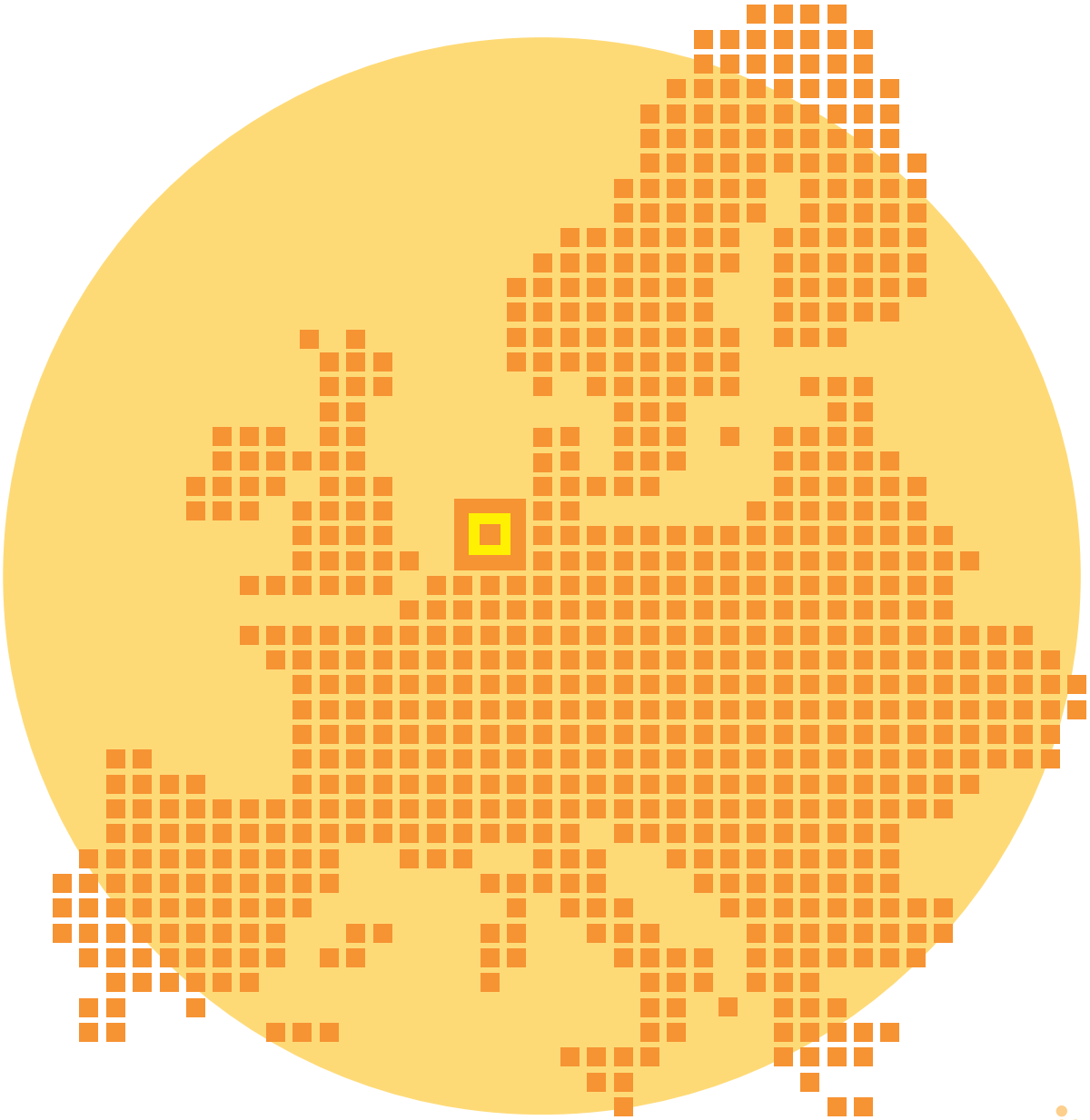
Health Consumer Powerhouse



European Commission
Information Society and Media

Euro Health Consumer Index 2008

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2008

Report

Arne Björnberg, Ph.D. and Marek Uhlir, M.A.

arne.bjornberg@healthpowerhouse.com

marek.uhlir@healthpowerhouse.com

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Contents

EHCI 2008: European healthcare improves trying to meet with consumer expectations

Measuring the expanding European healthcare landscape since 2005, the Health Consumer Powerhouse finds reasons to be optimistic about the development of European healthcare. There are evident positive trends – but also challenges to meet.

After our four years of comparisons we now see that the leading healthcare systems start adopting consumer trends. Some of the fore-runners seem to implement strategies with the aim to support choice by providing information and via consumer priorities building a down-top pressure for improvement of services and quality of care.

Patient rights legislation has become common around Europe (a fact in a slight majority of the 31 assessed national healthcare systems). In almost as many there is the right of a second opinion and free access to your medical record. This builds patient empowerment essential to meet tomorrows´ challenges in values, demography and funding. Here partnership between the individual and the care system will be the tool. Closing the gap between patients and professionals has to be part of any grand strategy for the future.

Another key movement must be to reduce the inequalities between old and new EU members. Here the EHCI 2008 suggests inspiring action among some Central European countries, using consumer empowerment as a tool to move ahead. The Hungarian "information revolution" has been rewarded by a quick climb in the Index rank.

But, some might ask, is it reasonable to give e-Health and consumer information such a weight in an overall comparison of healthcare performance? Yes, we believe so. Information will be the instrument for this huge transition, re-shaping healthcare the way we have already seen in other major service industries. With such a perspective e-Health is a spearhead to radically reduce costs opening for rapid treatment access and patient safety advancement.

In spite of improvement on many fronts there are reasons to be worried about the lack of progress in parts of the EU. The better the transparency on performance the more striking is the lack of progress among some member systems. It looks as it also takes joint systematic pan-European action to change cultures, systems design and outcomes. In order to support this idea we have added two accession countries this year, in order for policy makers to be able to include them in any actions and analysis.

This year Netherlands is the outstanding winner, deserving our congratulations for systems reform that seem to combine consumer influence with excellent outcomes. Denmark, in silver position, shows that a creative national health strategy can bear fruit rapidly. Following in the top ranks there are a number of climbers in different ways making inspiring advancement, to be closely followed during the next few years.

We thank the ministries and agencies in the Index countries for a creative dialogue and provision of data. We want as well to thank the European Commission for the co-operation on this year's Index.

We hope for the 2008 EHCI to become a useful tool for the development of European healthcare.

Brussels, November 13, 2008

Johan Hjertqvist
President
Health Consumer Powerhouse
Brussels/Stockholm/Winnipeg

1. Summary

The 2008 Euro Health Consumer Index has a completely novel ranking situation. In previous EHCI editions, as well as in the Euro Consumer Heart Index 2008 and the Euro Consumer Diabetes Index 2008 (all available at www.healthpowerhouse.com), 3 – 5 top countries are separated by only a few points on the 1000-point scale. The EHCI 2008 total ranking of healthcare systems shows an unprecedented landslide victory for The Netherlands, scoring 839 points out of 1000, 19 points ahead of runners-up Denmark at 820 points, with a 36-point gap to the 2007 winners Austria in 3rd place with 784 points.

The ranking is noticeably influenced by the introduction of an additional sixth sub-discipline, "e-Health" (for more information on e-Health sub-discipline see section e-Health), measuring essentially the penetration of electronic medical records and the use of web-based solutions for the transfer of medical information. Denmark is the only country scoring all Green on the four indicators, and The Netherlands score three Greens and one Yellow (see Section 9.7 for explanation on scoring colours). Although the e-Health sub-discipline has been given a modest weight, these scores are enough to catapult these two countries far ahead of European competition.

This should not at all be dismissed as an effect of changing indicators, of which there are 34 in the EHCI 2008, up from 28 in the previous year, and/or sub-disciplines. The Netherlands is the only country which has consistently been among the top three in the total ranking of any European Index the Health Consumer Powerhouse has published since 2005. Although being the sub-discipline winner, scoring full maximum points, in only one sub-discipline of the EHCI 2008; "Range and reach of services provided" (formerly called "Generosity" in previous EHCI editions), the Dutch healthcare system does not seem to have any really weak spots in the other sub-disciplines, except possibly some scope for improvement regarding the waiting times situation, where some central European countries excel.

Normally, the HCP takes care to state that the EHCI is limited to measuring the "consumer friendliness" of healthcare systems, *i.e.* does not claim to measure which European state has the *best* healthcare system across the board.

However, the fact that is seems very difficult to build an Index of the HCP type without ending up with The Netherlands on the medallists' podium, creates a strong temptation to actually claim that the landslide winner of the EHCI 2008 could indeed be said to have "the best healthcare system in Europe".

Denmark does gain a lot from the introduction of the e-Health sub-discipline. Non the less, as can been seen from the longitudinal analysis in Chapter 7, Denmark has been on a continuous rise since it was first included in the EHCI 2006. It would seem that the dedicated efforts made by Danish politicians and public agencies, to achieve a real upgrade of the healthcare system in Denmark, are paying off. This is corroborated by the fact than Denmark emerged as the total winner of the Euro Consumer Diabetes Index 2008.

On the bronze medallist's step on the podium resides the 2007 winner Austria at 784 points; not doing as well on e-Health services but scoring the first ever full score in the pharmaceuticals sub-discipline. Luxembourg comes in 4th at 758 points and Germany 6th at 740. These three countries offer truly excellent accessibility to healthcare services, but as they do not reach the same score levels on the heavily weighted ("the proof of the pudding is in the eating") Outcomes sub-discipline as do Sweden and the Netherlands, they do not quite reach the top.

The Swedish score for technically excellent healthcare services is, as ever, dragged down by the seemingly never-ending story of access/waiting time problems, in spite of national efforts such as *Vårdgaranti* (National Guaranteed Access to Healthcare); Sweden still makes a good 5th place with 743 points.

One country showing a significant downward slide in the EHCI is the 2006 overall winner France, ending up in 10th place in 2008. This is partially due to weakness in the implementation of e-Health solutions. As the HCP research team was informed at a visit to the French ministry of health already in 2006, France was starting to make access to healthcare specialist services less liberal. This seems to be reflected in the French 2008 scores on Waiting Times, where the survey commissioned to patient organisations seemed to confirm that access is now noticeably more restricted.

The easy-to-reform 1½ million population Estonia keeps climbing; to an impressive 11th place overall in the 2008 Index in competition with countries spending vastly more per capita on healthcare, and is a very clear winner in the academic exercise in our value-for-money adjusted Index – the "Bang-for-the-Buck" score (Chapter 6).

For the first time, the EU candidate states of Croatia and FYR Macedonia have been included in the EHCI. It might be that the scores of these countries are underestimated due to less participation in EU-instigated data collection activities.

1.1 BBB; Bismarck Beats Beveridge – yet again!

All public healthcare systems share one problem: Which technical solution should be used to funnel typically 7 – 10 % of national income into healthcare services?

Bismarck healthcare systems: Systems based on social insurance, where there is a multitude of insurance organisations, Krankenkassen etc, who are *organisationally independent of* healthcare providers.

Beveridge systems: Systems where financing and provision are handled within one organisational system, *i.e.* financing bodies and providers are wholly or partially within one organisation, such as the NHS of the UK, counties of Nordic states etc.

For more than half a century, particularly since the formation of the British NHS, the largest Beveridge-type system in Europe, there has been intense debating over the relative merits of the two types of system.

Already in the EHCI 2005, the first 12-state pilot attempt, it was observed that "In general, countries which have a long tradition of plurality in healthcare financing and provision, *i.e.* with a consumer choice between different insurance providers, who in turn do not discriminate between providers who are private for-profit, non-profit or public, show common features not only in the waiting list situation …"

Looking at the results of the EHCI 2008, it is very hard to avoid noticing that the top 10 consist of dedicated Bismarck countries, with the small population and therefore more easily managed Beveridge systems of the Nordic countries squeezing in. Large Beveridge systems seem to have difficulties at attaining really excellent levels of customer value. There could be (at least) two different explanations to this:

1. Managing a corporation or organisation with 100 000+ employees calls for considerable management skills, which are usually very handsomely rewarded. Managing an organisation such as the English NHS, with close to 1½ million staff,

who also make management life difficult by having a professional agenda, which does not necessarily coincide with that of management/administration, would require absolutely world class management. It is doubtful whether public organisations offer the compensation and other incentives required to recruit those managers.

2. In Beveridge organisations, responsible both for financing and provision of healthcare, there would seem to be a risk that the loyalty of politicians and other top decision makers could shift from being primarily to the customer/patient. Primary loyalty could become shifted to the *organisation* these decision makers with justifiable pride have been building over decades (or possibly to aspects such as the job-creation potential of such organisations in politicians' home towns).

2. Introduction

The Health Consumer Powerhouse (HCP) has become a centre for visions and action promoting consumer-related healthcare in Europe. "Tomorrow's health consumer will not accept any traditional borders", we declared in last year's report, but it seems that this statement is already becoming true in 2008; the "Commission proposal for a Directive for patients rights at Cross border care" is in this way being an excellent example of this trend. In order to become a powerful actor, building the necessary reform pressure from below, the consumer needs access to knowledge to compare health policies, consumer services and quality outcomes. The Euro Health Consumer Indexes are efforts to provide healthcare consumers with such tools.

2.1 Background

Since 2004 the HCP has been publishing a wide range of comparative publications on healthcare in various countries. First, the Swedish Health Consumer Index in 2004 (www.vardkonsumentindex.se, also in an English translation). By ranking the 21 county councils by 12 basic indicators concerning the design of "systems policy", consumer choice, service level and access to information we introduced benchmarking as an element in consumer empowerment. In two years time this initiative had inspired – or provoked – the Swedish Association of Local Authorities and Regions together with the National Board of Health and Welfare to start a similar ranking, making public comparisons an essential Swedish instrument for change.

For the pan-European indexes in 2005-2007, HCP aimed to basically follow the same approach, *i.e.* selecting a number of indicators describing to what extent the national healthcare systems are "user-friendly", thus providing a basis for comparing different national systems.

Furthermore, in 2008 the HCP has enlarged the existing benchmarking program considerably:

- In January 2008, the Frontier Centre and HCP released the first Euro-Canada Health Consumer Index, which compared the health care systems in Canada and 29 European countries.
- The Euro Consumer Heart Index, launched in July, compares 29 European cardiovascular healthcare systems in five categories, covering 28 performance indicators.

- The first edition of Canada Health Consumer Index was released in September 2008 in co-operation with Frontier Centre for Public Policy, examining healthcare from the perspective of the consumer at the provincial level.
- The first Euro Consumer Diabetes Index, launched in September 2008, provides the first ranking of European diabetes healthcare services across five key areas: Information, Consumer Rights and Choice; Generosity, Prevention; Access to Procedures and Outcomes.
- This year's edition of Euro Health Consumer Index covers 34 healthcare performance indicators for 31 countries.

Though still a somewhat controversial standpoint, HCP advocates that quality comparisons within the field of healthcare is a true win-win situation. To the consumer, who will have a better platform for informed choice and action. To governments, authorities and providers, the sharpened focus on consumer satisfaction and quality outcomes will support change. To media, the ranking offers clear-cut facts for consumer journalism with some drama into it. This goes not only for evidence of shortcomings and method flaws but also illustrates the potential for improvement. With such a view the EHCI is designed to become an important benchmark system supporting interactive assessment and improvement.

As we heard one of the Ministers of health saying when seeing his country's preliminary results: "It´s good to have someone still telling you: you could do better."

2.2 Index scope

The aim has been to select a limited number of indicators, within a definite number of evaluation areas, which in combination can present a telling tale of how the healthcare consumer is being served by the respective systems.

2.3 About the authors

Project Management for the EHCI 2008 has been executed by **Arne Björnberg, Ph.D.**

Dr. Björnberg has previous experience from Research Director positions in Swedish industry. His experience includes having served as CEO of the Swedish National Pharmacy Corporation ("Apoteket AB"), Director of Healthcare & Network Solutions for IBM Europe Middle East & Africa, and CEO of the University Hospital of Northern Sweden ("Norrlands Universitetssjukhus", Umeå).

Dr. Björnberg was also the project manager for the EHCI 2005 – 2007 projects.

Marek Uhlir, MA, has been Researcher on the Index.

Mr. Uhlir graduated in healthcare management in Prague and worked for six years in the Emergency Medical Service and for two years at the Ministry of Health of the Czech Republic. He was member of the international research panel of Hesculaep European project based in pre-hospital settings (funded by 7th Framework Program) and research manager on Enhanced Emergency Dispatch Support, a two-years research project funded by European Social Fund. His ongoing Ph.D. research is focusing on the problem of informal payments in transitional healthcare systems in Eastern Europe.

3. Countries involved

In 2005, the EHCI started with a dozen of countries and 20 indicators; this year's index includes already all 27 European Union member states, plus Norway and Switzerland, and the Candidate countries of Croatia and FYR Macedonia.

Countries included in Euro Health Consumer Index 2008:

Austria	Germany	Poland
Belgium	Greece	Portugal
Bulgaria	Hungary	Romania
Croatia	Ireland	Slovakia
Cyprus	Italy	Slovenia
Czech Republic	Latvia	Spain
Denmark	Lithuania	Sweden
Estonia	Luxembourg	Switzerland
Finland	Malta	United Kingdom
France	Netherlands	
FYR Macedonia	Norway	

3.1 The Candidate countries inclusion

The inclusion of the Candidate countries of Croatia and FYR Macedonia was at the beginning rather an idea of a trial period of one year, putting the two countries in a preliminary stage off the main competition. This idea was clearly rejected in the early talks with the local healthcare experts themselves, who told us: "We are annoyed by the fact that we are all the time in preliminary stages of something. Shall we be the last, never mind, but we want to be part of it!"

To include Croatia and Macedonia in the EHCI 2008 would not have been possible without an enthusiastic help of Karolina Kalanj, MD, and Prof. Ana Stavljenić Rukavina, Ph.D. in Croatia; and Biljana Dodeva, MD, in FYR Macedonia. Without their personal commitment, we wouldn't have found enough relevant data to justify a scoring in the main competition.

4. Results of the Euro Health Consumer Index 2008

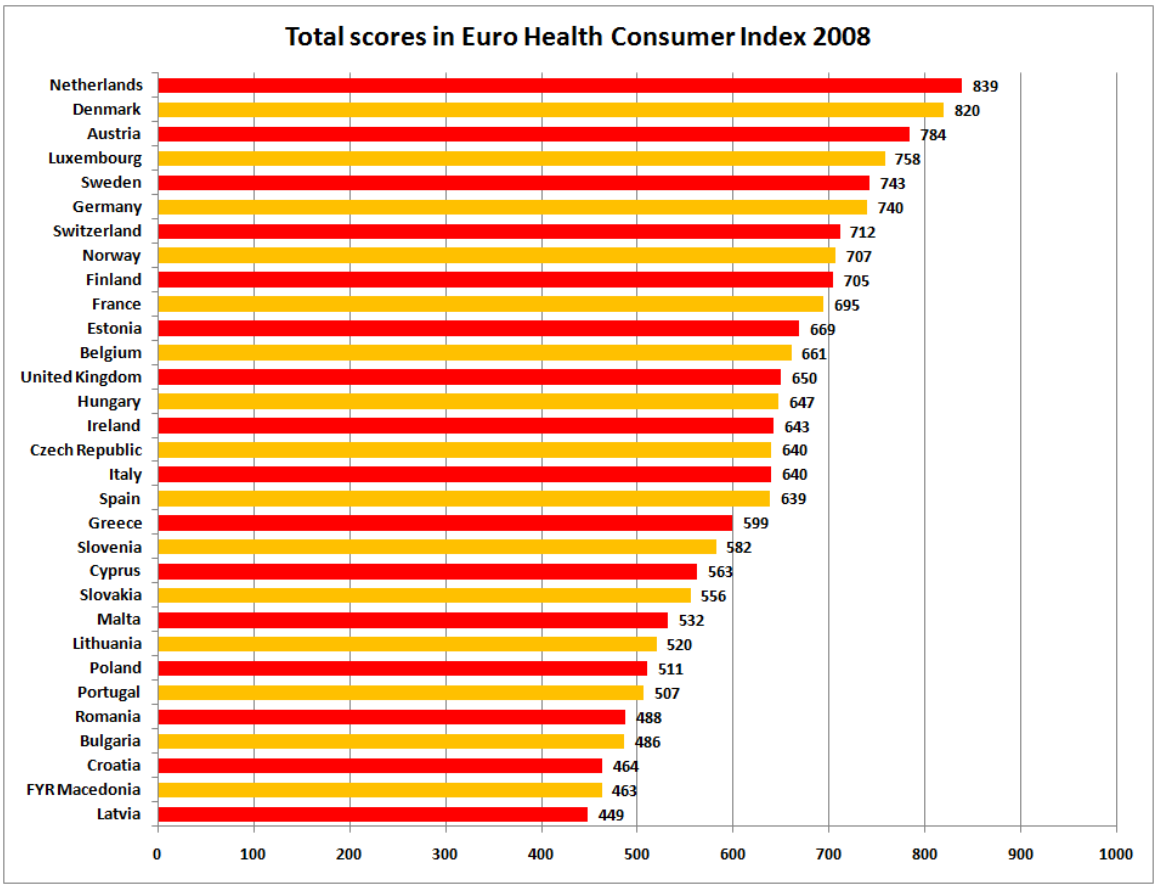
Euro Health Consumer Index 2008

Sub-discipline	Indicator	Austria	Belgium	Bulgaria	Croatia	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	FYR Macedonia	Germany	Greece	Hungary	Ireland	Italy
1. Patient rights and information	1.1. Healthcare law based on Patients' Rights	◑	●	○	●	●	○	●	●	●	●	●	○	●	●	○	◑
	1.2. Patient organisations involved in decision making	○	●	○	◑	◑	◑	◑	●	◑	◑	◑	●	◑	●	◑	◑
	1.3. No-fault malpractice insurance	○	○	○	○	○	○	●	○	●	◑	○	○	○	○	○	○
	1.4. Right to second opinion	●	●	◑	◑	○	◑	●	●	◑	●	◑	●	◑	●	◑	◑
	1.5. Access to own medical record	●	◑	●	●	◑	●	●	◑	●	◑	●	●	◑	●	◑	◑
	1.6. Register of legit doctors	●	○	◑	◑	◑	◑	●	●	●	●	○	◑	◑	●	●	●
	1.7. Web or 24/7 telephone HC info with interactivity	○	○	○	○	○	○	●	●	●	○	○	◑	○	○	◑	○
	1.8. Cross-border care information	◑	●	●	n.a.	◑	○	●	◑	◑	◑	n.a.	○	●	◑	○	●
	Subdiscipline weighted score	100	106	88	94	88	81	144	125	131	113	88	100	100	119	88	100
2. e-Health	2.1. Provider catalogue with quality ranking	○	○	○	○	◑	○	●	○	○	◑	○	○	○	◑	○	○
	2.2. EPR penetration	◑	◑	●	n.a.	◑	◑	●	●	◑	◑	●	●	○	●	◑	◑
	2.3. e-transfer of medical data	◑	○	○	n.a.	○	○	●	○	●	○	○	○	○	○	○	○
	2.4. e-prescriptions	○	○	○	n.a.	○	○	●	○	○	○	○	○	○	○	○	○
	Subdiscipline weighted score	50	42	50	33	50	42	100	50	58	50	50	50	33	58	42	42
3. Waiting time for treatment	3.1. Family doctor same day access	●	●	●	●	◑	●	●	◑	○	◑	●	●	○	◑	◑	◑
	3.2. Direct access to specialist	●	●	○	○	●	●	○	○	○	◑	○	●	●	◑	○	◑
	3.3. Major non-acute operations <90 days	◑	●	◑	n.a.	○	◑	◑	◑	○	◑	n.a.	●	◑	◑	●	◑
	3.4. Cancer therapy < 21 days	◑	●	◑	n.a.	◑	◑	◑	●	◑	●	n.a.	●	◑	●	○	◑
	3.5. MRI scan < 7days	●	○	◑	n.a.	○	○	○	●	○	○	○	◑	◑	●	○	○
	Subdiscipline weighted score	173	173	133	93	120	147	120	147	80	133	93	187	133	160	107	120
4. Outcomes	4.1. Heart infarct case fatality	◑	◑	◑	n.a.	◑	◑	◑	◑	◑	●	n.a.	◑	◑	○	◑	◑
	4.2. Infant deaths	●	◑	○	◑	●	●	●	◑	●	●	○	●	●	◑	●	●
	4.3. Cancer 5-year survival	●	◑	○	◑	n.a.	○	◑	○	◑	●	◑	◑	○	○	◑	◑
	4.4. Avoidable deaths – years of Life Lost	●	◑	○	○	●	◑	◑	○	◑	◑	○	●	●	○	●	●
	4.5. MRSA infections	◑	○	◑	○	○	◑	●	◑	●	○	○	○	○	○	○	○
	4.6 Rate of decline of suicide	●	○	◑	◑	n.a.	◑	●	●	●	◑	◑	●	◑	●	◑	◑
	4.7. % of patients with high HbA1c levels (> 7)	○	○	n.a	n.a.	○	●	●	○	●	◑	n.a.	◑	●	◑	●	●
	Subdiscipline weighted score	202	131	107	119	143	179	214	143	214	190	107	190	179	131	190	190
5. Range and reach of services provided	5.1. Cataract operations per 100 000 age 65+	◑	●	○	○	○	○	◑	◑	◑	◑	n.a.	◑	◑	●	○	●
	5.2. Infant 4-disease vaccination	○	●	◑	◑	◑	●	◑	◑	●	●	◑	◑	○	●	○	◑
	5.3. Kidney transplants per million pop.	●	◑	○	○	n.a.	◑	◑	●	●	●	n.a.	◑	○	◑	◑	○
	5.4. Dental care affordability	●	●	○	●	○	●	●	○	◑	○	●	◑	○	○	◑	◑
	5.5. Rate of mammography	◑	◑	n.a.	○	n.a.	○	◑	○	●	◑	n.a.	○	◑	○	◑	◑
	5.6. Informal payments to doctors	◑	●	○	○	●	○	●	◑	●	◑	○	●	○	○	●	◑
	Subdiscipline weighted score	108	133	58	75	75	92	117	92	133	108	75	100	67	92	92	100
6. Pharmaceuticals	6.1. Rx subsidy	●	◑	○	n.a.	○	◑	◑	○	○	●	n.a.	●	◑	◑	●	●
	6.2. Layman-adapted pharmacopeia?	●	○	○	n.a.	○	●	●	●	◑	◑	n.a.	○	○	●	◑	○
	6.3. New cancer drugs deployment speed	●	◑	○	n.a.	◑	○	◑	◑	◑	◑	n.a.	◑	◑	○	◑	◑
	6.4. Access to new drugs (time to subsidy)	●	○	○	n.a.	●	◑	●	●	◑	○	n.a.	●	◑	○	●	○
	Subdiscipline weighted score	150	75	50	50	88	100	125	113	88	100	50	113	88	88	125	88
	Total score	784	661	486	464	563	640	820	669	705	695	463	740	599	647	643	640
	Rank	3	12	28	29	21	16	2	11	9	10	30	6	19	14	15	16

Euro Health Consumer Index 2008

Sub-discipline	Indicator	Latvia	Lithuania	Luxembourg	Malta	Netherlands	Norway	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	Switzerland	United Kingdom
1. Patient rights and information	1.1. Healthcare law based on Patients' Rights	○	●	○	○	●	●	◑	◑	◑	●	●	●	○	●	◑
	1.2. Patient organisations involved in decision making	○	●	◑	○	●	◑	●	○	○	●	◑	○	◑	◑	◑
	1.3. No-fault malpractice insurance	○	◑	○	○	○	●	○	○	○	○	●	○	●	○	○
	1.4. Right to second opinion	○	●	●	●	●	◑	◑	○	●	◑	●	◑	◑	●	◑
	1.5. Access to own medical record	◑	●	●	○	●	●	●	○	○	◑	●	○	●	●	◑
	1.6. Register of legit doctors	○	●	●	●	●	○	○	○	○	○	◑	○	○	○	◑
	1.7. Web or 24/7 telephone HC info with interactivity	○	○	○	◑	◑	◑	○	◑	○	◑	○	○	●	◑	●
	1.8. Cross-border care information	○	●	●	●	◑	n.a.	◑	○	●	○	◑	◑	○	n.a.	○
	Subdiscipline weighted score	56	131	106	94	125	106	94	63	81	94	119	75	100	100	94
2. e-Health	2.1. Provider catalogue with quality ranking	○	○	○	○	◑	◑	○	○	○	○	◑	○	○	○	●
	2.2. EPR penetration	○	○	◑	○	●	●	○	◑	○	◑	◑	◑	●	●	●
	2.3. e-transfer of medical data	○	○	○	○	●	●	○	○	○	○	○	◑	◑	n.a.	●
	2.4. e-prescriptions	○	○	○	○	●	○	○	○	○	○	○	○	●	n.a.	◑
	Subdiscipline weighted score	33	33	42	33	92	75	33	42	33	42	50	50	75	50	92
3. Waiting time for treatment	3.1. Family doctor same day access	○	◑	●	●	◑	◑	◑	○	●	●	○	◑	○	◑	◑
	3.2. Direct access to specialist	○	◑	●	○	○	○	◑	○	◑	○	○	○	○	●	○
	3.3. Major non-acute operations <90 days	○	◑	●	○	◑	◑	○	○	◑	○	◑	○	○	●	○
	3.4. Cancer therapy < 21 days	○	◑	●	◑	●	◑	◑	◑	◑	●	○	◑	◑	●	◑
	3.5. MRI scan < 7days	○	○	◑	○	◑	○	○	○	●	◑	○	○	○	●	○
	Subdiscipline weighted score	67	120	187	107	133	107	107	80	160	133	80	93	80	187	93
4. Outcomes	4.1. Heart infarct case fatality	○	◑	●	◑	●	●	●	○	○	○	◑	●	●	●	◑
	4.2. Infant deaths	○	◑	●	◑	◑	●	◑	●	○	○	●	●	●	◑	◑
	4.3. Cancer 5-year survival	○	◑	◑	◑	◑	◑	○	◑	○	○	◑	◑	●	●	○
	4.4. Avoidable deaths – years of Life Lost	○	○	●	◑	●	●	○	◑	○	○	◑	●	●	●	◑
	4.5. MRSA infections	◑	○	○	○	●	●	◑	○	○	◑	◑	○	●	n.a.	○
	4.6 Rate of decline of suicide	●	○	◑	○	◑	◑	○	◑	○	◑	◑	◑	◑	◑	◑
	4.7. % of patients with high HbA1c levels (> 7)	●	○	◑	n.a	●	○	○	n.a	n.a	n.a	○	○	●	n.a	●
	Subdiscipline weighted score	143	119	190	119	214	202	131	131	71	95	167	179	238	167	155
5. Range and reach of services provided	5.1. Cataract operations per 100 000 age 65+	○	○	●	◑	●	◑	○	○	○	○	◑	●	◑	○	◑
	5.2. Infant 4-disease vaccination	●	◑	●	○	●	◑	●	◑	●	●	●	●	●	◑	◑
	5.3. Kidney transplants per million pop.	◑	○	◑	◑	●	●	○	◑	○	○	○	●	●	◑	◑
	5.4. Dental care affordability	●	◑	●	●	●	n.a.	●	○	○	●	◑	○	○	n.a.	●
	5.5. Rate of mammography	○	n.a.	●	n.a.	●	●	○	◑	n.a.	○	○	○	●	○	◑
	5.6. Informal payments to doctors	◑	○	◑	◑	●	●	○	●	○	◑	◑	●	●	●	●
	Subdiscipline weighted score	100	67	133	92	150	117	83	92	67	92	92	117	125	83	117
6. Pharmaceuticals	6.1. Rx subsidy	○	○	●	◑	●	◑	◑	◑	○	●	●	●	◑	●	●
	6.2. Layman-adapted pharmacopeia?	○	○	○	●	●	◑	○	◑	●	●	○	◑	●	○	○
	6.3. New cancer drugs deployment speed	○	○	●	○	◑	○	○	◑	○	○	○	●	◑	●	○
	6.4. Access to new drugs (time to subsidy)	○	○	○	○	◑	●	○	◑	○	○	○	◑	●	●	●
	Subdiscipline weighted score	50	50	100	88	125	100	63	100	75	100	75	125	125	125	100
	Total score	449	520	758	532	839	707	511	507	488	556	582	639	743	712	650
	Rank	31	24	4	23	1	8	25	26	27	22	20	18	5	7	13

4.1 Results Summary



This fourth attempt at creating a comparative index for national healthcare systems has confirmed that there is a group of EU member states, which all have good healthcare systems seen from the customer/consumer's point of view.

The scoring has intentionally been done in such a way that the likelihood that two states should end up sharing a position in the ranking is almost zero. It must therefore be noted that great efforts should not be spent on in-depth analysis of why one country is in 13th place, and another in 16th. Very subtle changes in single scores can modify the internal order of countries, particularly in the middle of the ranking list.

The EHCI 2008 total ranking of healthcare systems shows an unprecedented landslide victory for The Netherlands, scoring 839 points out of 1000, 19 points ahead of runners-up Denmark at 820 points, with a 36-point gap to the 2007 winners Austria in 3rd place with 784 points.

The ranking is noticeably influenced by the introduction of an additional sixth sub-discipline, "e-Health", measuring essentially the penetration of electronic medical records and the use of web-based solutions for the transfer of medical information. Denmark is the only country scoring all Green on the four indicators, and The Netherlands score three Greens and one Yellow (see Section 9.7 for explanation on scoring colours). Although the e-Health sub-discipline has been given a modest weight (see section Weight coefficients

on more information about the sub-discipline weightings), these scores are enough to catapult these two countries far ahead of European competition.

This should not at all be dismissed as an effect of changing indicators, of which there are 34 in the EHCI 2008, up from 28 in the previous year, and/or sub-disciplines. The Netherlands is the only country which has consistently been among the top three in the total ranking of any European Index the Health Consumer Powerhouse has published since 2005. Although being the sub-discipline winner, scoring full maximum points, in only one sub-discipline of the EHCI 2008; "Range and reach of services provided" (formerly called "Generosity" in previous EHCI editions), the Dutch healthcare system does not seem to have any really weak spots in the other sub-disciplines, except possibly some scope for improvement regarding the waiting times situation, where some other central European states excel. Normally, the HCP takes care to state that the EHCI is limited to measuring the "consumer friendliness" of healthcare systems, *i.e.* does claim to measure which European state has the *best* healthcare system across the board.

However, the fact that is seems very difficult to build an Index of the HCP type without ending up with The Netherlands on the medallists' podium, creates a strong temptation to actually claim that the landslide winner of the EHCI 2008 could indeed be said to have "the best healthcare system in Europe".

Denmark does gain a lot from the introduction of the e-Health sub-discipline. Non the less, as can been seen from the longitudinal analysis in Chapter 7, where the EHCI 2008 has been modelled back on the EHCI 2007 (with only five sub-disciplines), Denmark has been on a continuous rise since it was first included in the EHCI 2006. It would seem that the dedicated efforts made by Danish politicians and public agencies, to achieve a real upgrade of the healthcare system in Denmark, are paying off. This is corroborated by the fact than Denmark emerged as the total winner of the Euro Consumer Diabetes Index 2008.

On the bronze medallist's step on the podium resides the 2007 winner Austria at 784 points; not doing as well on e-Health services but scoring the first ever full score in the pharmaceuticals sub-discipline. Luxembourg comes in 4th at 758 points and Germany 6th at 740. These three countries offer truly excellent accessibility to healthcare services, but as they do not reach the same score levels on the heavily weighted ("the proof of the pudding is in the eating") Outcomes sub-discipline as do Sweden and the Netherlands, they do not quite reach the top.

The Swedish score for technically excellent healthcare services is, as ever, dragged down by the seemingly never-ending story of access/waiting time problems, in spite of national efforts such as *Vårdgaranti* (National Guaranteed Access to Healthcare); Sweden still makes a good 5th place with 743 points.

One country showing a significant downward slide in the EHCI is the 2006 overall winner France, ending up in 10th place in 2008. This is partially due to weakness in the implementation of e-Health solutions. As the HCP research team was informed at a visit to the French ministry of health already in 2006, France was starting to make access to healthcare specialist services less liberal. This seems to be reflected in the French 2008 scores on Waiting Times, where the survey commissioned to patient organisations seemed to confirm that access is now noticeably more restricted.

The easy-to-reform 1½ million population Estonia keeps climbing; to an impressive 11th place overall in the 2008 Index in competition with countries spending vastly more per capita on healthcare, and is a very clear winner in the academic exercise in our value-for-money adjusted Index – the "Bang-for-the-Buck" score (Chapter 6).

For the first time, the EU candidate states of Croatia and FYR Macedonia have been included in the EHCI. It might be that the scores of these countries are underestimated due to less participation in EU-instigated data collection activities.

In southern Europe, Spain and Italy provide healthcare services where medical excellence can be found in many places. Real excellence in southern European healthcare seems to be a bit too much dependent on the consumers' ability to afford private healthcare as a supplement to public healthcare. A mixed performance in shown by the U.K; the overall U.K. score is dragged down by waiting lists and uneven quality performance.

Some eastern European EU member systems are doing surprisingly well, considering their much smaller healthcare spend in Purchasing Power adjusted dollars per capita. However, readjusting from politically planned to consumer-driven economies does take time.

Consumer and patient rights are improving. In a growing number of European countries there is healthcare legislation explicitly based on patient rights and a functional access to your own medical record is becoming standard. Still very few countries have hospital/clinic catalogues with quality ranking.

Generally European healthcare continues to improve but medical outcomes statistics is still appallingly poor in many countries. This is not least the case regarding the number one killer condition: cardiovascular diseases, where data for one very vital parameter; 30-day case fatality for hospitalized heart infarct patients had to be compiled from several disparate sources.

If healthcare officials and politicians took to looking across borders, and to "stealing" improvement ideas from their EU colleagues, there would be a good chance for a national system to come much closer to the theoretical top score of 1000. As a prominent example; if Sweden could just achieve a German waiting list situation, that alone would suffice to lift Sweden to the Gold medal with 850 points.

Subsequent versions of the EHCI will in all likelihood have a modified set of indicators, as more data becomes available.

A further discussion on results of states and the changes observed over time can be found in Chapter 6: Important trends over the four years.

4.1.1 Country scores

There are no countries, which excel across the entire range of indicators. The national scores seem to reflect more of "national and organisational cultures and attitudes", rather than mirroring how large resources a country is spending on healthcare. The cultural streaks have in all likelihood deep historical roots. Turning a large corporation around takes a couple of years – turning a country around can take decades!

In an attempt to summarize the main features of the scoring of each country included in the EHCI 2008, the following table gives a somewhat subjective synopsis. To the care consumer – *i.e.* most of us – describing and comparing healthcare will require some simplifications. (A medical information system dealing with scientific evidence such as individual diagnosis or medication guidelines of course requires very strict criteria; the EHCI must be regarded as consumer information, and can by no means be considered as scientific research).

Country	**Scoring Synopsis**
Austria	Very good medical results and excellent accessibility to healthcare. Austria leads the EU on overall cancer survival and on the rapid and. Slightly autocratic attitude to patient empowerment risk affecting good therapy outcomes.
Belgium	Good at accessibility, suffers on outcome quality, possibly because of an even weaker reporting culture than the European average. Remarkably slow at offering access to new medicines.
Bulgaria	Has quite a long way to go. Public health situation also suffers from severe life-style related problems (obesity, smoking, alcohol) affecting cardiac disease and other death rates.
Croatia	Scores good on Patient Rights and Information, probably due to good legislative background of patient's position within the healthcare system. The ranking would be probably much better if statistics on waiting times and pharmaceuticals had been available. Possible future champion in the region, let's see in next year's Index!
Cyprus	Problematic to score, as no other member state has as high a proportion of healthcare being privately funded. If the patient can afford to pay out of pocket, good healthcare can be had in any country.
Czech Republic	Solid mid-field performer (message to western European media: being ranked behind CZ is no great shame!) with improvement record. Could reconsider resource distribution between healthcare staff and equipment/medicines; notoriously thrifty on prescription drugs.
Denmark	EU champions at Patient Rights and Information and e-Health. Danes very satisfied with their primary care, and Outcomes have improved; hence the solid silver medal! Waiting times could improve.
Estonia	Estonia, with its population of 1½ million people, keeps proving that a small country can do a dramatic change faster than bigger nations. It takes more than a dozen years to change a top-down planned economy to become a customer-driven one. Good on MRSA infections and efficient financial administration of pharmaceuticals. Sweeps the floor with competition on Value-for-money adjusted scores!
Finland	Good Outcomes and Range & Reach of services. The waiting list situation stills the Achilles heel in a European comparison. Not much

	of consumer empowerment to be seen yet!
France	Poor on e-health and increased restrictions on access to specialist care create a fall in ranking from top position two years ago. Reasonably good outcomes quality but slightly authoritarian. You want healthcare information – ask your doctor! Waiting times for specialist appointments are rising.
FYR Macedonia	Scores good on patients rights and information, probably due to good legislation and the ongoing reform, promising further improvement. Not bad at all, if we consider the resources available and socio-economic background of the country. Problem with lack of healthcare coverage, particularly for ethnic minorities.
Germany	Fantastic for access to healthcare, but surprisingly mediocre Outcomes and Range and Reach of services. Germany does not actively invite *e.g.* women to mammography screening, and has a poor coverage in spite of unlimited access. You want healthcare information – ask your doctor!
Greece	Doctors rule. Some improved outcomes, but still too many out-of-pocket (and under-the-table) payments. E-health – never heard of?
Hungary	Recent improvement of Patient rights and Information services paying off. Promising attempt to start an information revolution in healthcare! 60 years of publicly financed healthcare has resulted in quite good coverage, but Outcomes are still disappointing.
Ireland	The Health Service Executive reform seems to have started improving a historically dismal performance. The severe waiting list problems seem to be improving, and so are Outcomes. However, patient organisations do not seem to have discovered this.
Italy	Technically excellent in many places, but poor geographical equity. Autocratic attitude from doctors prevents Italy from scoring high in a consumer index. A power shift to patients necessary!
Latvia	At this point in time lacking in resources and organisational culture to be a really consumer-adapted system. The country does consist of more than downtown Riga; poor geographical equity! Acute need for a systems overhaul by external auditors!
Lithuania	Noticeable improvement on Patient Rights and Information and Access to Healthcare service! Still a long way to go for really good Outcomes, but seems to have taken off from the bottom level formerly occupied.
Luxembourg	Winners of the 2008 Heart Index and rising in the EHCI – have had the good sense (not self-evident in the public sector) to allow its citizens to visit centres of excellence in other countries instead of insisting to do everything at home. What has withheld e-Health implementation – complacency? And choose a faster and more efficient Medical

	Products Agency to piggyback on!
Malta	The opening of the first state-of-the-art hospital in Malta (Mater Dei, November 2007) should provide the opportunity to get really good. High diabetes prevalence – due to highest obesity rates in Europe?
Netherlands	During the past four years the HCP has been unable to design an Index, where the Dutch are *not* in the top three! Could in fact be "The best healthcare system in Europe", even though the EHCI does not aspire to determine that. Full marks on Range & Reach of services! Scrap GP gatekeeping, do away with waiting times and become Absolutely Superb!
Norway	Still some access problems in spite of having poured money into healthcare. Slow on new medicines deployment, and lots of prescription medicines outside subsidy system. E-Health proficient – in the top 4.
Poland	It takes more than a dozen years to change a top-down planned economy to a customer-driven one. Healthcare management reform in order to make decently paid professionals actually stay and work in hospitals the solution? Poor access to new medicines and to low-cost prevention such as mammography and blood sugar control.
Portugal	Severe access problems. Low infant mortality one of the few bright spots. It takes consistent action to change the long-term down-turn. Better transparency could be a first step.
Romania	Shares the problem of unofficial payments to doctors with several of its neighbours. Good healthcare obtained this way unfortunately does not score in the EHCI, apart from possibly improving Waiting times scores?
Slovakia	Not as financially stable as Czech neighbours, and not really consumer-oriented. Informal payment problems. Weak on Outcomes. Some improvement on Patients' Rights and involvement in decision-making.
Slovenia	Really improving on Patients' Rights and Information. Decent outcomes, but Range and Reach of services and Waiting times have scope for improvement. Still poor access to new medicines.
Spain	It still seems that going for private healthcare is needed if patients want real excellence. Informal payments in public system a small problem for being in southern Europe – honest doctors in public system. Fairly good access to medicines (*too* good in antibiotics?)
Sweden	Excels at medical outcomes, and good healthcare coverage. Really bad (and worsening) accessibility; strangely the system has found no cure for waiting. One of four top countries for e-Health proficiency.
Switzerland	Running outside of EU competition. In a consumer Index, a system based on individual responsibility since time began does score high.

	Good but expensive; Range and Reach of services surprisingly poor!
United Kingdom	The NHS shares some fundamental problems with other centrally planned healthcare systems such as Sweden. Would require some really top class management for that giant system. In top four for e-Health. Superbug problems improving, but still bad.

4.1.2 Results in "Hexathlon"

The EHCI 2008 is made up of six sub-disciplines. As no country excels across all aspects of measuring a healthcare system, it can therefore be of interest to study how the 31 countries rank in each of the six parts of the "hexathlon". The scores within each sub-discipline are summarized in the following table:

Sub-discipline	Austria	Belgium	Bulgaria	Croatia	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	FYR Macedonia	Germany	Greece	Hungary	Ireland	Italy	Latvia	Lithuania	Luxembourg	Malta	Netherlands	Norway	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	Switzerland	United Kingdom	Average
1. Patient rights and information	100	106	88	94	88	81	144	125	131	113	88	100	100	119	88	100	56	131	106	94	125	106	94	63	81	94	119	75	100	100	94	100
2. e-Health	50	42	50	33	50	42	100	50	58	50	50	50	33	58	42	42	33	33	42	33	92	75	33	42	33	42	50	50	75	50	92	51
3. Waiting time for treatment	173	173	133	93	120	147	120	147	80	133	93	187	133	160	107	120	67	120	187	107	133	107	107	80	160	133	80	93	80	187	93	124
4. Outcomes	202	131	107	119	143	179	214	143	214	190	107	190	179	131	190	190	143	119	190	119	214	202	131	131	71	95	167	179	238	167	155	160
5. Range and reach of services provided	108	133	58	75	75	92	117	92	133	108	75	100	67	92	92	100	100	67	133	92	150	117	83	92	67	92	92	117	125	83	117	98
6. Pharmaceuticals	150	75	50	50	88	100	125	113	88	100	50	113	88	88	125	88	50	50	100	88	125	100	63	100	75	100	75	125	125	125	100	93

As the table indicates, the total top position of the Dutch healthcare system is to a great extent a product of an even performance across the sub-disciplines, very good medical quality and the only full score on Range & Reach of services.

Runner-up Denmark is still in top position for **Patient rights and information**, and also top of Europe with a full score on e-Health. The Swedish healthcare system would be a real top contender, were it not for an accessibility situation, which by Belgian, Austrian, French or German standards can only be described as abysmal.

Sub-discipline	Top country/countries	Score	Maximum score
1. Patient rights and information	Denmark	144	150
2. e-Health	Denmark	100!	100
3. Waiting time for treatment	Germany, Luxembourg, Switzerland	187	200
4. Outcomes	Sweden	238	250
5. Range and reach of services provided	Netherlands	150!	150
6. Pharmaceuticals	Austria	150!	150

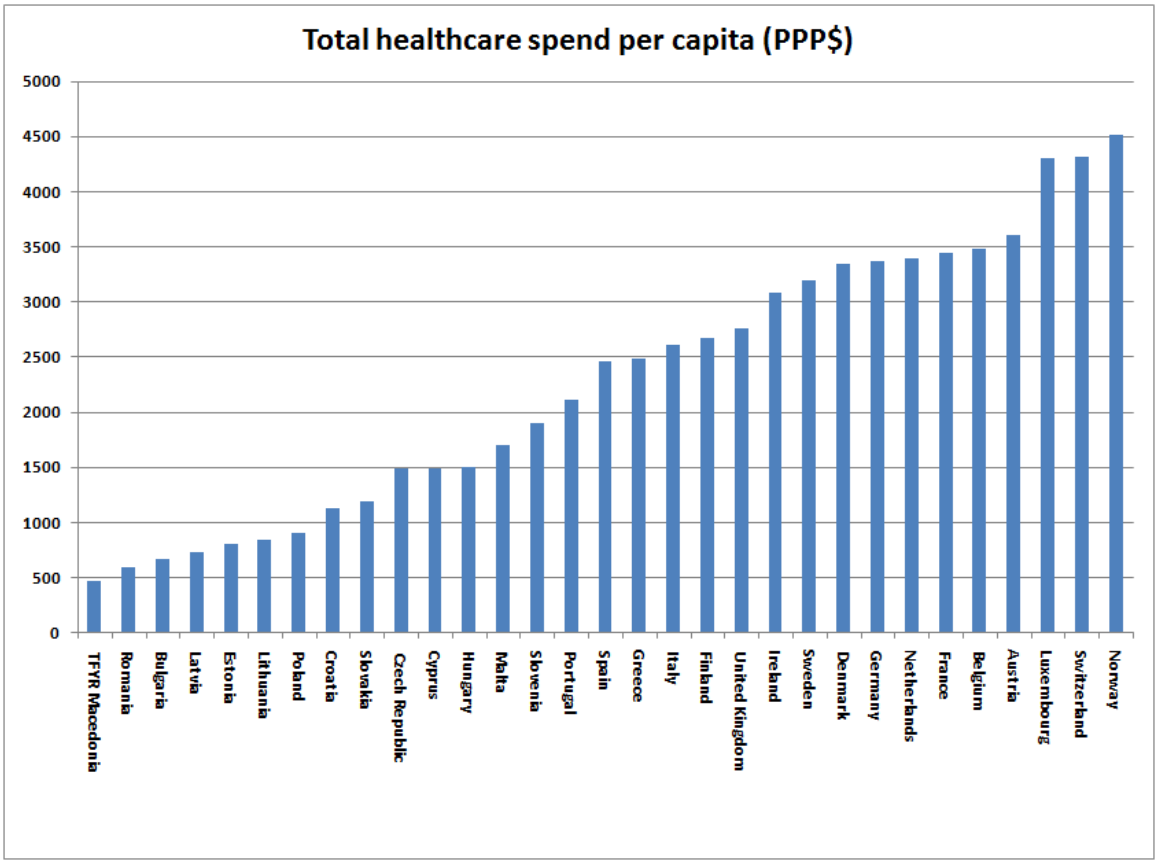
5. Bang-For-the-Buck adjusted scores

With all 27 EU member states and four other European countries included in the EHCI project, it becomes apparent that the Index tries to compare states with very different financial resources. The annual healthcare spending, in PPP-adjusted (Purchasing Power Parity) US dollars, varies from less than $500 in FYR Macedonia more than $4000 in Norway, Switzerland, and Luxembourg. Continental Western Europe and Nordic countries generally fall between $2700 and 3300. As a separate exercise, the EHCI 2008 has added a value for money-adjusted score: the Bang-For-the-Buck adjusted score, or "BFB Score".

5.1 BFB adjustment methodology

It is not obvious how to do such an adjustment. If scores would be adjusted in full proportion to healthcare spend per capita, the effect would simply be to elevate all less affluent states to the top of the scoring sheet. This, however, would be decidedly unfair to the financially stronger states. Even if healthcare spending is PPP adjusted, it is obvious that also PPP dollars go a lot further to purchase healthcare services in member states, where the monthly salary of a nurse is € 200, than in states where nurse's salaries exceed € 3500. For this reason, the PPP adjusted scores have been calculated as follows:

Healthcare spends per capita in PPP dollars have been taken from the WHO HfA database (July 2008; latest available numbers, most frequently 2006) as illustrated in the graph below*):



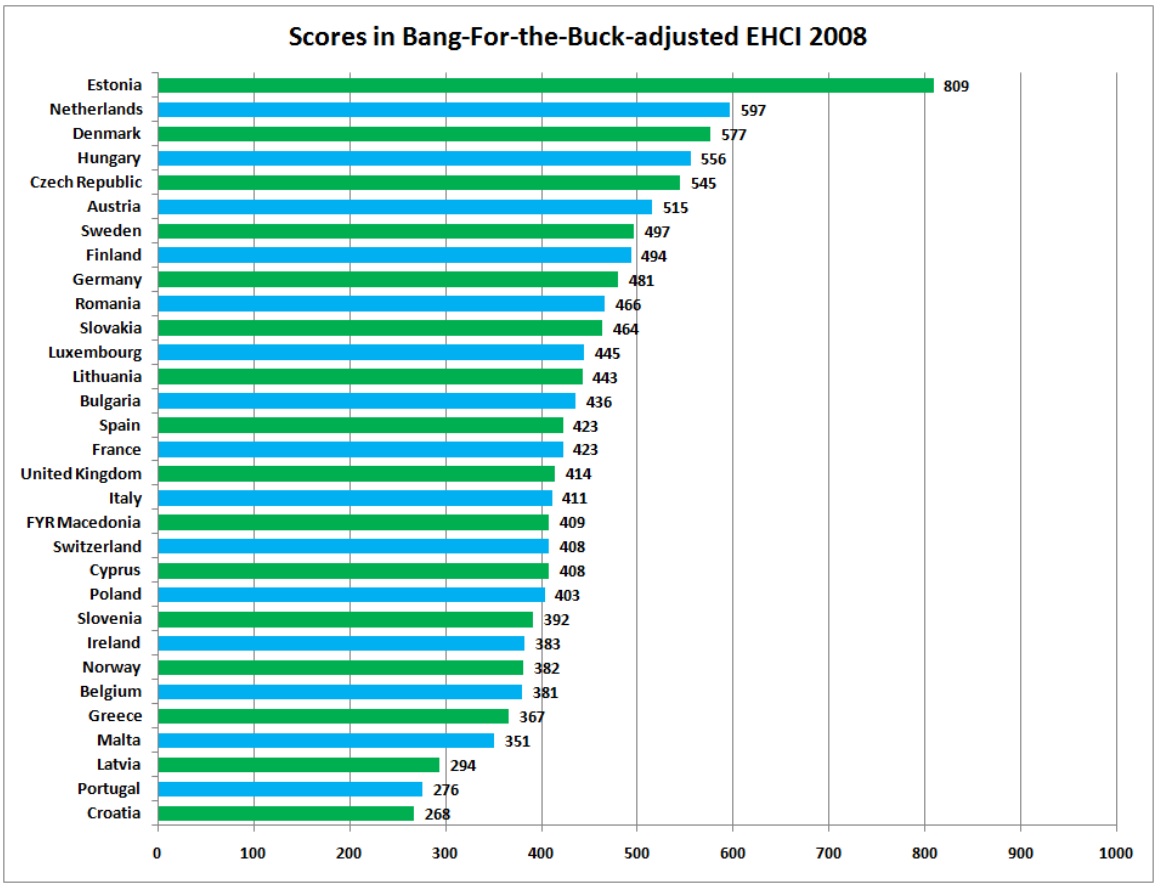
*) For Bulgaria and Romania, the WHO HfA database (July 2008) contains old values for the healthcare spend; "latest available" is $214 and $314, respectively, which are unreasonably low numbers. The European Observatory HiT report (http://www.euro.who.int/Document/E90023brief.pdf) on Bulgaria quotes the WHO, giving the number $648, also confirming the fact that this is slightly higher than the Romanian figure. The number for Romania was taken from a report from the Romanian MoH (http://www.euro.who.int/document/MPS/ROM_MPSEURO_countryprofiles.pdf), also quoting the WHO. Both these are a year old, and have therefore been raised by the same percentage as GDP growth for the purpose of this analysis.

For each country has been calculated *the square root* of this number. The reason for this is that domestically produced healthcare services are cheaper roughly in proportion to the healthcare spend. The basic EHCI scores have been divided by this square root. For this exercise, the basic scoring points of 3, 2 and 1 have been replaced by 2, 1 and 0. In the basic EHCI, the minimum score is 333 and the maximum 1000. With 2, 1 and 0, this does not (or only very marginally) change the relative positions of the 31 countries, but is necessary for a value-for-money adjustment – otherwise, the 333 "free" bottom points have the effect of just catapulting the less affluent countries to the top of the list.

The score thus obtained has been multiplied by the arithmetic means of all 31 square roots (creating the effect that scores are normalized back to the same numerical value range as the original scores).

5.2 Results in the BFB Score sheet

The outcome of the BFB exercise is shown in the graphic below. Even with the square root exercise described in the previous section, the effect is to dramatically elevate many less affluent nations in the scoring sheet.



The BFB scores, naturally, are to be regarded as somewhat of an academic exercise. Not least the method of adjusting to the square root of healthcare spent certainly lacks scientific support. After the research work, however, it does seem that certainly the supreme winner in the 2007 and 2008 BFB scores, Estonia, keeps doing very well within its financial capacity. To some extent, the same could be said about Hungary and the Czech Republic.

One thing the authors find interesting is to see which countries top the list in the BFB Scores, and which countries do reasonably well in the original scores. Examples of such countries are primarily the Netherlands and Denmark, with Austria and Sweden doing reasonably well. The U.K. has a less prominent position in the 2008 BFB exercise than in previous years – it would seem that the increased healthcare spend in the U.K. has not yet materialized fully in improved healthcare services.

It is good to remember that Croatia (and FYR Macedonia) are handicapped by many "n.a.:s" in the score sheet.

6. Important trends over the four years

6.1 Countries doing particularly well

From the point of view of a healthcare consumer, the overall situation is improving:

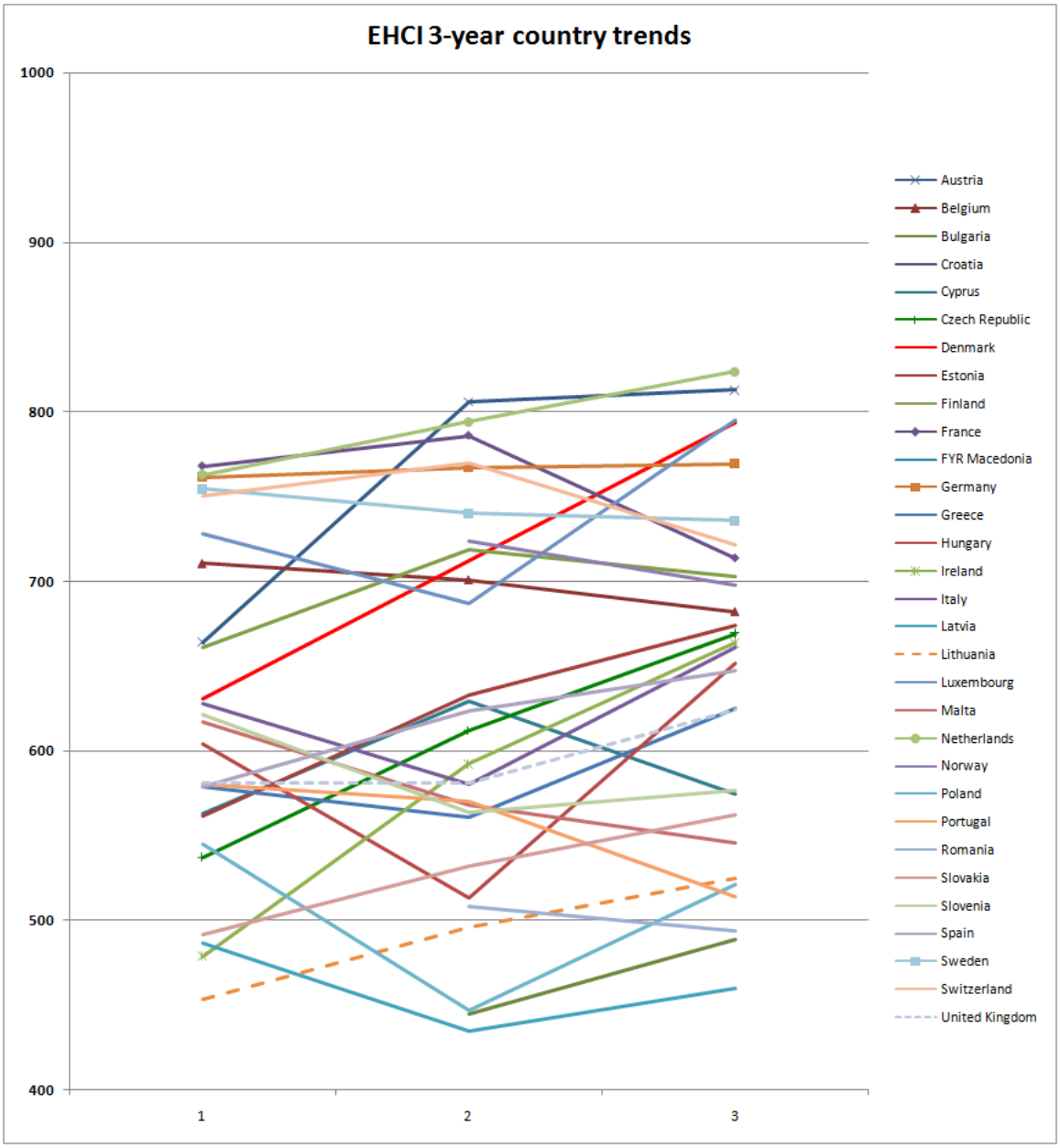


Figure 6.1. These results over the three years 2006 – 2008 have been normalized to all be calculated the same way as the EHCI 2007 (with its five sub-disciplines).

The fact that most countries show an upward trend in this normalized calculation can be taken as an indication that European healthcare is indeed improving over time. That some countries such as Belgium, France and Sweden have a downward trend cannot be

interpreted in the way that their healthcare systems have become worse over the time studied – only that they have developed less positively than the EU average!

Countries, where healthcare seems to develop faster than average in a direction of improved consumer friendliness are:

Denmark: A determined political effort to improve delivery and transparency of healthcare, which seems to be paying off.

Ireland: The creation of the Health Service Executive was obviously a much-needed reform.

Hungary, the **Czech Republic** and **Lithuania**: reforms in the area of Patient Rights and Information seem to be taking hold.

6.2 Closing the gap between the patient and professionals

When the indicator on the role of patients' organisations was introduced in 2006, no country deserved to get a Green score. This year, a high level of non-governmental patient's organisations involvement can be seen in Belgium, Estonia, Germany, Hungary, Lithuania, Netherlands, Poland and Slovakia, which is a remarkable improvement.

More and more states are changing the basic starting point for healthcare legislation, and there is a distinct trend towards expressing laws on healthcare in terms of rights of citizens/patients instead of in terms of (*e.g.*) obligations of providers (see section describing the indicator Healthcare law based on Patients' Rights).

Still, there is a lot to improve: if the patient has to fill a two-page form and pay 15 EUR to get access to her own medical record, it sounds more like a bad joke than a 21st century approach to patients' rights (this is an actual example).

Furthermore, only a handful of EU countries have integrated in their national legislation the Convention on Human Rights and Biomedicine[1] principles, being the first legally binding international instrument in the field of bioethics, awarding the patient with a systematic framework of direct and readily applicable rights.

6.3 Closing the gap between East and West

There seems to be a visible wave of legislation changes across the CEE, which results in patients' empowerment.

For example, in the past years Slovenia introduced changes in the domain of access to specialists, no-fault malpractice insurance, and the right to second opinion, together with considerable improvement in the area of access to information (register of legit doctors, pharmacopoeia, and even a nice attempt to construct a true providers' catalogue with quality ranking); some of these changes being attributable to the introduction of an Act On Patients' Rights of 2008. In the Czech Republic, a systematic reform of healthcare

[1]Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. Council of Europe, Oviedo 1997

legislation had impact on drug deployment speed; in Lithuania, the level of involvement of patient organisations increased in past years to a level higher than the majority of the wealthiest countries in the West.

Hungary improved a lot in the field of patient information by introducing the Doctor Info service with register of doctors and a nice attempt of provider catalogue, pharmacopoeia and other healthcare information.

The example of Hungary is a good indication that an important improvement in EHCI scoring can be done in one or two years, without the need to increase healthcare spending in a dramatic way. Usually it costs very little to incorporate the patients' rights in the national legislation or to make publicly available information already stored somewhere, such as a registry of doctors or information on pharmaceuticals.

Also the newly included Candidate countries have adapted patients' rights in their legislation.

However, an interesting observation is that all the CEE countries find themselves scoring Red in the mammography coverage indicator; probably by the combination of lower GDP and a lack of systematic approach to preventive measures. A generally lower level of attention to prevention in the CEE countries is confirmed also by the findings of both the Euro Consumer Heart Index 2008 and Euro Consumer Diabetes Index 2008.

It seems also from the limited data the HCP research team had, that the healthcare policies in the CEE countries remain focused on outcomes and procedures of intensive medicine – as were the Western countries into the late 1970's – and still have not made the transformation to meet the demands of global challenges and populations changes like ageing, chronic disease spread or palliative care needs.

6.4 Transparent monitoring of healthcare quality

In 2005, Dr. Foster of the UK was the single shining star on the firmament of provider (hospital) listing, where patients could actually see which hospitals had good results in term of actual success rates or survival percentages.

In 2007, there were already a few more examples, where the Health Consumer Powerhouse believes that the most notable is the Danish www.sundhedskvalitet.dk, where hospitals are graded from ★ to ★★★★★ as if they were hotels, with service level indicators as well as actual results, including case fatality rates on certain diagnoses. Perhaps the most impressive part of this system is that it allows members of the public to click down to a link giving the direct-dial telephone number of clinic managers.

This year, we can find not-so-perfect, but already existing catalogues with quality ranking in Cyprus, France, Hungary, Netherlands, Norway and Slovenia!

6.5 Layman-adapted comprehensive information about pharmaceuticals

In a discussion as late as January 2007, a representative of the Swedish Association of Pharmaceutical Industry (LIF), who were certainly pioneers with their well-established

pharmacopoeia "Patient-FASS" (www.fass.se), was arguing that this and its Danish equivalent were the only examples in Europe. Today, easy-to-use web-based instruments to find information on pharmaceuticals can be found in several countries, even in CEE countries, e.g. Czech Republic, Estonia, Hungary, Romania, and Slovakia.

6.6 Waiting lists: Who cares (for the patient)?

Not all the trends show an improvement. Over the years, one fact becomes clear: gatekeeping means waiting. Contradictory to general belief, direct access to specialist care does not generate access problems to specialists by the increased demand; repeatedly, waiting times are found predominately in restrictive systems, which seem to be rather an absurd observation.

One of the most characteristic systems of this kind, the NHS in the UK, recently spent millions pounds on reducing waiting and introduced a maximum of 18 weeks to definitive treatment after diagnosis. The patient survey commissioned by the HCP for this year's Index does not show any kind of improvement. It might be too soon to expect improvements visible to the rather blunt instrument of the EHCI 2008.

Furthermore, even the strong winners of past years' rankings are turning to restrictive measures: France, for example, is restraining access, which results in waiting times, and therefore worse score (together with not really brilliant results in the e-Health sub-discipline).

Even more notable: one of the indicators, introduced this year for the first time, is asking whether patients are expected to make informal payments to the doctor in addition to any official fees. Under-the-table payments serve in some (rather surprising western European) countries as a way to gain control over the treatment: to skip the waiting list, to access excellence in treatment, to get the use of modern methods and medicines. More on informal payments can be found in the sections Informal payments to doctors and Black market for healthcare information.

In this context, HCP will henceforward advocate the free choice, equal and direct access and measures intended to diminish the information handicap of the consumer as cornerstones of a 21st century modern European healthcare.

6.7 Change under pressure

Some general beliefs about healthcare in Europe would say that the best performers are the relatively rich countries with a long tradition of full-coverage healthcare systems. It is therefore very difficult to score well for a non-western country. To some extent this can be true: generally speaking, outcomes need money and continuity. The HCP work is, nevertheless, not concentrated on outcomes to the same extent that the common comparative studies. GDP-correlated indicators have been avoided as best possible. Against the beliefs presented above, it must be admitted that the way to the top of the Euro Health Consumer Index is not too difficult; the key measures are: choice, patients' rights, accessibility, information/transparency, quality measurement – and some of these cost little to introduce.

The key factor seems to be the overall responsiveness of the national system, and the capability to implement strategic changes. Under external pressure, visible in the past few years, individual countries take very different measures to keep healthcare sustainable, ranging from deep systematic reforms to defensive restrictive measures on the level of provision and access. Apparently, some national healthcare systems experience a sort of inertial status persistent to any change. As a result, some of the Good Old Europe countries slowly submerge (France being the most visible example this year). On the other hand, quick learners like Estonia or Slovakia have had the questionable advantage of facing a crisis so threatening that it became an opportunity to redesign the whole approach to healthcare.

Still European healthcare systems are to a high degree funded in "collective" ways, by taxes or regulated insurance solutions. Medium-term the HCP anticipates a growing discussion about additional ways to finance healthcare as the economic restrictions grow. The sustainability of the present sources of funding will be questioned at the same time as the empowerment of consumers will open for co-payment perspectives. The recent debate and development in the UK about "top up-options" on new, expensive medicines probably is just an early reflection of this different reality. Will uniform systems stand the challenge to serve individuals with not only very different needs but with huge variations in demand and expectations as well?

Such system provocations will initially be ignored but over time they cannot be neclected or forgotten. To avoid unpleasant surprises it would be wise to accept this discussion. If not, change will happen, but no doubt under sudden pressure. That is often how transition takes place but there should be better ways to do it?

A humble way for the HCP to contribute would be looking more into funding issues, with a consumer angle. This will probably be another EHCI direction for the coming years.

6.8 Why do patients not know?

Each year, the results of the survey made in co-operation with Patient View reveal an interesting fact: in some countries, the patients' organisations and health campaigners (even very respectful ones) do not know about some of the services available in their country. For example, the research team constantly finds negative answers on the existence of doctors' registries, pharmacopoeias, access to medical records etc. in countries where HCP researchers can easily find this kind of information even without the knowledge of local language. To sum up, probably the reason is that national authorities make considerable improvements, but miss out on communicating these to the wide public.

6.9 MRSA spread

In the EHCI 2007, a considerable attention was paid to the problem of antibiotics resistance spread: "MRSA infections in hospitals seem to spread and are now a significant health threat in one out of two measured countries." Unfortunately, the only countries where an improvement can be seen are Bulgaria, Poland and the British Isles, and the situation worsened in Estonia, Germany, Lithuania, Luxembourg and Romania. In

addition, both the newly included Candidates countries face the MRSA spread as well. Only five countries out of 34 can say that MRSA is not a major problem, thus scoring Green.

7. How to interpret the Index results?

The first and most important consideration on how to treat the results is with care.

The Euro Health Consumer Index 2008 is an attempt at measuring and ranking the performance of diabetes care provision from a consumer viewpoint. The results definitely contain information quality problems. There is a shortage of pan-European, uniform set procedures for data gathering.

But again, the HCP finds it far better to present the results to the public, and to promote constructive discussion rather than staying with the only too common opinion that as long as healthcare information is not a hundred percent complete it should be kept in the closet. Again, it is important to stress that the Index displays consumer information, not medically or individually sensitive data.

While by no means claiming that the EHCI 2008 results are dissertation quality, the findings should not be dismissed as random findings. On the contrary, previous experience from the general Euro Health Consumer Indexes reflects that consumer ranking by similar indicators is looked upon as an important tool to display healthcare service quality. The HCP hopes that the EHCI 2008 results can serve as inspiration for how and where European healthcare can be improved and does therefore also give recommendations for change in co-ordination with the launch of this report. Those points of policy advice can be found on the HCP website.

8. European data shortage

8.1 Black market for healthcare information

In the past years, the HCP was constantly voicing the problem of non-availability of relevant data focused on real performance indicators. The predominant data set that national health statistic units are working with is based on an obsolete approach counting beds and professionals, measuring for how long people live and what they die from.

Working on this year's index data set, the HCP research team encountered the intriguing situation of being asked by a public servant to meet at a petrol station and there been asked for money in exchange for information that is presumed to be publicly available. This rather shocking situation, together with the evidence that in some countries, a real black market for healthcare information exists, inspired the introduction of the informal payments indicator in the Health Consumer Index 2008 (see section 5.6. Informal payments to doctors).

The cross-European survey on informal payments is, in spite of its obvious imperfections, the first one in history, which also illustrates the low level of attention paid by nations and European institutions to the problem of parallel economy in healthcare.

This observation gives reason for two questions:

1. Unlike other professionals, such as airline pilots, lawyers, systems engineers etc, working for large organisations, doctors are unique in being allowed to run side jobs without the explicit permission of the main employer. What is the reason(s) for keeping that?
2. What could be done to give doctors "normal" professional employment conditions, *i.e.* a decent salary and any extra energy spent on working harder (Yes, and making more money) for the main employer?

8.2 Medical outcomes indicators included in the EHCI

There is one predominant feature, which characterizes European/Canadian public healthcare systems as opposed to their more industrialised counterparts in countries such as the U.S.A.: there is an abundance of statistics on input of resources, but a traditional scarcity of data on quantitative or qualitative *output*.

Organisations like the WHO and OECD are publishing easily accessible and frequently updated statistics on topics like:

- the number of doctors/nurses per capita
- hospital beds per capita
- share of patients receiving certain treatments
- number of consultations per capita
- number of MR units per million of population
- health expenditure by sources of funds
- drug sales in doses and monetary value (endless tables)

Systems with a history of funding structures based on grant schemes and global budgeting often exhibit a management culture, where monitoring and follow-up is more or less entirely focused on input factors. Such factors can be staff numbers, costs of all kinds (though not usually put in relation to output factors) and other factors of the nature illustrated by the above bullet list.

Healthcare systems operating more on an industrial basis have a natural inclination to focus monitoring on *output*, and also much more naturally relate measurements of costs to output factors in order to measure productivity, cost-effectiveness and quality.

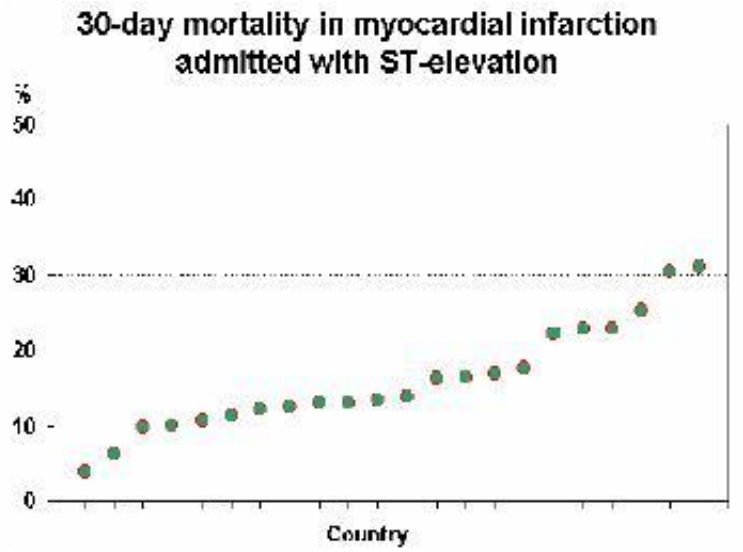
The EHCI project has endeavoured to obtain data on the quality of actual healthcare provided. Doing this, the ambition has been to concentrate on indicators, where the contribution of actual healthcare provision is the main factor, and external factors such as lifestyle, food, alcohol or smoking are not heavily interfering. Thus, the EHCI has also

avoided including public health parameters, which often tend to be less influenced by healthcare performance than by external factors.

The chosen quality indicators have become:

- Heart infarct case fatality <28 days after hospitalisation (de-selecting such parameters as total heart disease mortality, where the Mediterranean states have an inherent, presumably life-style dependent, leading position). The data used were those from the so-called MONICA study, completed with data obtained directly from healthcare authorities of countries not part of MONICA. For Sweden, Finland, Denmark and Austria much more recent data from national sources have been used, but with the cut-off to get a Green score set at 8% case fatality rather than 18%. In the early 1990's, 18% was state-of-the-art – 15 years later, that has improved considerably.

There is a surprising lack of more recent data on this the #1 killer disease in modern-day Europe. The graph shown below is in its original form from material published by the European Society of Cardiology, (with the identities of countries not given) based on what is by now very ancient MONICA data.



The Health Consumer Powerhouse wishes the best of success to the European Society of Cardiology in its efforts on the Euro Heart Survey, the EUROASPIRE and EUROCISS projects (the two latter of which were started fairly recently), which will in all likelihood remedy the lack of outcomes data in this very vital field.

- Infant mortality/1000 live births (presumed to be to a large degree dependent on the quality of healthcare services)
- 5-year cancer survival (all cancers except skin).
- MRSA infections; EARSS statistics - for patients, who get a Hospital Acquired Infection; what % of these cases is infected by bacteria which are resistant to conventional treatment with antibiotics? This is probably the medical quality

indicator, which has the most systematic follow-up and reporting in public form in European healthcare. Unfortunately, Switzerland does not report to EARSS.

- Potential years of life lost (PYLL).
- Percentage of patients with high HbA1c levels (> 7)
- Relative rate of decline of suicide

9. Evolvement of the EuroHealth Consumer Index

9.1 Scope and content of EHCI 2005

Countries included in the EHCI 2005 were: Belgium, Estonia, France, Germany, Hungary, Italy, the Netherlands, Poland, Spain, Sweden, the United Kingdom and, for comparison, Switzerland.

To include all 25 member states right from the start would have been a very difficult task, particularly as many memberships were recent, and would present dramatic methodological and statistic difficulties

The EHCI 2005 was seeking for a representative sample of large and small, long-standing and recent EU membership states.

The selection was influenced by a desire to include all member states with a population of ~40 million and above, along with the above-mentioned mix of size and longevity of EU membership standing. As the Nordic countries have fairly similar healthcare systems, Sweden was selected to represent the Nordic family, purely because the project team members had a profound knowledge of the Swedish healthcare system.

As already indicated, the selection criteria had nothing to do with healthcare being publicly or privately financed and/or provided. For example, the element of private providers is specifically not at all looked into (other than potentially affecting access in time or care outcomes).

One important conclusion from the work on EHCI 2005 was that it is indeed possible to construct and obtain data for an index comparing and ranking national healthcare systems seen from the consumer/patient's viewpoint.

9.2 Scope and content of EHCI 2006 – 2007

The EHCI 2006 included all the 25 EU member states of that time, plus Switzerland using essentially the same methodology as in 2005.

The number of indicators was also increased, from 20 in the EHCI 2005 to 28 in the 2006 issue. The number of sub-disciplines was kept at five; with the change that the "Customer Friendliness" sub-discipline was merged into "Patient Rights and Information". The new sub-discipline "Generosity" (What is included in the public healthcare offering?) was introduced, as it was commented from a number of observers, not least healthcare politicians in countries having pronounced waiting time problems, that absence of waiting

times could be a result of "meanness" – national healthcare systems being restrictive on who gets certain operations could naturally be expected to have less waiting list problems.

In order to test this, the new sub discipline "Generosity" of public healthcare systems, or shorter "Provision levels" was introduced. A problem with this sub discipline is that it is only too easy to land in a situation, where an indicator becomes just another way of measuring national wealth (GDP/capita). The indicator "Number of hip joint replacements per 100 000 inhabitants" is one prominent example of this. The cost per operation of a hip joint is in the neighbourhood of € 7000 (can be slightly more in Western Europe – slightly less in states with low salaries for healthcare staff). That cost, for a condition that might be crippling but not life-threatening, results in Provision levels being very closely correlated to GDP/capita.

Cataract operations seem a better and less GDP-correlated indicator on the Generosity of public healthcare systems. The cost per operation is only one tenth of that for a hip joint and thus much more affordable in less affluent countries. Interestingly, Belgium – a country with minimal waiting list problems, and which was most often to us accused of achieving this through restrictiveness, by far has (along with Canada) the highest provision levels for cataract operations in the OECD.

The second indicator selected under Provision levels is "Is dental care a part of the public healthcare offering?" As a measure of this, the very simple indicator "What percentage of public healthcare spend is made up by dental care?" was selected, on the logic that if dental care accounts for close to 10 % of total public healthcare expenditure, this must mean that dental care is essentially a part of the public healthcare offering.

To achieve a higher level of reliability of information, one essential work ingredient has been to establish a net of contacts directly with national healthcare authorities in a more systematic way than was the case for the 2005 issue. The weaknesses in European healthcare statistics described in previous EHCI reports can only be offset by in-depth discussions with key personnel at a national healthcare authority level.

In general, the responsiveness from Health Ministries, or their state agencies in charge of supervision and/or Quality Assurance of healthcare services, has been good in 2006-7. Written responses have been received from 19 EU member states.

9.3 EHCI 2008

The project work on the Index is a compromise between which indicators were judged to be most significant for providing information about the different national healthcare systems from a user/consumer's viewpoint, and the availability of data for these indicators. This is a version of the classical problem "Should we be looking for the 100-dollar bill in the dark alley, or for the dime under the lamppost?"

It has been deemed important to have a mix of indicators in different fields; areas of service attitude and customer orientation as well as indicators of a "hard facts" nature showing healthcare quality in outcome terms. It was also decided to search for indicators on actual results in the form of outcomes rather than indicators depicting procedures, such

as "needle time" (time between patient arrival to an A&E department and trombolytic injection), percentage of heart patients trombolysed or stented, etcetera.

Intentionally de-selected were indicators measuring public health status, such as life expectancy, lung cancer mortality, total heart disease mortality, diabetes incidence, etc. Such indicators tend to be primarily dependent on lifestyle or environmental factors rather than healthcare system performance. They generally offer very little information to the consumer wanting to choose among therapies or care providers, waiting in line for planned surgery, or worrying about the risk of having a post-treatment complication or the consumer who is dissatisfied with the restricted information.

9.4 No indicators taken out from the EHCI 2007 set

Of the totally 28 indicators used for the EHCI 2007, none has been discontinued in the 2008 Index.

Despite a frenetic disagreement from some countries, HCP proudly keeps the indicator "Direct access to specialists" in the EHCI, as there is absolutely no evidence that the GP gatekeeping role has an impact on expenses side of healthcare. Studies such as that made by Kroneman et al.[2] provide more respectful reasoning in this regard than statements like "The gatekeeping is a matter of policy and we insist that this indicator is removed from the index."

9.5 New sub-discipline and indicators introduced for EHCI 2008

As every year the international expert panel has fed in a long list of new indicators to be included in this year's Index (find more on expert panel composition), there was a true brainstorm of new bright ideas to be included in this year's Index. Unfortunately, the research team was unable to turn all of them into a green-yellow-red score in the matrix; for example, the indicator "Number of hospitalisations per 1000 population over 75 years", as a negative proxy of community care, is on the remaining agenda for future indexes.

Nevertheless, the research team was able to present data for seven new indicators.

For description and more details on the indicators, see section "Content of indicators in the EHCI 2008".

Sub-discipline 1 (Patient rights and information)

1.8. Cross border care information

Sub-discipline 2 (e-Health)

This sub-discipline has been introduced to highlight the fact that the largest, most information-intensive industry in society (= healthcare) is incredibly under-developed in

[2] Kroneman et al: Direct access in primary care and patient satisfaction: A European study. Health Policy 76 (2006) 72–79

the field of computer use. A nurse handles probably one hundred times more information on an 8-hour shift than a nightwatchman does. Nevertheless, nightwatchmen in many countries are sporting handheld computers, and nurses are not. The potential for improvements in outcomes, patient safety, flow rationalization and other areas of healthcare through increased intelligent use of computers is enormous.

The sub-discipline contains two novel indicators (in 2007, the first two were in Sub-discipline 1).

2.3. e-transfer of medical data

2.4. e-prescriptions

Sub-discipline 4 (Outcomes)

4.6 Relative rate of decline of suicide

4.7. % of patients with high HbA1c levels (> 7)

Sub-discipline 5 (Range and Reach of services provided)

5.5. Rate of mammography

5.6. Informal payments to doctors

9.6 Indicator areas (sub-disciplines)

The 2008 Index is, just like in 2007, built up with indicators grouped in sub-disciplines. The 2008 Index has been given a sixth, new sub-discipline: e-Health, containing two indicators previously found in the Patient rights and information sub-discipline, plus two novel indicators. After having had to surrender to the "lack of statistics syndrome", and after scrutiny by the expert panel, 34 indicators survived into the EHCI 2008.

The indicator areas for the EHCI 2008 thus became:

Sub-discipline	Number of indicators
1. Patient rights and information	8
2. e-Health	4
3. Waiting time for treatment	5
4. Outcomes	7
5. Range and reach of services ("Generosity")	6
6. Pharmaceuticals	4

9.7 Scoring in the EHCI 2008

The performance of the respective national healthcare systems were graded on a three-grade scale for each indicator, where the grades have the rather obvious meaning of Green

= good (), Amber = so-so () and red = not-so-good (). A green score earns 3 points, an amber score 2 points and a red score (or a "not available") earns 1 point.

In the EHCI 2005, the green **3**, amber **2** and red **1** were just added up to make up the country scores.

For the 2006 Index a different methodology was used: For each of the five sub disciplines, the country score was calculated as a percentage of the maximum possible (*e.g.* for Waiting times, the score for a state has been calculated as % of the maximum 3 x 5 = 15).

Thereafter, the sub-discipline scores were multiplied by the weight coefficients given in the following section and added up to make the final country score. These percentages were then multiplied by 100, and rounded to a three digit integer.

9.8 Weight coefficients

The possibility of introducing weight coefficients was discussed already for the EHCI 2005, *i.e.* selecting certain indicator areas as being more important than others and multiplying their scores by numbers other than 1.

For the EHCI 2006 explicit weight coefficients for the five sub-disciplines were introduced after a careful consideration of which indicators should be considered for higher weight. The accessibility and outcomes sub disciplines were decided as the main candidates for higher weight coefficients based mainly on discussions with expert panels and experience from a number of patient survey studies. Here, as for the whole of the Index, we welcome input on how to improve the Index methodology.

In the EHCI 2008, the scores for the six sub-disciplines were given the following weights:

Sub discipline	**Relative weight** **("All Green" score contribution to total maximum score of 1000)**	**Points for a Green score in each sub-discipline**
Patient rights and information	150	18.75
e-Health	100	25.00
Waiting time for treatment	200	40.00
Outcomes	250	35.71
Range and reach of services ("Generosity")	150	25.00
Pharmaceuticals	150	37.50
Total sum of weights	**1000**	

Consequently, as the percentages of full scores were added and multiplied by (1000/Total sum of weights), the maximum theoretical score attainable for a national healthcare system in the Index is 1000, and the lowest possible score is 333.

It should be noted that, as there are not many examples of countries that excel in one sub-discipline but do very poorly in others, the final ranking of countries presented by the EHCI 2008 is remarkably stable if the weight coefficients are varied within rather wide limits.

The project has been experimenting with other sets of scores for green, amber and red, such as 2, 1 and 0 (which would really punish low performers), and also 4, 2 and 1, (which would reward real excellence). The final ranking is remarkably stable also during these experiments.

9.8.1 Regional differences within European states

The Health Consumer Powerhouse is well aware that many European states have very decentralised healthcare systems. Not least for the U.K. it is often argued that "Scotland and Wales have separate HNS services, and should be ranked separately".

The uniformity among different parts of the U.K. is probably higher than among regions of Spain and Italy, Bundesländer in Germany and possibly even among counties in tiny 9 million population Sweden.

Grading healthcare systems for European states does present a certain risk of encountering the syndrome of "if you stand with one foot in an ice-bucket and the other on the hot plate, on average you are pretty comfortable". This problem would be quite pronounced if there were an ambition to include the U.S.A. as one country in a Health Consumer Index.

As equity in healthcare has traditionally been high on the agenda in European states, it has been judged that regional differences are small enough to make statements about the national levels of healthcare services relevant and meaningful.

9.9 Indicator definitions and data sources for the EHCI 2008

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
1. Patient rights and information	1.1. Healthcare law based on Patients' Rights	Is national HC legislation explicitly expressed in terms of Patients' rights?	Yes	various kinds of patient charters or similar byelaws	No	Patients' Rights Law (Annex 1); http://www.healthline.com/galecontent/patient-rights-1; http://www.adviceguide.org.uk/index/family_parent/health/nhs_patients_rights.htm; ww.dohc.ie ; http://www.sst.dk/Tilsyn/Individuelt_tilsyn/Tilsyn_med_faglighed/Skaerpet_tilsyn_med_videre/Skaerpet_tilsyn/Liste.aspx ; http://db2.doyma.es/pdf/261/261v1n2a13048764pdf001.pdf.
	1.2. Patient organisations involved in decision making		Yes, statutory	Yes, by common practice in advisory capacity	No, not compulsory or generally done in practice	Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Personal interviews.
	1.3. No-fault malpractice insurance	Can patients get compensation without the assistance of the judicial system in proving that medical staff made mistakes?	Yes	Fair; > 25% invalidity covered by the state	No	Swedish National Patient Insurance Co. (All Nordic countries have no-fault insurance); www.hse.ie ; www.hiqa.ie .
	1.4. Right to second opinion		Yes	Yes, but difficult to access due to bad information, bureaucracy or doctor negativism	No	Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, Patient View 2005. Personal interviews.
	1.5. Access to own medical record	Can patients read their own medical records?	Yes	Yes, restricted or with inter-mediary	No	Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, Patient View 2005. Personal interviews; www.dohc.ie .

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
1. Patient rights and information	1.6. Register of legit doctors	Can the public readily access the info: "Is doctor X a bona fide specialist?"	Yes, easily on the www	Yes, in easily accessible publication	Difficult or costly, or not at all.	Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2007. National physician registries.; http://www.sst.dk/Tilsyn/Individuelt_tilsyn/Tilsyn_med_faglighed/Skaerpet_tilsyn_med_videre/Skaerpet_tilsyn/Liste.aspx
	1.7. Web or 24/7 telephone HC info with interactivity	Information which can help a patient take decisions of the nature: "After consulting the service, I will take a paracetamol and wait and see" or "I will hurry to the A&E department of the nearest hospital"	Yes	yes, but not generally available	No	Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Personal interviews; http://www.nhsdirect.nhs.uk/ ; www.hse.ie ; www.ntpf.ie .
	1.8. Cross-border care information	% stating Lack of information as a reason for not seeking medical treatment abroad	Less than EU average	Close to EU average	More than EU average	Cross-border health services in the EU. Eurobarometer, June 2007
2. e-Health	2.1. Provider catalogue with quality ranking	www.sundhedskvalitet.dk the standard European qualification for a "Yes" (green score). The "750 best clinics" published by LaPointe in France would warrant a Yellow.	Yes	"not really", but nice attempts under way	No	http://www.drfoster.co.uk/home.aspx ; http://www.sundhedskvalitet.dk /; http://www.sykehusvalg.no/sidemaler/VisStatiskInformasjon_____2109.aspx ; http://www.hiqa.ie/ ; http://212.80.128.9/gestion/ges161000com.html .
	2.2. EPR penetration	% of GP practices using electronic patient records for diagnostic data	≥ 90 % of GP practices	<90 ≥ 50 % of practices	< 50 % of practices	http://ec.europa.eu/public_opinion/flash/fl126_fr.pdf ; http://www.europartnersearch.net/ist/communities/indexmapconso.php?Se=11 ; www.icgp.ie ; Commonwealth Fund International Health Policy Survey of Primary Care Physicians"Benchmarking ICT use among GP:s in Europe"; European Commission, April 2008; study made by Empirica, Bonn, Germany (p.60), Gartner Group

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
2. e-Health	2.3. e-transfer of medical data	% of GP practices using e-networks for transfer of medical data to care providers / professionals	≥ 25 % of GP practices	<25 ≥10 % of practices	< 10 % of practices	"Benchmarking ICT use among GP:s in Europe"; European Commission, April 2008; study made by Empirica, Bonn, Germany (p.45), Gartner Group, Cambio Sweden
	2.4. e-prescriptions	% of GP practices using electronic networks for prescriptions to pharmacies	≥ 50 % of GP practices	<50 ≥ 5 % of practices	< 5 % of practices	"Benchmarking ICT use among GP:s in Europe"; European Commission, April 2008; study made by Empirica, Bonn, Germany. (p.45), Gartner Group, Cambio Sweden
3. Waiting time for treatment	3.1. Family doctor same day access	Can I count on seeing my primary care doctor today?	Yes	yes, but not quite fulfilled	No	Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2008. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, Patient View 2005. Personal interviews; http://www.nhs.uk
	3.2. Direct access to specialist	Without referral from family doctor (GP)	Yes	not really, but quite often in reality	No	Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2008. Personal interviews with healthcare officials; http://www.im.dk/publikationer/healthcare_in_dk/healthcare.pdf ; http://www.ic.nhs.uk/ ; http://www.oecd.org/datao
	3.3. Major non-acute operations <90 days	Coronary bypass/PTCA and hip/knee joint	90% <90 days	50 - 90% <90 days	> 50% > 90 days	OECD data: Siciliani & Hurst, 2003 / 2004. Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2008. www.frittsykehusvalg.no ; www.sst.dk ; http://www.im.dk/publikationer/healthcare_in_dk/healthcare.pdf ; http://sas.skl.se
	3.4. Cancer therapy < 21 days	Time to get radiation/ chemotherapy after decision	90% <21 days	50 - 90% <21 days	> 50% > 21 days	OECD data: Siciliani & Hurst, 2003 / 2004. Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2008. www.frittsykehusvalg.no ; www.sst.dk ; http://www.sst.dk/Nyheder/Seneste_nyheder/Ventetider_straalebehl_uge23_24.aspx?l
	3.5. MRI scan < 7days		Typically <7 days	Typically <21 days	Typically > 21 days	Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2008. www.frittsykehusvalg.no ; www.sst.dk ; http://www.venteinfo.dk/ ; http://sas.skl.se ; Personal interviews with healthcare officials.

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
4. Outcomes	4.1. Heart infarct case fatality	28 (30)-day case fatality of hospitalised MI patients	Clearly better than EU average	Not clearly far from EU average	Clearly not as good as EU average	Compilation from OECD Health at a Glance; December 2007, MONICA, national heart registries
	4.2. Infant deaths	/1000 live births	<4	< 6	≥6	WHO Europe Health for All mortality database, latest available statistics. http://globalis.gvu.unu.edu/indicator_detail.cfm?IndicatorID=25&Country=BE
	4.3. Cancer 5-year survival	All cancers except skin	≥ 60 %	50 - 60 %	≤ 50 %	Eurocare 4; "A pan-European comparison regarding patient access to cancer drugs", Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm 2007; http://www.breastcancer.org/press_cancer_facts.html ; http://info.cancerresearchuk.org/ ; www.ncri.ie ;
	4.4. Avoidable deaths – years of Life Lost	All causes, Years lost, /100000 populat.,0-69	< 3300	3300 - 4500	>4500	OECD Health Data 2008; Non-OECD: WHO HfA SDR all causes, all ages per 100000
	4.5. MRSA infections	% of hospital-acquired infections being resistent	<5%	<20%	>20%	EARSS. Data from 2007; Croatia, Germany, Lithuania, Luxembourg, Malta 2008; Poland 2006; Slovakia 2005
	4.6 Rate of decline of suicide	Incline of e-log line for suicide SDR:s 1990 - l.a.	Greater reduction than EU average	Reduction rate close to EU average	No reduction or increase	MINDFUL, WHO HfA Mortality database
	4.7. % of patients with high HbA1c levels (> 7)	Percentage of total diabetic population with HbA1c above 7	< 50 %	50-60 %	>60 %	EUCID, Interviews with national diabetes experts and health care officials, National Registries

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
5. Range and reach of services provided	5.1. Cataract operations per 100 000 age 65+	Cataract surgery, # of procedures per 100 000 pop. > 65 years	> 5000	5000 - 3000	< 3000	OECD Health Data 2008, WHO Prevention of Blindness and Visual Impairment Programme, European Community Health Indicators
	5.2. Infant 4-disease vaccination	Diphteria, tetanus, pertussis and poliomyelitis, arithmethic mean	≥97 %	≥92 - <97%	<92 %	European health for all database. Data from 2006, except Croatia, Germany, Luxembourg, Netherlands, Slovenia, Switzerland (2005), France, Greece, Hungary, Romania (2004)
	5.3. Kidney transplants per million pop.	Living and deceased donors, procedures p.m.p.	≥ 40	40 - 30	< 30	OECD Health Data 2008, Council of Europe Newsletter 11/2006, Croatian registry for renal replacement therapy, Rozental R: Donation and transplantation in Latvia 2006.
	5.4. Dental care affordability	% responding dental care to be "not at all affordable/not very affordable"	≤ 40	>40 - <60	≥ 60	Eurobarometer 283, Dec -07
	5.5. Rate of mammography	Percentage of females aged 50-69 screened, latest data available; European target is 70%.	≥ 80	<80 - >60	≤ 60	OECD Health Data 2008; WHO World Health Survey 2006.
	5.6. Informal payments to doctors	Mean response to question: "Would patients be expected to make unofficial payments?"	No	Sometimes ; depends on the situation	Yes, frequently	Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Personal interviews; http://www.nhsdirect.nhs.uk/ ; www.hse.ie ; www.ntpf.ie .
6. Pharmaceuticals	6.1. Rx subsidy	% of Rx sales paid for by public subsidy	>90%	60 - 90%	<60%	http://www.efpia.org/6_publ/infigure2004h.pdf 2005 update? WHO Health for All database 2005; http://www.laegemiddelstyrelsen.dk/statistik/overvaagning/udgifter/2007-1/2007-1.asp.
	6.2. Layman-adapted pharmacopeia?	Is there a layman-adapted pharmacopeia readily accessible by the public (www or widely avaliable)?	Yes	Yes, but not really easily accessible	No	Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2006. Personal interviews. LIF Sweden. http://www.doctissimo.fr/html/sante/sante.htm ; http://www.legemiddelverket.no/custom/templates/gzInterIFrame____1548.aspx.

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
	6.3. New cancer drugs deployment speed		Quicker than EU average	Close to EU average	Slower than EU average	"A pan-European comparison regarding patient access to cancer drugs", Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm 2007.
	6.4. Access to new drugs (time to subsidy)	Between registration and inclusion in subsidy system	<150 days	<300 days	>300 days	"A pan-European comparison regarding patient access to cancer drugs", Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm 2007.

Table 9.8: Indicator definitions and data sources for the EHCI 2008

9.9.1 Additional data gathering - survey

In addition to public sources, as was also the case for the 2007 Index, an e-mail survey to Patient organisations was commissioned from PatientView, Woodhouse Place, Upper Woodhouse, Knighton, Powys, LD7 1NG, Wales, Tel: 0044-(0)1547-520-965 · E-mail: info@patient-view.com. In 2008, this survey included the five Waiting Time indicators plus the other indicators listed in Appendix 1. A total of 539 patient organisations responded to the survey. The lowest number of responses from any single country was 3 (Malta), except from FYR Macedonia, from where no responses were obtained.

9.9.2 Additional data gathering – feedback from National Ministries/Agencies

On October 8th, 2008, preliminary score sheets were sent out to Ministries of Health or state agencies of all 31 states, giving the opportunity to supply more recent data and/or higher quality data than what is available in the public domain.

This procedure had been prepared for during the spring and summer of 2008 by extensive mail, e-mail, telephone contacts and personal visits to ministries/agencies. Finally, feedback responses have been had from official national sources as illustrated in the following table:

Country	Responded in 2006	Responded in 2007	Responded in 2008
Austria		√	√
Belgium	√		
Bulgaria	not applicable	√	
Croatia	not applicable	not applicable	√
Cyprus	√		
Czech Republic	√		√
Denmark		√	√
Estonia	√	√	√
Finland	√	√	√
France		√	
FYR Macedonia	not applicable	not applicable	
Germany			
Greece			√
Hungary	√	√	√
Ireland		√	√
Italy			
Latvia	√		
Lithuania		√	√
Luxembourg		√	√
Malta	√	√	
Netherlands	√		
Norway	not applicable		
Poland	√	√	√
Portugal	√		
Romania	not applicable	√	√
Slovakia		√	
Slovenia	√		√
Spain		√	
Sweden			
Switzerland			
United Kingdom		√	

Countries ticked off in the table are only those, who actually returned a "single country score sheet" with comments. With few exceptions, simpler forms of feedback on a limited number of indicators has been had from all but a handful of countries – several of those returning a full score sheet in 2007, have sent simpler responses this year.

Score sheets sent out to national agencies contained only the scores for that respective country. Corrections were accepted only in the form of actual data, not by national agencies just changing a score (frequently from red to something better, but surprisingly often honesty prevailed and scores were revised downwards).

9.10 Threshold value settings

It has not been our ambition to establish a global, scientifically based principle for threshold values to score green, amber or red on the different indicators. Threshold levels have been set after studying the actual parameter value spreads, in order to avoid having indicators showing "all Green" or "totally Red".

Also, the HCP believes that Patient Organisation involvement in healthcare decision making is a good idea. This indicator was included in 2006, with no country scoring Green. In 2008, Green score is attained by Belgium, Estonia, Germany, Hungary, Ireland, Lithuania, the Netherlands, Poland and Slovakia and on this indicator. (Incidentally, patient organisation involvement was made law in Germany in November of 2004, but not until 2008 did this reflect in the responses to the Patient View survey.)

Setting threshold values is typically done by studying a bar graph of country data values on an indicator sorted in ascending order. The usually "S"-shaped curve yielded by that is studied for notches in the curve, which can distinguish clusters of states, and such notches are often taken as starting values for scores.

A slight preference is also given to threshold values with even numbers. An example of this is the **Cancer 5-year survival** indicator, where the cut-offs for Green and Amber were set at 60 % and 50 % respectively, with the result that only four states score Green.

The performance of national healthcare systems was graded on a three-grade scale for each indicator (see more information in Scoring section).

For each of the five sub-disciplines, the country score was calculated as a percentage of the maximum possible (e.g., for prevention, the score for a state has been calculated as percent of the maximum: 8 x 3 = 24).

Thereafter, the sub-discipline scores were multiplied by the weight coefficients given in the following section and added to make the total country score. The scores thus obtained were multiplied by (1000/the sum of weights; see Section 5.2.1) and rounded to a three digit integer, giving a score system where a state with "all Green" would receive 1000 points (and "all Red" 333 points).

One (minor) reason for this somewhat complex scoring methodology has been driven by the "competition" element of the Heart Index, reducing the likelihood of two or more states ending up in a tied position. The "Eurovision Song Contest" method, for example, changed the score in the same direction after four countries tied for first place in 1969.

Finally, the HCP is a value-driven organisation. We believe in Patient/Consumer Empowerment, an approach that places highest importance on quantitative and qualitative healthcare services. As is illustrated by the "Quality information about care providers" indicator, this sometimes leads to the inclusion of indicators where only few countries, theoretically none, score green (in this case, only Denmark and the Netherlands do).

9.11 "CUTS" data sources

Whenever possible, research on data for individual indicators has endeavoured to find a "CUTS" (Comprehensive Uniform Trustworthy Source). If data on the underlying parameter behind an indicator is available for all or most of the 29 states from one single and reasonably reliable source, then there has been a definitive preference to base the scores on the CUTS. As CUTS would be considered EUCID data, WHO databases, OECD Health data, Special Eurobarometers, and scientific papers using well-defined and established methodology.

Apart from the sheer effectiveness of the approach, the basic reason for the concentration on CUTS, when available, is that data collection primarily based on information obtained from 31 national sources, even if those sources are official Ministry of Health or National Health/Statistics agencies, generally has high noise levels. It is notoriously difficult to obtain precise answers from many sources even when these sources are all answering the same question. For example, in the Euro Consumer Diabetes Index 2008, it was difficult to find answers to indicators like "Do you have nurse practitioners in your country?" or "Is diabetes foot (podiatrist) a recognized sub-speciality in your country?". The reason is very simple: the definition of what is a diabetes nurse or a diabetes podiatrist and the amount of education and training required to qualify are different in every country. It has to be emphasized that also when a CUTS for an indicator has been identified, the data are still reviewed through cross-check procedures, as there have frequently been occasions where national sources or scientific papers have been able to supply more recent and/or higher precision data.

9.11.1 The "Rolls-Royce gearbox" factor

Another reason for preferably using CUTS whenever possible is the same reason why Rolls-Royce (in their pre-BMW days) did not build their own gearboxes. The reason was stated as "We simply cannot build a better gearbox than those we can get from outside suppliers, and therefore we do not make them ourselves". For the small size organisation HCP, this same circumstance would be true for an indicator where a Eurobarometer question, the WHO HfA database, or another CUTS happens to cover an indicator.

9.12 Content of indicators in the EHCI 2008

The research team of the EuroHealth Consumer Index 2008 has been collecting data on 34 healthcare performance indicators, structured to a framework of six sub-disciplines. Each of these sub-disciplines reflects a certain logical entity, e.g. medical outcomes or E-health implementation.

This year, the indicators come numbered in the report, to provide more reader friendliness and clarity.

Where possible, CUTS - Comprehensive Uniform Trustworthy Sources - were used; see section "CUTS Data Sources" for more information on this approach, typical for HCP research work.

9.12.1 Patients' Rights and Information

This sub-discipline is testing the ability of a healthcare system to, basically, provide the patient with a status strong enough to diminish the information skew walling the professional and patient.

Why does HCP love this sub-discipline? Because it is a GDP non-dependent indicator's family. Even the poorest countries can allow themselves to grant the patient with a firm position within the healthcare system; and this year's EuroHealth Consumer Index is proving this observation again.

There are eight indicators in this sub-discipline:

1.1. Patients' Rights-based healthcare law

Is national healthcare legislation explicitly expressed in terms of patients' rights? By law or other legislative act? Are there professional ethical codes, patients' charters, etc.?

Sources of data: Personal interviews, web-based research, journals search. European Ethical-Legal Papers by KU Leuven. Non-CUTS data.

1.2. Patients' Organisations in decision making

Do patient organisations have right to participate in healthcare decision making? Sometimes we find that patient's organisations are welcomed to get involved, sometimes they do it by law, sometimes they do it only informally, but usually, sometimes only formally without a real participation, sometimes not at all.

Sources of data: Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Personal interviews. Non-CUTS data.

1.3. No-fault malpractice insurance

Can patients get compensation without the assistance of the judicial system? Does the compensation prerequisite proving who among the medical staff made a mistake? Each year, the HCP research staff is meeting high healthcare officials who have never heard of no-fault malpractice system, such as that put in place essentially in the Nordic countries.

Source of data: Personal interviews, web-based research, journals search. Non-CUTS data.

1.4. Right to second opinion

As in other areas of human life, there are not many questions and conditions with only one right answer, in medicine also. Therefore, do the patients have the right to get the

second opinion, without having to pay extra? Is it a formal right, but unusual practice, or well-established institute?

Sources of data: Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, Patient View 2005. Personal interviews. Non-CUTS data.

1.5. Access to own medical record

Can patients readily get access to, and read, their own medical records? Hard to believe, at some places in Europe, the patient's personal data and integrity is so protected, that he cannot access his own medical record. This is remarkable, as the Data protection directive is very clear on the fact that the patient should have this right by law. Elsewhere, he cannot access it neither, but at least he is not being told it is for his own good.

Sources of data: Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, Patient View 2005. Personal interviews; web and journal research. Non-CUTS data.

1.6. Register of legit doctors

Can the public readily access the information: "Is doctor X a bona fide specialist?" Has to be a web/telephone based service and we do not score green for Yellow pages – with an exception of Luxembourg, where the chapter on physicians is yearly reviewed and approved by the Ministry of health. Very easy and cheap to implement, but still very difficult to find sources of information.

Sources of data: Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2007. National physician registries. Personal interviews; web and journal research. Non-CUTS data.

1.7. Web or 24-7 telephone healthcare info

Simple description of this indicator used in previous years' editions remains the same in 2008: Information which can help a patient take decisions of the nature: "After consulting the service, I will take a paracetamol and wait and see" or "I will hurry to the A&E department of the nearest hospital" The most comprehensive service of this kind is the British NHS Direct.

Sources of data: Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Personal interviews, web search. Non-CUTS data.

1.8. Crossborder care information

HCP consciously and with pleasure uses data that imply other information than its explicit meaning. Thus, this indicator, described as "Percentage of responders mentioning the lack of information as a reason for being unprepared to seek for medical treatment in another EU country" (question from June 2007 Eurobarometer) provide us with information on individual state's ability to: first, make good marketing to its decisions in healthcare amongst the population; second, the level of motivation of the states to get

involved in providing/receiving care for citizens in trans-national settings. This is one of the indicators where we can find a widespread range of measured values (from 33% to 74%), meaning that the willingness of national governments to perform a good PR to cross-border healthcare is very different across Europe. Needless to say, that this interpretation could not be the only one and the HCP is fully aware that the indicator can have ambiguous explanations.

Sources of data: Cross-border health services in the EU. Eurobarometer, June 2007. CUTS data.

9.12.2 E-health

This is a new sub-discipline introduced to EHCI 2008. Healthcare which is supported by electronic processes and communication is healthcare aiming to provide evidence based and safe practice. Surprisingly, contrary to general beliefs, e-health implementation is not truly a question of national wealth, which is seen in these sub-discipline results. E-health reflects the new face of healthcare, with a high degree of information processing to ensure access, speed and safety.

2.1. Provider catalogue with quality ranking

In 2005, Dr. Foster of the UK was the single shining star on the firmament of provider (hospital) listing, where patients could actually see which hospitals had good results in term of actual success rates or survival percentages.

In 2007, there are already a few more examples, where the Health Consumer Powerhouse believes that the most notable is the Danish www.sundhedskvalitet.dk, where hospitals are graded from ★ to ★★★★★ as if they were hotels, with service level indicators as well as actual results, including case fatality rates on certain diagnoses. Perhaps the most impressive part of this system is that it allows members of the public to click down to a link giving the direct-dial telephone number of clinic managers.

Still, in 2008 "Dr. Foster" in the U.K. remains the standard European qualification for a green score (achieved also in Denmark), the "750 best clinics" published by LaPointe in France would warrant a yellow, as a nice attempt, as in three other countries. The rest of the countries are desperately red.

Sources of data: http://www.drfoster.co.uk/home.aspx ; http://www.sundhedskvalitet.dk/ ; http://www.sykehusvalg.no/sidemaler/VisStatiskInformasjon____2109.aspx ; http://www.hiqa.ie/ ; http://212.80.128.9/gestion/ges161000com.html . Non-CUTS data.

2.2. EPR penetration

Percentage of GP practices using computer for storage of individual patient diagnosis data.

Sources of data:
http://ec.europa.eu/public_opinion/flash/fl126_fr.pdf ;
http://www.europartnersearch.net/ist/communities/indexmapconso.php?Se=11 ;
www.icgp.ie ; Commonwealth Fund International Health Policy Survey of Primary Care

Physicians"Benchmarking ICT use among GP:s in Europe"; European Commission, April 2008; study made by Empirica, Bonn, Germany (p.60), Gartner Group. CUTS data.

2.3. e-transfer of medical data

Indicator similar to the previous one: percentage of GP practices using electronic networks for transfer of medical data to care providers /professionals.

Sources of data: "Benchmarking ICT use among GP:s in Europe"; European Commission, April 2008; study made by Empirica, Bonn, Germany (p.45). CUTS data.

2.4. e-prescriptions

What percentage of GP practices is using electronic networks for prescriptions to pharmacies?

Sources of data: "Benchmarking ICT use among GP:s in Europe"; European Commission, April 2008; study made by Empirica, Bonn, Germany (p.45). CUTS data.

9.12.3 Waiting times

3.1. Family doctor same day access

Testing a very reasonable demand: Can I count on seeing my primary care doctor today? This indicator basically shows that there is no explication for waitings in healthcare; the findings seem to be randomly placed in the matrix and we found no correlation with GDP nor the range of services provided, nor the density of primary care network. In some rather unexpected countries, the GP has even the obligation to answer the phone to every patient registered in his practice by 24/7.

Sources of data: Patients' Perspectives of Healthcare: Waiting times in Europe; survey commissioned by HCP 2008. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, Patient View 2005. Personal interviews; journal search. Non-CUTS data.

3.2. Direct access to specialist

Can patients see a specialist without first having to gain a referral from a primary-care doctor?

This indicator happens to be the most disputed of all in the history of HCP indexes. Although, or maybe consequently, we keep it and we must agree with the notion that "no significant effects of gatekeeping were found on the level of ambulatory care costs, or on the level or growth of total health care expenditure"[3]

[3] G Van Merode, A Paulus, P Groenewegen: Does general practitioner gatekeeping curb health care expenditure? J Health Serv Res Policy. 2000 Jan ;5 (1):22-6

See also Kroneman et al: Direct access in primary care and patient satisfaction: A European study. Health Policy 76 (2006) 72–79

Sources of data: Patients' Perspectives of Healthcare: Waiting times in Europe; survey commissioned by HCP 2008. Personal interviews with healthcare officials; http://www.im.dk/publikationer/healthcare_in_dk/healthcare.pdf ; http://www.ic.nhs.uk/ ; http://www.oecd.org . Non-CUTS data.

3.3 Major non-acute operations

What is the interval between diagnosis and treatment for a basket of coronary bypass/PTCA and hip/knee joint?

Sources of data: OECD data: Siciliani & Hurst, 2003 / 2004. Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2008. www.frittsykehusvalg.no; www.sst.dk ; http://www.im.dk/publikationer/healthcare_in_dk/healthcare.pdf ; http://sas.skl.se .

Non-CUTS data.

3.4 Cancer therapies

Time to get radiation/chemotherapy after decision.

Sources of data: OECD data: Siciliani & Hurst, 2003 / 2004. Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2008. www.frittsykehusvalg.no ; www.sst.dk ; http://www.sst.dk/Nyheder/Seneste_nyheder/Ventetider_straalebehl_uge23_24.aspx?l

Non-CUTS data.

3.5 MRI examinations

Time to get MRI scan after decision.

Sources of data: OECD data: Siciliani & Hurst, 2003 / 2004. Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2008. www.frittsykehusvalg.no ; www.sst.dk ; http://www.sst.dk/Nyheder/Seneste_nyheder/Ventetider_straalebehl_uge23_24.aspx?l

Non-CUTS data.

9.12.4 Outcomes

The Outcomes sub-discipline assesses the performance of different national healthcare systems when it comes to results of treatment. The healthcare professionals sometimes tend to think about the healthcare systems predominantly in the terms of outcomes – saying that what really counts, is the result. We do agree to some extent, and this is reflected in the weight attributed to the outcomes sub-discipline indicators.

4.1. Heart infarct mortality[4]

Data availability on this vital indicator is shockingly fragmented and incoherent over Europe. The OECD Health at a Glance Report (December 2007) lists this parameter. To illustrate the problem, the best number in Europe, 6.4% for Denmark, should be compared with official communication from the Danish Sundhedsstyret that the Danish number (Hjaerteregistret, 2004) is 15.5%. One explanation could be that the OECD asked for the "*in-hospital* 30-day case fatality", which is a different (and lower) number. The scores on this indicator are therefore based on a compilation of data from various sources and points in time (back to MONICA data), national registries and finally checked against the SDR:s for ischaemic heart disease – in this checkup, scores have been given a negative bias for states with high SDR:s (Standardized Death Rates), and *vice versa*. The logic behind that would be that if a country claims excellent case fatality rates, and still has high SDR:s it could be feared that this excellent care is not accessible to everybody.

Definitively non-CUTS data.

Sources of data: Compilation from OECD Health at a Glance; December 2007, MONICA, national heart registries. Non-CUTS data.

4.2. Infant deaths

Infant mortality rate is the number of infants dying before reaching one year of age, per 1,000 live births in a given year. In the well developed countries the increased infant mortality occurs primarily among very low birth weight infants, many of whom are born prematurely; in Europe, very low birth weight infants probably account for more than half of all infant deaths.

Sources of data: European health for all database (HFA-DB). CUTS data.

4.3. Cancer 5-year survival

What percentage of patients were alive 5 years after they were diagnosed with cancer (all types except skin)? The probability of the cancer recurrence after 5 years is usually small, therefore the 5 year survival remains the most suitable indicator of oncology care performance.

Sources of data: Eurocare 4; "A pan-European comparison regarding patient access to cancer drugs", Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm; http://www.breastcancer.org/press_cancer_facts.html ; http://info.cancerresearchuk.org/ ; www.ncri.ie . Non-CUTS data.

4.4. Years of life lost

All causes, Years lost per 100.000 population 0-69. Potential Years of Life Lost (PYLL), used by the OECD, take into account the age at which deaths occurs by giving greater weight to deaths at younger age and lower weight to deaths at older age.

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[4] This indicator and other cardiac care indicators are explained in detail in the Euro Consumer Heart Index 2008, Health Consumer Powerhouse AB, Brussels 2008, www.healthpowerhouse.com .

Potential Years of Life Lost are calculated from the number of deaths multiplied by a standard life expectancy at the age at which death occurs. PYLL is preferred as an indicator over and above the popular "Healthcare Amenable Deaths", as that indicator automatically gives low values to states with a low CVD death rate, such as the Mediterranean states.

The PYLL (Potential Years of Life Lost) is produced by the OECD, and consequently does not cover all the 31 countries in the EHCI. However, it was found that there is a strong correlation between PYLL and SDR (all causes), which can be obtained for all countries from the WHO: a linear regression calculation did confirm that the correlation (R-value) between the two is 93 %. Therefore, for non-OECD countries, the PYLL values are calculated as the function PYLL = K*SDR + M.

Sources of data: OECD Health Data 2008; Non-OECD: WHO HfA SDR all causes, all ages per 100 000. CUTS data.

4.5. MRSA infections

Percentage of hospital-acquired strains being resistant. The aim of this indicator is to assess the prevalence and spread of major invasive bacteria with clinically and epidemiologically relevant antimicrobial resistance. As in the previous year's indexes, The European Antimicrobial Resistance Surveillance System (EARSS) data is used. The data is collected by 800 public-health laboratories serving over 1300 hospitals in 31 European countries.

Sources of data: EARSS; Data from 2007; Croatia, Germany, Lithuania, Luxembourg, Malta 2008; Poland 2006; Slovakia 2005. For Macedonia (Skopje region): Cekovska et al: Incidence of Staphylococcus aureus isolated from patients treated at the clinical center of Skopje, Macedonia, with special attention to MRSA. Acta microbiologica et immunologica hungarica 2005, vol. 52, no3-4.

CUTS data.

4.6. Relative decline of suicide rate

Incline of e-log line for suicide SDR:s 1990 - latest available.

Since 2005, HCP has wanted to introduce an indicator on quality of psychiatric care. Due to substantial methodological and definitions problems, we rejected the usual indicators as psychiatric beds per population, mental disorders hospitalisation, drug sales and many others. The decline of suicide in a ten year period, e.g. since 1995, somehow returned, every year, to the expert panel's working sessions. But, adding to uncertain data reliability, there was a practical problem to solve: taking into account the enormous peak of suicide in Eastern European countries in 1991-1995, how to make the indicator fair for all the European region? This year, following long and vivid discussions, the indicator "inclination of e-log line for suicide SDR:s 1990 – l.a." is introduced, being fully aware of its interpretative limitations. The use of logarithmic values eliminates effects from countries having very different absolute suicide rates, i.e. countries lowering the suicide SDR from 4 to 3 get the same trend line as those lowering it from 40 to 30.

Sources of data: MINDFUL project, WHO HfA Mortality database. CUTS data.

4.7. % of diabetes patients with high HbA1c levels

Percentage of total diabetic population with HbA1c level above 7.

This indicator has been adapted from the Euro Consumer Diabetes Index[5]. It is an important assessment tool of how well diabetes has been managed on individual patients for the previous two or three months.

Sources of data: EUCID, Swedish National Diabetes Registry, Interviews with national diabetes experts and health care officials. Non-CUTS data.

9.12.5 Range of services provided

5.1. Cataract operations

Surgical procedures by ICD-CM, Cataract surgery, Total procedures performed divided by 100 000's of population over 65.

Cataract operations per 100 000 total population has been continuously used in previous EHCI editions as a proxy of capability of the healthcare systems to provide non-lifesaving care aimed to improve the quality of life of the patient. This year, it has been age-adjusted following a suggestion made by Irish officials (which is not surprising, as the former construction of the indicator would have disadvantaged Europe's youngest populations of Macedonia, Ireland and Romania).

Sources of data: OECD Health Data 2008; WHO Prevention of Blindness and Visual Impairment Programme; European Community Health Indicators; personal interviews. Non-CUTS data.

5.2. Infant 4-disease vaccination

Percentage of children vaccinated (Diphteria, tetanus, pertussis and poliomyelitis, arithmethic mean)

Sources of data: European health for all database; Data from 2006, except Croatia, Germany, Luxembourg, Netherlands, Slovenia, Switzerland (2005), France, Greece, Hungary, Romania (2004). CUTS data.

5.3 Kidney transplants

Procedures per million population. There is a commonly encountered notion that this number is greatly influenced by factors outside the control of healthcare systems, such as the number of traffic victims in a country. It must be judged that the primary explanation factors are inside healthcare, such as "the role and place of organ donation in anaesthesiologists' training", "the number of Intensive Care Unit beds p.m.p." etc.

Sources of data: OECD Health Data 2008; Council of Europe Newsletter 2006; Rozental R: Donation and transplantation in Latvia 2006. Ann Transplant. 2007;12(1):37-9; Croatian registry for renal replacement therapy. Personal interviews. Non-CUTS data.

[5]For more information, see Euro Consumer Diabetes Index 2008, Health Consumer Powerhouse AB, Brussels 2008. ISBN 978-91-976874-7-8

5.4. Dental care affordability

In the past years, a the very simple indicator "What percentage of public healthcare spend is made up by dental care?" was selected as a measure of affordability of dental care, on the logic that if dental care accounts for close to 10 % of total public healthcare expenditure, this must mean that dental care is essentially a part of a fair public healthcare offering.

This year, another Eurobarometer survey was used. This indicator was redesigned as "Percentage responding dental care to be "not at all affordable/not very affordable". For FYR Macedonia, we used the ratio of a dental filling co-payment to the price of a Big Mac at McDonald's in Skopje (c:a 5 EUR to 1,95 USD).

Sources of data: Eurobarometer 283, December 2007. CUTS data.

5.5. Mammography reach

Percentage of females aged 50-69 screened, latest data available. This indicator was introduced as a proxy of practical ability to organize and follow a simple screening on well-defined and easily reachable target population. Results are desperately variable across Europe: the target is set to 70 % (the HCP logic would say: why not 100 %?) and the actual values range from 10 % to 98 %.

Sources of data: OECD Health Data 2008; WHO World Health Survey 2006; personal interviews, journal search. Non-CUTS data.

5.6. Informal payments to doctors

Mean response to question: "Would patients be expected to make unofficial payments?" with range of answers: plain "No!", "Sometimes, depends on situation" and "Yes, frequently". A new indicator, introduced this year. As an informal payment was considered any payment made by the patient in addition to official co-payment. This survey on informal payments is the first cross-European survey done ever on this problem.

Sources of data: Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2008. Non-CUTS data.

9.12.6 Pharmaceuticals

6.1. Rx subsidy %

What percentage of total prescription drug sales is paid by subsidy?

Sources of data: http://www.efpia.org/6_publ/infigure2004h.pdf 2005 update? WHO Health for All database 2005; http://www.laegemiddelstyrelsen.dk/statistik/overvaagning/udgifter/2007-1/2007-1.asp .

Non-CUTS data.

6.2. Layman-adapted pharmacopeia

Is there a layman-adapted pharmacopeia readily accessible by the public (www or widely avaliable)?

Sources of data: Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2006. Personal interviews. LIF Sweden.
http://www.doctissimo.fr/html/sante/sante.htm ;
http://www.legemiddelverket.no/custom/templates/gzInterIFrame____1548.aspx

Non-CUTS data.

6.3. New cancer drugs deployment speed

Time scale classification used by Wilking & Jönsson.

Sources of data: "A pan-European comparison regarding patient access to cancer drugs", Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm 2007. CUTS data.

6.4. Access to new drugs (time to subsidy)

Interval between registration and inclusion in subsidy system.

Sources of data: Phase 6 Report Feb 2007. PATIENTS W.A.I.T. Indicator Commissioned by EFPIA. IMS Global Consulting. "A pan-European comparison regarding patient access to cancer drugs", Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm. CUTS data.

9.13 This is how the Euro Health Consumer Index 2008 was built

9.13.1 Strategy

The Index does not take into account whether a national healthcare system is publicly or privately funded and/or operated. The purpose is health consumer empowerment, not the promotion of political ideology. Aiming for dialogue and co-operation, the ambition of HCP is to be looked upon as a partner in developing healthcare around Europe.

9.14 Production phases

The EHCI 2008 was constructed under the following project plan.

9.14.1 Phase 1

Start-up meeting with the Expert Reference Panel - Mapping of existing data

The composition of the Expert panel can be found in the section 9.15. The major area of activity was to evaluate to what extent relevant information is available and accessible for the selected countries. The basic methods were:

- Web search, journal search

- Telephone and e-mail interviews with key individuals, and
- Personal visits when required.

Web search:
a) Relevant byelaws and policy documents
b) Actual outcome data in relation to policies

Information providers:

a) National and regional Health Authorities

b) Institutions (EHMA, Cochrane Institute, Picker Institute, University of York Health Economics, Legal-ethical papers of Catholic University in Leuwen, others)

c) Private enterprise (IMS Health, pharmaceutical industry, others)

Interviews (to evaluate findings from earlier sources, particularly to verify the real outcomes of policy decisions):
a) Phone and e-mail

b) Personal visits to key information providers

9.14.2 Phase 2

- Data collection to assemble presently available information to be included in the EHCI 2008.
- Identification of vital areas where additional information needed to be assembled was performed.
- Collection of raw data for these areas
- A round of personal visits by the researchers to Health Ministries and/or State Agencies for supervision and/or Quality Assurance of Healthcare Services.
- We kept regular contact with the Expert Reference Panel mainly to discuss the indicators, the criteria to define them, and the data acquisition problems. Finally, we had a second meeting on October 8th, in which we talked in detail about each of the indicators, including the ones that could not be included in the Index due to lack of data. Also, the discrepancies between data from different sources were analyzed.

9.14.3 Phase 3

9.14.3.1 Consulting European patient advocates and citizens through HCP survey performed by external research facility (Patient View, U.K.).

The EHCI survey contained of the questions found in Appendix 1 of this report and was committed in partnership with The Patient View (see also section Additional data

gathering - survey for more information). The closing date was October 31st; 833 responses were submitted.

9.14.3.2 "Score update sheet" send-out.

On October 8, 2008, all 31 states received their respective preliminary score sheets (with no reference to other states' scores) as an e-mail send-out asking for updates/corrections by October 31. The send-out was made to contacts at ministries/state agencies as advised by states during the contact efforts prior to October 2008. Two reminders were also sent out. Corrective feedback from states was accepted up until November 4th, by which time replies had been received from countries denoted in section Additional data gathering – feedback from National Ministries/Agencies for more information on national feedback.

9.14.4 Phase 4

Project presentation and reports

- A report describing the principles of how the EHCI 2008 was constructed.
- Presentation of EHCI 2008 at a press conference and seminar in Brussels.
- On-line launch on www.healthpowerhouse.com .

9.15 External expert reference panel

As is the standard working mode for all HCP Indexes, an external Expert Reference Panel was recruited. The panel met for two 6-hour sittings during the course of the project, the Panel Members having been sent the Index working material in advance. The following persons have taken part in the Expert Reference Panel Work:

Name	**Affiliation**
Juan Acosta, Chief Medical Officer	Best Doctors, Inc. (Europe), Madrid, Spain
Martin R. Cowie, Professor	National Heart and Lung Institute, Imperial College London, U.K.
Wilfried von Eiff, Professor Dr. Dr.	Centrum für Krankenhaus-Management, Universität Münster, Germany
Iva Holmerova, Asst. prof. MUDr.	Gerontologicke centrum and Charles University, Prague, Czech Republic
Danguole Jankauskiene, Asst. prof., Vicedean of Strategic management and policy department	Mykolas Romeris University, Vilnius, Lithuania
Meni Malliori, Ass. Prof of Psychiatry	Athens, Greece
Leonardo la Pietra, Chief Medical Officer	Eur Institute of Oncology, Milan, Italy

The Expert Reference Panel for a HCP Index has two core tasks:

A. To assist in the design and selection of sub-disciplines and indicators. This is obviously of vital importance for an Index, if the ambition is to be able to say that a state scoring well can truly be considered to have good, consumer-friendly healthcare services.

B. To review the final results of research undertaken by HCP researchers before the final scores are set. If the information obtained seems to clash too violently with the many decades of cardiac care experience represented by the panel members, this has been taken as a strong signal to do an extra review of the results.

The HCP wishes to extend its sincere thanks to the members of the panel for their fundamentally important contribution to the Index work, and for very valuable discussions.

10.FAQ:s

Why is the EHCI produced, and for whom?

The HCP provides the EHCI – as the title suggests – to empower consumers of healthcare services. HCP believes that increasing transparency in healthcare systems can only benefit consumers; insight into differing levels of performance will help healthcare delivery to improve all over.

The main audiences are those involved in healthcare policy formation: civil servants and clinicians and, of course, journalists. However, the HCP also continually strives to reach the consumer directly – hence the press launch!

Improved insight into to the standards of our European neighbours will support patient mobility within the EU.

It is called a Consumer Index – can consumers understand this information easily?

Rankings of consumer services – be it housing, mobile phones or cars – are increasingly becoming important news. Healthcare consumers have a clear interest in learning more to enable them to make the best possible choice.

Although HCP communicates a great deal of relatively complex information, HCP does so in a condensed way, and in a format that illustrates clearly the good and the bad. In addition, the HCP is working to ensure our information is as consumer-friendly as possible.

This is now the 4th year of the Index. What actual difference have the Index findings made to date?

The index has made concrete improvements to healthcare investment in a number of countries, For instance, following on our 2006 Index the Danish government added more money to improve Danish healthcare. In Ireland, the poor ranking 2006 caused a media outcry and intense political debate, pressuring for reform. In Sweden significant steps towards public ranking of healthcare have been taken following on our action.

One of the biggest differences the Index has made is to improve the transparency of information required to make such comparisons. This in turn improves the reliability of the Index.

The European Commission declares that transparency is essential elements to make European healthcare more efficient. There now seems to be an understanding that there is not only the patient perspective to take into regard but as well the citizens view of themselves as healthcare consumers. Policy makers have also rapidly accepted the concept that comparisons in healthcare performance increases transparency and supports consumer choice – two key ingredients to improve access and outcomes.

What kind of impact can be expected this year?

The HCP now expects governments to look into the findings, draw conclusions and take appropriate action to remedy the problems in their healthcare systems. Following on from our analysis, HCP has a set of recommendations addressing those areas that the Index has identified as severe problems.

What kind of action should governments take in those countries with low scores?

The whole set of recommendations can be found on the website www.healthpowerhouse.com.

It is not a simple as making blanket recommendations for low-scoring countries; therefore the HCP makes recommendations for each country, as each has its own specific challenges which they need to face; some of these are failings which are common to many healthcare systems (lack of information, access to new medicines). The logic behind the granular nature of the index is to make it easy to see where the strengths and weaknesses are.

Can all countries really afford to follow the recommendations?

Once again, it differs from country to country. Some of the actions proposed do not cost much, such as introducing patients' rights-based legislation and transparent information systems. Other steps are more demanding, such as improving quality of outcomes or attacking hospital acquired 'killer bug' infections. Providing poor access to care, i.e. running long waiting lists, hardly saves money – it just postpones the costs and ignores the fact that waiting has a price for the patient (cost for suffering, treatments and medicines while waiting, sick-leave etc.).

How can the consumer use the Index?

The consumer can use the Index to learn about the strong and weak aspects of their national healthcare system. This can provide a foundation for making informed choices; for example if one needs to go abroad to find treatment. At the same time it also assists in building action to demand better access, improved quality of care or increased levels of information.

What will be the next step?

In a few years the HCP hopes to be providing distinct consumer services, such as guidebooks and report systems, which will provide hands-on support to care consumers. HCP is also working on pan-European disease-specific indexes, such as heart disease and diabetes. We hope to build a consistent information system for international healthcare.

Is it really possible to measure and compare healthcare in this way?

Absolutely. You can measure and compare in many ways; the HCP feels this approach has several advantages:

- Focuses on those measures which impact the ability of the consumers to best use the available healthcare services;
- Focuses on such aspects of healthcare delivery, which the medical profession, administrators, and/or regional or national politicians could actually do something about if they want to; and
- Highlights the differences between countries, helping consumers understand where they could and should reasonably expect more from their providers.

A recent report[6] from the Canadian Institute for Health Information and Statistics Canada describes the important issues for measuring and comparing healthcare systems.

Do WHO or the EU not already deliver this kind of data?

HCP data is complementary to theirs. The WHO and the EU provide statistical information, which the HCP also uses, but HCP wants qualitative data also. Their focus is on overall public health, the focus of the EHCI is on providing consumer information. The comparative analyses provided by the Index are not delivered by other institutions.

How reliable are EHCI data?

As reliable as the HCP can possibly make them. HCP brings data together from public statistics and our own investigations and research. The access to public data in many fields is not only slow but also appallingly poor around Europe. This means that for one country the latest data may be quite recent, for another one several years old. The HCP has a system to assess and validate all data, but of course there might be uncertain data. National Ministries of Health or state agencies are also been given the opportunity to correct/update/validate the results.

How are care consumers involved in the Index development process?

[6] Canadian Institute for Health Information, *Making Sense of Health Rankings*, (Ottawa, Ont.: CIHI, 2008).

The HCP would love to have national consumer organisations represented in our expert panels. Sadly, these groups seldom engage in healthcare matters. It means that HCP consults individual care consumers and patient organisations. The latter are included in a major study commissioned from Patient View. For next year, HCP hopes to involve consumers directly, through, for example, patient focus groups.

How are the indicators selected?

They are developed through dialogue with numerous stakeholders and the Index expert panels. Since the initial Index in 2005, the HCP has looked into five areas: patient rights and information, waiting times, medical outcomes, the generosity of the healthcare system and access to medicines.

How has the range of indicators changed?

Between 2006 and 2007 three indicators were excluded and four new ones introduced (and two pairs of indicators have been merged into one) after discussion with expert panels and authorities. For 2008, 6 new indicators and one subcategory has been added. There are more indicators the HCP would like to include, but often there are difficulties to access relevant data (see Index report). Also, for practical reasons the Index matrix has limits.

Some of the data used for the indicators is relatively dated; other sources are very current. Why such a variation?

The Index always uses "latest available" data. Highlighting the fact that such data can be quite dated is one purpose of the entire Index exercise. This is consumer information, and the philosophy is that presenting data – even where inconsistent – is better than saying nothing at all. This poor reporting of public data is mainly a challenge to European governments and institutions than part of an Index weakness. It highlights the situation that, for example, the most up-to-date information that Belgian nationals can access about their healthcare system is from 1997!

Differing weights are given to indicators. Why?

There are numerous surveys that show that patients generally value medical results quality and accessibility to healthcare as the most important aspects on healthcare services. This is true also for countries, where waiting list problems are moderate.

What is measured – public health or health care performance?

Definitely the latter. Governments, EU and WHO deliver data on public health – undeniably important at the policy level. For consumers, HCP finds that assessment of what is delivered by national healthcare is more relevant.

Is this really research?

The Euro Health Consumer Index is compiled consumer information. It is not clinical or quantative research and is not to be looked upon as research in the true academic sense.

Who is behind the EHCI?

The Index was initiated by, and is produced by, the Health Consumer Powerhouse, who holds the copyright to the EHCI. The HCP is a private healthcare analyst and information provider, registered in Sweden.

Who supports the EHCI?

The HCP accepts unrestricted research or educational grants from institutions and companies and also sell healthcare-related information in the competitive intelligence market. The HCP does not accept grants from any entities measured in the indexes.

11.References

11.1 Main sources

The main sources of input for the various indicators are given in Table 9.8 above. For all indicators, this information has been supplemented by interviews and discussions with healthcare officials in both the public and private sectors.

11.2 Useful links

Web search exercises have yielded useful complementary information from, among others, these websites:

http://www.aesgp.be/

http://www.wrongdiagnosis.com/a/amputation/stats-country_printer.htm

http://www.easd.org/

http://www.diabetes-journal-online.de/index.php?id=1

http://www.drfoster.co.uk/

http://www.rivm.nl/earss/

http://www.eudental.org/index.php?ID=2746

http://europa.eu/abc/governments/index_en.htm

http://europa.eu/pol/health/index_en.htm

http://ec.europa.eu/public_opinion/index_en.htm

http://europa.eu.int/youreurope/index_sv.html

http://www.eurocare.it/

http://www.ehnheart.org/content/default.asp

http://www.euro.who.int/observatory

http://www.escardio.org/

http://epp.eurostat.cec.eu.int/portal/page?_pageid=1090,30070682,1090_33076576&_dad=portal&_schema=PORTAL

http://ec.europa.eu/health-eu/index_en.htm

http://www.who.dk/eprise/main/WHO/AboutWHO/About/MH#LVA (Health Ministries of Europe addresses)

http://www.hospitalcompare.hhs.gov/

http://www.hope.be/

http://www.activemag.co.uk/hhe/error.asp?m=2&productcode=&ptid=3&pid=2&pgid=34&spid= (Hospital Healthcare Europe)

http://www.idf.org/home/

http://www.eatlas.idf.org/

http://www.hospitalmanagement.net/

http://www.lsic.lt/html/en/lhic.htm (Lithuanian Health Info Centre)

http://www.lse.ac.uk/collections/LSEHealthAndSocialCare/

http://www.medscape.com/businessmedicine

http://www.oecdbookshop.org/oecd/display.asp?TAG=XK4VX8XX598X398888IX8V&CID=&LANG=EN&SF1=DI&ST1=5LH0L0PQZ5WK#OtherLanguages (OECD Health Data 2005)

http://www.oecd.org/department/0,2688,en_2649_33929_1_1_1_1_1,00.html (OECD Health Policy & Data Department)

http://www.medscape.com/medline/abstract/15176130 (Patient Ombudsmen in Europe)

http://aitel.hist.no/~walterk/wkeim/patients.htm (Patients' Rights Laws in Europe)

http://www.patient-view.com/hscnetwork.htm

http://www.pickereurope.org/

http://www.vlada.si/index.php?gr1=min&gr2=minMzd&gr3=&gr4=&id=&lng=eng (Slovenia Health Ministry)

http://www.lmi.no/tf/2004/Engelsk/Chapter%206/6.20.htm (Tall og fakta)

http://www.100tophospitals.com/

http://www.worldcongress.com/presentations/?confCOde=NW615

http://www.who.int/healthinfo/statistics/mortestimatesofdeathbycause/en/index.html

http://www.who.int/topics/en/

http://www.who.int/healthinfo/statistics/mortdata/en/

http://www.euro.who.int/hfadb (WHO "Health for All" database)

http://www.who.dk/healthinfo/FocalPoints (addresses to Health Statistics contacts in Europe)

http://www.who.int/genomics/public/patientrights/en/

http://www.waml.ws/home.asp (World Association of Medical Law)

http://www.wrongdiagnosis.com/risk/geography.htm

Annex 1: Source document for the Patients' Rights Indicator **(in addition to feedback from national authorities).**

Patients' Rights Laws

Country	**Name with Link**	**Language**
Finland, 1992	**Lag om patientens ställning och rättigheter** (785/1992): http://www.mhbibl.aland.fi/patient/patientlag.html	Swedish
Netherlands, 1994	**Dutch Medical Treatment Act 1994**: http://home.planet.nl/~privacy1/wgbo.htm	English
Israel, 1996	**Patient´s Rights Act**: http://waml.haifa.ac.il/index/reference/legislation/israel/israel1.htm	English
Lithuania, 1996	**Law on the Rights of Patients and Damage Done to Patients:** http://www3.lrs.lt/c-bin/eng/preps2?Condition1=111935&Condition2=	English
Iceland, 1997	**Lög um réttindi sjúklinga**: http://www.althingi.is/lagas/123a/1997074.html	Swedish
Latvia, 1997	**Law of Medicine** (= The law on medical treatment): http://aitel.hist.no/~walterk/wkeim/files/Latvia_The_law_of_Medicine.htm	English
Hungary, 1997	**Rights and Obligations of Patients** (According to Act CLIV of 1997 on Public Health): http://www.eum.hu/index.php?akt_menu=4863. The Szószóló Foundation supports patients' rights.	Hungarian / English
Greece, 1997	**Law 2519/21-8-97**	
Denmark, 1998	**Lov om patienters retsstilling, LOV nr 482 af 01/07/1998**	
Norway, 1999	**Pasientrettighetsloven**: http://www.lovdata.no/all/hl-19990702-063.html. Other Norwegian Health laws.	Norwegian
Georgia, 2000	**The Law of Georgia on the Rights of patients**	
France, 2002	**LOI n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé (1):** http://www.legifrance.gouv.fr/WAspad/UnTexteDeJorf?numjo=mesx0100092l#	French
Belgium, 2002	**Act on Patients' Rights**: http://www.lachambre.be/	Dutch / French
Switzerland,	**Patientenrechtverordnung 1991, Patientenrechtsgesetz ist in**	German

2003	**Vorbereitung**: http://www.zh.ch/gd/aktuell/news/presseberichte/news_21_12_00_1a.htm	
Russia	**Fundamentals of The Russian Federation Legislation**: On protection of citizens' health.	
Estonia, 2002	**Draft of the Act on Patients' Rights PATSIENDISEADUS:** http://www.riigikogu.ee/	Estonian
Romania, 2003	**Legea nr 46/2003, legea drepturilor pacientului (Law of Patients' Rights)**: http://www.dreptonline.ro/legislatie/legea_drepturilor_pacientului.php	Romanian
Cyprus, 2005	**European Ethical-Legal Papers N° 6 Patient Rights in Greece**: http://www.eurogentest.org/web/info/public/unit4/ethical_legal_papers.xhtml#legal_5	English

Charters of the Rights of Patients

Country	Name with Link	Language
France 1974 and 1995	Charte du Patient Hospitalisé: http://www.ch-erstein.fr/charte/chartepatient.html	French
UK, (1991), 1997	The Patient's Charter for England: http://www.pfc.org.uk/medical/pchrt-e1.htm	English
Czech Republic, 1992		
Spain, 1994	Charter of Rights and Duties of Patients	
Ireland, 1995	Charter of Rights for Hospital Patients	
South Africa, 1996	PATIENTS RIGHTS CHARTER: http://www.hst.org.za/doh/rights_chart.htm	English
Portugal, 1997	Patients' Rights Charter: Carta dos Direitos e Deveres dos Doentes http://www.dgsaude.pt	Portuguese
Honk Kong, 1999	Patients' Charter: http://www.ha.org.hk/charter/pceng.htm	English
Poland, 1999	Karta Praw Pacjenta: http://wojtas_goz.webpark.pl/karta.html Polish Patients Association: Letter to Commissioner for Human Rights.	Polish
Slovakia, 2001	Charter on the Patients Rights in the Slovak Republic: http://www.eubios.info/EJ143/ej143e.htm	English
Austria,	Vereinbarung zur Sicherstellung der Patientenrechte (Patientencharta): http://www.noel.gv.at/service/politik/landtag/LandtagsvorlagenXV/We	German

2001	itereVorlagenXV/795/795V.doc	
Germany, 2001	Experts support patients' rights law: Sachverständigenrat tritt für Patientenrechte-Gesetz ein. The German health system is most expensive in EU, but only under average (World Health Report 2000: Rank 25) in quality of services. Petition der Bundesarbeitsgemeinschaft der Notgemeinschaften Medizingeschädigter: http://www.patientenunterstuetzung.de/Grundsaetzliches/Petition.pdf	German
Cyprus, 2001	Cyprus Patients Rights' Charter: http://www.activecitizenship.net/documenti/Cyprus Charter Patients' Rights.doc	English
Germany, 2002	Patientenrechtscharta: http://www.bag-selbsthilfe.de/archiv/jahr-2002/patientencharta/patientenrechte-in-deutschland/	German
Europe, 2002	Active Citizenship Network: European Charter of Patients Rights http://www.activecitizenship.net/projects/europ_chart.htm	English
Italy	Active Citizenship Network: Italian Charter of Patients Rights http://www.activecitizenship.net/health/italian_charter.pdf	English

Six years after the WHO *Declaration on the Promotion of Patients' Rights in Europe* (Amsterdam, 1994), more than eight countries (Denmark, Finland, Georgia, Greece, Iceland, Israel, Lithuania, the Netherlands and Norway) have enacted laws on the rights of patients; and four countries (France, Ireland, Portugal and the United Kingdom) have used Patients' Charters as a tool to promote patients' rights. (German version). *European Journal of Health Law* 7: 1-3, 2000: Lars Fallberg: Patients' Rights in Europe: Where do we stand and where do we go?

Appendix 1. Questionnaire used in the survey commissioned from Patient View for the Euro Health Consumer Index 2008.

SURVEY OBJECTIVE:
"To compare the extent to which the national healthcare systems of Europe take the patient and the consumer into consideration".

Dear health campaigner,
For the fourth year running, Health Consumer Powerhouse (HCP) is asking health campaigners across Europe to help it compile the annual EUROHEALTH CONSUMER INDEX. The Index is designed to measure the user-friendliness of national healthcare systems across Europe.
If you would like to contribute your views on the condition of your country's healthcare system in 2008, this year's questionnaire for the Index is short — only ten questions — and should take no more than about 5 (or, at most, 10) minutes of your time to complete. All responses will be anonymous. You will find the questions on the next four pages.

To thank you for contributing your opinions to the study, and to allow you to read the results, PatientView, the survey manager, will send you the weblink to the EuroHealth Consumer Index upon publication in October 2008. Also, if you are not already a member of the Health and Social Campaigners' Network International, PatientView will make you one.

The survey's closing date is Wednesday October 1st 2008 (but HCP would welcome your opinions before then, in order to draw up some initial trends).

Yours faithfully,
Johan Hjertqvist and Dr Arne Björnberg
Health Consumer Powerhouse
Brussels, Stockholm, and Winnipeg.

If you have any questions about this survey, please contact:
Louise Oatham,
PatientView,
Woodhouse Place,
Upper Woodhouse,
Knighton,
Powys, LD7 1NG, Wales
Tel: 0044-(0)1547-520-965
e-mail: info@patient-view.com

Question 1/10:
Can patients in your country readily get access to, and read, their own medical records? [Please specify only what you think is the single most-relevant option]

1. Yes, the information is readily available to patients.
2. The information available, but it is difficult for patients to obtain.
3. The information is available, but patients are only permitted to read it with an 'intermediary', such as a medical professional,
4. present to explain it.
5. No, patients in my country do not have access to such information.

Do you wish to add any comments on this subject?

Question 2/10:
Does your country have a healthcare information service that is publicly available, 24 hours a day, 7 days a week?
[The service could be web-based or a telephone service, and the sort of information it provides would help members of the public who consult it make decisions of the nature: "I will now take an aspirin, and wait to see if I get better", or "I must hurry to the A&E department of the nearest hospital".] [Please specify only what you think is the single most-relevant option]

1. Yes.
2. Such a service exists, but few members of the public know about it.

3. Such a service exists, but it is hard to access.
4. No.

Do you wish to add any comments on this subject?

Question 3/10:
Do patients in your country have the statutory right to request a second opinon on a non-trivial medical problem, without having to pay extra (except for any regular copayment fee for an appointment)? [Please specify only what you think is the single most-relevant option]

1. Yes.
2. Patients do have such a right, but it is difficult to access, due to a lack of information about the right given out to the public.
3. Patients do have such a right, but it is difficult to access, due to bureaucracy within the healthcare system.
4. Patients do have such a right, but medical professionals discourage patients from using it.
5. No.

Do you wish to add any comments on this subject?

Question 4/10:
Can I always get an appointment with my primary-care doctor today?
[Please specify only what you think is the single most-relevant option]

1. Yes, always.
2. Yes, but the doctor may not be the patient's own or usual doctor.
3. Yes, Monday to Friday, but not when the GP practice is closed (for instance at weekends and holidays).
4. Only in certain parts of the country.
5. Only if the patient is able to persuade the practice telephonist that they should be seen on the same day.
6. It depends on the medical condition.
7. The process of getting an appointment is bureaucratic.
8. No, a wait of more than one day is normal for all NON-EMERGENCY appointments.

Other/any comments?

Question 5/10:
Can patients in your country see a specialist without first having to gain a referral from a primary-care doctor? [Please specify only what you think is the single most-relevant option]

1. Yes.
2. Only in certain parts of the country.
3. Only if the patient is able to persuade the specialist's telephonist that they should be seen without going through a primary care doctor.
4. Only if the patient is willing to go through the healthcare system's bureaucratic processes.
5. It depends on the medical condition.
6. No.

Other/any comments?

Question 6/10:
Which of the following would be the more typical waiting time in your country for an operation for a NON-LIFE-THREATENING CONDITION, such as for a hip-joint replacement or a non-acute heart bypass?
[Please regard "waiting time" as the period between when a doctor/specialist decides that the operation is needed, and when the patient actually receives the operation — without the patient having to pay extra.]
[Please specify only what you think is the single most-relevant option]

1. The vast majority of patients (over 90%) would get the operation WITHIN three months.
2. Most patients (over 50%) would get the operation WITHIN three months.
3. Most patients (over 50%) would typically WAIT MORE THAN three months.

Other/any comments?

Question 7/10:
Which of the following would be the more TYPICAL waiting time in your country for chemotherapy or radiotherapy for cancer patients?
[Please regard "waiting time" as the period between when a doctor decides that treatment is needed, and when the patient actually receives it — without the patient having to pay extra.] [Please specify only what you think is the single most-relevant option]

1. The vast majority of patients (over 90%) would get the treatment WITHIN three weeks.
2. Most patients (over 50%) would get the treatment WITHIN three weeks.
3. Most patients (over 50%) would typically WAIT MORE THAN three weeks.

Other/any comments?

Question 8/10:
Which of the following would be the more TYPICAL waiting time in your country for a magnetic resonance imaging (MRI) scan? [Please regard "waiting time" as the period between when a doctor decides that an MRI scan is needed, and when the patient actually receives it — without the patient having to pay extra.]
[Please specify only what you think is the single most-relevant option]

1. Typically LESS THAN 7 days.
2. Typically MORE THAN 7 days, but LESS THAN 21 days.
3. Typically MORE THAN 21 days.

Other/any comments?

Question 9/10:
Are patient organisations in your country involved in healthcare decision making?
[Please specify only what you think is the single most-relevant option]

9a) At national/government level.
9b) At regional level.
9c) At local level.

- Yes.
- Sometimes (or perhaps only occasionally, in an advisory capacity).
- No.
- I do not know/not relevant.

Do you wish to add any comments on this subject?

The tenth and final question looks at one aspect of the financial probity of medical professionals:

Question 10/10:
Would patients in your country be expected to make unofficial payments [sometimes described as 'under-the table' payments] to doctors for their services (in addition to any official co-payment of appointment fees)?
[Please specify only what you think is the single most-relevant option]

1. Yes, frequently.
2. Sometimes/it depends on the services provided, or on the doctor.
3. No.

Any comments you wish to make on this subject?