MoU 05.02.2012 – MINISTRY OF HEALTH

STRUCTURAL FISCAL REFORMS

2.8 To modernise the health care system

The Government continues to implement the comprehensive reform of the health care system started in 2010 with the objective of keeping public health expenditure at or below 6 percent of GDP, while maintaining universal access and improving the quality of care delivery. Policy measures include reducing the fragmented governance structure, reinforcing and integrating the primary healthcare network, streamlining the hospital network, strengthening central procurement and developing a strong monitoring and assessment capability and e-health capacity.

The Government continues the efforts undertaken in 2010-11and intensifies measures to reach savings in the purchasing (accruals basis) of outpatient medicines of close to EUR 1 billion in **2012** compared to the 2011. This will contribute to the goal of bringing average public spending on outpatient pharmaceuticals to about 1 percent of GDP (in line with the EU average) by **end-2014**.

More specifically, the following measures are implemented:

Governance

To strengthen health system governance, improve health policy coherence, reduce fragmentation in the purchasing of health services and reduce administrative costs, the Government further concentrates all health-related decision making procedures and responsibilities (including payroll expenditures) under the Ministry of Health by at the latest **June 2012**. In order to do this, the Government prepares a plan and the necessary legislative changes by **end-February 2012**. As part of this concentration process, all health insurance funds are merged into EOPYY and come under the responsibility of the Ministry of Health. EOPYY buys services in a cost effective way from NHS facilities and private providers through contracts. All other welfare / social assistance schemes under the Ministry of Health are moved to the Ministry of Labour by at the latest **June 2012**.

From **January 2013** EOPYY will purchase hospital services on the basis of prospective budgets following the development of costing of procedures by treatment/ pathology categories (full absorption cost DRGs).

As a result of the concentration process, EOPYY rationalises the number of contracts with private doctors so as to bring down the doctor-to-patients ratio close to the much lower EU average. **[Q2-2012]**

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Contributions paid by OGA members are progressively equalised to those of other members of EOPYY, as envisaged in the medium-term fiscal strategy. The process of equalisation of contributions will be completed in **2013**.

Controlling pharmaceutical spending

In order to achieve EUR 1 billion of reduction in outpatient pharmaceutical spending in **2012**, the Government will simultaneously implement a set of consistent policies comprising changes in pricing, prescribing and reimbursement of medicines that enhance the use of less expensive medicines, control prescription and consumption and prosecute misbehaviour and fraud. The Government defines a consistent set of incentives and obligations for all participants along the medicines supply chain (including producers, wholesalers, pharmacies, doctors and patients) to promote the use of generic medicines.

The Government will revise the co-payment system in order to exempt from co-payment only a restricted number of medicines related to specific therapeutic treatments. **[Q1-2012]**

Pricing of medicines

The Government continues to update, on a quarterly basis, the complete price list for the medicines in the market, using the new pricing mechanism based on the three EU countries with the lowest prices. **[Q1-2012]**

The Government introduces an automatic cla-back mechanism (quarterly rebate) on the turnover of pharmaceutical producers which guarantees that the outpatient pharmaceutical expenditure does not exceed budget limits. **[Q1-2012]**

Starting from **Q1-2012**, the pharmacies' profit margins are readjusted and a regressive margin is introduced - *i.e.* a decreasing percentage combined with flat fee of EUR 30 on the most expensive drugs (above EUR 200) - with the aim of reducing the overall profit margin to below 15 percent.

Government produces an implementation report on the impact of the new profit margins by **Q1-2013**. If it is shown that this new model to calculate profit margins does not achieve the expected result, the regressive margin will be further revised.

Starting from **Q1-2012**, the wholesalers' profit margins are reduced to converge to 5 percent upper limit.

Prescribing and monitoring

The Government

- takes further measures to extend in a cost-effective way the current e-prescribing to all doctors, health centres and hospitals. E-prescribing is made compulsory and must include at least 90 percent of all medical acts covered by public funds (medicines, referrals, diagnostics, surgery) in both NHS facilities and providers contracted by EOPYY and the social security funds. [**Q1-2012**]
- introduces a temporary and cost-effective mechanism (until all doctors are able to use the e-prescription system) which allows for the immediate and continuous monitoring and tracking of all prescriptions not covered by e-prescription. This mechanism will make use of the web-based e-prescription application established by IDIKA, which allows the pharmacies to electronically register manual prescriptions from a specific doctor to a specific patient. For medicines to be reimbursed by EOPYY (and other funds), pharmacies must register in the web-based application all manual prescriptions. For this service, doctors who prescribe manually will be charged a monthly administrative fee by EOPYY to compensate the pharmacies. The introduction of this temporary mechanism would ensure that all prescriptions are electronically recorded, allowing for the full and continuous monitoring of doctors' prescription behaviour, their compliance with prescription guidelines. **[February 2012]**
- continues publishing prescription guidelines/protocols for physicians. Starting with the guidelines for the most expensive and/or mostly used medicines the government makes it compulsory for physicians to follow prescription guidelines. Prescription guidelines/protocols are defined by EOF on the basis of international prescription guidelines to ensure a cost-effective use of medicines and are made effectively binding. **[Q1-2012]**
- enforces the application of prescription guidelines also through the e-prescription system, therefore discouraging unjustified prescriptions of most expensive medicines and diagnostic procedures. **[Q1-2012]**
- produces (Ministry of Health and EOPYY together with the other social security funds until they merge) detailed monthly auditing reports on the use of e-prescription in NHS facilities and by providers contracted by EOPYY and other social security funds (until they merge). These reports are shared with the European Commission, ECB and IMF staff teams. **[Q1-2012]**
- implements (Ministry of Health and EOPYY together with the other social security funds until they merge) an effective monitoring system of prescription behaviour. They establish a process to regularly assess the information obtained through the e-prescribing system. **[Q2-2012]**
- produces regular reports, at least on a quarterly basis, on pharmaceutical prescription and expenditure which include information on the volume and value of medicines, on the use of generics and the use of off-patent medicines, and on the rebate received from pharmacies and from pharmaceutical companies. These reports are shared with the European Commission, ECB and IMF staff teams. **[Q1-2012]**

- provides feedback and warning on prescription behaviour to each physician when they prescribe above the average of comparable physicians (both in NHS facilities and contracted by EOPYY and other social security funds until they merge) and when they breach prescription guidelines. This feedback is provided at least every month and a yearly report is published covering: 1) the volume and value of the doctor's prescription in comparison to their peers and in comparison to prescription guidelines; 2) the doctor's prescription of generic medicines vis-à-vis branded and patent medicines and 3) the prescription of antibiotics. **[Q2-2012]**
- enforces sanctions and penalties as a follow-up to the assessment and reporting of misconduct and conflict of interest in prescription behaviour and non-compliance with the EOF prescription guidelines. Continuous or repeated non-compliance with the prescription rules will lead to the termination of the contract between the doctor and the EOPYY and the doctor's permanent loss of his/her capability/right to prescribe pharmaceuticals which are reimbursed by the government/EOPYY in the future. **[Q1-2012]**
- continuously updates the positive list of reimbursed medicines using the reference price system developed by EOF. **[Q1-2012]**
- selects a number of the most expensive medicines currently sold in pharmacies, to be sold in hospitals or EOPYY pharmacies, so as to reduce expenditure by eliminating the costs with outpatient distribution margins, and by allowing for a strict control of the patients who are being administered the medicines. **[Q1-2012]**

If the monthly monitoring of expenditure shows that the reduction in pharmaceutical spending is not producing expected results, additional measures will be promptly taken in order to keep pharmaceutical consumption under control. These include a prescription budget for each doctor and a target on the average cost of prescription per patient and, if necessary, across-the-board further cuts in prices and profit margins and increases of co-payments. **[Q2-2012]**

In compliance with EU procurement rules, the Government conducts the necessary tendering procedures to implement a comprehensive and uniform health care information system (*e-health system*). **[Q1-2012]**

Increasing use of generic medicines

A comprehensive set of measures is adopted simultaneously to promote the use of generic and less expensive medicines. The aim of these measures is to gradually and substantially increase the share of the generic medicines to reach 35 percent of the overall volume of medicines sold by pharmacies by **end-2012**, and 60 percent by **end-2013**. This will be achieved by:

- reducing the maximum price of the generic to 40 percent of the price of the originator patented medicine with same active substance at the time its patent expired. This is set as a maximum price; producers can

offer lower prices, thus allowing an increased competition in the market. **[Q1-2012]**

- automatically reducing the prices of originator medicines when their patent expires (off-patent branded medicines) to a maximum of 50 percent of its price at the time of the patent expiry. Producers can offer lower prices, thus allowing an increased competition in the market. **[Q1-2012]**
- creating dynamic competition in the market for generic medicines through price reductions of at least 10 percent of the maximum price of each generic follower. **[Q4-2012]**
- associating a lower cost-sharing rate to generic medicines that have a significantly lower price than the reference price for reimbursement (lower than 40 percent of the reference price) on the basis of the experience of other EU countries, while increasing substantially the co-payment of more expensive medicines in the reference category and of new molecules. **[Q1-2012]**
- allowing the reimbursement of newly patented medicines (*i.e.* new molecules) only after at least 2/3 of the EU countries are already reimbursing them and on the basis of a proper assessment of their cost-effectiveness carried out in other European countries. **[Q1-2012]**
- excluding from the list of reimbursed medicines those which are not effective or cost-effective on the basis of the experience of other countries. **[Q1-2012]**
- making it compulsory for physicians to prescribe by international non-proprietary name for an active substance, rather than the brand name. **[Q1-2012]**
- mandating the substitution of prescribed drugs by the lowest–priced product of the same active substance in the reference category by pharmacies (compulsory "generic substitution"). **[Q1-2012]**

The Government takes further measures to ensure that at least 40 percent of the volume of medicines used by public hospitals is made up of generics with a price below that of similar branded products and off-patent medicines. This should be achieved, in particular by making compulsory that all public hospitals procure pharmaceutical products by active substance, by using the centralised tenders procedures developed by EPY and by enforcing compliance with therapeutic protocols and prescription guidelines. **[Q2-2012]**

The Government, pharmaceutical companies and physicians adopt a code of good conduct (ethical rules and standards) regarding the interactions between pharmaceutical industry, doctors, patients, pharmacies and other stakeholders. This code will impose guidelines and restrictions on promotional activities of pharmaceutical industry representatives and forbids any direct (monetary and non-monetary) sponsorship of specific physicians (sponsorship should be attributed through a common and transparent allocation method), based on international best practice. **[Q1-2012]**

The Government simplifies administrative and legal procedures, in line with EU legal frameworks, to speed up the entry of cheaper generic medicines. **[Q2-2012]**

Pricing and use of diagnostic services

Fees for diagnostic services contracted to private providers are reviewed with the aim of reducing related costs by EUR 45 million in 2012. **[Q1-2012]**

The government starts publishing a quarterly report on the prescription and expenditure of diagnostic tests. **[Q1-2012]**

NHS (ESY) service provision

The plan for the reorganisation and restructuring is implemented for the short and medium term with a view to reducing existing inefficiencies, utilising economies of scale and scope, and improving quality of care for patients. The aim is to reduce further hospital operating costs by 8 percent in **2012**. This is to be achieved through:

- increasing the mobility of healthcare staff (including doctors) within and across health facilities and health regions.
- adjusting public hospital provision within and between hospitals within the same district and health region.
- revising the activity of small hospitals towards specialisation in areas such as rehabilitation, cancer treatment or terminal care where relevant.
- revising emergency and on-call structures.
- optimise and balance the resource allocation of heavy medical equipment (e.g. scanners, radiotherapy facilities, etc.) on the basis of need.

A first annual report comparing hospitals performance on the basis of the defined set of benchmarking indicators will be published by **end-March 2012**.

Wages and human resource management in the health care sector

The Government updates the existing report on human resources conducted by the Ministry of Health to present the staff structure according to specialty. This report will be updated annually and will be used as a human resource planning instrument. The 2012 report will also present plans for the allocation and re-qualification of human resources for the period up to 2013. It will also provide guidance for the education and training system and it will specify a plan to reallocate qualified and support staff within the NHS with a focus in particular on training and retention of primary care healthcare professionals and hospital nurses. **[Q3-2012]**

The revised payment system used by EOPYY for contracting with physicians, and the efficiency gains in the use of staff (including reduction in overtime costs) will lead to savings of at least EUR 100 million in the overall social security costs associated with wages and fees of physicians in 2012. **[Q4-2012]**

Accounting and control

Internal controllers are assigned to all hospitals and all hospitals adopt commitment registers. **[Q1-2012]**

By **end-March 2012**, the Government publishes the monthly report with analysis and description of detailed data on healthcare expenditure by all social security funds with a lag of three weeks after the end of the respective month. This report will make it possible a detailed monitoring of the budget execution, by including both expenditure commitments/purchases (accruals basis) and actual payments (cash basis). The report will also (1) describe performance of entities on execution of budget and accumulation of arrears, (2) highlight any defaulters, and (3) recommend remedial actions to be taken. **[Q1-2012]**

EOPYY and other social security funds (until they merge) start publishing an annual report on medicine prescription. The annual report and the individual prescription reports examine prescription behaviour with particular reference to the most costly and most used medicines. **[Q1-2012]**

Hospital computerisation and monitoring system

The necessary tendering procedures are carried out by HDIKA to develop the full and integrated system of hospitals' IT systems. **[Q1-2012]**

Throughout 2012, further measures are taken to improve the accounting, book-keeping of medical supplies and billing systems, through:

- the introduction of analytical cost accounting systems and the regular annual publication of balance sheets in all hospitals. [Q2-2012]
- the calculation of stocks and flows of medical supplies in all the hospitals using the uniform coding system for medical supplies developed by the Health Procurement Commission (EPY) and the National Centre for Medical Technology (EKEVYL) for the purpose of procuring medical supplies. [Q1-2012]
- timely invoicing of full treatment costs (including staff payroll costs) - i.e. no later than 2 months to other EU countries and private health insurers for the treatment of non-nationals/non-residents. **[Q2-2012]**
- enforcing the collection of co-payments and implementing mechanisms that fight corruption and eliminate informal payments in hospitals. [Q2-2012]

ELSTAT starts providing expenditure data in line with Eurostat, OECD and WHO databases i.e. in line with the System of Health Accounts (joint questionnaire collection exercise). **[Q1-2012]**

The programme of hospital computerisation allows for a measurement of financial and activity data in hospital and health centres. Moreover, the Minister of Health defines a core set of non-expenditure data (e.g. activity indicators) in line with Eurostat, OECD and WHO health databases, which takes account of the future roll-out of DRG (diagnostic-related groups) schemes in hospitals. **[Q1-2012]** The programme of hospital computerisation will continue the development of a system of patient electronic medical records. [**Q3-2012**]

In all NHS hospitals, the Government pilots a set of DRGs, with a view to developing a modern hospital costing system for contracting (on the basis of prospective block contracts between EOPYY and NHS). To support the development of DRGs, the government develops clinical guidelines and assesses existing international examples of DRG-base schemes, in particular considering observations on DRG costing and proportionality of DRG-based tariffs. DRGs include a detailed item on costs of personnel. **[Q3-2012]**

An analysis will be made of how hospital accounting schemes integrate DRGs at hospital level in view of future activity-based cost reporting and prospective budgets payment for hospitals **[Q3-2012]**

Centralised procurement

Government continues centralised procurement through EPY and regional procurement through the Regional Health Authorities, witn the aim of increasing substantially the number of expenditure items and therefore the share of expenditure covered by centralised tender procedures. **[Q4-2012]**

EPY will undertake a major effort to utilise tender procedures for framework contracts for the most expensive medicines used in the outpatient context so as to substantially reduce the price paid by EOPYY. **[Q4-2012]**

Government puts in place the procurement monitoring mechanism. **[Q1-2012]**

Independent task force of health policy experts

The Independent Task Force of Health Policy Experts, established as an advisory group, produces an annual report on the implementation of reforms. **[Q4-2012]**