Escola Nacional de Saúde Pública

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Book of Abstracts

Health care rationing in Europe: the past, present and future. A multidisciplinary approach

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Content

Conference introduction

Confronted with increased health spending, worldwide, we can expect issues on scarcity of resources and health care rationing will become more urgent in the healthcare debate. Healthcare rationing, or denial of health care services, is concerned with prioritisation of healthcare resources.

Emerging rationing questions are:
- who is responsible for rationing (the market, governments, bureaucrats, physicians or others);
- how does it function (explicit or implicit);
- what are relevant and acceptable selection criteria;
- to what extent is current rationing just and what can be done to make it more just;
- how will healthcare rationing affect equal access to health care;
- what is the relationship between healthcare rationing and differences in health status;
- what are the institutional patterns that may help governing health care rationing.

A key challenge of this conference is to address healthcare rationing on several levels (macro, meso and micro); types of rationing (demand and supply side-rationing); to what extent it influences political decision-making; and how to cope with the 'legitimacy problem' in rationing decision-making. Therefore, ENSP has invited colleagues from various disciplines to exchange experiences on health care rationing in different health care systems in Europe.

Paula Lobato de Faria and André den Exter
Lisbon, October 2018

Key-note Lecture by Werner Brouwer

Abstract 'Rationing from an economic perspective: developments and challenges?'

Rationing health care, either implicit or explicit, is unavoidable due to scarcity of resources. This implies that choices needed to be made regarding the fair and efficient allocation of health and health care. Here, I will address this issue from an economic perspective, with a focus on choices regarding which health care technologies to fund in public health systems. Such choices are increasingly informed by economic evaluations in which costs and benefits of interventions are compared. Developments in performing and using these evaluations are discussed and future challenges for their use in rationing health care highlighted.

2. Abstracts

Rationing Healthcare and 'Big Data Analytics': a Data Protection Perspective

Can rationing healthcare be achieved through Big Data analytics? If so, what would be the data protection implications?

Authors: Jos Dumortier, Mahault Piéchaud-Boura

'Big Data analytics' in the field of health provides many opportunities but also raises many legal challenges. Indeed, health data and genetic data are legally qualified as sensitive data and therefore subject to particular protection. Moreover, with the implementation of the new European legal framework applicable to the processing of personal data, also known as the GDPR, the rules for the processing of health data and other special categories of personal data have changed Europe-wide. Additionally, because the regulation of the healthcare sector remains mostly in the hands of the EU Member States, national legislations may provide additional rules applicable to the processing of health data.
In the context of the AEGLE Horizon 2020 Innovation Action, aiming at the development of a Big Data Analytics framework for health data, Timelex prepared an assessment of the data protection rules applying to the processing of health data; and proposed an approach to comply with the requirements of EU and national data protection law. This assessment of the situation is based on national reports presenting the legislative changes to the protection of health and genetic data in the wake of the GDPR.

The main result of the legal assessment is that despite the creation of a clear European framework, national specificities remain and require that Big Data Analytics in the health sector comply with different sets of rules simultaneously. When applying this differentiated framework to healthcare rationing at micro level several points must be taken into consideration, such as the means of rationing or the person performing it, but also the source of data used. When applied to healthcare rationing at macro level different issues arise due to different factors such as the possibilities to process anonymous or pseudonymous data or to restrict the storage duration.

Health care rationing in Italy: right to health vs. budget restraints in a regional-based health system.

Author: Alceste Santuari – Department of Sociology and Business Law – University of Bologna

After the enactment of the 2001 Constitutional Reform Act, the Italian health system consists of as many as 21 regional health systems. The central government retains the public task of ensuring that all citizens, regardless of their territorial residence, may access to the same universal and equitable health services and provisions.

After the economic crisis of 2007/2008, as it has been the case in many other EU MSs, the Italian central government has decreased public expenditure for healthcare. Not only has such an approach undermined citizens' fundamental right to health. It has also triggered a fierce confrontation between regional governments and the State, which has also been the object of some rulings of the Italian Supreme Court.

Against this background, the paper aims to analyse the impacts that health care rationing have on the organisation of health and care services and on the evolution of social enterprises as health providers.

Arrears in Portuguese NHS hospitals: a case of post-traumatic stress

Authors: Carlos Matos1,2, Julian Perelman1
1 Escola Nacional de Saúde Pública, Universidade NOVA de Lisboa
2 Unidade de Saúde Pública ACES Porto Oriental

Introduction
The Great Recession started in Portugal in 2009, followed by a public debt crisis and an external bailout. In 2011, austerity measures were implemented, including budget cuts in the National Health Service (NHS), restrictions in hospitals' autonomy, and severe wage reductions for health professionals, a part of which opted to quit the NHS. In 2015, a left-wing government was elected, with the promise of wages' recovering and re-investment in the NHS. Subsequently, worrisome news emerged about hospitals' huge arrears, mainly to the pharmaceutical industry, which obligated the State to regularly bailout hospitals. This study aims at analysing the evolution of arrears over the 2014-2017 period and its determinants.

Methods
We followed all 39 NHS corporate public entities (hospitals, hospital centres and local health units) monthly over the 2014-2017 period (n=1872). We modelled the monthly year-on-year change of arrears, as function of variations in hospital's expenditures and existence of a bailout. We used panel data analysis with linear regressions including time (month*year) and hospital fixed effects.

Results
The annual growth in arrears significantly increased over the period, from an average 1,2 million euros growth in 2015 to an average 11,1 million euros growth in 2017. The past-year bailout decreased arrears by an average 3 million euros, but this decrease was not statistically significant. By contrast, the growth in arrears was significantly related to the growth in human resources expenditures, both related to fixed wages and extra-hour payments.

Discussion
After several years of budget cuts, there was a need to reinvest in the Portuguese NHS, through the recovering of better working conditions. However, this recovery was not matched by increases in hospital budgets, while hospital managers continued to lack autonomy and accountability. This study confirms the emergence of huge arrears in the post-traumatic context and describes related factors.

Rationing and quantifying: Utilitarianism, 19th century science and disease objectification in public health care

Author: Aleksandra Traykova

Utilitarian bioethics is often regarded as a contemporary phenomenon originating in the 1970's with the works of philosophers like Peter Singer, but its historic roots reach as far back as the 19th century, when a plethora of scientific discoveries mixed with an unprecedented level of philosophical concern about rational resource distribution, ultimately producing new forms of medical thinking which continue to influence us to this day. Amongst them is the construction of an objectified view of disease as a measurable property rather than a value-laden term for an undesirable physical trait – a view echoed both by the biostatistical theory developed by contemporary philosopher of medicine Christopher Boorse and by the writings of French scientist Claude Bernard which anticipated Boorse's over a hundred years beforehand. This objectified view of disease as a calculable parameter underpins a wide range of concepts in contemporary utilitarian bioethics – including, but not limited to, "quality of life", "productive value", "chance of survival", and even "future economic value". This paper will present a brief analysis of 19th century science's constructions of medical abnormality and explore their relation to the utilitarian philosophy produced during this historical period (most notably that of John Stuart Mill and Jeremy Bentham).

Using personal responsibility as a rationing principle. Technical and regulatory challenges

Author: Andrea Martani. PhD Candidate
Institute of Biomedical Ethics – University of Basel
andrea.martani@unibas.ch
Bernoullistrasse 28 – 4056 Basel - Switzerland

In the last decades, priority-setting and rationing have called into question the nature of healthcare, which is now often considered a conditioned service rather than an absolute right. This paradigm-shift has been fostered not only by the rise of managerialism and the increasing role of private actors, but also by two additional factors. On the one hand, advances in life sciences and the rise of autonomy in the medical field have contributed to giving health a subjective connotation, whereby treating diseases has now turned into an articulated process dependent on a series of individual choices. On the other hand, as the world is entering the big data era, the greater availability of detailed personal information has strengthened the predictive value of data and has made it easier to link individual behaviour with health status. This emphasis on health as an individual issue raises the questions whether the principle of personal responsibility should prevail over that of solidarity in the healthcare sector, and to what extent personal responsibility can be used as a criterion to allocate resources.

The objective of this contribution is to investigate, both from a technical and a regulatory perspective, some of the challenges posed by the use of personal responsibility as a rationing criterion in the healthcare sector. At a technical level, we will present the preliminary results of a scoping review studying “digital-pills”, medical devices capable of automatically monitor patients’ medication-taking behaviour. At a regulatory level, we will examine an example of legislation from Germany (§52 Book V SGB) whereby access to public healthcare resources is conditioned upon individual behaviour. In both cases, it will be underscored how, despite appealing and promising at a theoretical level, the practical implementation of personal responsibility as a rationing criterion can be problematic.

Why does deprivation of liberty pose a problem for health care rationing?

Author: Athina Sophocleous, PhD Law Candidate; Legal Partners Law Office Cyprus

Health disparities do not benefit the individuals on the losing side of the disparities, nor do they benefit any other individuals, violating the principle of beneficence. Health disparities instead can be said to be a significant harm in the form of poorer health, pain and suffering, violating the principle of non-maleficence. The paper will explore the right to health of persons deprived of liberty. It will address the broader context of health in prisons, reviewing some of the global health challenges affecting incarcerated populations and the unique health vulnerabilities created in closed settings. This will include a consideration of the impact of criminal laws, and how these laws can contribute to health problems in places of detention. Health disparities violate equity in that many people suffer from significantly lower health outcomes on the basis of their race/ethnicity or class. The system of injustices, as a result of a repeating old system based on race, ethnicity and class is clearly an ethical issue; thus, States which perpetuate these injustices are likely ethically problematic as well. However, there is a distinction between the right to equal access to health care and the duty to address health disparities. Even if a moral right to health care can be established, that right would not necessarily entail a duty to address health disparities; a moral right to equal access to health care only entails the duty to ensure that the access to health care is provided to all. Significant disparities exist among the universe and health care has a primarily role to play in achieving health equity. While healthcare organizations do not have the ability to achieve this equity alone or they do not have the power to improve all the social determinants, they have the power to address disparities at the point of care and to impact all these *determinants* that create disparities.

Health care rationing in Europe: the past, present and future. A multidisciplinary approach
"Cross-border cooperation in the supply of healthcare services: legal obstacles, ongoing criticalities and possible future perspectives"

Author: Giacomo Di Federico, University of Bologna

What are the institutional patterns that may help governing health care rationing? From an EU perspective, the question cannot be addressed without making reference to Directive 2011/24 on patients' rights in cross-border healthcare. In particular, Art. 10(3) promotes the conclusion of specific agreements between neighbouring countries. If adequately supported, cooperation in border regions can effectively compensate for health care rationing in times of strict deficit control policies. Indeed, health care providers and patients can benefit from the sharing of premises, devices, know-how, procedures and economic resources on a territorial basis. As a matter of fact, a number of cross-border health cooperation projects have been financed by the European Union and are currently in place. However, while some initiatives have a broad scope of application, others only address certain categories of patients, specific diseases or medical services, which makes comparison and benchmarking difficult, if not impossible.

After an overview of the most significant experiences, concerning urban and rural areas, northern, southern, eastern and western Member States, the presentation will dwell on the added value (if any) of cooperation in this field and the role played by the European institutions in promoting synergies and cost-savings for the interested health care systems (e.g. pooling of resources; joint purchases, common investments in telemedicine, etc.).
As will be argued, the success of the existing and future partnerships in the medium and long term largely depends on the involvement of the Commission and its ability to favour efficiency-driven choices at the national level, especially in cross-border regions. In this sense, capitalization on the results, and dissemination of good practices, is of the utmost importance.

Hospital Efficiency Changes during the Crisis

Author: Juan José Muñoz González.
Hospital Universitario Santa Cristina. Madrid (SPAIN)

Introduction
In spite of WHO call to face financial crisis targeting health care inefficiencies instead of cuts across the board, EU member states policies have been mainly directed to cost containment measures. The aim of this work was to study hospitals efficiency change during the crisis.

Data and Methods
We have collected every two years data of 24 public hospitals running from 2009 to 2015 in Madrid (Spain). To measuring efficiency we have used DEA, a nonparametric frontier method which provides a measure of the relative efficiency of an individual hospital comparing its output and inputs observed levels with the best practice production frontier. We have measured the variation by means of the Malmquist Productivity Index (MI) for each pair of periods; further, MI has been decomposed into a technical change and an efficiency change component.

Results
Considering the period between the first and the last year of the study, IM shows an increase of 4.3%, but while the technical efficiency change increases a 6.6%, technical change decreases 2.2%. That is, the improvement due to the shift of the frontier overcomes the reduction in technical efficiency. This trend in IM is not homogeneous during all periods; the largest increase happens during the first two years and declines in subsequent periods. The route of technical change and technical efficiency change is also different in the periods considered: in the first two years, technical change increases a 10,6% while in the following two years technical change decreases a 7,6% and further decreases a 4,1% in the next two years. On the contrary, technical efficiency change exhibit a tent shape with a highest value in the period 2013-2011.

Conclusion
Our results indicate that hospitals efficiency has improved during the crisis, mainly due to a shift of the production frontier, but dynamics of efficiency change varied from period to period.

SDGs, right to health and priority-setting: is there a hierarchy?

Author: Luciano Bottinifilho
l.bottini filho @surrey.ac.uk

Sustainable Development Goals (SDGs) were established giving the idea of a commitment to an international priority agenda. Creating targets for the world means also to direct resources to certain ends, but in countries low on financial means choices should be made. This study attempts to analyse the contradictions and limitations of electing a superior group of objectives without determining a priority-setting mechanism among them. Drawing on the experience of the right to health and its international legal standards, I will examine what SDGs have in common with the major fault-finding arguments towards socio-economic rights. I argue that if used as an entitlement to forced implementation of health targets, SDGs face serious moral dilemmas: sequence of progression from core and remaining health obligations against SDGs programmatic decisions, disinvestment between competing needs and difficulty to achieve an egalitarian management of resources as a whole, when social determinants of health may in fact request money being transferred to other State policies outside health administration.

A Cross-national Study of the Prevalence of Age-based Rationing in Health Care

Author: Michele Castelli, Newcastle university

Health care systems continue to face intractable decisions in allocating scarce resources for health in an equitable manner. In the aftermath of economic and political developments following the 2008-10 global financial crash, health care budgets in many countries have come under severe pressure. Against this context, the issue of rationing of health services is once again being raised by decision-makers (Campbell, 2017). A key issue concerns the challenges presented by a growing population of older people who are living longer, often with multiple morbidities, and this demographic trend raises a series of questions with regard to the level, and the quality, of access to health care services that the elderly population receives. Studies suggest that elderly patients receive proportionately less treatment, less expensive treatment, or later access to diagnostic and surgical procedures than younger cohorts (e.g. Age UK, MHP Health Mandate and The Royal College of Surgeons of England, 2012). The prevalence and reasons for this state of affairs remain under-explored.

Against this background, we have developed a research project aimed at exploring the existence of, and policy responses to, age-based rationing in health care. Focusing on England, Germany and Italy, we will investigate whether/how age-based rationing manifests itself in health systems characterised by different institutional designs and policy contexts. This paper will present the rationale for the project, its methodology, insights on the approaches to rationing in the three countries, its main aims and expected findings, in order to stimulate a debate and exchange ideas on age-based rationing at a European level.
By offering comparative insights on the prevalence of age-based rationing we seek to make a contribution to the policy, societal and academic debates concerning the sustainability of publicly-financed health systems in responding to the growing demands of an ageing population.

Research team:
Prof. David Hunter, Prof. Theodore Schrecker, Dr. Michele Castelli (Newcastle University)
Dr. Katharina Kieslich (University of Wien)
Prof. Peter Littlejohns (Kings' College)
Dr. Katharina Bohm (University of Bochum)
Dr. Francesca Ferre (Sant'Anna School of Advanced Studies)
Dr. Paolo Berta (University pf Milan Bicocca)

Rationing in a Beveridge system: The conundrum of adopting Bismarckian patient choice

Author: Maria Sheppard, Queen Mary university London

Rationing healthcare is not a new phenomenon as all healthcare budgets are finite while the objective of all healthcare systems is to optimise health outcomes by ensuring efficiency and equity subject to these cost constraints. Rationing measures can be Implicit or explicit, e.g. by delay, by dilution, by deterrence, on the basis of clinical guidelines based on evidence and cost effectiveness, by clinical discretion. A need for transparency mandates explicit rather than implicit rationing measures. In England The National Institute for Health and Care Excellence (NICE) was established to develop guidance based on clinically effective, evidence-based treatments which reach a threshold level of cost-effectiveness, and to end unequal geographical access to healthcare. However, as much of NICE guidance is not binding on local decision-makers, inequity of access persists. Bridging the tension between efficiency, equity of access and cost-effectiveness policy-makers have introduced patient choice, a market-based tool traditionally associated with Bismarckian healthcare systems. Choice is a useful device giving the impression to the electorate that policy-makers are responsive to patient needs and demands. At the same time it is linked by policy-makers with the concept of patient responsibility, making patients responsible for their own health and lifestyle choices. Choice is thus argued to be consistent with the underlying values of the NHS rather than simply a strategy of marketization. Although the choice policy may be understood as a response to broader social change generally it can also be seen as an instrument of change, intended to disrupt the entrenched institutional architecture of the NHS, to encourage reform, greater efficiency and responsiveness and cost containment. Although the domestic choice agenda in England may represent a process of convergence towards Bismarckian systems it raises the question whether patient choice should ever trump evidence-based, cost-effective medicine.

The impact of austerity programs in Greece on public health

Author: Theodoros Trakanas, Scientific Collaborator, Hellenic Open University, Attorney-At-Law, Thessaloniki Bar Association

It is widely known that from 2010 to 2018 a prolonged austerity policy was imposed on Greece as a prerequisite to a financial bailout of the country by the European Commission, the European Central Bank and International Monetary Fund, leading the Greek economy to shrinkage. Austerity measures featured, among others, a curtailment in health expenses, which in turn took a heavy toll on the health provision within the National Health System (ΕΣΥ). This paper intends to present and explain the impact of austerity measures on public health in Greece. The paper will derive important findings from a recently published study which mainly explores the correlation of reduced health spending and mortality rates in post-austerity Greece in comparison to other Western European countries. It is noteworthy that the aforementioned study concurrently evaluates the role of other plausible explanations for the trends of disease burden in Greece, such as population ageing, youth brain drain, unhealthy habits or even the refugee crisis.

The idea alien to both worlds: why rationing is not acceptable in Russia and USA

Authors: Vasiliy V. Vlassov, Sergey V. Shishkin, Alla E. Chirikova, National Research University Higher School of Economics, Moscow, Russia

The simple idea of rationing appears not acceptable both for the relatively poor "socialist" health care in Russia and for the USA health care. In Russia the idea of rationing is not acceptable, because the Constitution promise the free medical care, unlimited. In USA the idea is not acceptable, because citizens are understood as having the right of free choice of legal access to any care, without intervention of the 'death jury'.
We analyse the similarities and differences in the arguments rejecting the explicit application of rationing in health care in USA and Russia.

In this report we describe the analysis of the legal framework in Russia related to rationing, and of the qualitative study of the understanding the concept of rationing by Russian doctors and of the practices in Russian health care institution to limit the use of the expensive diagnostic and treatment options.

While the Constitution promise the free medical care, unlimited, legally there are limits imposed by the quotation of the specific treatments, limited access to the care abroad, and problematic access to the drugs not included in the essential drug list while in inpatient care. Explicit rationing is not rejected by the society as well as by a medical profession. In the medical organizations the more explicit techniques are second opinion by the committee (physicians' commission), especially in the case of prescription of the drugs and diagnostic tests. Physicians tend to behave as medical professionals do: provide the more access to the care for severe cases.

The Ukrainian project "PRIMARY MEDICAL AID ON THE BASIS OF FAMILY MEDICINE"

Authors: Olena Verlan-Kulshenko, Oksana Adamchuk, Vinnitsya national Pirogov memorial medical university

Today Ukraine takes 104th place among 183 countries for the life expectancy of the population. From the experience of developed countries, it is known that more than 80 percent of human's health problems can be solved at the primary level of health care. That is why the development of primary health care has become a solution in the medical system crisis for many countries.

Nowadays the primary health care is the basis of any health care system. It takes care of prevention and satisfies almost 80-90% of the population's needs in medical care, and is considered rational from the point of view of the economy. It requires only up to 30% of the health care area resources in general.

In accordance to the European Framework Program of WHO, which was presented at the 66th session of the European Regional Committee for Integrated Health Services Initiative, primary health care was recognized as one of the main components of effective health care systems. It is "the first level of contact between individuals, families and communities with the national health system; it makes health and medical assistance closer to the place of residence and work of people; and is considered as the first stage in the continuous process of public health."

An important principle of primary care based on family medicine is to treat patients as a reliable partner, retaining responsibility for the results of treatment in the meanwhile.

Primary health care systems vary in different countries according to historical and socio-economic conditions of development, but most of them are based on the principles of general practice which is family medicine.

Currently in the most countries of the world the share of general practitioners in family medicine is between 30-50% among all doctors. This number is the largest in France - 54%, and the smallest in Spain - 15%, in the USA the number of GPs is 39%. In Europe there is an average amount of 68 family doctors per 100,000 population (from 47 in the Netherlands to 115 in Belgium).

In order to reduce the level of illnesses, disability and mortality in Ukraine, a comprehensive reform of the medical sector was launched in 2011, leading to the establishment of effective functioning of the system of providing affordable and high-quality primary health care to the population on the basis of family medicine.

Today, the network of primary health care institutions in Ukraine is represented by 5,500 centres of primary health care and outpatient family medicine centres, the number of medical staff is more than 35 thousand people, including 13 thousand of general practitioners, family doctors, and 22 thousand people with a medical education in the field of "general practice - family medicine". One general practitioner-family doctor serves an area from 1,500 to 2,000 adults and children (500-600 families).

The centre of primary health care is created for the provision of primary medical care on the basis of family medicine at the rate of 15-20 thousand adults and children.

The general norms of loading for specialists in family medicine are: 1,400-1500 adults and children in the city and 1100-1200 adults and children in rural areas.

Primary care has different types: primary pre-medical care, primary medical care and primary specialized medical care.

Primary pre-medical care is provided in an outpatient setting or at the place of residence of a patient who does not require primary medical care and primary specialized care and is given for preventive measures, counselling, diagnostics and treatment of the most common diseases, injuries, poisoning, pathological or physiological (during pregnancy) conditions according to medical indications; provision of elements of palliative care and elements of medical rehabilitation; providing urgent medical care in case of an acute disorder of the patient's physical or mental health.
Primary pre-medical care is provided by a family nurse, a nurse of health facilities and their structural (separate) units, irrespective of the form of ownership and organizational-legal form that provides the organization and provision of primary health care to the population, as well as family nurses, medical nurses and physicians who conduct business activities in medical practice as individual entrepreneurs and may be in civil-law relations with these institutions.
Primary medical care is provided in an outpatient setting or at the place of residence of a patient who does not require emergency, secondary (specialized) or tertiary (highly specialized) medical care and provides preventive measures, consultations, diagnostics and treatment of the most common diseases, injuries, poisoning, pathological, physiological (during pregnancy) conditions; provision of emergency medical items, palliative care items, and elements of medical rehabilitation; referral of the patient according to medical indications to provide emergency medical, secondary (specialized), tertiary (highly specialized) medical care, palliative care and medical rehabilitation; providing urgent medical care in case of an acute disorder of the patient's physical or mental health.
Primary medical care is provided by general practitioners - family physicians of health care institutions and their structural (separated) units, regardless of the form of ownership and organizational and legal form, which ensures the organization and provision of primary health care to the population, as well as family doctors of general practice physicians who conduct business activities in medical practice as individual entrepreneurs and may be in civil-law relations with these institutions.
Primary specialized medical care is provided in outpatient settings or at the place of residence (stay) of the patient, and provides preventive measures, consultations, diagnostics and treatment of the most common diseases, injuries, poisonings, pathological, physiological (during pregnancy) conditions according to medical indications; provision of urgent medical care in case of an acute disorder of the patient's physical or mental health; provision of elements of secondary (specialized) medical care.
Primary specialized medical care is provided by doctors (paediatricians, dentists, etc.) of health facilities and their structural units, regardless of the form of ownership and organizational and legal form, which ensures the organization and provision of primary health care to the population, as well as doctors (paediatricians, dentists, etc.), which conduct business activities in medical practice as individual entrepreneurs and may be in civil-law relations with these institutions.
E-Health is the newest electronic system which aims to transfer the paper medical records to electronic. At the same time, this process is accompanied by a number of issues, especially in the field of providing personal non-property rights.
The Law of Ukraine on State Financial Guarantees for the Provision of Medical Services and Medicines, the Law of Ukraine "On Electronic Signature", "Fundamentals of the Legislation of Ukraine on Health Care", Article 43 "The Right to Medical Intervention", the Order of the Ministry of Health of Ukraine No.110 "On Approval of Forms of Primary accounting

documents and instructions on their filling, used in health care institutions irrespective of the form of ownership and subordination, "Order of the Ministry of Health of Ukraine No. 29" On Amendments to the Initial Registration Form and Instructions for their Filing».
In accordance with the bills № 6327 and № 6604, from August 1, 2018, the payment of medical services will be made according to the number of declarations registered in the system. The patient signs a declaration about choosing a primary care physician with a family doctor or a therapist or paediatrician. This declaration is certified by the electronic signature of the patient and the doctor in accordance with Article 8 of the Law of Ukraine "On Electronic Digital Signature". Everyone will be able to choose a doctor: a family doctor, a therapist, a paediatrician. And it will clear what is included in his work: reception, examination, analyses. The state pays the doctor for all this service. The more patients the doctor has - the more he will earn.
It is also important that the patient now has the opportunity to sign the contracts with the doctor that he likes, regardless of the place of registration, in any hospital in the country. The doctor has no right to refuse if the number of his patients is less than a certain norm (2000 patients). Ar.284 of the Civil Code of Ukraine states that an individual who has attained the age of fourteen and applied for medical care shall have the right to choose a physician and methods of treatment in accordance with his recommendations. One of the problems is the registration of the consent of a minor patient for medical intervention and the choice of a doctor. Issues concerning the preservation of the personal medical information of a minor patient and the right of parents to control the quality of the medical service provided remain relevant. In addition, the computerization of medical institutions, and especially rural ones, is not sufficiently developed. Therefore, in this direction, there are a number of problems in the implementation of the e-Health system. Among them: the lack of Internet, computers and computer literacy, which should be solved in the future.
In the future e-Health will easily enable everyone to use medical information. There will be no need for paper medical cards and printed materials, these systems will be able to predict and prevent the spread of diseases. In the future the e-Health system will be extended not only to primary care physicians, but also to the involvement of the system will be the subject to both secondary and tertiary links. Today, the e-Health system is only gaining its popularization and should bring Ukrainian medicine to a new level, in case it complies with legal standards and establishes an appropriate legal framework.

Latvia abandons general health care: linking healthcare entitlement to the health insurance or tax contributions

Author: Solvita Olsena, Faculty of Medicine, University of Lavia

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3. List of speakers

Name	Organisation	E-mail
1. Werner Brouwer	Erasmus University Rotterdam/ESHPM	brouwer@eshpm.eur.nl
2. Vasiliy V. Vlassov, Sergey V. Shishkin, Alla E. Chirikova	National Research University Higher School of Economics, Moscow, Russia	vvvlas@gmail.com
3. Giacomo Di Federico	University of Bologna	giacomo.difederico@unibo.it
4. Alceste Santuari	Department of Sociology and Business Law, University of Bologna	alceste.posta@gmail.com
5. Maria Sheppard	Queen Mary university of London	<maria.sheppard@qmul.ac.uk>
6. Michele Castelli	Newcastle university	<Michele.Castelli@newcastle.ac.uk>
7. Luciano Bottinifilho	University of surrey	l.bottinifilho@surrey.ac.uk
8. Olena Verlan-Kulshenko & Oksana Adamchuk	Vinnitsya national Pirogov memorial medical university	Лея <kul555@ukr.net>
9. Juan José Muñoz González	Hospital Universitario Santa Cristina. Madrid	juanjose.munoz@salud.madrid.org
10. Athina Sophocleous	Legal Partners Law Office Cyprus	<asophocleous@hotmail.gr>
11. Andrea Martani	Institute of Biomedical Ethics – University of Basel	andrea.martani@unibas.ch
12. Aleksandra Traykova		<al.tra@abv.bg>
13. Carlos Matos & Julian Perelman	Escola Nacional de Saúde Pública, Universidade NOVA de Lisboa; Unidade de Saúde Pública ACES Porto Oriental	carlosmdmatos@gmail.com
14. Mahault Piéchaud Boura	Timelex	<mahault.piechaud@timelex.eu>

15. Theodoros Trokanas	Hellenic Open University, Thessaloniki Bar Association	<trokanas@mycosmos.gr>
16. Paula Lobato de Faria	ENSP	pa.lobfaria@ensp.unl.pt
17. Andre den Exter	EUR/ENSP	denexter@law.eur.nl
18. Martin Buijsen	EUR/ESHPM	buijsen@law.eur.nl