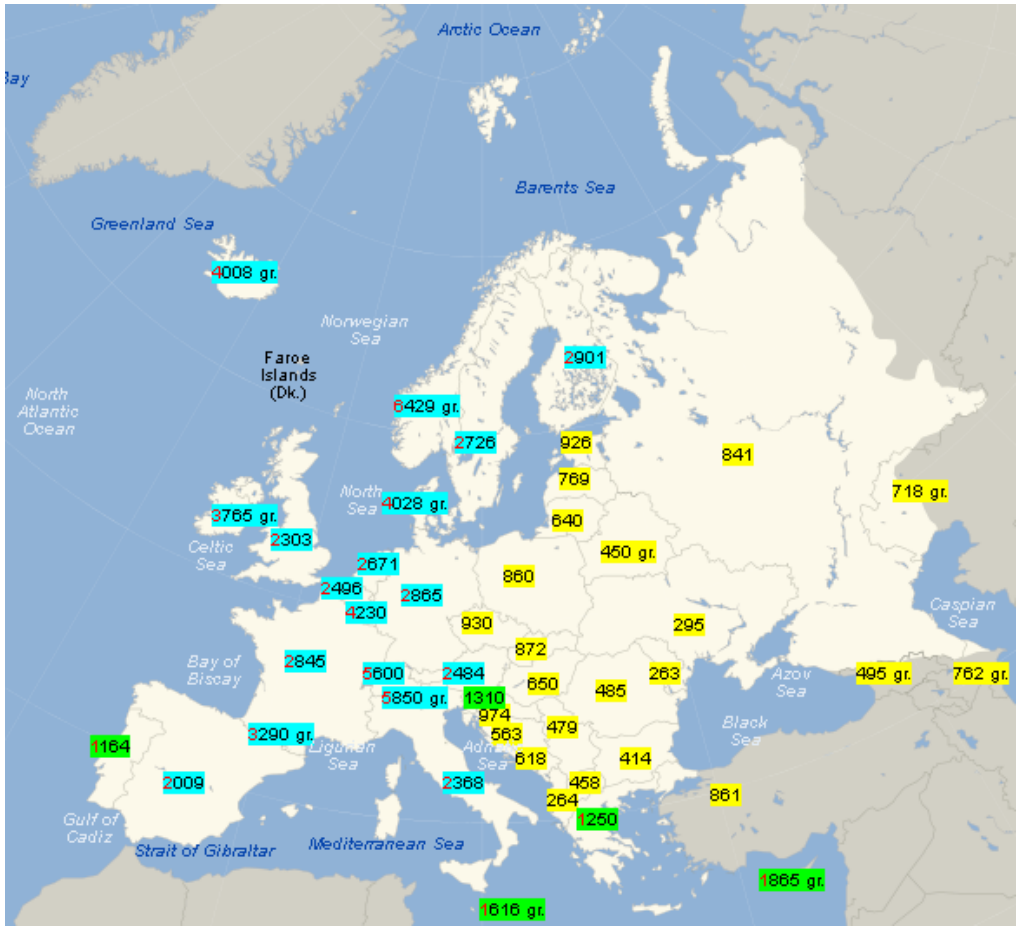
- 750 million people
- 6 time zones
- 50 sovereign states
  - Each responsible for its own health policy
  - No common public health policy

Vast differences among individual regions

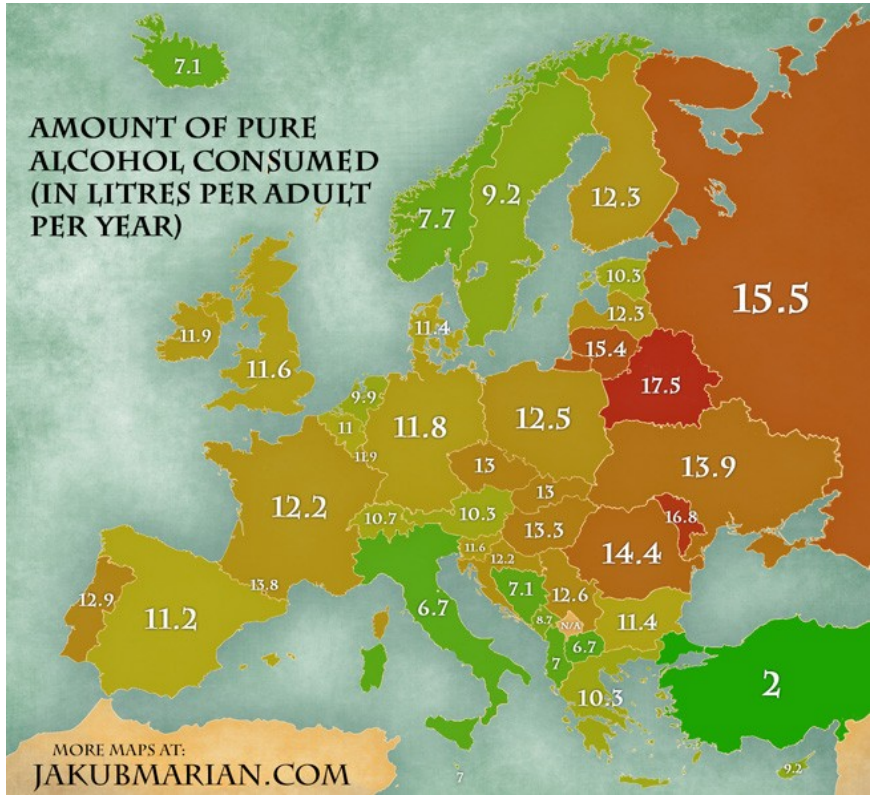
- Living standards
- Lifestyle
- Diet
- Life expectancy

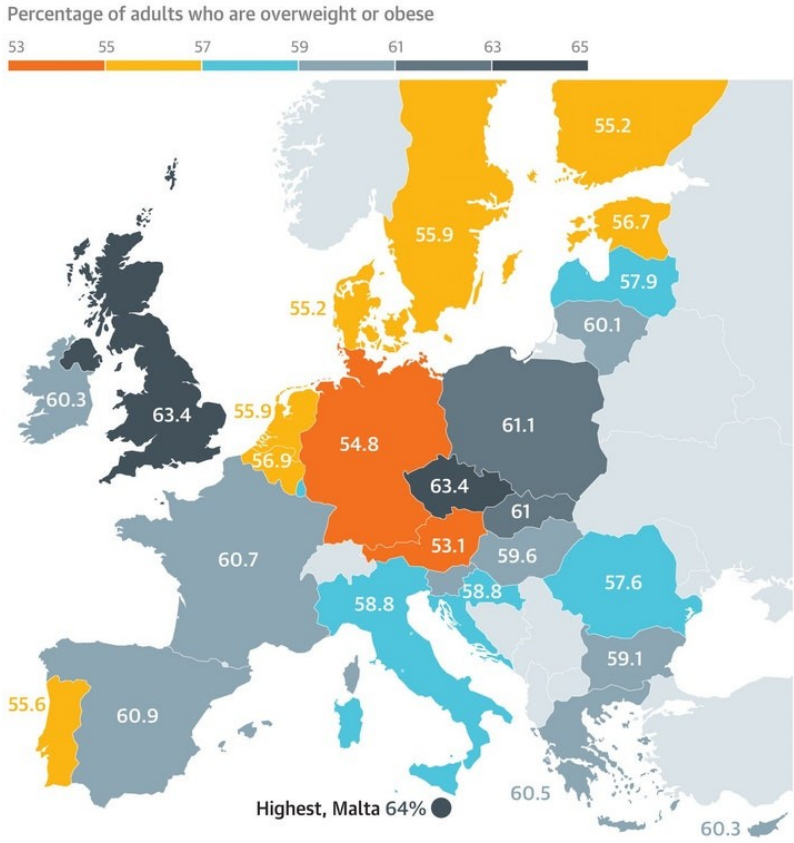
European gap in life expectancy/income





Other lifestyle differences





What do European states have in common /healthcare and public health perspective/

Christian tradition

- catholic and orthodox church used to be a major healthcare provider
- Hospitals were established in monasteries,
- Medical schools were run by churches

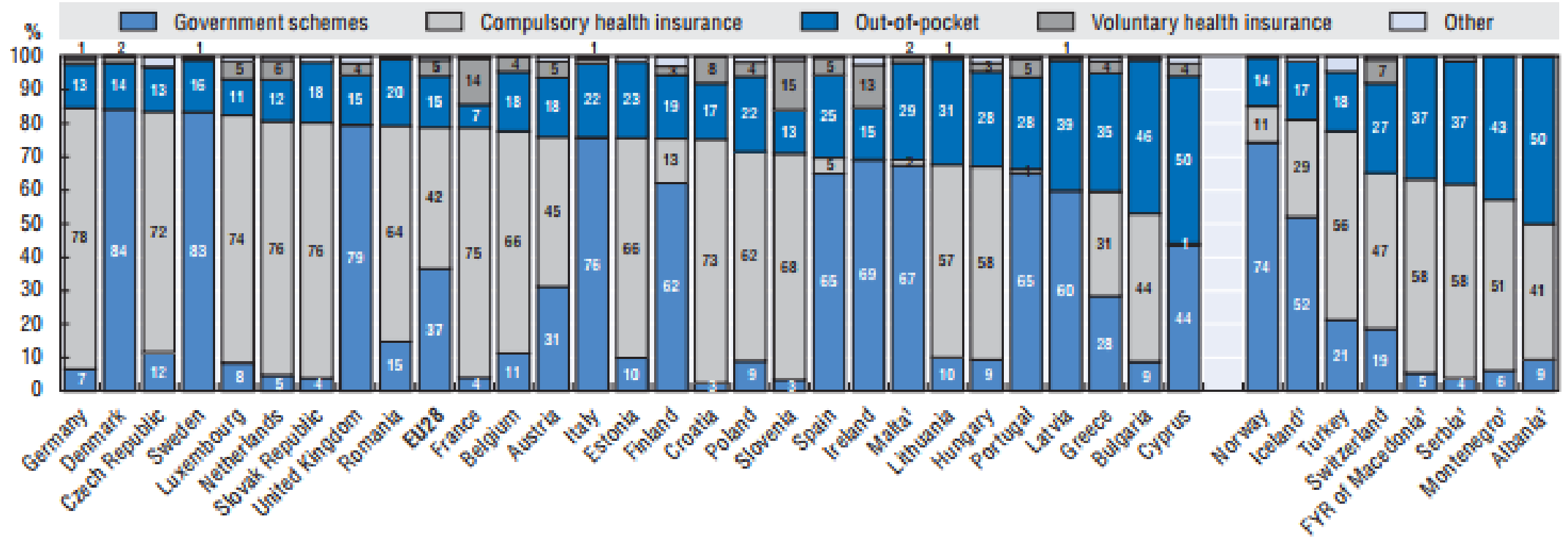
Welfare state

- Concept from 19th century
- Solidarity, social policies, welfare spending
- Public (and obligatory) health insurance

Result

- *All* European countries guarantee free (or heavily subsidized) access to Healthcare
- Health is (mistakenly) percieved to be a public service
- Much higher emphasis is on the provision of healthcare than public health

5.11. Current health expenditure by type of financing, 2014

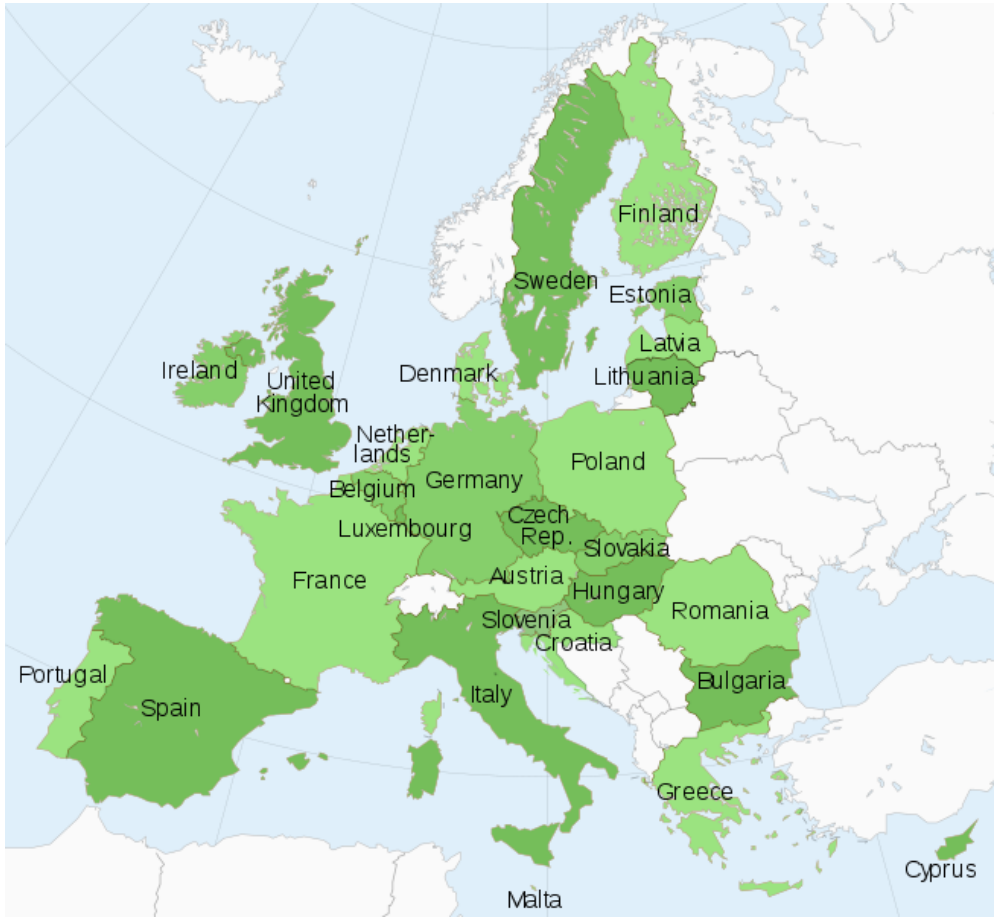


lote: Countries are ranked by government schemes and compulsory health insurance as a share of current health expenditure.

. Includes investments.

European union perspective

European union



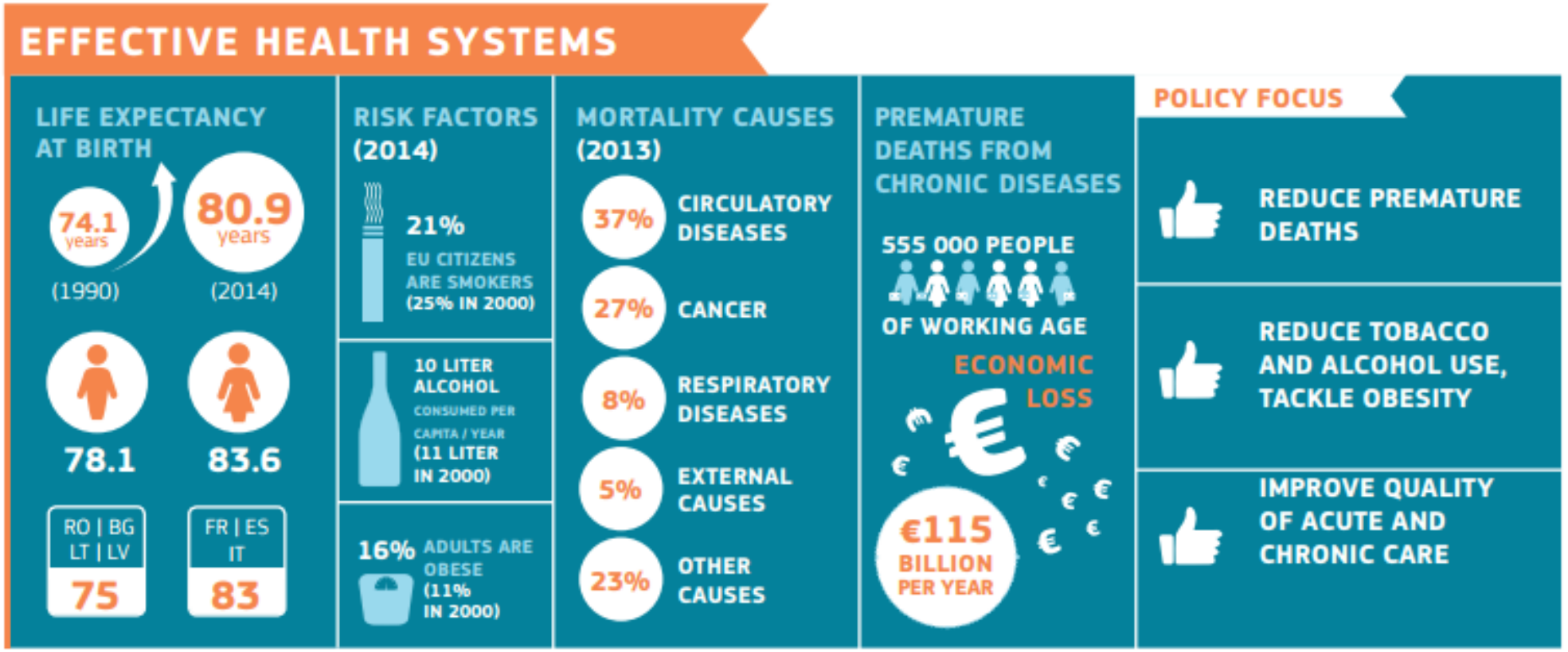
Basic facts

- 27 countries
- 550 million citizens

It is not a state but …

- Union of sovereign states
- Common currency (in most countries)
- Free movement of citizens, goods, services
- Common policies in certain areas

Public Health Objectives and challenges



ACCESSIBLE HEALTH SYSTEMS

UNMET NEED FOR MEDICAL CARE

DUE TO FINANCIAL CONSTRAINTS, DISTANCE OR TIME DELAYS

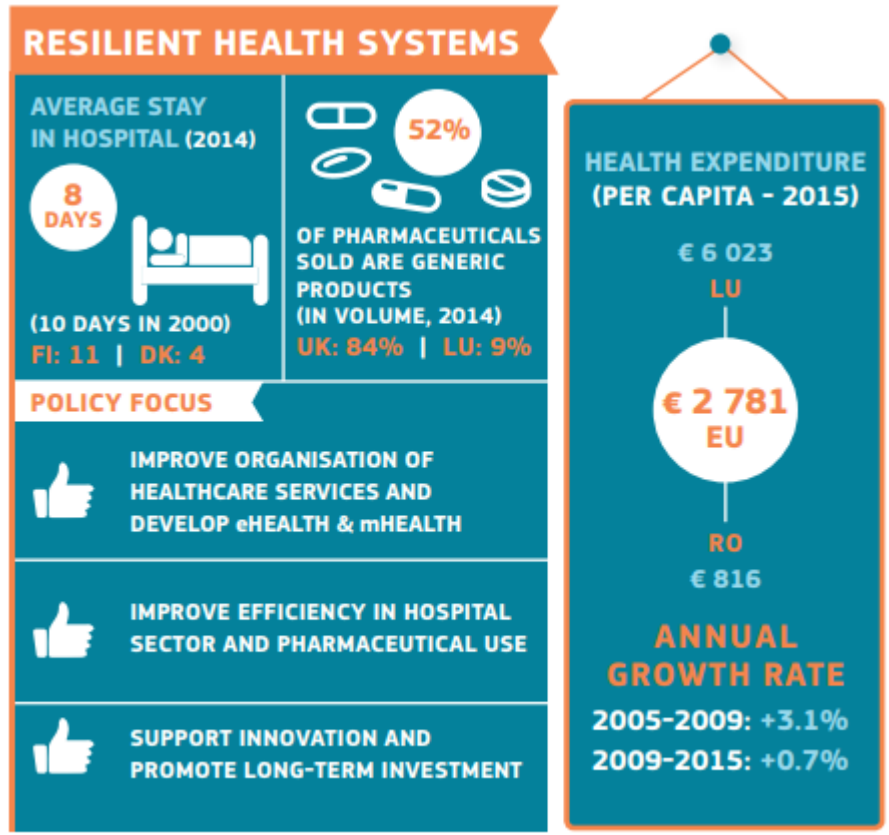
HIGH INCOME	AVERAGE	LOW INCOME
1.5%	3.6%	6.4%

27% OF PATIENTS GO TO EMERGENCY DEPARTMENT BECAUSE PRIMARY CARE IS NOT AVAILABLE

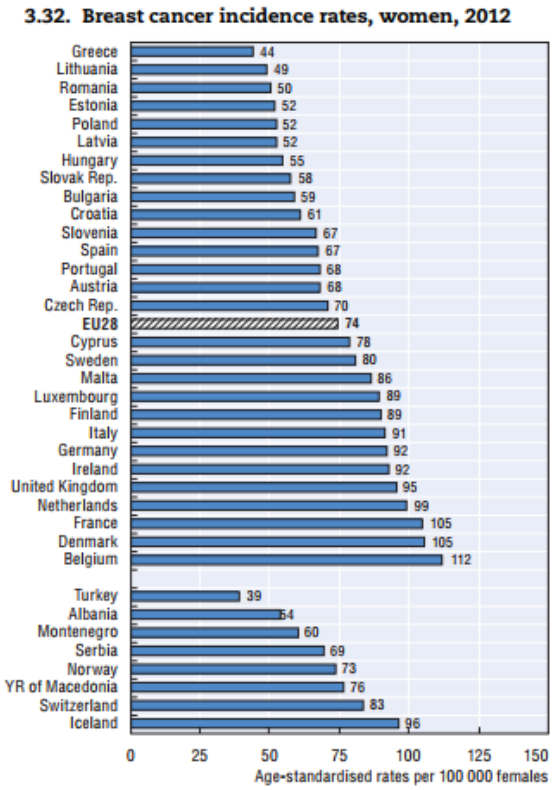
15% OF HEALTH SPENDING IS PAID DIRECTLY OUT-OF-POCKET BY PATIENTS

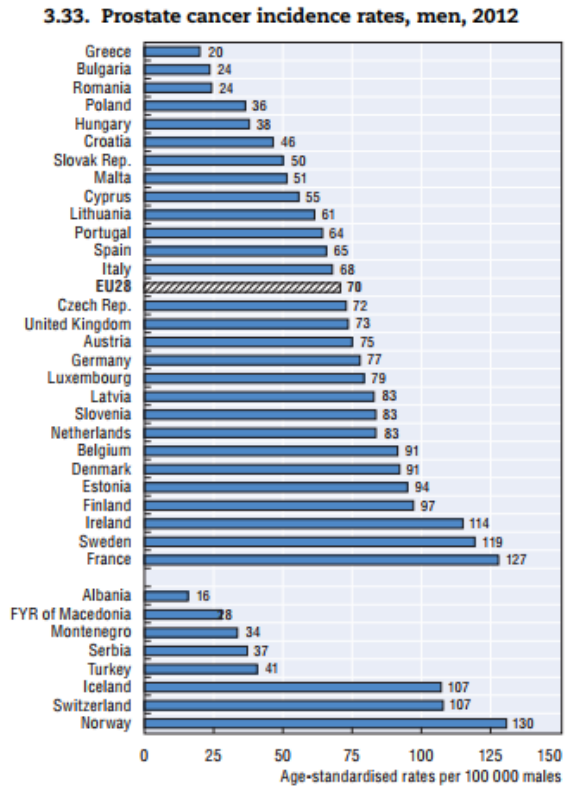
POLICY FOCUS

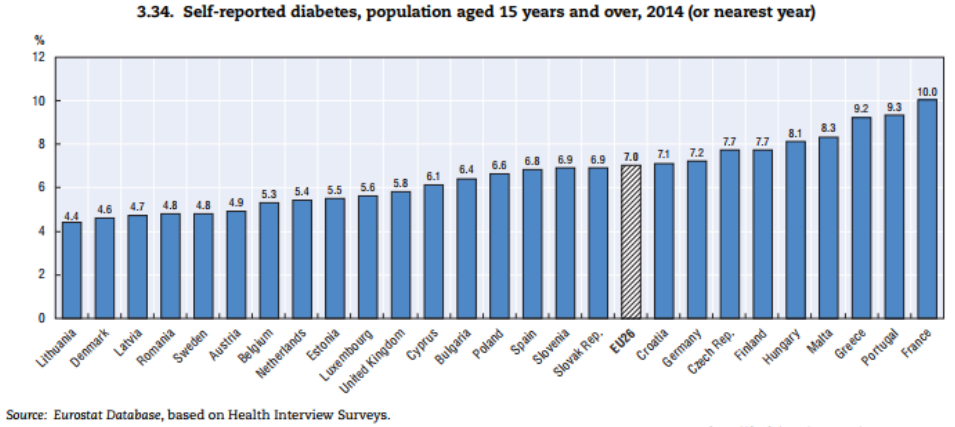
- REDUCE FINANCIAL BARRIERS TO HEALTHCARE
- STRENGTHEN ACCESS TO PRIMARY CARE
- REDUCE EXCESSIVE WAITING TIMES


RESILIENT HEALTH SYSTEMS
AVERAGE STAY IN HOSPITAL (2014)
8 DAYS
(10 DAYS IN 2000)
FI: 11 | DK: 4
52%
OF PHARMACEUTICALS SOLD ARE GENERIC PRODUCTS (IN VOLUME, 2014)
UK: 84% | LU: 9%
POLICY FOCUS
IMPROVE ORGANISATION OF HEALTHCARE SERVICES AND DEVELOP eHEALTH & mHEALTH
IMPROVE EFFICIENCY IN HOSPITAL SECTOR AND PHARMACEUTICAL USE
SUPPORT INNOVATION AND PROMOTE LONG-TERM INVESTMENT
HEALTH EXPENDITURE (PER CAPITA - 2015)
€ 6 023
LU
€ 2 781
EU
RO
€ 816
ANNUAL GROWTH RATE
2005-2009: +3.1%
2009-2015: +0.7%

The regional differences are again huge

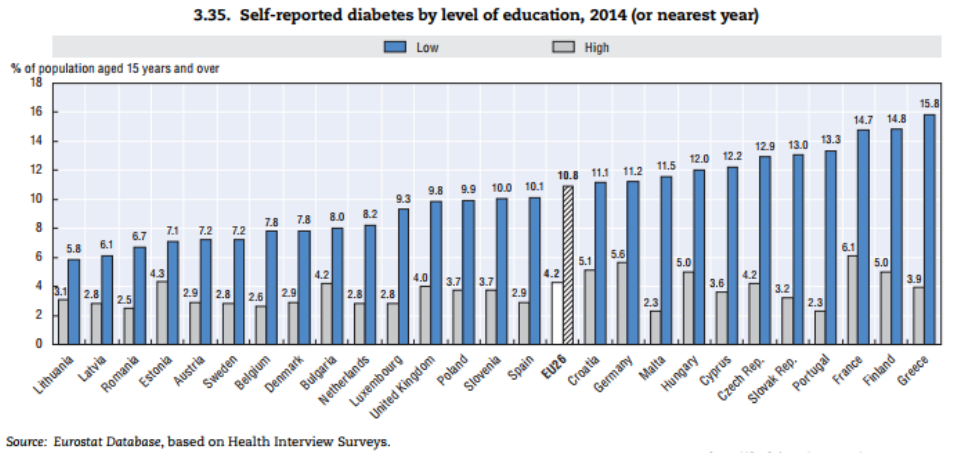






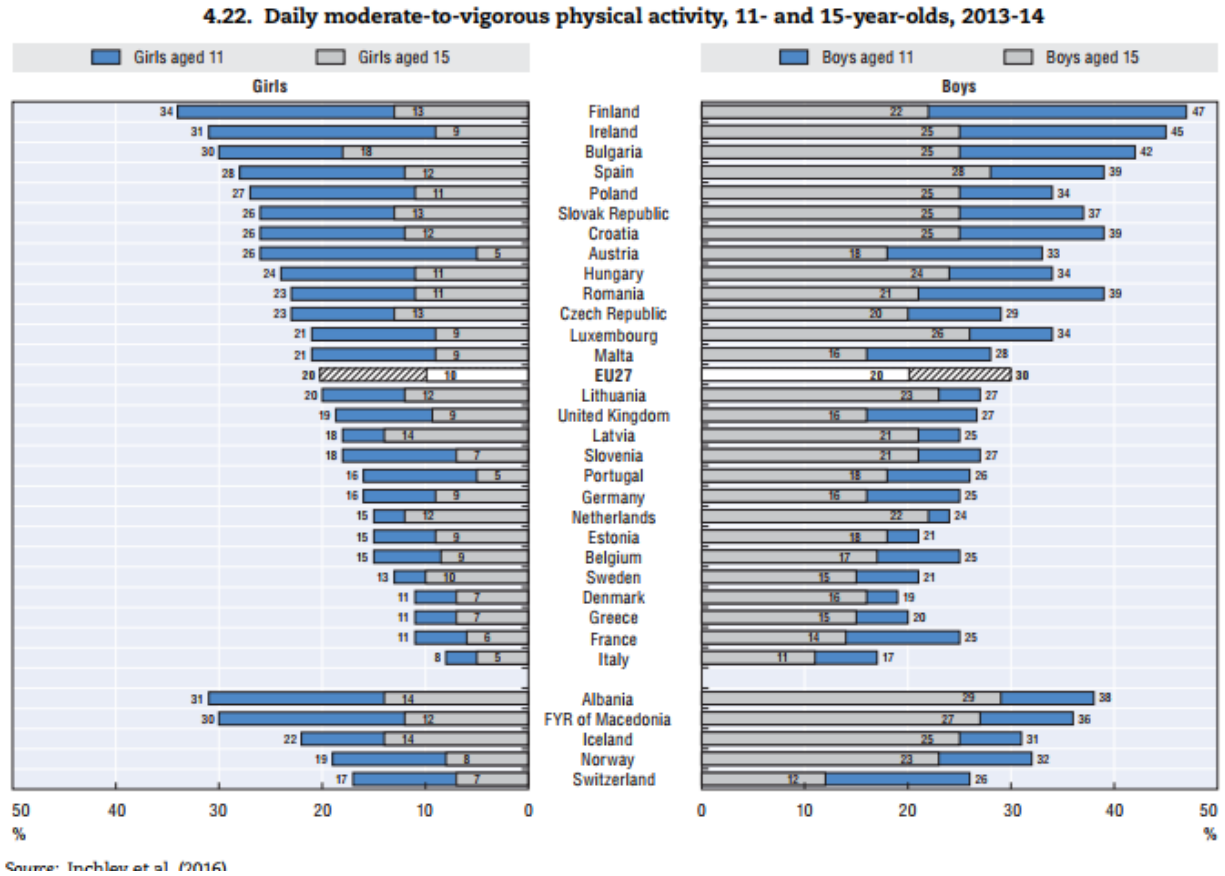
Source: *Eurostat Database*, based on Health Interview Surveys.

StatLink http://dx.doi.org/10.1787/888933428845

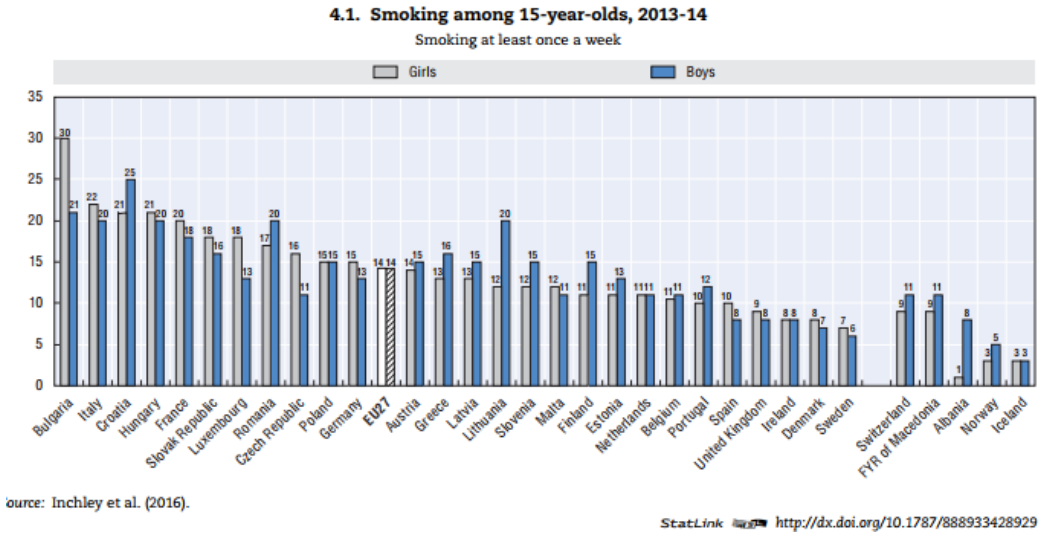


Source: *Eurostat Database*, based on Health Interview Surveys.

Health determinants are completely



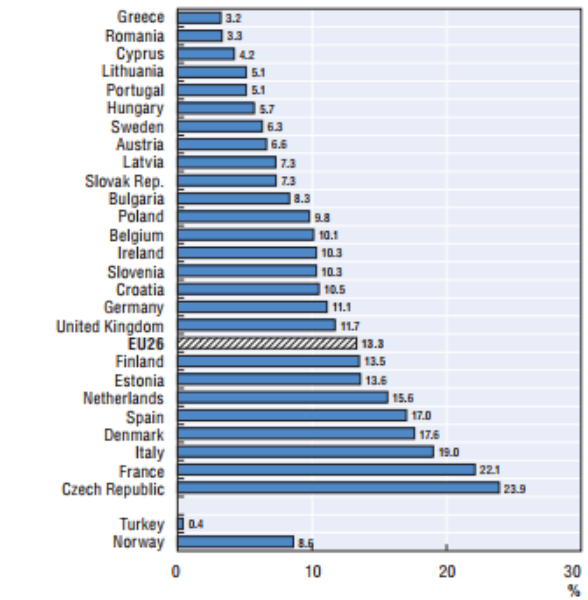
Source: Inchley et al. (2016)



Source: Inchley et al. (2016).

StatLink http://dx.doi.org/10.1787/888933428929

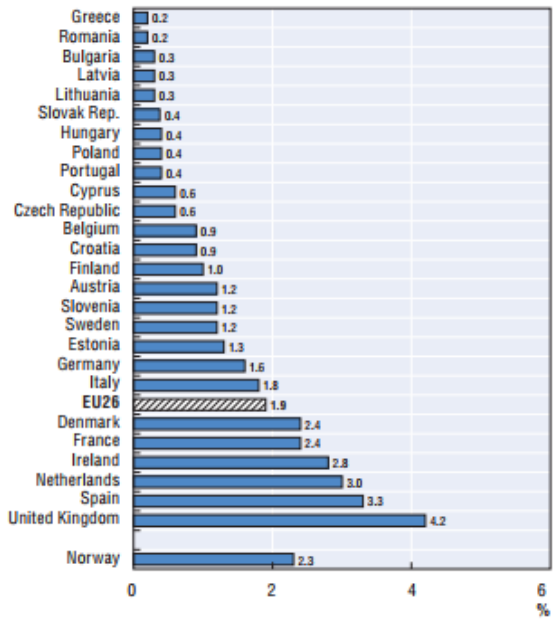
4.26. Cannabis use over the last 12 months among people aged 15 to 34, 2014 (or nearest year)



Source: EMCDDA (2016), *European Drug Report 2016: Trends and Developments.*

StatLink http://dx.doi.org/10.1787/888933429174

4.27. Cocaine use over the last 12 months among people aged 15 to 34, 2014 (or nearest year)



Source: EMCDDA (2016), *European Drug Report 2016: Trends and Developments.*

StatLink http://dx.doi.org/10.1787/888933429180

What can EU do about it (and what should be left for national sates).

1. Health in all policies

Since health is determined to a large extent by factors outside the health area, an **effective health policy must involve all relevant policy areas**, in particular:

- social and regional policy
- taxation
- environment
- education
- research.

All EU policies are required by the EU treaty to follow this "*Health in all Policies*" (HIAP) approach. But to be fully effective, this approach needs to be extended to **national, regional and local** policies.

Agencies on EU level

Consumers, Health and Food Executive Agency (Chafea) –

- implements the EU Health Programme, Consumer Programme and Better Training for Safer Food initiative.

European Centre for Disease Prevention and Control (ECDC) –

- works to strengthen Europe's defences against infectious diseases.

European Environment Agency (EEA)

- provides reliable, independent information on the environment.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

- supplies comprehensive information on drugs and drug addiction in Europe.

European Medicines Agency (EMA) –

- protects and promotes public and animal health by evaluating medicines for human and veterinary use.

European Chemicals Agency (ECHA) –

- ensures chemical substances are registered, evaluated, authorised and restricted consistently across the EU.

European Food Safety Authority (EFSA) –

- provides independent scientific advice and clear communication on risks to food and feed safety.

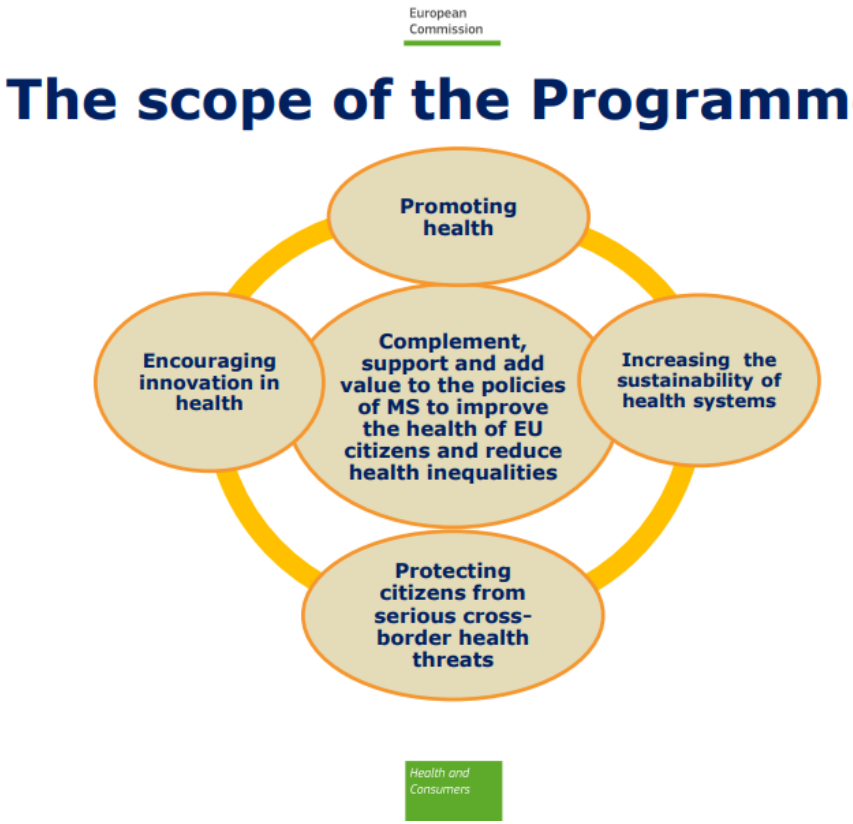
European Agency for Safety and Health at Work (EU-OSHA) –

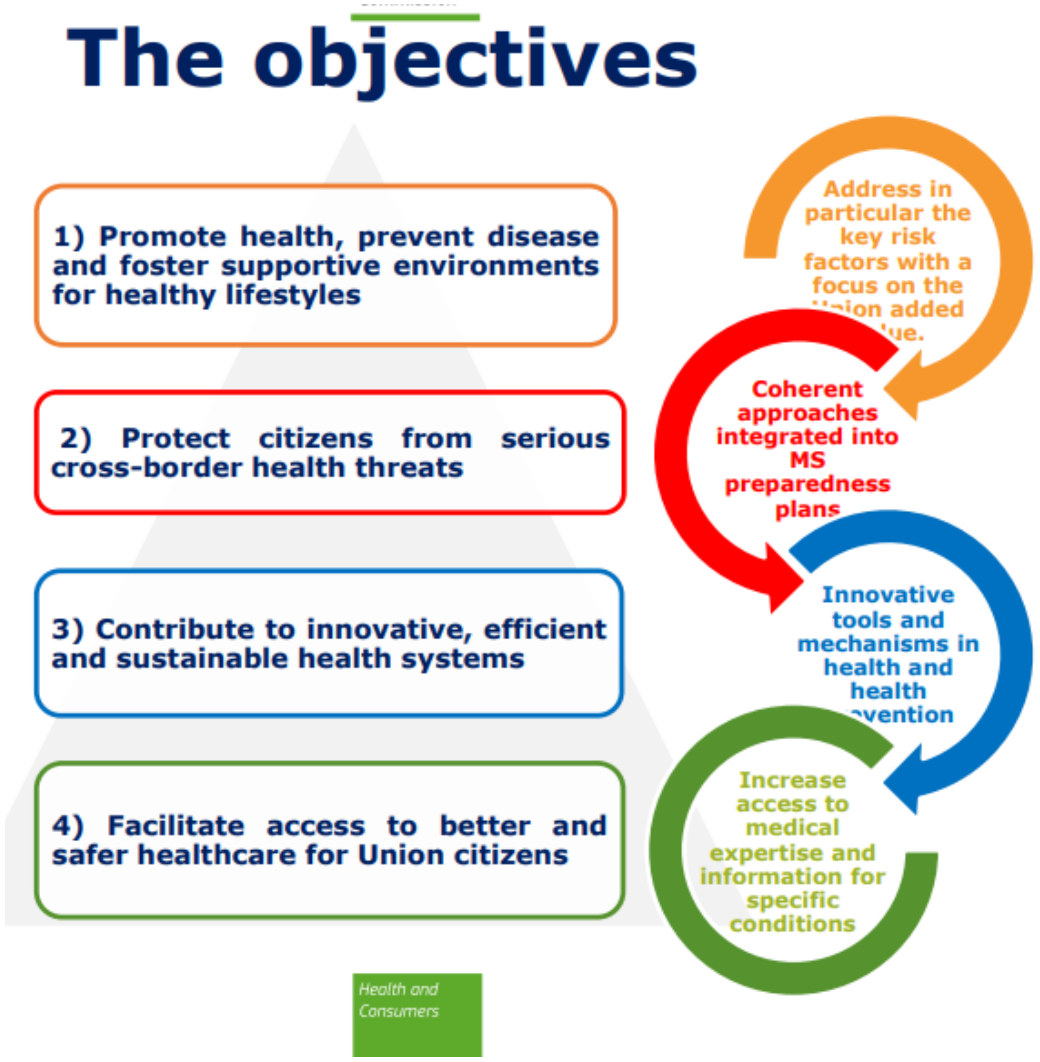
- supplies information needed by EU employers and workers to address safety and health issues.

Eurofound

- – provides expertise on living and working conditions, industrial relations and managing change for key EU social policy actors.

Third EU Health Programme 2014-2020





Where is EU taking action (?)

Ensuring health security

- Blood, tissues and organs
- Climate change
- Crisis preparedness and response

Improving health systems

- Cross-border healthcare
- European Reference Networks
- Health workforce
- Patient safety
- Health systems performance assessment
- Health technology assessment
- eHealth
- Expert panel

Taking Action against Diseases

- Antimicrobial resistance
- Communicable diseases
- Vaccination
- Major and chronic diseases
- Rare diseases

Health in Society

- Migrants' health
- Social determinants and health inequalities
- Ageing
- Population groups
- Interest groups
- Healthy environments

Fostering good health

- Nutrition and physical activity
- Alcohol
- Tobacco
- Illicit drugs
- Mental health
- Sexually transmitted diseases

Indicators and data

- Health indicators
- Data collection

Indicators and data

- Health indicators
- Data collection

Pharmaceuticals

- Medicinal products for human use
- Medicinal products for veterinary use
- International activities

Endocrine disruptors

- Endocrine disruptors

Biocides

- Biocides

Further actions

Movement of workforce

- Health professional

Movement of goods

- Safety standards
- Marketing rules

Cross-border provision of healthcare

Czech republic

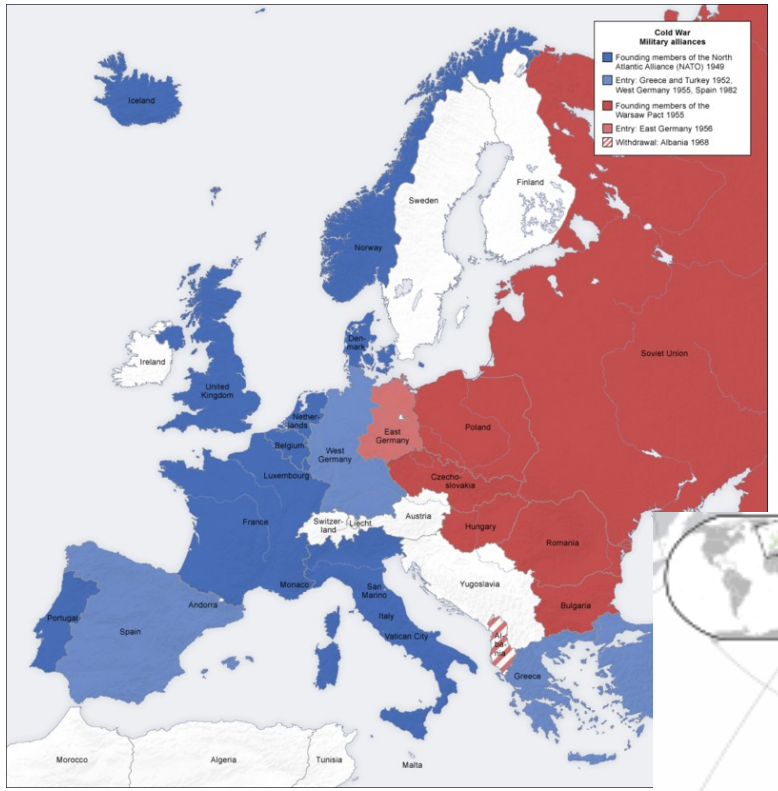
Public health action perspective

Czech republic

Flag

Greater coat of arms

Historical context



Current situation and problems

Health in all policies

- Little attention to core health policies
- Many agencies with partial public health interest
- Public health as a punitive action

Welfare-based system

- Compulsory health insurance
- Healthcare is provided for free in every necessary medical condition
- Hospital is forbidden to accept any payment for necessary treatment
- Patients pay only cosmetic treatments or „above the standard treatment“

HEALTH 2020

National Strategy for Health Protection and Promotion and Disease Prevention

Strengths

- Tradition of primary prevention
- Grounding in society and the health care system
- Past and present achievements
- Legislative framework (Act No. 258/2000 Coll. on public health protection and other laws)
- Primary prevention embedded in different medical fields
- History of high-quality primary prevention
- Evidence-based effectiveness of primary prevention
- Reliable information database on health and its determinants
- Public recognition of the health protection and promotion system

Opportunities

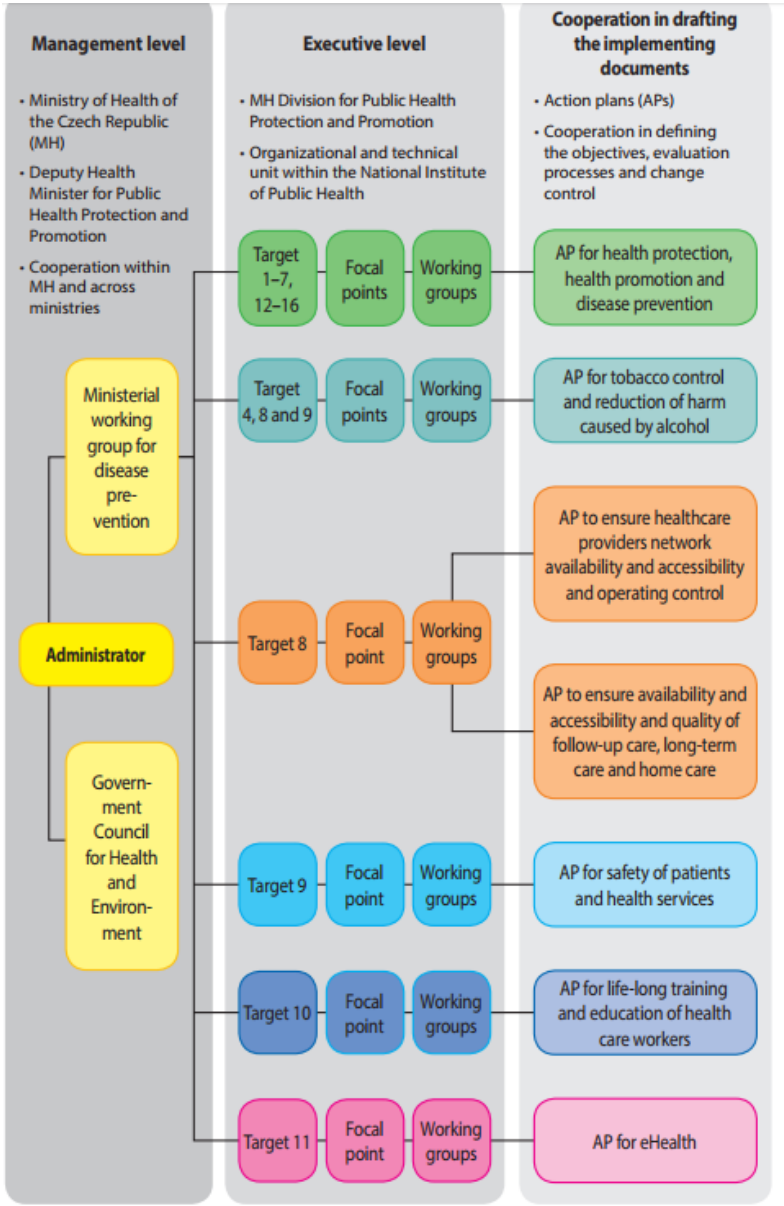
- Application of international experience and good practice – e.g. public consultation on the EC Green Paper, on the EU workforce for health, strategic and other documents or impact studies at the EU, WHO or OECD level
- Participation in international projects and grants for primary prevention and health promotion
- Revitalization of the public health protection and promotion system
- Existing human resources for renewed primary care
- Public recognition of disease prevention and health improvement

Threats

- Continuing reduction of health promotion and protection capacities (following restructuralization which reduced capacity by more than 40 %)
- Insufficient education of the next generation in the necessary range of fields
- Financial instability affecting health system performance
- Failure to utilise the existing potential, tools and possibilities of the state to mitigate adverse effects on population health and reduce healthcare costs

Weaknesses

- Slow response to social changes
- Insufficient participation of idividual societal components in solving problems affecting health
- Longterm instability in the research, educational and institutional framework
- Unfavourable age structure of experts
- Decreasing level of expertise of health services driven by commercially motivated and scientifically unfounded approaches
- Legacy of former coercive practices in management of infectious disease risks and health protection
- Mistakes made in public health system management
- Insufficient funding, no investment strategy in primary prevention
- No systematic assessment of effectiveness in disease prevention, health protection and promotion



Law in public health

How to improve public health by legal regulations

Institutions

Incentives

Institutions vs. Incentives

Institutions

- Hygiene (sanitation)
- Food inspection
- Drug inspection
- Supervision of technology

Incentives

- Economic incentives
  - Punitive
  - Motivational
  - Environmental

Drug (medicine control)

Areas of scope

- Drug safety
- Marketing
- Market access
- Price regulation

Incentives

- Economic incentives
  - Consumption taxes, minimum sales price

Sugar Tax Success for Mexico

Email Print Share

23 Feb 2017 --- More than three years after Mexico enforced a one peso tax on sugary sweetened drinks, there is evidence that fewer people are buying sodas with an overall decline of 7.6%. The latest data shows purchases of taxed beverages decreased 5.5% in 2014 and 9.7% in 2015, yielding an average reduction of 7.6% over the study period.

Households at the lowest socioeconomic level had the largest decreases in purchases of taxed beverages in both years and meanwhile purchases of untaxed beverage increased 2.1% in the study period.

Findings from Mexico may encourage other countries to use fiscal policies to reduce consumption of unhealthy beverages along with other interventions to reduce the burden of chronic disease

Alcohol

Scotland's minimum pricing for alcohol to take effect in May 2018

Shona Robison announces plan to fix level at 50p a unit, aiming to reduce hospital admissions by 8,254 in first five years

There were 1,265 alcohol-related deaths in Scotland last year. Photograph: Jane Barlow/PA

Incentives

- Behavioural, environmental incentives and bans

Original article

PDF

The cost-effectiveness of bike lanes in New York City

ng Gu, Babak Mohit, Peter Alexander Muennig

uthor affiliations +

Abstract

Background Our objective is to evaluate the cost-effectiveness of investments in bike lanes using New York City's (NYC) fiscal year 2015 investment as a case study. We also provide a generalizable model, so that localities can estimate their return on bike lane investments.

Most Czechs favor restaurant smoking ban

Survey of pub owners by Charles University and Ipsos agency shows ban could lead to Kč 6 billion annual windfall for restaurateurs

Increasing the tax on tobacco products was among the few popular budgetary measures | foto: © Reuters, Česká pozice

Compulsory healthcare

- Vaccination
- Quarantines
- Compulsory treatment in psychiatry

GENERALLY available healthcare

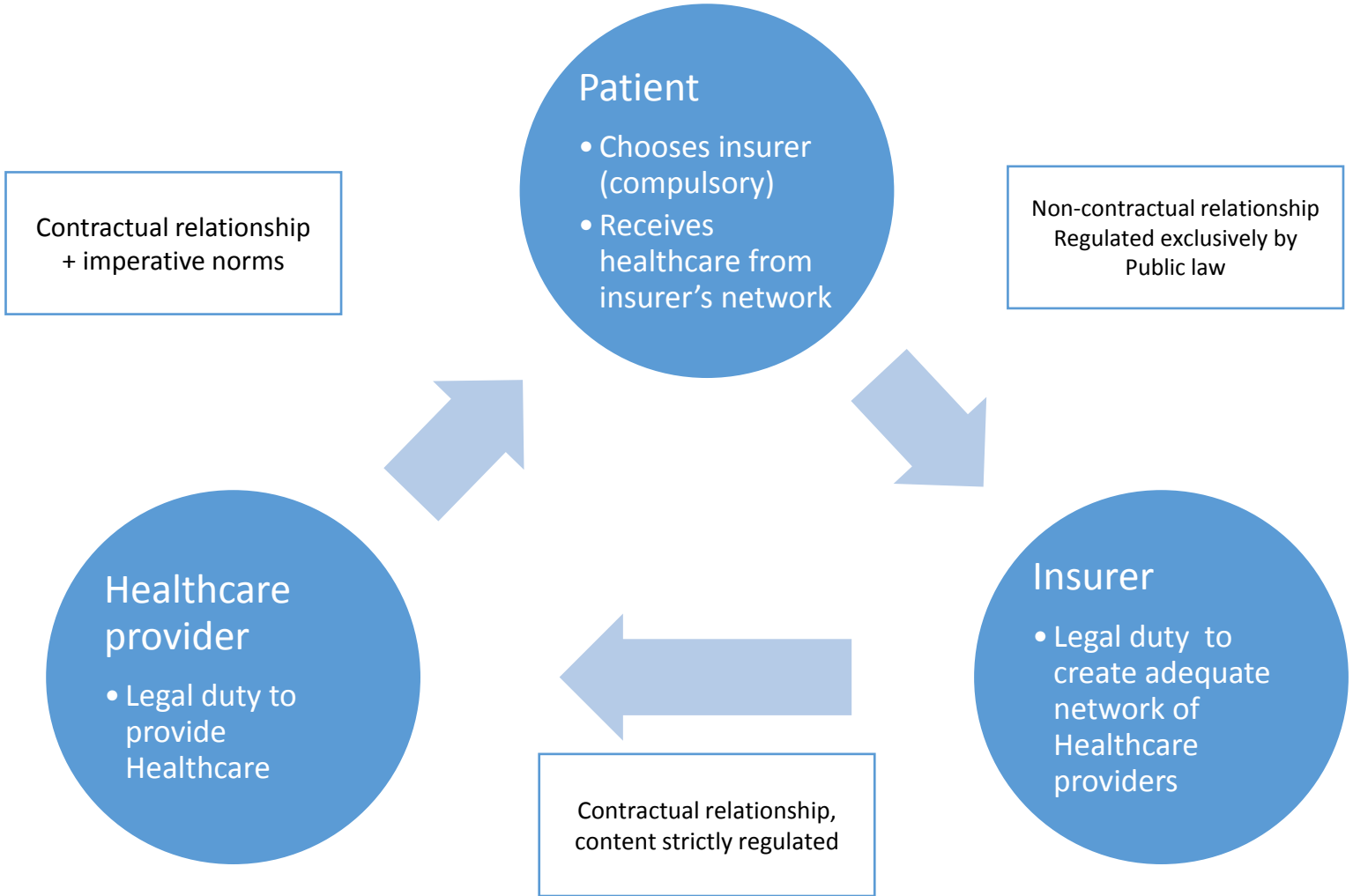
Financing of healthcare

Current problems of free healthcare

Outline

I. System of public insurance in Czechia (CZE)
II. Rights of a patient towards Provider of Healthcare and towards Insurer
III. Cost effectiveness assessment in CZE
IV. Economic Implications
V. Rationing
VI. Case study 1: Rationing of expensive medicines
VII. Case study 2: Prescription of innovative medicines

System of public insurance in Czechia



Legislative solution

- Constitution / Charter of fundamental rights and freedoms
  - Free access to medical healthcare is a basic human right
  - Under conditions set by law
- Act on public health insurance
  - Medicines are integral part of healthcare and every insured person has a right for free medicines (Art. 11 and Art. 13 of the APHI)
  - The physician prescribing this medicine has ultimate responsibility to prescribe only those medicines that are truly needed
- Ultimate objective (principle?)
  - If the patient truly needs a medicine, he shall get it (for free, or at a marginal cost)

Health technology assessment (or lack thereof) in CZE

Step 1 Assesment of medicinal effects of a drug

- State instute for drug control
- EMEA

Step 2 Introduction to the insurance system

- State institute for drug control (again!)
- Insurance companies are just parties discussed in the administrative procedure, but they have no competence to decide or veto
- The economic element is evaluated by „cost effectiveness“

Cost effectiveness

$$x = \frac{Costs}{Benefits}$$

In health insurance system, the cost effectiveness is only performed in relation to another medicine

If the medicine is unique, the cost effectiveness is not assessed = medicine is reimbursed

Economic implications

The entity which decides about reinbursement is not the one that will actually reimburse it

- Impossible not to reimburse „medicine without alternative“
- Regardless of whether the system can afford it

New drugs are parachuting into the system without moderation

- reluctance of a national legislator to act; Process is accelerated by EMEA

Result – the health insurance budgets are bloating

- The costs of special „centric“ medicines of the largest insurance company have risen from 4,2 billion to 7,2 billion in five years
- The cost increase between 2014 and 2015 is 12 percent

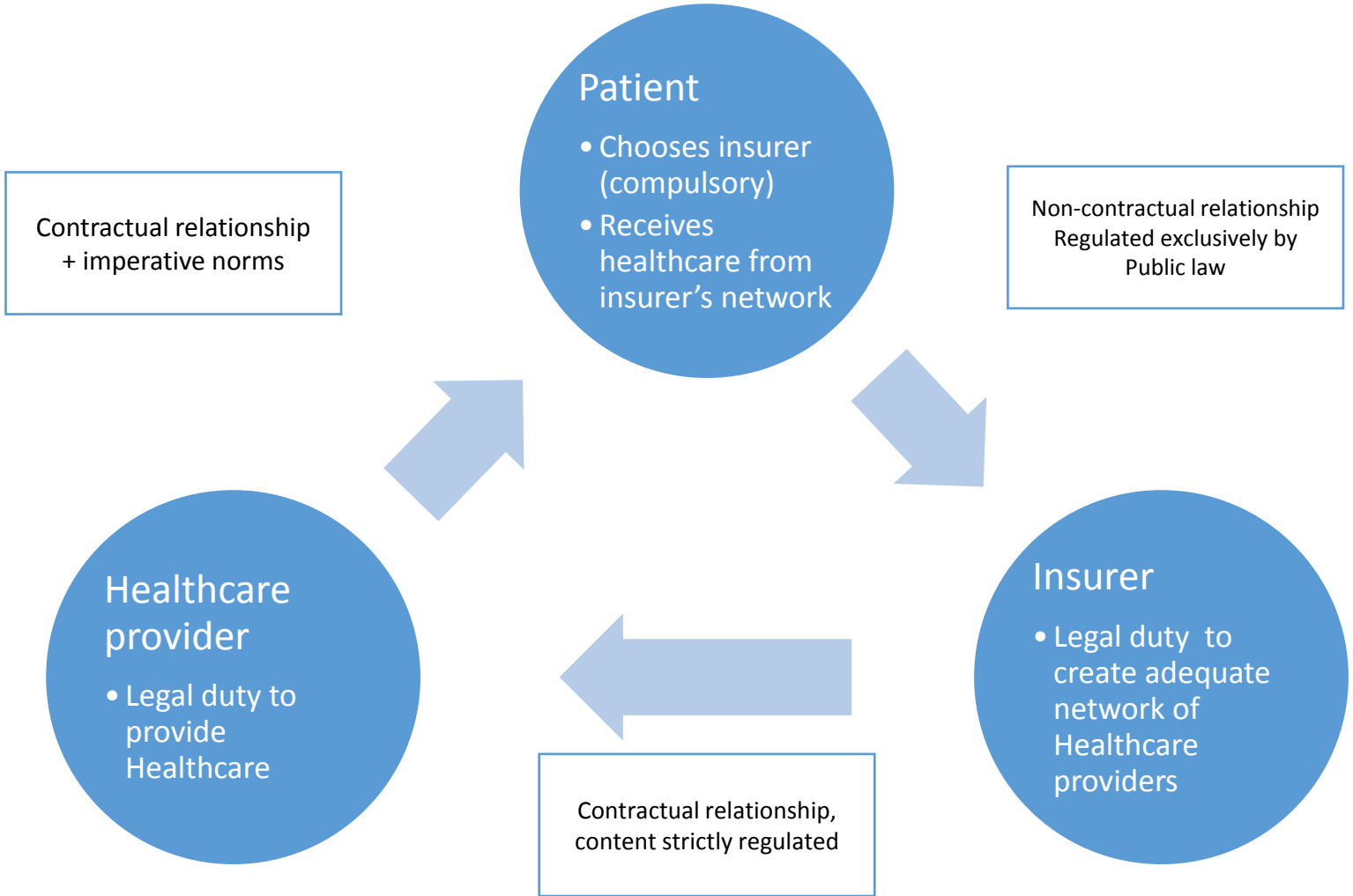
So - who does the rationing?

Contract	Health insurance companies	The most expensive drugs are labelled as „centric“
		distributed only by selected „centres“ app. 60 providers
		There are approximately 160 „centric“ drugs, 0,4% of clients are recipients of centric dugs, generate 23% of total expenses on drugs
	„Centric“ healthcare providers	budget caps for each diagnostic group
		ultimate entities that are responsible for rationing
		also responsible to provide adequate healthcare
		Contract

What if the budget cap is reached ?

Case study no. 1

System of public insurance in Czechia



Conflicting perspectives

Patient	Healthcare provider	Insurer
• I don’t care about the contract between those two • My right to medicine is guaranteed by law and constitution	• My obligation to provide healthcare ends where the budget cap is • I cannot treat patients if the insurer does not cover them	• I have contracted adequate healthcare, • If provider cannot treat all the patients within the budget, he shouldn’t have signed the contract in the first place

Perspective of a physician

- Will I be prosecuted if I refuse to prescribe centric medicine due to budget restrictions?

Will I be prosecuted if I prescribe the medicine despite the budget cap?

Am I allowed to prescribe cheaper medicine, or should I wait untill the next budget period?

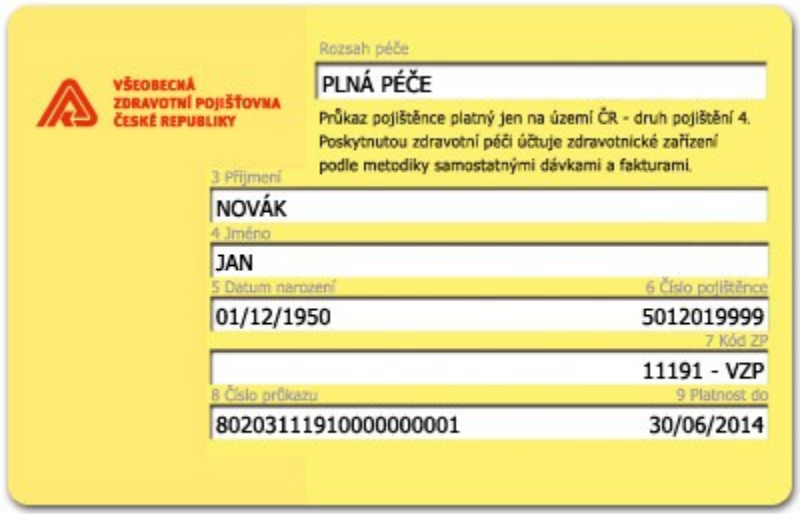
Perspective of rationing

- Who should make difficult decisions?

Cross border provision of healthcare within the EU

Your right to have the costs of treatment covered

- If you are entitled to a particular treatment in your home country, then you have a right to be reimbursed when you receive it in another country.
- Your level of reimbursement will be up to the costs of that treatment in your home country.
- You may choose whichever healthcare provider you wish, whether public or private.
- For some treatments (certain in-patient or highly specialised services) you may be required to get authorisation from your own health system before receiving the treatment abroad.
- If you are facing a medically unjustifiable waiting time for treatment at home then authorisation must be granted. In this case, you may even be entitled to a higher level of coverage for your healthcare costs.


VŠEOBECNÁ
ZDRAVOTNÍ POJIŠŤOVNA
ČESKÉ REPUBLIKY
Rozsah péče
PLNÁ PÉČE
Průkaz pojištěnce platný jen na území ČR - druh pojištění 4.
Poskytnutou zdravotní péči účtuje zdravotnické zařízení
podle metodiky samostatnými dávkami a fakturami.
3 Příjmení
NOVÁK
4 Jméno
JAN
5 Datum narození
01/12/1950
6 Číslo pojištěnce
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7 Kód ZP
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8 Číslo průkazu
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9 Platnost do
30/06/2014


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REGION
Region
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Gyldig fra/Valid from:
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7. Institutionens identifikationsnummer
8. Kortnummer
9. Udløbsdato