



Health Consumer
Powerhouse



European Commission
Information Society and Media



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Euro Health Consumer Index 2009

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2009

Report

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The flying Dutchman reigns European healthcare as the inequity gap grows

This 5th annual edition of the Euro Health Consumer Index, is offering a user-focused, performance-related comparison of 33 national healthcare systems.

The most remarkable outcome is no doubt the outstanding position of the Dutch healthcare, indicating that the ongoing healthcare reform now pays off. Can we imagine a new “model” gaining a lead, similar to the impact from the British NHS in the 1950’s and 60’s?

The Dutch progress is essential from another point of view: the strategic role of the health consumer created by the reform. It combines competition for funding and provision within a regulated framework. There are information tools to support active choice among consumers. The Netherlands started to work on patient empowerment early, which now clearly pays off in many areas.

The Dutch are not alone in the systematic efforts to engage patients and consumers using choice and information. The most prominent European healthcare systems all move in this direction, which contributes to the growing healthcare divide indicated by this year’s Index. Most Central and Eastern European healthcare systems lose *rank*, although they almost all score more *points* in the Index every year. And this might be a very real manifestation of the financial crisis and the competition among healthcare approaches: some healthcare systems move ahead, driven by not only economic wealth but good policy as well, while others move slower, thus failing to meet the growing needs and expectations of the citizens.

The signals of expanding inequalities in healthcare following on the financial crisis challenge EU principles of solidarity and equity. It is not only a matter of money but attitude. With patient mobility growing around Europe, there is a strong need for transparency exposing the pros and cons of the national healthcare systems. The EU intends to introduce a cross-border care scheme which requires significantly better information to patients. Qualities such as access to your medical record, second opinion and information about results produced by care providers have been slowly spreading. The trend of user empowerment makes provider catalogues and layman pharmacopoeias take off. Sensible policy integrates e-Health in this change, providing a spearhead to radically reduce costs, opening for rapid treatment access and patient safety advancement.

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 DG Information Society and Media for the support of this year’s Index, presented under the auspices of the Swedish EU Presidency.

Brussels, September 23, 2009

Johan Hjertqvist

President

Health Consumer Powerhouse

1. Summary

The 2009 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 2009 total ranking of healthcare systems shows an unprecedented landslide victory for The Netherlands, scoring 875 points out of 1000, 56 points ahead of runners-up Denmark at 819 points, followed by newcomers in the EHCI, Iceland, at 811 and Austria at 795.

The ranking was noticeably influenced by the 2008 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 e-solutions solutions for the transfer of medical information between professionals, and from professionals to patients. The *e-solutions for communication to patients* indicators are new for 2009, and very much show that essentially all of European healthcare still has a long way to go in the implementation of IT solutions in healthcare. No country scores all Green on the six e-Health indicators (see [Section 9.7](#) for explanation on scoring colours).

1.1 Some interesting countries

(not necessarily in Index score order).

1.1.1 The Netherlands!!!

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. The 2009 NL score of 875 points is by far the highest ever seen in a HCP Index. The NL shares the sub-discipline victory with Denmark only on e-Health and Pharmaceuticals, and the large victory margin seems essentially due to that the Dutch healthcare system does not seem to have any really weak spots, 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 it 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”.

1.1.1.1 So what are the Dutch doing right?

It has to be emphasized that the following discussion does contain a substantial amount of speculation outside of what can actually be derived from the EHCI scores:

The NL is characterized by a multitude of health insurance providers acting in competition, and being separate from caregivers/hospitals. Also, the NL probably has the best and most structured arrangement for patient organisation participation in healthcare decision and policymaking in Europe.

Here comes the speculation: one important net effect of the NL healthcare system structure would be that healthcare operative decisions are taken, to an unusually high degree, by medical professionals with patient co-participation. Financing agencies and healthcare amateurs such as politicians and bureaucrats seem farther removed from operative healthcare decisions in the NL than in almost any other European country. This could in itself be a major reason behind the NL landslide victory in the EHCI 2009.

1.1.1.2 So what, if anything, are the Dutch doing wrong?

The NL scores very well in all sub-disciplines, except Waiting times/Access, where the score is more mediocre. As was observed by Siciliani & Hurst of the OECD in 2003/2004, and in the EHCI 2005 – 2009, waiting lists for specialist treatment, paradoxically, exist mainly in countries having “GP gatekeeping” (the requirement of a referral from a primary care doctor to see a specialist).

GP gatekeeping, a “cornerstone of the Dutch healthcare system” (said to the HCP by a former Dutch Minister of Health) is widely believed to save costs, as well as providing a continuum of care, which is certainly beneficial to the patient. As can be seen from the references given in Section 9.12.3 on indicator 3.2, there is no evidence to support the cost-reducing hypothesis. Also, as can be seen in Section 5.1, the NL has risen in healthcare spend to actually having the *highest per capita spend in Europe* (outside of what the HCP internally calls “the three rich bastards”; Norway, Switzerland and Luxembourg, who have a GDP per capita in a class of their own).

It could well be that the Netherlands would break the 900 points barrier by relaxing the GP gatekeeping rules!

1.1.2 Denmark

Denmark did gain a lot from the introduction of the e-Health sub-discipline. Denmark has been on a continuous rise since it was first included in the EHCI 2006. Denmark is doing particularly well on Patient Rights and Information, being one of only three countries (not the same three) scoring Green both on Free choice of caregiver in the EU and on having a hospital registry on the Internet showing which hospitals have the best medical results. Mainly for this reason, Denmark is outdistancing its Nordic neighbours in the EHCI, in spite of having a slightly lower score on Outcomes than these.

1.1.3 Iceland

Due to its location in the North Atlantic, Iceland has been forced to build a system of healthcare services, which has the capability (not dimensions!) of a system serving a couple of million people, which is serving only 300 000 Icelanders. The Icelandic bronze medal did not come as a surprise to the HCP research team.

Lacking its own specialist qualification training for doctors, Iceland does probably benefit from a system, which resembles the medieval rules for carpenters and masons: for a number of years after qualification, these craftsmen were forbidden to settle down, and forced to spend a number of years wandering around working for different builders. Naturally, they did learn a lot of different skills along the way. Young Icelandic doctors generally spend 8 – 10 years after graduation working in another country, and then frequently come back (and they do not

need to marry a master builder's widow to set up shop!). Not only do they learn a lot – they also get good contacts useful for complicated cases: the Icelandic doctor faced with a case not possible to handle in Iceland, typically picks up the phone and calls his/her ex-boss, or a skilled colleague, at a well-respected hospital and asks: Could you take this patient?, and frequently gets the reply: “Put him on a plane!

1.1.4 Germany – the “Mystery Country”

In 6th place with 787 points, Germany probably has the most restriction-free and consumer-oriented healthcare system in Europe, with patients allowed to seek almost any type of care they wish whenever they want it. The main reason Germany is not engaged in the fight for medals is the mediocrity of Outcomes (and “Germany” and “mediocre quality” are rarely heard in the same sentence!). This is probably due to a characteristic of the German healthcare system: a large number of rather small *general* hospitals, not specializing.

The “mystery” is: how is it possible to operate a restriction-free system, and not have healthcare costs run wild? As can be seen from the cost graph in Section 5.1, German healthcare costs are in the middle of the Western European countries.

Another speculative explanation: There are studies, that show that German doctors work harder; long hours and many appointments/operations per doctor per year. It is well known that hindering a German from working is difficult. Could the relatively good cost containment in German healthcare be explained simply be “German work ethic”? Unfortunately, the EHCI does not provide the answer.

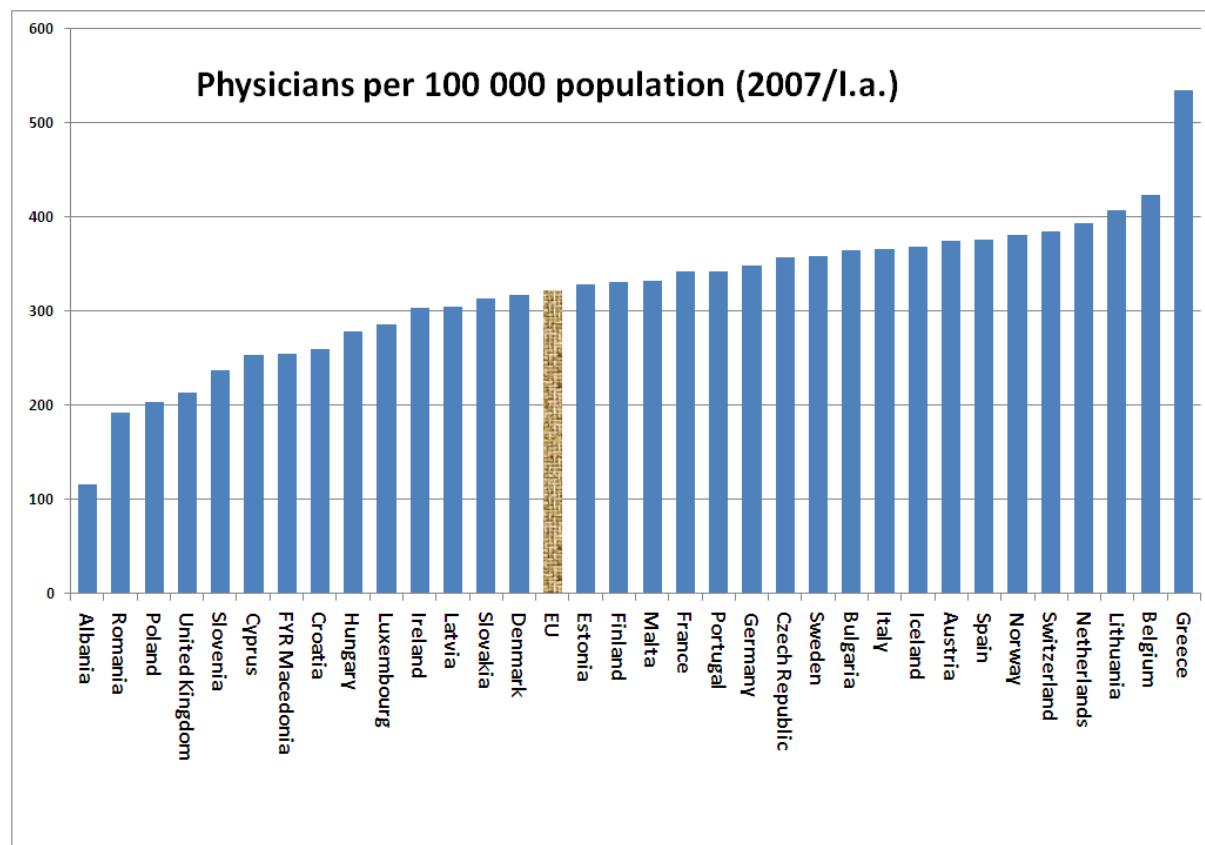
1.1.5 Ireland, Spain and Greece

In 13th, 21st and 23rd place respectively.

For the EHCI 2009, the HCP has had much better contact with national healthcare bodies than in previous years. For that reason, the Patient View survey to patient organizations, which provides part of the data for the EHCI, has essentially not been used as a single CUTS (see section 9.11) data source, but mainly as a “reality check”.

These three countries seem to have a domestic “marketing problem” for their healthcare services. This is particularly striking for Ireland, which after is HSE reform has been steadily climbing in the EHCI, but where the responses from patient organizations on issues such as waiting times are very negative still in 2009.

Greece leads Europe by a wide margin in the number of doctors per capita (below). Still the picture of Greek healthcare, painted by the patient organization responses, does not at all indicate any sort of healthy competition to provide superior healthcare services.



1.1.6 Albania

30th place, 562 points. Albania is included in the EHCI at the request of the Albanian Ministry of Health, who in a very nice e-mail wrote that “we might well finish last, but we want to be in there anyway”. Albania, as can be seen above and in Section 5.1, does have very limited healthcare resources. The country avoids ending up last chiefly due to a very strong performance on Access, where patient organizations confirmed the official ministry version that waiting times essentially do not exist. In fact, Albania tops the Waiting Times sub-discipline together with Belgium, Germany and Switzerland!

The ministry explanation for this was that “Albanians are a hardy lot, who only go to the doctor when carried there”, *i.e.* underutilization of the healthcare system. This is an oversimplification; Albanians visit their primary care doctor more than twice as often as Swedes (3.9 visits per year *vs.* 1.6)!

1.1.7 Sweden

8th place, 762 points. Still, the European champion on medical outcomes. For five years, it has not seemed to matter which indicators are tried on Outcomes (at least for rather serious conditions); Sweden keeps being the only country to score All Green.

At the same time, the notoriously poor accessibility situation seems very difficult to rectify, in spite of state government efforts to stimulate the decentralized county-operated healthcare system to shorten waiting lists. The HCP survey to patient organizations confirms the picture obtained from www.vantetider.se, that the targets for maximum waiting times, which on a European scale are very modest, are not really met. The target for maximum wait to see your

primary care doctor (no more than 7 days) is underachieved only by Portugal, where the corresponding figure is < 15 days.

Another way of expressing the vital question: Why can Albania operate its healthcare services with practically zero waiting times, and Sweden cannot?

1.1.8 Estonia

1½ million population Estonia has dropped rather dramatically; from an impressive 11th place overall in the 2008 Index (score 669) to 18th in 2009, with 638 points. What this might show is one of the few visible examples of the financial crisis hitting a healthcare system.

1.1.9 Croatia

22nd place, 627 points. As was assumed in the EHCI 2008 report, Croatia was then handicapped by numerous “not available” in the score matrix. What the HCP finds particularly encouraging is that data, which in 2008 was confined to the Croatian MoH, has since been released into the public domain, to the benefit of citizens and the EHCI score.

1.2 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 2006 – 2009, it is very hard to avoid noticing that the top consists 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. The largest Beveridge countries, the U.K. and Italy, keep clinging together in the middle of the Index. 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 – 2008, 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, since 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 2009 edition was released in May, 2009.
- The Euro Consumer Heart Index, launched in July 2008, 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 38 healthcare performance indicators for 33 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 – 2008 projects, the Euro Consumer Heart Index 2008 and numerous other Index projects.

Beatriz Cebolla, Ph.D.

After graduating in biochemistry, Dr. Cebolla has worked as a researcher for the last ten years and has been attached to various institutions relevant to the healthcare field. She completed her Ph.D. at the Biomedical Research Institute (IIB/CSIC) in Madrid and continued with a postdoctoral fellowship at the Institute for Molecular Pathology (IMP) in Vienna in Dr. Meinrad Buslinger's laboratory.

She has carried out several collaborations with other scientist groups working on cancer and diabetes and is currently studying a Master in International Public Health, and was also the Project Manager for the 2008 Euro Consumer Diabetes Index.

Sonja Lindblad, DIHR

Sonja Lindblad has been employed in various health care companies. She holds a teacher's degree and is presently working on her master degree in public health at the University of Stockholm. She has been engaged as researcher/project manager in several Swedish healthcare index projects.

3. Countries involved

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

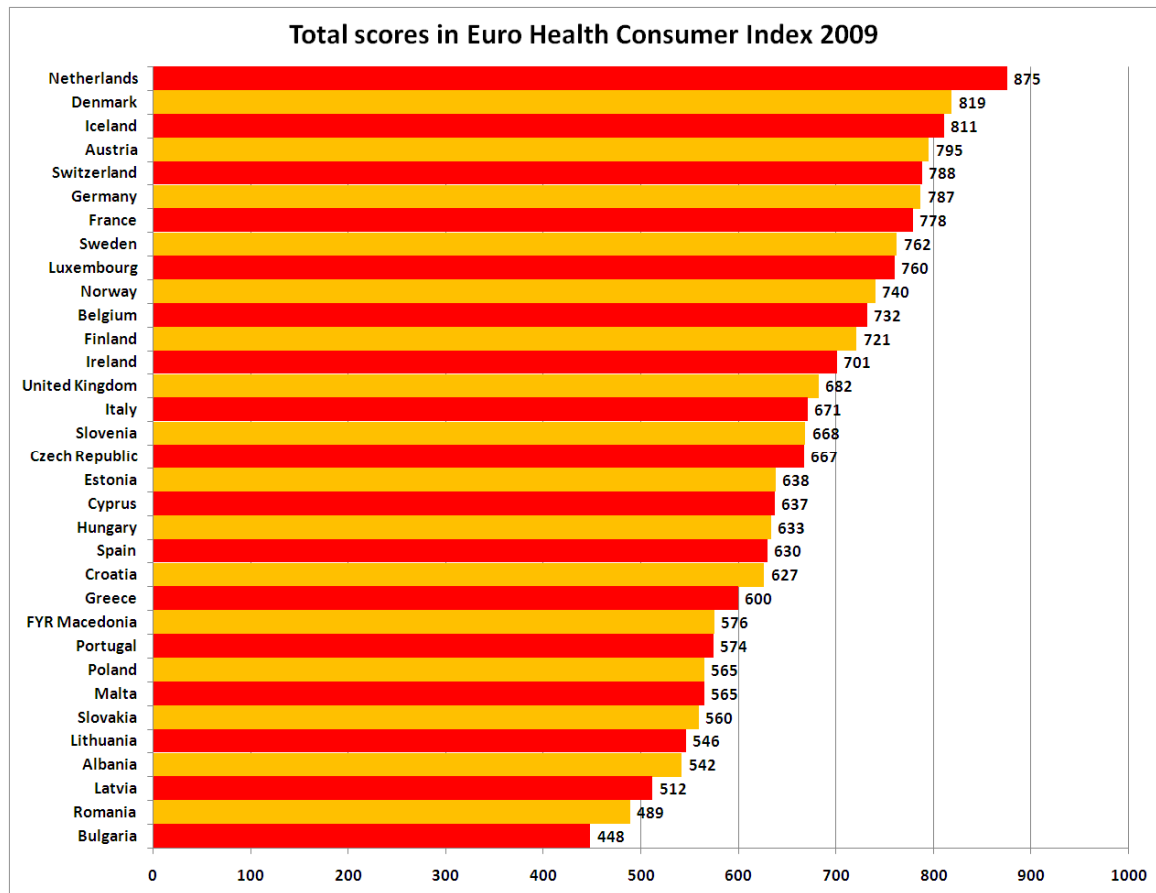
4. Results of the Euro Health Consumer Index 2009

EuroHealth Consumer Index 2009																			
Sub-discipline	Indicator	Albania	Austria	Belgium	Bulgaria	Croatia	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	FYR Macedonia	Germany	Greece	Hungary	Iceland	Ireland	
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 seeking financed from home	n.ap.	○	○	○	n.ap.	○	○	●	○	○	○	n.ap.	○	○	○	○	n.ap.	○
	1.9 Provider catalogue with quality ranking	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Subdiscipline weighted score	117	149	130	84	117	110	84	175	130	143	143	110	123	84	136	143	110	
2. e-Health	2.1 EPR penetration	○	○	○	●	●	○	○	●	○	○	○	○	○	○	○	○	○	○
	2.2 e-transfer of medical data between health professionals	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	2.3 Lab test results communicated direct to patients via e-health solutions?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	2.4 Do patients have access to on-line booking of appointments?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	2.5 on-line access to check how much doctors/clinics have charged insurers for	n.ap.	○	○	○	n.ap.	○	○	n.ap.	n.ap.	n.ap.	○	n.ap.	○	○	○	○	n.ap.	n.ap.
	2.6 e-prescriptions	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Subdiscipline weighted score	29	50	38	42	54	38	38	63	46	50	33	50	38	25	46	54	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	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	3.4 Cancer therapy < 21 days	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	3.5 CT scan < 7days	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Subdiscipline weighted score	187	173	187	120	120	160	133	120	120	93	173	160	187	147	147	173	120	
4. Outcomes	4.1 Heart infarct case fatality	○	○	○	○	○	○	○	○	○	○	○	n.a.	○	○	○	○	○	○
	4.2 Infant deaths	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	4.3 Ratio of cancer deaths to incidence 2006	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	4.4 Preventable Years of Life Lost	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	4.5 MRSA infections	○	○	○	○	○	○	○	○	○	○	○	n.a.	○	○	○	○	○	○
	4.6 Rate of decline of suicide	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	4.7 % of diabetics with high HbA1c levels (> 7)	○	○	○	n.a.	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Subdiscipline weighted score	95	190	155	95	143	155	190	202	143	226	202	107	214	190	119	226	202	
5. Range and reach of services provided	5.1 Equity of healthcare systems	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	5.2 Cataract operations per 100 000 age 65+	n.a.	○	○	○	○	○	○	○	○	○	○	n.a.	○	○	○	○	○	○
	5.3 Infant 4-disease vaccination	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	5.4 Kidney transplants per million pop.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	5.5 Is dental care included in the public healthcare offering?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	5.6 Rate of mammography	○	○	○	n.a.	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	5.7 Informal payments to doctors	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Subdiscipline weighted score	64	107	136	57	93	100	121	121	100	121	114	86	100	79	86	114	114	
6. Pharmaceuticals	6.1 Rx subsidy	n.a.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	6.2 Layman-adapted pharmacopeia?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	6.3 Novel cancer drugs deployment rate	○	○	○	○	n.a.	n.a.	○	○	○	○	○	n.a.	○	○	○	○	n.a.	○
	6.4 Access to new drugs (time to subsidy)	○	○	○	○	○	○	○	○	○	○	○	n.a.	○	○	○	○	○	○
	Subdiscipline weighted score	50	125	88	50	100	75	100	138	100	88	113	63	125	75	100	100	113	
Total score	542	795	732	448	627	637	667	819	638	721	778	576	787	600	633	811	701		
Rank	30	4	11	33	22	19	17	2	18	12	7	24	6	23	20	3	13		

EuroHealth Consumer Index 2009

Sub-discipline	Indicator	Italy	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 seeking financed from home	●	○	○	○	○	○	n.ap.	○	○	○	○	○	○	○	○	n.ap.	○
	1.9 Provider catalogue with quality ranking	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Subdiscipline weighted score	110	91	136	136	97	162	136	117	110	91	104	149	84	117	136	123	
2. e-Health	2.1 EPR penetration	●	○	○	○	○	●	●	○	○	○	○	○	○	○	○	○	
	2.2 e-transfer of medical data between health professionals	○	○	○	○	○	●	●	○	○	○	○	○	○	○	○	○	
	2.3 Lab test results communicated direct to patients via e-health solutions?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	2.4 Do patients have access to on-line booking of appointments?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	2.5 on-line access to check how much doctors/clinics have charged insurers for	n.ap.	n.ap.	n.ap.	○	n.ap.	○	n.ap.	n.ap.	n.ap.	○	○	n.ap.	n.ap.	n.ap.	○	n.ap.	
	2.6 e-prescriptions	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
Subdiscipline weighted score	33	29	38	38	29	63	50	38	46	25	29	38	42	54	46	54		
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 CT scan < 7days	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
Subdiscipline weighted score	120	120	120	173	120	147	107	107	80	120	133	120	93	93	187	80		
4. Outcomes	4.1 Heart infarct case fatality	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	4.2 Infant deaths	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	4.3 Ratio of cancer deaths to incidence 2006	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	4.4 Preventable Years of Life Lost	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	4.5 MRSA infections	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	4.6 Rate of decline of suicide	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	4.7 % of diabetics with high HbA1c levels (> 7)	○	○	○	○	n.a.	○	○	○	n.a.	n.a.	n.a.	○	○	○	n.a.	○	
Subdiscipline weighted score	214	131	131	202	131	238	226	131	131	107	95	155	179	250	214	179		
5. Range and reach of services provided	5.1 Equity of healthcare systems	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	5.2 Cataract operations per 100 000 age 65+	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	5.3 Infant 4-disease vaccination	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	5.4 Kidney transplants per million pop.	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	5.5 Is dental care included in the public healthcare offering?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	n.a.	○	
	5.6 Rate of mammography	○	○	○	○	n.a.	○	○	○	○	n.a.	○	○	○	○	○	○	
	5.7 Informal payments to doctors	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
Subdiscipline weighted score	93	79	71	136	100	129	121	86	107	71	86	107	107	136	93	121		
6. Pharmaceuticals	6.1 Rx subsidy	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	6.2 Layman-adapted pharmacopeia?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	6.3 Novel cancer drugs deployment rate	○	○	○	○	n.a.	○	○	○	○	○	○	○	○	○	○	○	
	6.4 Access to new drugs (time to subsidy)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	
	Subdiscipline weighted score	100	63	50	75	88	138	100	88	100	75	113	100	125	113	113	125	
Total score	671	512	546	760	565	875	740	565	574	489	560	668	630	762	788	682		
Rank	15	31	29	9	26	1	10	26	25	32	28	16	21	8	5	14		

4.1 Results Summary



This fifth 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 2009 total ranking of healthcare systems shows an even greater landslide victory for The Netherlands, scoring 875 points out of 1000, 56 points ahead of runners-up Denmark at 819 points, closely followed by newcomers Iceland at 811 points, and 2007 winners Austria in 4th place with 795 points.

This should not at all be dismissed as an effect of changing indicators, of which there are 38 in the EHCI 2009, up from 34 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 2009; "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 it 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 2009 could indeed be said to have “the best healthcare system in Europe”.

Denmark did gain a lot from the introduction of the e-Health sub-discipline. Non the less, as can be seen from the longitudinal analysis in Chapter 7, where the EHCI 2009 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 that Denmark emerged as the total winner of the Euro Consumer Diabetes Index 2008.

Bronze medallists are newcomers Iceland at 811 points.

In 4th place resides the 2007 winner Austria at 795 points; not doing as well on e-Health services but scoring the first ever full score in the pharmaceuticals sub-discipline. Switzerland comes in 5th at 788 points and Germany 6th at 787. 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.

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 accessibility situation seems to have improved again, with France in 7th place at 778 points.

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 8th place with 762 points.

For the second time, the EU candidate states of Croatia and FYR Macedonia have been included in the EHCI. In 2008, the scores of these countries were 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 is 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 Silver medal with ~850 points.

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!

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	Albania	Austria	Belgium	Bulgaria	Croatia	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	FYR Macedonia	Germany	Greece	Hungary	Iceland	Ireland	Italy	Latvia	Lithuania	Luxembourg	Malta	Netherlands	Norway	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	Switzerland	United Kingdom
1. Patient rights and information	117	149	130	84	117	110	84	175	130	143	143	110	123	84	136	143	110	110	91	136	136	97	162	136	117	110	91	104	149	84	117	136	123
2. e-Health	29	50	38	42	54	38	38	63	46	50	33	50	38	25	46	54	42	33	29	38	38	29	63	50	38	46	25	29	38	42	54	46	54
3. Waiting times	187	173	187	120	120	160	133	120	120	93	173	160	187	147	147	173	120	120	120	120	173	120	147	107	107	80	120	133	120	93	93	187	80
4. Outcomes	95	190	155	95	143	155	190	202	143	226	202	107	214	190	119	226	202	214	131	131	202	131	238	226	131	131	107	95	155	179	250	214	179
5. Range and reach of services	64	107	136	57	93	100	121	121	100	121	114	86	100	79	86	114	114	93	79	71	136	100	129	121	86	107	71	86	107	107	136	93	121
6. Pharmaceuticals	50	125	88	50	100	75	100	138	100	88	113	63	125	75	100	100	113	100	63	50	75	88	138	100	88	100	75	113	100	125	113	113	125
Total score	542	795	732	448	627	637	667	819	638	721	778	576	787	600	633	811	701	671	512	546	760	565	875	740	565	574	489	560	668	630	762	788	682
Rank	30	4	11	33	22	19	17	2	18	12	7	24	6	23	20	3	13	15	31	29	9	26	1	10	26	25	32	28	16	21	8	5	14

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 shared top scores on e-Health and Access to pharmaceuticals.

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 Albanian, Belgian, Austrian, German or Swiss standards can only be described as abysmal.

Sub-discipline	Top country/countries	Score	Maximum score
1. Patient rights and information	Denmark	175!	175
2. e-Health	Denmark, Netherlands	63	75
3. Waiting time for treatment	Albania, Belgium, Germany, Switzerland	187	200
4. Outcomes	Sweden	250!	250
5. Range and reach of services	Belgium, Luxembourg, Sweden	137	150
6. Pharmaceuticals	Denmark, Netherlands	138	150

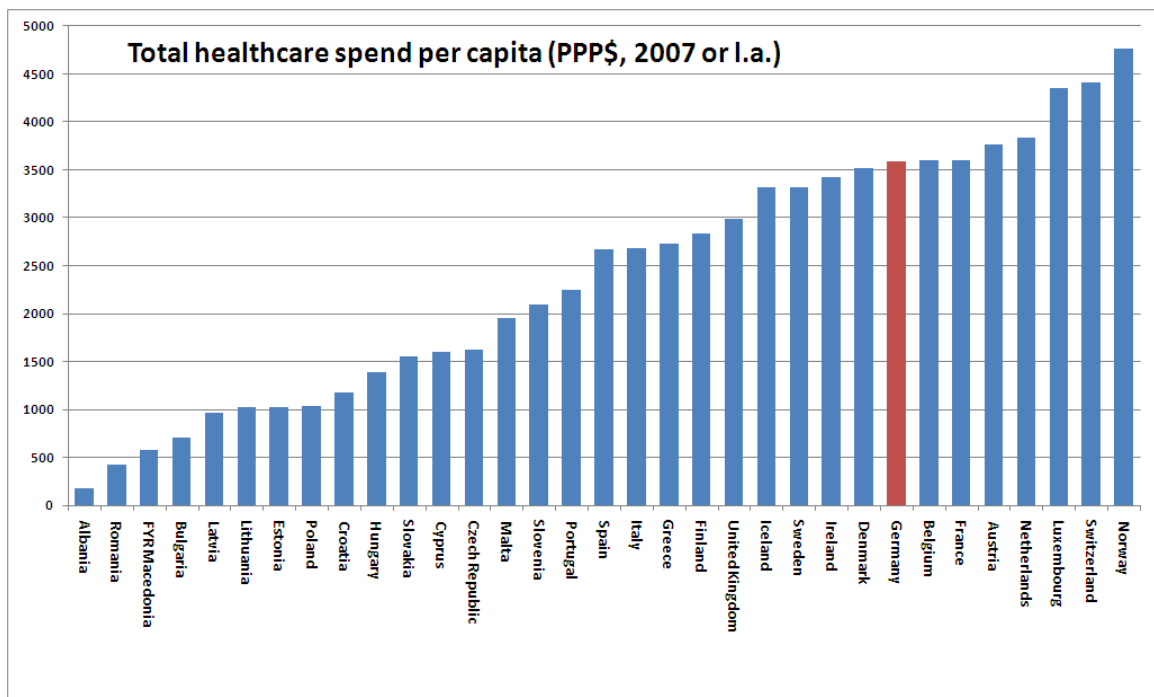
5. Bang-For-the-Buck adjusted scores

With all 27 EU member states and six 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 \$400 in Albania more than \$4000 in Norway, Switzerland, and Luxembourg. Continental Western Europe and Nordic countries generally fall between \$2700 and \$3700. As a separate exercise, the EHCI 2009 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 (Purchasing Power Parity) 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 (August 2009; latest available numbers, most frequently 2007) as illustrated in the graph below:



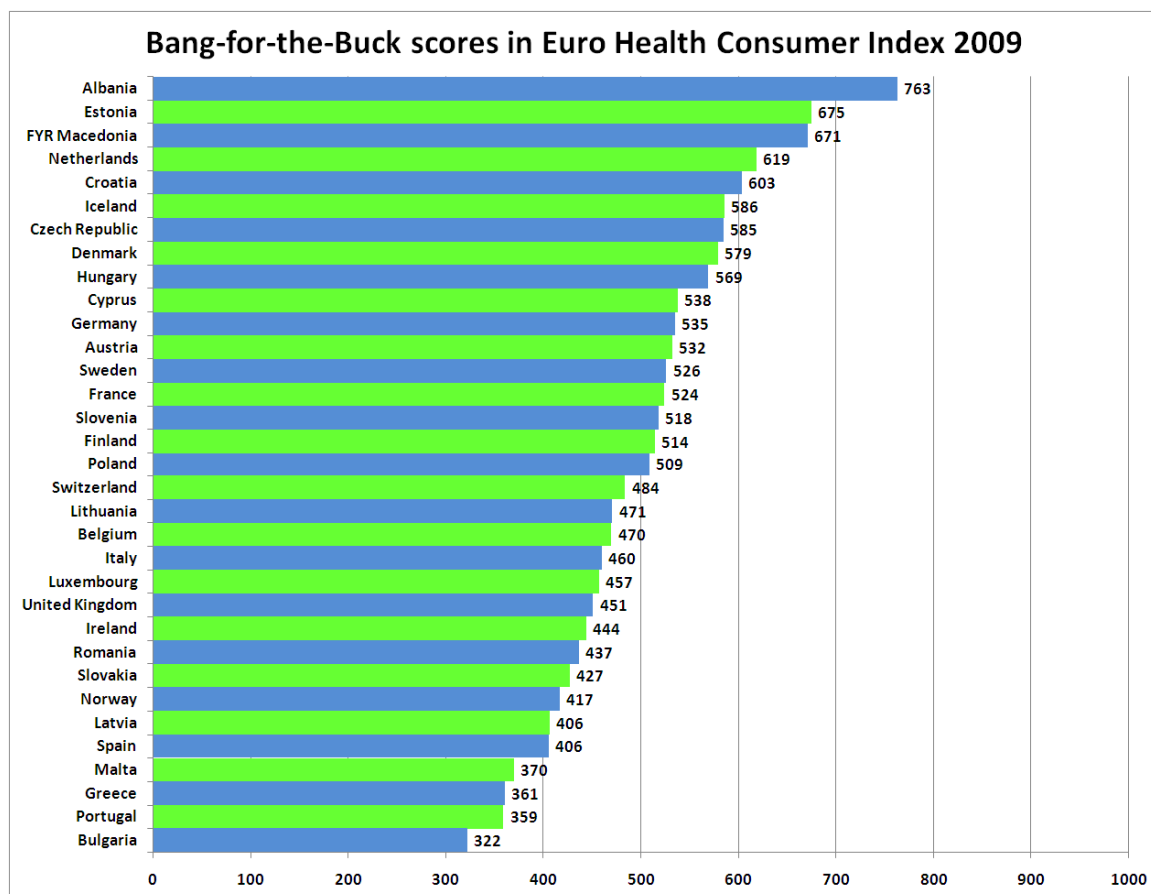
For countries not having a 2007 value in the database, the “latest available” number has been multiplied by the average % increase in the EU since the “latest available” year.

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 33 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 33 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. The BFB method is also a shade too blunt to accommodate countries, who have a very low healthcare spend, such as Albania and FYR Macedonia; particularly Albania's official healthcare spend is very modest. 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.

It is good to remember that Croatia (and FYR Macedonia) were handicapped by many “**n.a.s**” in the 2008 score sheet. The good position of Croatia in the B-F-B sheet is probably not just an artifact; Croatia does have “islands of excellence” in its healthcare system, and might well become a popular country for “health tourism”; there are few other places where a state-of-the-art hip joint operation can be had for €3000.

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, Iceland and Denmark. The U.K. has a less prominent position in the 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.

In public sector services (and also in private enterprise; *cf.* IBM in 1990!), the availability of a lot of money frequently results in decreasing cost effectiveness. This is probably illustrated by the modest positions of Ireland and Norway in the BFB scores.

5.3 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?

6. Trends over the five years

EHCI 2005 was a pilot attempt with only 12 countries and 20 indicators, and is hence not included in the longitudinal analysis.

6.1 Score changes 2006 - 2009

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

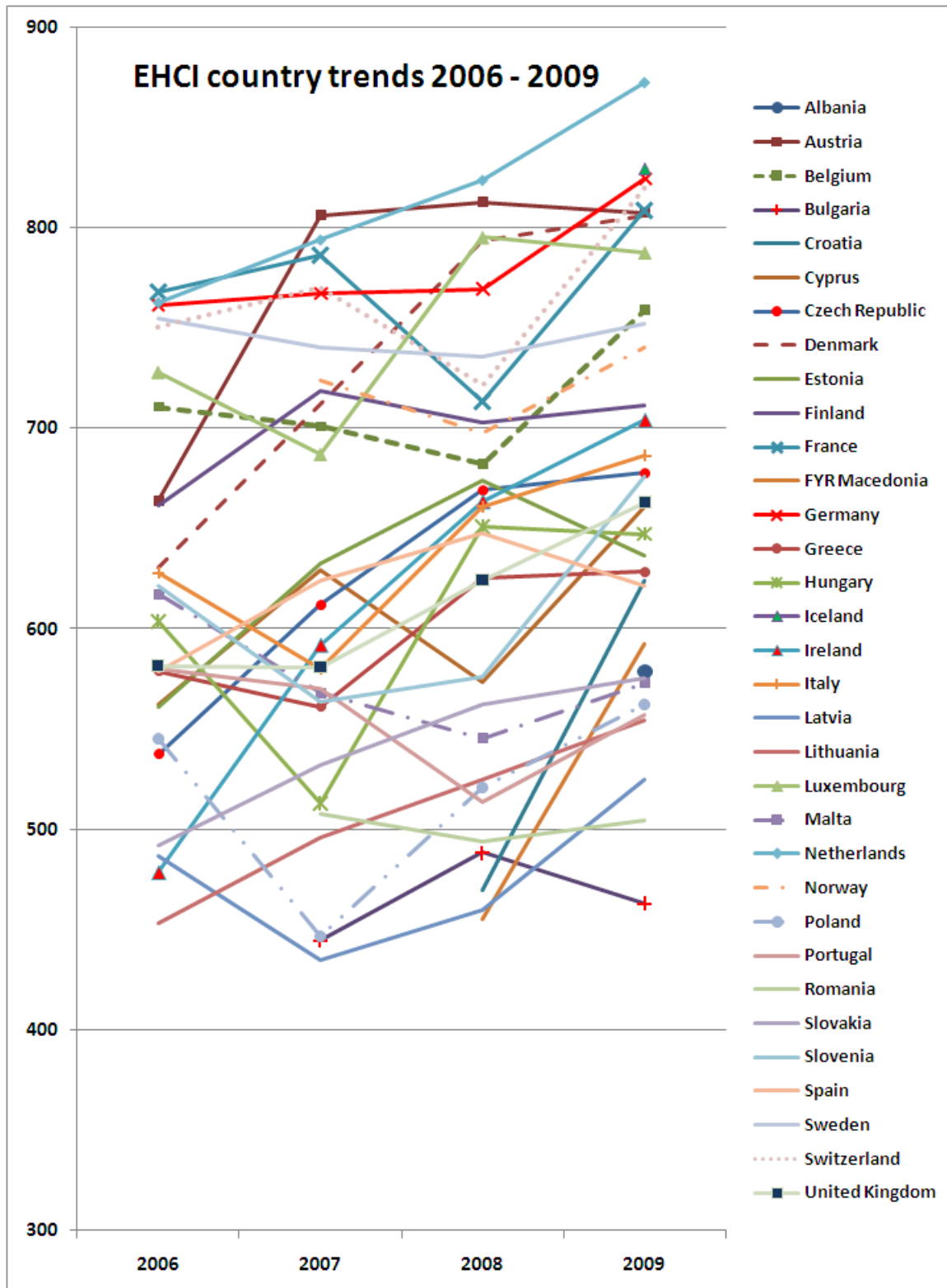


Figure 6.1. These results over the four years 2006 – 2009 have been normalized to all be calculated the same way as the EHCI 2007 (with its five sub-disciplines). This means that “2.1 EPR penetration” has been moved back to “1. Patients’ Rights and Information”, and the “e-Health” sub-discipline has been taken out. New additional indicators in sub-disciplines 4. Outcomes and 5. Range and Reach of services are in the 2008 and 2009 scores.

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 Malta 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:

The Netherlands: Found the keys to a truly consumer-friendly healthcare system?

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

Germany: Outcomes scores are creeping up from the “all Yellow” a couple of years ago. Will be a real top contender, if this trend continues.

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

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 got a Green score. This year, a high level of non-governmental patient's organisations involvement can be seen in Belgium, Croatia, Denmark, Estonia, France, Germany, Hungary, Lithuania, Netherlands, Norway, Poland, Slovakia and Switzerland, 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 in a two-page form and pay EUR 15 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 Biomedicine¹ 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.

¹Convention 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

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 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. Access to how much caregivers have charged for a person's care has been introduced – this is the only example of a country with a “monolithic” financing system having done this, and also nice attempts on 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.

In e-Health, some CEE countries have introduced applications, which are still rare in Western Europe. This is probably similar to the rapid uptake of mobile telephones in India – sometimes, it can be an advantage *not* to have had an ancient technology established.

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.

Germany has joined the limited ranks of countries (now 3!) scoring Green by the power of state company Bundesgeschäftsstelle Qualitätssicherung GGmbH, www.bqs-online.de, which also provides results quality information on a great number of German hospitals.

This year, we can find not-so-perfect, but already existing catalogues with quality ranking in Cyprus, France, Hungary, FYR Macedonia, Italy (regional; Tuscany *et al.*), Netherlands, Norway, Portugal 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 13 countries, also 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. Contrary to popular belief, direct access to specialist care does not generate access problems to specialists by the increased demand; repeatedly, waiting times for specialist care 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. On the contrary, UK patient organizations in 2009 have been surprisingly negative in their responses to the Waiting times questions!

Furthermore, even the strong winners of past years' rankings are turning to restrictive measures: France, for example, was restraining access in 2007, which resulted in waiting times, and therefore worse score (together with not really brilliant results in the e-Health sub-discipline). In 2009, French patients (and doctors?) seem to have learned to work the new regulations, as the French survey responses on this sub-discipline were very positive.

Even more notable: one of the indicators, introduced for the first time in 2008, 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 section [Informal payments to doctors](#).

In this context, HCP will continue to advocate the free choice, equal and direct access and measures intended to diminish the information handicap of the consumer as cornerstones of 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, good 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 inertia to any change. 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.

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.

Three countries, where the opinions of patient organizations are deviating negatively from official statistics, are Greece, Ireland and Spain. One example: Spanish regulations do give patients the right to read their own patient records – nevertheless, Spanish patient organizations returned the most pessimistic responses to this survey question of any of the 33 countries.

6.9 MRSA spread

In the EHCI 2007, 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 significant improvement can be seen are Bulgaria, Poland and the British Isles. In addition, both the newly included Candidates countries face the MRSA spread as well.

Only 7 countries out of 33 can say that MRSA is not a major problem, thus scoring Green.

6.9.1 Ban sales of antibiotics without prescription!

There is one measure, which could be very effective against the spread of microbial resistance; the banning of sales of antibiotics without a prescription. There is no country, where this practice is commonplace, which does *not* have a significant resistance problem!

7. How to interpret the Index results?

The first and most important consideration on how to treat the results is: with caution!

The Euro Health Consumer Index 2009 is an attempt at measuring and ranking the performance of healthcare 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 2009 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 2009 results can serve as inspiration for how and where European healthcare can be improved.

8. European data shortage

8.1 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)

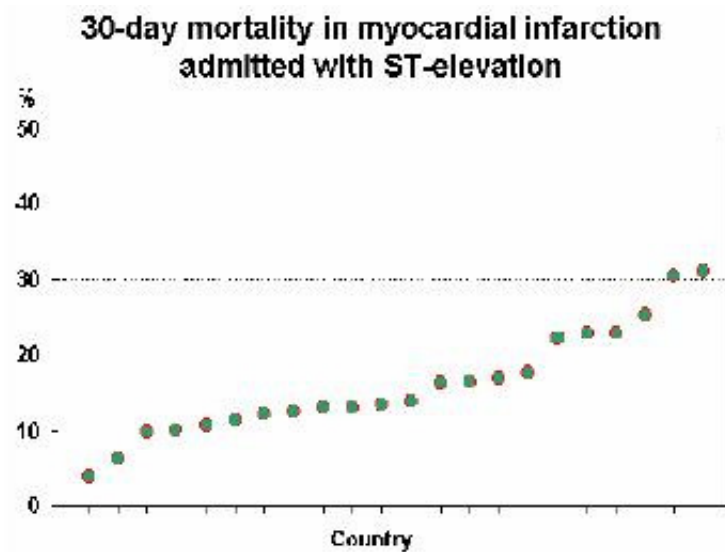
Systems with a history of funding structures based on grant schemes and global budgeting often exhibit a management culture, where monitoring and follow-up is more or less entirely focused on input factors. Such factors can be staff numbers, costs of all kinds (though not usually put in relation to output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

One chosen quality indicator has been: 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 originally 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 and a few more countries 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, which will in all likelihood remedy the lack of outcomes data in this very vital field.

9. Evolvement of the Euro Health 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 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 – 2009

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, in 2009 called "Range and reach of services". 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 – 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.

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 previous EHCI editions. 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, was good in 2006 – 2008. Written responses were received from 19 EU member states. This situation greatly improved in 2009 (see section 9.9.2).

9.3 EHCI 2009

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 2008 set

Of the totally 34 indicators used for the EHCI 2008, none has been discontinued in the 2009 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 indicators introduced for EHCI 2009

In the design and selection of indicators, the EHCI has been working on the following three criteria since 2005:

1. Relevance
2. Scientific soundness
3. Feasibility (*i.e.* can data be obtained)

The HCP team was happy to learn that those same three principles are also governing the new German quality indicators project, www.bqs-online.de.

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

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 "Hospital admissions for asthma" (a high number giving a Red score) had to be discarded due to the chaos of diagnosis differentiation between asthma, COPD, bronchitis and possibly other ailments.

Nevertheless, the research team was able to present data for six new/modified indicators.

For description and more details on the indicators, see section ["Content of indicators in the EHCI 2009"](#).

Sub-discipline 1 (Patient rights and information)

1.8. Cross border care seeking

1.9 Provider catalogue with quality ranking; this was moved back from the e-Health sub-discipline into sub-discipline 1 (where it used to reside 2005 – 2007).

Sub-discipline 2 (e-Health)

This sub-discipline was introduced to highlight the fact that the largest, most information-intensive industry in society (= healthcare) is incredibly under-developed in 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 three novel indicators:

2.3 Lab test results communicated direct to *patients* via e-health solutions?

2.4 Do patients have access to on-line booking of appointments?

2.5 on-line access to check how much doctors/clinics have charged insurers for your care?

Sub-discipline 4 (Outcomes)

4.3 "Ratio of cancer deaths to incidence 2006" replaced the previous Cancer 5-year survival indicator, as no fresh data could be found – the most recent are still the EURO CARE data on patients diagnosed 1995 – 1999.

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

5.1 Equity of healthcare systems

9.6 Indicator areas (sub-disciplines)

The 2009 Index is, just like in 2008, built up with indicators grouped in six sub-disciplines. After having had to surrender to the "lack of statistics syndrome", and after scrutiny by the [expert panel](#), 38 indicators survived into the EHCI 2009.

The indicator areas for the EHCI 2009 thus became:

Sub-discipline	Number of indicators
1. Patient rights and information	9
2. e-Health	6
3. Waiting time for treatment	5
4. Outcomes	7
5. Range and reach of services (“Generosity”)	7
6. Pharmaceuticals	4

9.7 Scoring in the EHCI 2009

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”, **n.a.**) earns 1 point.

The introduction of indicator “2.5 On-line access to check how much caregivers have charged for care give to an individual”, together with having six non-EU countries in the Index, which should not be stigmatized for not (yet) being EU member states on indicator “1.8 Free choice of care in another EU state”, forced the introduction of a new score in the EHCI 2009: “not applicable”. The numerous countries, who have tax-financed healthcare systems, have no insurers to charge. These countries therefore receive the “**n.ap.**” score, which earns 2 points. That score was also applied on indicator 1.8 for non-EU member states.

Since the 2006 Index the same methodology has been used: For each of the 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, so that an “All Green” score on the 38 indicators would yield 1000 points.

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 2009, 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	175	19.44
e-Health	75	12.50
Waiting time for treatment	200	40.00
Outcomes	250	35.71
Range and reach of services (“Generosity”)	150	21.43
Pharmaceuticals	150*)	37.50
Total sum of weights	1000	

*) 15 % is the typical share of European healthcare budgets going into pharmaceuticals

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 2009 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 HCP 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 NHS 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 than 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

It is important to note, that 2009 has been different from earlier EHCI editions in that the HCP has been receiving much more active feedback from national healthcare agencies in all but a few of the 33 countries. In those cases, the responses in the survey commissioned from Patient View 2009 have been applied very cautiously, *e.g.* when the “official” data says Green, and the survey says “definitely Red”, the country has been awarded a Yellow score.

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	http://europatientrights.eu/about_us.html ; Patients' Rights Law (Annex 1 to EHCI report); http://www.healthline.com/galecontent/patient-rights-1 ; http://www.adviceguide.org.uk/index/family_parent/health/nhs_patients_rights.htm ; www.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 organizations 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 2009. National healthcare agencies.
	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; (such as > 25% invalidity covered by the state)	No	Swedish National Patient Insurance Co. (All Nordic countries have no1 fault insurance); www.hse.ie ; www.higa.ie . In Austria, the Patientombudsman can award < kEUR 36 compensation. National healthcare agencies.
	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. National healthcare agencies.
	1.5 Access to own medical record	Can patients read their own medical records?	Yes, they get a copy by simply asking their doctor(s)	Yes, requires written application or only access with medical professional "walk-through"	No, no such statutory right.	Patients' Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2009. Health and Social Campaigners', News International: Users' perspectives on healthcare systems globally, Patient View 2005. National healthcare agencies; www.dohc.ie

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
	1.6 Register of legit doctors	Can the public readily access the info: "Is doctor X a <i>bona fide</i> specialist?"	Yes, on the www or in widely spread publication	Yes, but in publication expensive or cumbersome to acquire	No	Survey commissioned from Patient View by HCP 2009. National physician registries.; p://www.sst.dk/Tilsyn/Individuelt_tilsyn/Tilsyn_med_faglighed/Skaerpet_tilsyn_med_videre/Skaerpet_tilsyn/Liste.aspx; http://
	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 2009. National healthcare agencies; http://www.nhsdirect.nhs.uk/; www.hse.ie; www.ntpf.ie.
	1.8 Cross-border care seeking financed from home	Can patients choose to be treated in another EU state	Yes; including elective in-patient procedures	Yes, with pre-approval, but usually no problem, or limited to out-patient procedures	Yes, with pre-approval, or very limited choice (for care not given in home country)	Survey commissioned for Heart Index by HCP from Patient View 2009. National Healthcare agencies.
	1.9 Provider catalogue with quality ranking	"Dr. Foster" in the U.K. a typical qualification for a Green score. The "750 best clinics" published by LePoint in France would warrant a Yellow.	Yes	"not really", but nice attempts under way	No	http://www.drfooster.co.uk/home.aspx ; http://www.sundhedskvalitet.dk ; http://www.bgs-online.de ; http://www.sykehusvalg.no/sidemaler/VisStatiskInformasjon_2109.aspx ; http://www.higa.ie/ ; http://212.80.128.9/gestion/ges161000com.html . National healthcare agencies
2. e-Health	2.1 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
	2.2 e-transfer of medical data between health professionals	% 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
	2.3 Lab test results communicated direct to patients via e-health solutions?	Can patients receive test results either by e-mail or by logging on to personal web page?	Yes, widely available	Only from some pioneer hospitals/laboratories	No, or very rare	Survey commissioned by HCP from Patient View 2009. National healthcare agencies.
	2.4 Do patients have access to on-line booking of appointments?	Can patients book doctor appointments on-line?	Yes, widely available	Only from some pioneer hospitals/laboratories	No, or very rare	Survey commissioned by HCP from Patient View 2009. National healthcare agencies.
	2.5 on-line access to check how much doctors/clinics have charged insurers for your care?	Can patients check on-line how much caregivers have claimed from their health insurance?	Yes	For some caregivers, from some insurance providers, or "Not applicable" (e.g. in tax-financed systems)	No	Survey commissioned by HCP from Patient View 2009. National healthcare agencies.
	2.6 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
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	Survey commissioned from Patient View by HCP 2009. National healthcare agencies.
	3.2 Direct access to specialist	Without referral from family doctor (GP)	Yes	Quite often in reality, or for limited number of specialities	No	Survey commissioned by HCP from Patient View 2009. National healthcare agencies.

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
	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	Survey commissioned by HCP from Patient View 2009. National healthcare agencies,
	3.4 Cancer therapy < 21 days	Time to get radiation/ chemotherapy after decision	90% <21 days	50 - 90% <21 days	> 50% > 21 days	Survey commissioned by HCP from Patient View 2009. National healthcare agencies,
	3.5 CT scan < 7days		Typically <7 days	Typically <21 days	Typically > 21 days	Survey commissioned by HCP from Patient View 2009. National healthcare agencies,
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 August 2009, latest available statistics. http://globalis.gvu.unu.edu/indicator_detail.cfm?IndicatorID=25&Country=BE
	4.3 Ratio of cancer deaths to incidence 2006	Cancer deaths/number of new cancer cases (2006)	≤ 0.45	0.45 - 0.50	≥ 0.50	J. Ferlay et al., Annals of Oncology, 2007
	4.4 Preventable Years of Life Lost	All causes, Years lost, /100000 populat., 0-69	< 3300	3300 - 4500	>4500	OECD Health Data 2009; Non-OECD: WHO HfA Aug 2009: SDR all causes per 100000, ages 0-64
	4.5 MRSA infections	Susceptibility results for S. aureus isolates, %	<5%	<20%	>20%	EARSS, September 2009 (data for 2008).
	4.6 Rate of decline of suicide	Incline of e-log line for suicide SDR:s 1995 - l.a.	Strongly negative	Modestly negative	Positive (increased suicide rate)	MINDFUL, WHO HfA Mortality database, January 2009
	4.7 % of diabetics 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 Equity of healthcare systems	Public HC spend as % of total HC spend	≥ 80 %	<80 % - >70 %	≤ 70 %	WHO HfA database, Aug -09
	5.2 Cataract operations per 100 000 age 65+	Total number of procedures divided by 100 000's of pop. > 65 years	> 5000	5000 - 3000	< 3000	OECD Health Data 2009, WHO HfA database, Aug -09, WHO Prevention of Blindness and Visual Impairment Programme, European Community Health Indicators
	5.3 Infant 4-disease vaccination	Diphtheria, tetanus, pertussis and poliomyelitis, arithmetic mean	≥97 %	≥92 - <97%	<92 %	WHO HfA database, Aug -09
	5.4 Kidney transplants per million pop.	Living and deceased donors, procedures p.m.p.	≥ 40	40 - 30	< 30	OECD Health Data 2009, Council of Europe Newsletter 13/2008, Croatian registry for renal replacement therapy, Rozental R: Donation and transplantation in Latvia 2006.
	5.5 Is dental care included in the public healthcare offering?	Is dental care subsidized on essentially the same terms as somatic healthcare (pat:s 20 - 64)?	Yes, financially treated as other forms of healthcare	> 40 % of the cost reimbursed	Essentially a private affair for people 20 - 64	European Observatory HiT Reports, National healthcare agencies
	5.6 Rate of mammography	Percentage of females aged 50-69 screened, latest data available; European target is 70%.	≥ 80 %	<80 % - >60 %	≤ 60 %	OECD Health Data 2009; WHO World Health Survey 2006.
	5.7 Informal payments to doctors	Mean response to question: "Would patients be expected to make unofficial payments?"	No!	Sometimes; depends on the situation	Yes, frequently	Survey commissioned from Patient View by HCP 2009. National healthcare agencies.

Sub-discipline	Indicator	Comment	Score 3	Score 2	Score 1	Main Information Sources
6. Pharmaceuticals	6.1 Rx subsidy	Proportion of total sales of Rx drugs 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 : National healthcare agencies
	6.2 Layman-adapted pharmacopeia?	Is there a layman-adapted pharmacopeia readily accessible by the public (www or widely available)?	Yes	Yes, but not really easily accessible or frequently consulted	No	www.fass.se and other similar websites from other countries. National healthcare agencies.
	6.3 Novel cancer drugs deployment rate		More intense than EU average	Close to EU average	Less intense than EU average	"A pan-European comparison regarding patient access to cancer drugs", February 2009, Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm.
	6.4 Access to new drugs (time to subsidy)	Between registration and inclusion in subsidy system	<150 days	<300 days	>300 days	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. National healthcare agencies

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 2005 - 2008 Indexes, a web-based 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 2009, this survey included the five Waiting Time indicators, the new e-Health indicators plus the other indicators listed in [Appendix 1](#). A total of 602 patient organisations responded to the survey. The lowest number of responses from any single country was 4 (Albania and Iceland), except from FYR Macedonia, from where only one response was obtained.

2009 is different from previous EHCI editions in that the feedback from National Agencies has been a lot better and more ambitious in 2009 than ever before. For that reason, the responses from the PV survey have been used very cautiously when scoring the indicators. On any indicator, where the HCP has received substantial information from national sources (*i.e.* information including actual data to support a score), the PV survey results have only been used to modify the score based on national feedback data, when the PV survey responses indicate a radically different situation from that officially reported.

Consequently, unlike in 2008, the PV survey has essentially not been used as a CUTS data source (see section 9.11) for the waiting time indicators, and indeed not for any indicator (except 5.7 Informal payments do doctors). However, on the new e-Health indicators 2.4 and 2.5, the PV survey responses have been a very important source of information, as there is very little European (or indeed national) statistics available on those.

9.9.2 Additional data gathering – feedback from National Ministries/Agencies

On July 2nd, 2009, preliminary score sheets were sent out to Ministries of Health or state agencies of all 33 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 2009 by extensive mail, e-mail, telephone contacts and personal visits to ministries/agencies. Finally, feedback responses, in the form of returned “single country score sheets” and/or thorough discussions at personal visits to MoH:s/national agencies, have been had from official national sources as illustrated in the following table:

Country	Responded in 2006	Responded in 2007	Responded in 2008	Responded in 2009
Albania	not applicable	not applicable	not applicable	√
Austria		√	√	√
Belgium	√			√
Bulgaria	not applicable	√		√
Croatia	not applicable	not applicable	√	√
Cyprus	√			√
Czech Republic	√		√	
Denmark		√	√	√
Estonia	√	√	√	√
Finland	√	√	√	√
France		√		

Country	Responded in 2006	Responded in 2007	Responded in 2008	Responded in 2009
FYR Macedonia	not applicable	not applicable		√
Germany				
Greece			√	√
Hungary	√	√	√	√
Iceland	not applicable	not applicable	not applicable	√
Ireland		√	√	√
Italy				√
Latvia	√			√
Lithuania		√	√	√
Luxembourg		√	√	√
Malta	√	√		
Netherlands	√			√
Norway	not applicable			
Poland	√	√	√	√
Portugal	√			√
Romania	not applicable	√	√	√
Slovakia		√		
Slovenia	√		√	√
Spain		√		
Sweden				
Switzerland			√	
United Kingdom		√		

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 the 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”.

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.

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 six sub-disciplines, the country score was calculated as a percentage of the maximum possible (e.g., for Outcomes, the score for a state has been calculated as percent of the maximum: $7 \times 3 = 21$).

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 $(1000/\text{the sum of weights})$; 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, 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, Germany 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 33 national sources, even if those sources are official Ministry of Health or National Health/Statistics agencies, generally yields a high noise level. 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 2009

The research team of the Euro Health Consumer Index 2009 has been collecting data on 38 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.

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 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 family. Even the poorest countries can allow themselves to grant the patient with a firm position within the healthcare system; and this year's Euro Health Consumer Index is proving this observation again.

There are nine 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: http://europatientrights.eu/about_us.html ; Patients' Rights Law (Annex 1 to EHCI report); National healthcare agencies, web-based research, journals search. Non-CUTS data.

1.2 Patients' Organisations involved 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 2009. National healthcare agencies. 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: Swedish National Patient Insurance Co. (All Nordic countries have no1fault insurance); www.hse.ie; www.hiqa.ie. National healthcare agencies, 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 2009. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, Patient View 2005. National healthcare agencies. 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 2009. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, Patient View 2005. National healthcare agencies; 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 Yellow pages do not score Green – with an exception for 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 2009. National physician registries. National healthcare agencies; web and journal research. Non-CUTS data.

1.7 Web or 24-7 telephone healthcare info with interactivity

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 2009. National healthcare agencies, web search. Non-CUTS data.

1.8 Crossborder care seeking financed from home

After the spring 2009 EU directive on cross-border care, the indicator on cross-border mobility was reintroduced in the form it had in 2007. The only three countries scoring Green are Denmark, Luxembourg and the Netherlands. Denmark had its 2007 law on free mobility in the EU temporarily suspended between November 2008 and June 30, 2009, but that has now come back into effect. The Luxembourg Green might strike as “cheating”, but in the insourcing-prone public sectors, the LUX good common sense to refrain from building their own comprehensive healthcare services (which LUX certainly could have afforded), and let its citizens seek care in neighbouring countries, does deserve recognition.

Sources of data: Survey commissioned for Heart Index by HCP from Patient View 2009. National healthcare agencies.

1.9 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 2009, 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.

In 2009 the Danish www.sundhedskvalitet.dk remains the standard European qualification for a green score, the “750 best clinics” published by LaPointe in France would warrant a yellow, as a nice attempt, as in eight other countries. The rest of the countries are desperately red.

Sources of data: <http://www.drfooster.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>, www.bqs-online.de . Non-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 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.

2.2 e-transfer of medical data between health professionals

Indicator similar to the previous one: percentage of GP practices using electronic networks for transfer of medical data between 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.

2.3 Lab test results communicated direct to patients via e-health solutions?

What percentage of GP practices is using electronic networks for transferring medical data such as lab test results directly to patients? Could be e-mail, or a personal webpage which the patient could log on to. As seen in the EHCI, these solutions have been implemented very sparingly across Europe. In waiting list-free countries, there is frequently the argument that electronic communication between doctor and patient is "awful information quality", which is probably a major reason why Germany scores low on some e-Health Indicators.

Sources of data: Survey commissioned by HCP from Patient View 2009. National healthcare agencies.

2.4 Do patients have access to on-line booking of appointments?

The supply/demand ratio for specialist appointments or major surgery is very similar to that of hotel rooms or package holidays. There is no real reason why patients should not be able to book available "slots" at their convenience. This exists very sparingly in Europe; one of the only two Green scores goes to Portugal, where "4 million people in the Lisbon region" have access to this service. The other Green is Croatia – note the "Indian mobile telephone penetration" referred to above!

Sources of data: Survey commissioned by HCP from Patient View 2009. National healthcare agencies.

2.5 On-line access to check how much doctors/clinics have charged insurers for your care?

This service was introduced in the Czech Republic in 2007, and has had a few followers by 2009. In Austria and a couple of other countries, patient get this information on a paper "bill" when discharged from hospital; however, this does not count towards a

Green score on this e-Health indicator. Many tax-financed systems do not have any insurers being charged – the cowardly way out of this dilemma has been the introduction of the “**n.ap.**” score (“not applicable” = Yellow) not to unfairly stigmatize these countries. Hungary is an interesting country scoring Green while having a “monolithic” financing system: the reason is that the Hungarian government has wanted to enlist 10 million Hungarians as “auditors”, to help the government check up on hospital fraud!

Sources of data: Survey commissioned by HCP from Patient View 2009. National healthcare agencies.

2.6 e-prescriptions

What percentage of GP practices can send prescriptions electronically to pharmacies?

Sweden, with its centralized pharmacy system, is a role model: more than 70% of all prescriptions are sent to a central e-mailbox, and the patient can then walk into any pharmacy in the country, where they simply pull down the prescription from the mailbox.

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

9.12.3 Waiting time for treatment

3.1 Family doctor same day access

Testing a very reasonable demand: Can patients count on seeing a primary care doctor today, simply because the *patient* believes he/she needs to? This indicator basically shows that there is no explication for waiting times in primary care; the findings seem to be randomly placed in the matrix and there is 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 24 hours per day, 7. days a week.

Sources of data: Patients' Perspectives of Healthcare: Waiting times in Europe; survey commissioned by HCP 2009. Health and Social Campaigners' News International: Users' perspectives on healthcare systems globally, Patient View 2005. National healthcare agencies; 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, it has been kept since 2005, and seems to confirm 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

Sources of data: Patients' Perspectives of Healthcare: Waiting times in Europe; survey commissioned by HCP 2009. National healthcare agencies with healthcare officials; http://www.im.dk/publikationer/healthcare_in_dk/healthcare.pdf ; <http://www.ic.nhs.uk/> ; <http://www.oecd.org>, www.vantetider.se, . Non-CUTS data.

3.3 Major non-acute operations <90 days

What is the interval between diagnosis and treatment for a basket of coronary bypass/PTCA and hip/knee joint? It is difficult to avoid the observation that for countries, which *do* have official waiting time statistics (Ireland, Sweden, UK etc), this is in itself a not very flattering circumstance. Countries such as Germany, where waiting times tend to vary in the 2 – 3 weeks range, have never felt the urge to produce waiting time data, for principally the same type of reason that Madrid has less snow-ploughs than Helsinki.

Sources of data: Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2009. National healthcare agencies.

Non-CUTS data.

3.4 Cancer therapies < 21 days

Time to get radiation/chemotherapy after decision.

Sources of data: Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2009. National healthcare agencies. Non-CUTS data.

3.5 CT scan < 7days

As a representative for waiting times for advanced diagnostics was chosen Time to get a CT scan after decision. There proved to be some difficulty making respondents (in national healthcare agencies) not answer in terms of “acute” or “non-acute” examinations. Again, it has to be emphasized that waiting times for a CT scan is both poor service quality and also *increases* costs, not saving money, as the procedure of keeping track of patients for weeks/months is by no means costless, and the examination itself is if anything cheaper if the patient (and the care provider) has the underlying cause fresh in their minds.

Sources of data: Patients' Perspectives of Healthcare Waiting times in Europe; survey commissioned by HCP 2009. National healthcare agencies. Non-CUTS data.

³G 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

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 case fatality⁴

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. In Europe, with infant deaths normally counting below 6/1000, good check-ups during pregnancy and access to state-of-the-art delivery care are probably the key factors behind attaining really low numbers. Iceland has the lowest infant death rate on Earth, less than 2/1000.

Sources of data: WHO Europe Health for All mortality database August 2009, latest available statistics. CUTS data.

4.3. Ratio of cancer deaths to incidence 2006

The EHCI 2008 indicator on cancer outcomes was the more conventional 5-year survival rates of cancer (all types except skin). As no more recent (EURO CARE-4, patients diagnosed 1995 – 1999) data was available in 2009, the very comprehensive paper by J. Ferlay *et al*, listing cancer incidences and cancer deaths in 2006 for all 33 countries was

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.

chosen as 2009 indicator data. In this indicator, a ratio of less than 0.4 for Deaths/Incidence, would in principle be equal to a survival rate > 60%. Not surprisingly, there are more Green scores (11 vs. 4) based on the 2006 data than on the 5-year data on patients diagnosed in the 2nd half of the 1990's.

Sources of data: J. Ferlay et al., *Annals of Oncology*, 2007.

4.4 Preventable 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.

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 33 countries in the EHCI. However, it was found that there is a strong correlation between PYLL and SDR (all causes), ages 0 – 64, which can be obtained for all countries from the WHO: a linear regression calculation did confirm that the correlation (R-value) between the two was 97 %. Therefore, for non-OECD countries, the PYLL values are calculated as the function $PYLL = K * SDR + M$.

Sources of data: OECD Health Data 2009; Non-OECD: WHO HfA, August 2009, SDR all causes per 100000, ages 0-64. 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, August 2009. CUTS data.

4.6 Relative decline of suicide rate

Incline of e-log line for suicide SDR:s 1995 - 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 very significant peak of suicide in Eastern European countries in 1991-1995, how to make the indicator fair for all the European region? In 2008, following long and vivid discussions, the

indicator “inclination of e-log line for suicide SDR:s 1995 – l.a.” was 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, WHO HfA Mortality database, January 2009. 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 Index⁵. 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, Interviews with national diabetes experts and health care officials, National Diabetes Registries. Non-CUTS data.

9.12.5 Range and reach of services provided

5.1 Equity of healthcare systems

The simple indicator “What % of total healthcare spend is public?” has been introduced in 2009 as a measure on equity of healthcare systems. A few countries report 100% in the WHO database. These countries all get a Red score on indicator 5.7 (below). Therefore, the 100% did not survive the customary “*Do we believe this? test*” in the expert panel discussions, and 100% therefore gives a Red score. Also, Switzerland was judged to be a victim of the same kind of definition problems as pre-reform (2006) Netherlands, where on formal grounds a large part of the common health insurance was reported as private spend, and given a Green score. Sources of data: WHO HfA database, Aug -09

5.2 Cataract operations per 100 000 age 65+

Surgical procedures by ICD-CM, Cataract surgery, Total procedures performed on patients of all ages, but divided by 100 000’s of population over 65. Few cataracts are performed on patients under 65, and age-separated data is not available.

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. As of 2008, 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 2009, WHO HfA database, Aug -09, WHO Prevention of Blindness and Visual Impairment Programme, European Community Health Indicators

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

5.3 Infant 4-disease vaccination

Percentage of children vaccinated (Diphtheria, tetanus, pertussis and poliomyelitis, arithmetic mean).

Sources of data: WHO HfA database, Aug -09, National vaccination registries

5.4 Kidney transplants per million population

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 2009, Council of Europe Newsletter on Organ Donation and Transplantation, Vol 13, Sept. 2008, Croatian registry for renal replacement therapy, Rozental R: Donation and transplantation in Latvia 2006.

5.5 Is dental care included in the public healthcare offering?

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.

In 2008, an Eurobarometer survey was used. This indicator was redesigned as “Percentage responding dental care to be "not at all affordable/not very affordable"”.

In 2009, the data on this indicator is chiefly based on information from National healthcare agencies, with the actual question: “Is dental care subsidized on the same terms as somatic care, for patients aged 20 – 64?”

Sources of data: European Observatory HiT Reports, National healthcare agencies. Non-CUTS data.

5.6 Rate of mammography

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 2009; WHO World Health Survey 2006, WHO World Health Statistics 2009.

5.7 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". The indicator was first introduced in 2008. As an informal payment was considered any payment made by the patient in addition to official co-payment. That survey on informal payments was the first cross-European survey done ever on this problem, and was repeated in 2009, with highly compatible results compared with 2008.

Sources of data: Survey commissioned from Patient View by HCP 2009. National healthcare agencies. 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_publications/2004h.pdf 2005 update? WHO Health for All database 2005; <http://www.laegemiddelstyrelsen.dk/statistik/overvaagning/udgifter/2007-1/2007-1.asp> ., National healthcare agencies.

Non-CUTS data.

6.2 Layman-adapted pharmacopoeia

Is there a layman-adapted pharmacopoeia readily accessible by the public (www or widely available)? The existence of these (a comprehensive data collection on all drugs registered and offered for sale in a country, searchable both on chemical substance and brand name, and containing at least the same information as do the packing leaflets, written in a way to be understandable by non-professionals) has grown considerably from 2005, when essentially only Denmark and Sweden had them.

Sources of data: Survey commissioned from Patient View by HCP 2009. National healthcare agencies.

Non-CUTS data.

6.3 Novel cancer drugs deployment rate

This indicator measures the use, in DDD/100 000 inhabitants, of a basket of 21 latest-generation cancer drugs. The use of each drug has been indexed, and the indicator data is the average of those 21 indexes.

Sources of data: "A pan-European comparison regarding patient access to cancer drugs", February 2009, Nils Wilking & Bengt Jönsson, Karolinska Institute, Stockholm. CUTS data.

6.4. Access to new drugs (time to subsidy)

Time lag between registration of a drug, and the drug being included in the national 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.

9.13 How the Euro Health Consumer Index 2009 was built

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,, Picker Institute, Legal-ethical papers of Catholic University in Leuven, 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 2009.
- 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.
- 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 September 10th, 2009, at which was discussed in detail each of the indicators, including those that could not be included in the Index due to lack of data. Also, the discrepancies between data from different sources were analyzed. Sub-discipline relative weights were discussed and set.

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 survey was available on the Internet from June 7th in English, German, Spanish and Scandinavian (Swedish). The closing date was September 1st, 2009; 602 responses were submitted.

9.14.3.2 “Score update sheet” send-out.

On July 2, 2009, all 33 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 August 25. The send-out was made to contacts at ministries/state agencies as advised by states during the contact efforts prior to July 2009. One reminder was also sent out. Corrective feedback from states was accepted up until September 17, 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 for EHCI 2009:

Name	Affiliation
Martin R. Cowie, Professor	National Heart and Lung Institute, Imperial College London, U.K.
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
Ulrich Keil, Professor Dr. Dr.	Institut für Sozialmedizin, Universität Münster, Germany
Meni Malliori, Ass. Prof of Psychiatry	Athens, Greece
Leonardo la Pietra, Chief Medical Officer	Eur Institute of Oncology, Milan, Italy
Francisco Rodriguez Perera, Dr.	Best Doctors, Inc. (Europe), Madrid, Spain

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. References

10.1 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.

10.2 Useful links

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

<http://www.aesgp.be/>

<http://www.bqs-online.de>

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.drfooster.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)

www.fass.se

<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.sundhedskvalitet.dk>

<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.lovdato.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=mex0100092l#	French
Belgium, 2002	Act on Patients' Rights: http://www.lachambre.be/	Dutch / French
Switzerland, 1991	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/Grundsuetzliches/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.

How user friendly is your country's healthcare system in 2009?

About this survey

SURVEY OBJECTIVE:

"To compare the extent to which the national healthcare systems of Europe take the patient and the consumer into consideration in 2009".

Dear health campaigner,

For the fifth year running, Health Consumer Powerhouse (HCP) is asking health campaigners across Europe to help it compile the annual EURO HEALTH 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 2009, this year's questionnaire for the Index is short — only 15 questions — and should take no more than about 10 minutes of your time to complete. All responses will be anonymous. You will find the questions on the next 4 pages.

The survey's closing date is Tuesday August 25th 2009 (but HCP would welcome your opinions before then, in order to draw up some initial trends).

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 (if you wish) the weblink to the Euro Health Consumer Index upon publication on September 28th 2009.

Yours faithfully,
Dr Arne Björnberg and Dr Beatriz Cebolla
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, UK.
Tel: 0044-(0)1547-520-965
e-mail: info@patient-view.com

Questions 1 to 6: on patients rights' and information

1/15:

Are patient organisations in your country involved in healthcare decision-making?

(Such involvement might be at Ministry of Health level, or it might be at local government level.)

- Yes, patient groups in my country have a legal right/obligation to become involved.
- There is no legal right to become involved, but patient groups OFTEN DO (by common practice).
- There is no legal right to become involved, but patient groups OCCASIONALLY do, or RARELY do.
- Patient groups in my country DO NOT USUALLY become involved.

2/15:

Do patients in your country have the statutory right to request a second opinion on an important medical problem, without having to pay extra (except, perhaps, for any regular co-payment fee for an appointment)?

- Yes.
- Patients do have such a right, but it is difficult to access (perhaps due to a public lack of information about the right, or due to bureaucracy within the healthcare system, or because the healthcare system discourages patients from using such a right).
- No.

3/15:

Can patients in your country readily get access to, and read, their own medical records?

- Yes, simply by asking their doctor.
- The information is available, but the patient has to make a written application for it, or is only permitted to read it with an 'intermediary', such as a medical professional, present to explain it.
- No, patients in my country do not have access to such information.

4/15:

Can patients in your country readily get access to information about whether their doctor (or any other doctor in their country) is a legitimate, bona fide, qualified healthcare professional?

- Yes, the information is readily available on the Internet or in a well-known free publication.
- The information is available, but the patient has to pay for it (or the information is, in some other way, difficult to access).
- No, patients in my country do not have access to such information.

5/15:

Does your country have a web-based or a telephone healthcare information service that is publicly available in all parts of the country, runs 24 hours a day/7 days a week, and is interactive? [The sort of information that the service provides could typically be: "Take an aspirin, and wait to see if you get better", or "You must hurry to the A&E department of the nearest hospital".]

- Yes.
- Such a service exists, but few members of the public know about it, or it is hard to access.
- No.

6/15:

Can patients in your country choose to be treated in another EU state **of their choice** on the same economic terms as for treatment at home? [This facility is known as 'cross-border care'.]

- Yes, even if they would only have to wait a modest amount of time (perhaps one month) for treatment in their home country.
- Yes—they have to have pre-approval, but that is usually given with no problem, or have had to wait for a long time (> 3 months) for treatment.
- No—or the pre-approval is usually only granted for very rare, special treatments.

Questions 7 to 9: on E-health

7/15:

Can your country's patients receive their test results by email (or by logging onto a personal web page)?

- Yes, this facility is widely available.
- It does exist, but is only offered by a few pioneering hospitals, laboratories, health authorities, etc.
- No (or it is very rare).

8/15:

Can your country's patients book appointments with their doctor online?

- Yes, this facility is widely available.
- It does exist, but is only offered by a few pioneering health authorities, hospitals, etc.
- No (or it is very rare).
 - Primary-care doctors (GPs).
 - Hospital specialists.

9/15:

Can your country's patients check ONLINE how much their healthcare providers (doctors/clinics) have been charging their insurers for supplying them with treatment/care?

- Yes.
- This information is not available online, but can be obtained annually in print format.
- No (or not applicable, or not an insurance-based system).

Questions 10 to 14: on waiting times

10/15:

Can your country's patients see their primary-care doctor that same day (with or without an appointment)?

- Yes.
- Sometimes, but not always.
- Normally not on the same day.

11/15:

Can your country's patients see a specialist (for a non-acute condition) without first having to get a referral from a primary-care doctor?

- Yes.
- Yes, but only for a few specialties (such as gynaecology or paediatrics).
- Yes, but only if the patient is able to 'beat the system' and avoid going through the primary-care doctor.
- No.

12/15:

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 go privately.]

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

13/15:

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 go privately.]

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

14/15:

Which of the following would be the more TYPICAL waiting time in your country for a CT scan (computed tomography X-ray scan)? [Please regard “waiting time” as the period between when a doctor decides that a CT scan is needed, and when the patient actually receives it — without the patient having to go privately.]

- Typically LESS THAN 7 days.
- Typically MORE THAN 7 days, but LESS THAN 21 days.
- Typically MORE THAN 21 days.

Finally, question 15: on 'informal' payments to doctors

The survey's final question looks at one aspect of the financial probity of medical professionals.

15/15:

Would your country's patients 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)?

- Yes, frequently.
- Sometimes/it depends on the the services provided, or on the doctor.
- No.